

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Video Slideshow Presentation from April 18 “Begin Transitioning to ICD-10 in 2013” National Provider Call Now Available

Are you ready to transition to ICD-10? Now is the time to prepare. The Centers for Medicare & Medicaid Services has released a YouTube video slideshow presentation from the April 18 call on “Begin Transitioning to ICD-10 in 2013.” The call presentation is now available on the [CMS YouTube Channel](#) as a video slideshow that includes the call audio. Visit the [April 18](#) call web page for access to all of the related call materials, including the slide presentation, complete audio recording, and written transcript.

MLN Matters® Number: MM8358

Related Change Request (CR) #: CR 8358

Related CR Release Date: January 31, 2014

Effective Date:

Voluntary Reporting Effective January 1, 2014

Mandatory Reporting Effective April 1, 2014

Related CR Transmittal #: R2864CP

Implementation Date: January 6, 2014

Additional Data Reporting Requirements for Hospice Claims

Note: This article was revised on August 31, 2015. For more information on this revision and other revisions, please refer to the “Document History” section in this article.

Provider Types Affected

This MLN Matters® article is intended for hospices submitting claims to Medicare Home Health and Hospice Medicare Administrative Contractors (HH & H MACs)) for services provided to Medicare beneficiaries.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Provider Action Needed

This article is based on Change Request (CR) 8358 which requires additional claim data reporting for hospices to support hospice payment reform as authorized by Section 3132(a) of the Affordable Care Act. Additional data reporting includes visit reporting for general inpatient care, reporting the service facility National Provider Identifier (NPI) where the service was performed when the service is not performed at the same location as the billing hospice's location, and reporting of infusion pumps and prescription drugs.

Specifically, hospices shall report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care. Make sure that your billing staff is aware of these changes.

Background

Over the past several years the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO), and the Office of the Inspector General (OIG) have all recommended that the Centers for Medicare & Medicaid Services (CMS) collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit.

CMS began collecting additional data on hospice claims beginning in January, 2007, when CMS began required reporting of a Healthcare Common Procedure Code System (HCPCS) code on the claim to describe the location where services were provided. (See MLN Matters® article MM5245 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5245.pdf> on the CMS website.)

CMS continued the data collection effort with CR5567 which requires Medicare hospices to, beginning in July 2008, provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. (See the MLN Matters® article MM5567 corresponding to CR5567 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5567.pdf> on the CMS website),

In January 2010, with the issuance of CR6440, CMS required the reporting of visits performed by therapists and certain phone calls made by social workers, who are paid by the hospice, on hospice claims. CR6440 also required that hospices report the length of visits made by nurses, aides, therapists, and social workers (to include certain phone calls made by social workers) who are paid by the hospice, with the associated time per visit (or per social worker call) in the number of 15 minute increments.(See MM6440 at

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf> on the CMS website.)

Effective in October 2010, CR6905 added an additional HCPCS site of service code (Q5010, for hospice home care provided in a hospice facility), to supplement those Q-codes implemented in 2007 with CR5245. (See the MLN Matters® article MM6905 corresponding to CR6905 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6905.pdf> on the CMS website.)

On several occasions, industry representatives have communicated to CMS that the required claims information was not comprehensive enough to accurately reflect hospice care. Industry stakeholders also commented that to understand hospice costs, CMS should consider non-labor costs, as these 1) can be significant, and 2) are largely comprised of data on drugs, Durable Medical Equipment (DME), and medical supplies.

Finally, the Affordable Care Act, Section 3132(a) gives CMS the authority to collect additional data as needed to revise payments for hospice care. This claims data collection will support hospice payment reform. See <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> to view the Affordable Care Act.

CR8358 instructs that Medicare hospices will report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in skilled nursing facilities (site of service HCPCS code Q5004) or in hospitals (site of service HCPCS codes Q5005, Q5007, Q5008). This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for routine home care and continuous home care. It also includes certain calls by hospice social workers (as described in CR6440, Transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for the home levels of care. CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (site of service HCPCS code Q5006). For all visit/call reporting, only report visits/calls by the paid hospice staff; do not report visits by non-hospice staff. See the MLN Matters® article MM6440 corresponding to CR6440 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf> on the CMS website.

Hospices shall report the National Provider Identifier (NPI) of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided, when the site of service is not the billing hospice. In compliance with the 837i requirements, the billing hospice shall report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice's location. When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Hospices shall report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Due to system limitations with reporting services after the date of the death, post mortem visits occurring on a date subsequent to the date of death shall not be reported. Visits occurring after death, and on the date of death, shall be reported using a PM modifier to differentiate them from visits occurring before death. The reporting of post-mortem visits, on the date of death, shall occur regardless of the patient's level of care or site of service. Date of death is defined as the date of death reported on the death certificate. Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.

For example, assume that a nurse arrives at the home at 9 pm to provide routine home care (RHC) to a dying patient, and that the patient passes away at 11 pm. The nurse stays with the family until 1:30 am. The hospice should report a nursing visit with eight 15-minute time units for the visit from 9 pm to 11 pm. On a separate line, the hospice should report a nursing visit with a PM modifier with four 15-minute time units for the portion of the visit from 11 pm to midnight to account for the 1 hour post mortem visit. If the patient passes away suddenly, and the hospice nurse does not arrive until after his death at 11:00 pm, and remains with the family until 1:30 am, then the hospice should report a line item nursing visit with a PM modifier and four 15-minute increments of time as the units to account for the 1 hour post mortem visit from 11:00 pm to midnight.

Hospice agencies shall report injectable and non-injectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injectable prescription drugs shall be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy. Over-the-counter drugs shall not be reported.

When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a system (such as Pyxis) where each administration of a hospice medication is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.

Hospices shall report multi-ingredient compound prescription drugs (non-injectable) using revenue code 0250. The hospice shall specify the same prescription number for each ingredient of a compound drug according to the 837i guidelines in loop 2410. In addition, the hospice shall provide the National Drug Code (NDC) for each ingredient in the compound; the NDC qualifier represents the quantity of the drug filled (meaning the amount dispensed) and shall be reported as the unit measure.

When reporting prescription drugs in a comfort kit/pack, the hospice shall report the NDC of each prescription drug within the package, in accordance with the procedures for non-injectable prescriptions given in this instruction.

Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump and for each medication fill and refill. The hospice claim shall reflect the total charge

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems so long as, in total, the claim reflects the charges for the pump for the time period of that claim. DME other than infusion pumps, and medical supplies, are not to be reported at this time.

Note: CMS is not making any changes to the existing claims requirements for physician services reported on the hospice claim.

Coding for New Required Hospice Claims Reporting:

Hospice staff provided GIP visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + Units of 15 minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008

Other provider NPI reporting: Other Provider Location Loop 2310 E (Only required on the 5010 Electronic Claim). Required for hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 when not the same as the billing hospice, Q5007 and Q5008.

Post-mortem visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments

Injectable drugs: Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled (i.e. if says Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2).

Non-injectable prescriptions: Report on a line-item basis per fill (based on the amount dispensed by the pharmacy), using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and shall be reported as the unit measure.

Infusion pumps: Report on the claim, on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.

Additional Information

The official instruction, CR8358 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Document History

Date	Description
August 27, 2015	The article was revised to add a reference link to MM9255 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9255.pdf) that advises providers that Medicare systems are being revised to allow oral anti-cancer and anti-emetic drugs to be reported on hospice claims as intended by this CR.
February 3, 2014,	The article was revised to reflect the revised CR8358 issued on January 31, 2014. The article was revised to add clarifying language and examples in the "Background" section. In addition, references to legacy contractors were removed. The CR release date, transmittal number, and the Web address for accessing the CR were also revised.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.