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: July 26, 2013

Effective Date:
Voluntary Reporting Effective January 1, 2014
Mandatory Reporting Effective April 1, 2014

Related CR Transmittal #: R2747CP

Implementation Date: January 6, 2014

Additional Data Reporting Requirements for Hospice Claims

Provider Types Affected

This MLN Matters® article is intended for hospices submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

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, CMS required line item reporting on hospice claims, including visit time reporting, and added therapists and social work phone calls to the data collected with CR6440.(See MM6440 at 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 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 or in hospitals. 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. 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. 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.

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:

Coding for GIP reporting: Revenue code 0656 + HCPCS for the discipline + Units of 15 minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008

Coding for NPI reporting: Other Provider Location Loop 2310 E (Only required on the 5010 Electronic Claim)

- The NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving 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 must 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 reports the NPI of the facility where the patient was last treated.

Effective for claims with dates of service on or after April 1, 2014, Medicare will return hospice claims that do not report this new required information in 2310E when the claims have a HCPCS of Q5003, Q5004, Q5005, Q5007, or Q5008.

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

The following modifier is required reporting for claims with dates of service on or after April 1, 2014:

- PM – Post-mortem visits.

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. Post mortem visits occurring on a date subsequent to the date of death are not to be reported. The reporting of post-mortem visits, on the date of death, should occur regardless of the patient's level of care or site of service.

Coding for 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 Q1234 Drug 100mg is supplied and the fill was for 200 mg, units reported = 2).

Coding for Non-injectable Prescriptions: Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and should be reported as the unit measure.

Coding for 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/R2747CP.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.