Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

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Related Change Request (CR) #: 5567
Related CR Release Date: April 29, 2008
Effective Date: January 1, 2008 (optional);July 1, 2008 (mandatory)
Related CR Transmittal #: R1494CP
Implementation Date: January 7, 2008

Reporting of Additional Data to Describe Services on Hospice Claims

Note: This article was revised on May 1, 2008, to reflect that CMS revised CR5567 to suspend temporarily the reporting of visit data from non-hospice staff in contract facilities providing General Inpatient Care. Also, the CR transmittal date, transmittal number, and Web address for accessing CR5567 were changed. These changes were made as CMS re-issued CR5567 on April 29, 2008. All other information remains the same.

Provider Types Affected

Hospices billing Medicare regional home health intermediaries (RHHIs) for hospice services provided to Medicare beneficiaries.

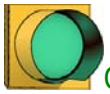
Provider Action Needed


STOP – Impact to You

Effective This instruction, Change Request (CR) 5567, requires hospices to report an **expanded level of claims data** for Medicare payments that describe the services provided in the course of delivering **each hospice level of care billed.**


CAUTION – What You Need to Know

CR 5567 provides instructions for the expansion of required data on hospice claims.



GO – What You Need to Do

Make certain that your billing staffs are aware of these changes as listed in the *Key Points* below and in the revisions to the *Medicare Claims Processing Manual* chapter 11, sections 30.1 and 30.3. The revised manual sections are attached to the official instruction in CR5567. The Web address for accessing CR5567 is in the *Additional Information* section of this article.

Background

Historically, billings by institutional providers to Medicare fiscal intermediaries contained limited service line information. Claim lines on a typical institutional claim in the 1980s or early 90s may have reported only a revenue code, a number of units, and a total charge amount.

Over the last decade, legislated payment requirements have changed and Medicare has implemented increasingly complex payment methods. These changes have required more line item detail on claims for most institutional provider types, such as line item dated services, reporting HCPCS codes and modifiers, and submission of non-covered charges. This detail has supported the payment requirements of legislated payment systems and also improved the quality and richness of Medicare analytic data files.

Hospice claims have been an exception to this process. Since the inception of the hospice program in 1983, hospices have been required to submit on Medicare claims only a small number of service lines to report the number of days at each of the four hospice levels of care. HCPCS coding was required only to report procedures performed by the beneficiary's attending physician if that physician was employed by the hospice. The Centers for Medicare & Medicaid Services (CMS) believes that this limited claims data has restricted Medicare's ability to ensure optimal payment accuracy in the hospice benefit, and to carefully analyze the services provided in this growing benefit.

Key Points

Effective for service dates on or after January 1, 2008, hospice providers may begin to report data on their claims for Medicare payments that describe the services provided in the course of delivering each hospice level of care billed. As of July 1, 2008, such reporting is mandatory. Specifically:

For each week, beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of services/visits provided by nurses (registered, licensed and/or nurse practitioner), home health aides, social workers, physicians, and nurse practitioners serving as the beneficiary's attending physician.

- Each line shall reflect the total number of direct patient care visits for each category and not as an aggregate total for all.
- A service/visit constitutes direct care to the beneficiary. An entry in a medical record without a visit does not constitute a visit and as such is not counted.
- Rounds in facilities do not constitute a visit and as such are not counted. Items and services provided within a visit are not counted as separate items.
- Only the number of direct patient care visits are counted and all items and services within that visit are not separately counted.
- If the site of service changes, a separate line will be required to reflect the site where the direct patient care visit was made.
- To be counted a service/visit must be medically reasonable and necessary and this applies in circumstances where separate billing for physician or nurse practitioner, serving as the attending physician.
- For the nurse, home health aide and social worker, the weekly total of services/visit by discipline are not for the purpose of separate payment but to provide transparency into the services that are being provided to beneficiaries who are electing the Medicare hospice benefit.
- CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care in contract facilities.

Codes

Effective on claims with dates of service on or after January 1, 2008, hospices may report the services (effective July 1, 2008, reporting is mandatory) that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes listed below.

- Medicare systems will allow revenue codes 055X, 056X and 057X on types of bill 81X and 82X.
- Medicare systems require 055X, 056X and 057X revenue code lines reported on types of bill 81X and 82X to contain units and charges.
- Medicare systems will accept one or more 055X, 056X or 057X revenue code lines associated with each hospice level of care revenue code (651, 652, 655, 656).
- Medicare systems will accept for each hospice level of care revenue code that there is one or more 055X, 056X or 057X revenue code lines with a date of service equal to or later than the date of that level of care revenue code and prior to the date of the next level of care revenue code. Medicare systems will not make payment on 055X, 056X or 057X revenue code lines.

- Medicare systems will reflect the charges associated with each 055X, 056X or 057X revenue code as paid under the all-inclusive payment for the associated level of care revenue code line and Medicare systems will change any charges and units associated with each 055X, 056X, or 057X revenue code to be non-covered.
- Medicare systems will reflect bundling of services into level of care revenue codes on the remittance advice with reason code 97. Reason code 97 is defined as "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."
- Medicare systems will not allow reporting of V-codes as the principal diagnosis on hospice claims and will return claims to the provider if a V-code is reported as the principal diagnosis.

Special Reminder: The site of service code Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay, while Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.

The revised manual section 30.3 also contains clarification for the entry of other fields on the claim as well and providers should review this revised section to assure accurate claims submission. Note that the last sentence of the revenue codes portion of section 30.3 states that the information is being collected for purposes of research and will not affect the amount of reimbursement.

Additional Information

For complete details regarding CR5567, please see the official instruction, including the revised sections of the *Medicare Claims Processing Manual*, issued to your Medicare RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1494CP.pdf* on the CMS website.

If you have questions, please contact your Medicare RHHI, at their toll-free number which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

Transmittal 1011 (Change Request (CR) 5245) was implemented effective January 1, 2007 and that transmittal represented a first phase in the expansion of line level detail information requirements on hospice claims. It required codes describing the location where hospice levels of care were delivered and created line item dating requirements for continuous home care level of care. CR5245 can be viewed at

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf on the CMS website.