MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Physicians and non-physician practitioners in all States and Washington, D.C. can now use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet. CMS will make Internet-based PECOS available next year to organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers). For information about Internet-based PECOS, including important information that physicians and non-physician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* on the CMS website.

MLN Matters® Number: MM6440 Revised

Related Change Request (CR) #: 6440

Related CR Release Date: May 15, 2009

Effective Date: October 1, 2009 for **optional reporting** by hospices and January 1, 2010 for mandatory reporting by hospices

Related CR Transmittal #: R1738CP

Implementation Date: October 5, 2009

Additional Data Collection on Hospice Claims

Note: This article was revised on May 18, 2009, to reflect a revised CR 6440, which was issued on May 15, 2009. The article was revised to amend the language on page 3 that discusses the reporting of time in 15 minute increments. The CR transmittal number, release date, and Web address were also revised. All other information remains the same.

Provider Types Affected

Hospices billing Regional Home Health Intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs) for providing routine home care, continuous home care, or respite care to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

Effective January 1, 2010, hospices must report additional detail for visits with the appropriate Revenue Codes (RCs) and HCPCS codes, or their claims will be returned.

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.

CAUTION – What You Need to Know

Change Request (CR) 6440, from which this article is taken, requires hospices (effective January 1, 2010) to report additional data on claims for Medicare payment that describe the services provided when delivering routine home care, continuous home care, and respite care.

GO – What You Need to Do

You should make sure that your billing staffs are aware of these new requirements. See the Background section for details.

Background

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

In response, CMS began collecting additional data on hospice claims beginning in January 2007 with CR 5245, which required the reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services were provided. CR 5245 also required reporting of continuous home care time in 15-minute increments. (You can find the MLN Matters® article related to CR 5245 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf* on the CMS website).

In April 2008, CMS issued CR 5567, requiring Medicare hospices (effective July 2008) to provide detail on claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. (You can find the MLN Matters® article related to CR 5567 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf* on the CMS website).

Since then, MedPAC and industry representatives have informed CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care, and this restricts Medicare's ability to ensure optimal payment accuracy in the hospice benefit. Of particular concern, was the fact that CMS was not requiring that visit intensity be reported. Reporting visit intensity would improve Medicare's ability to analyze the services provided in this growing benefit.

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Reporting Requirements

CR 6440, from which this article is taken, requires that (effective January 1, 2010) hospices begin to report additional detail for visits on their claims. Specifically, on a separate line on your claims for all Routine Home Care (RHC), Continuous Home Care (CHC), and Respite care billing, you must report:

- Each visit performed by nurses, aides, and social workers, whom you employ, along with their associated time per visit (in 15-minute increments) with the time reported using the associated HCPCS G-code as follows:
  - Revenue Code 055x (nursing services) with HCPCS G0154,
  - Revenue Code 057x (aide services) with HCPCS G0156, or
  - Revenue Code 056x (medical social services) with HCPCS G0155.
- Each RHC, CHC, and Respite visit that physical therapists, occupational therapists, and speech-language therapists performed and their associated time per visit (in 15-minute increments), with the time reported using the associated HCPCS G-code as follows:
  - Revenue Code 042x (physical therapy) with HCPCS G0151,
  - Revenue Code 043x (occupational therapy) with HCPCS G0152, or
  - Revenue Code 044x (speech language therapy) with HCPCS G0153.
- Report each telephone call that social workers made to the patient or the patient's family using Revenue Code 0569 and HCPCS G-code G0155 for the length of the call, with each call being a separate line item. Report only those telephone calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care (such as counseling or speaking with a patient's family or arranging for a placement). Report only social worker phone calls related to providing and or coordinating care to the patient and family, and documented as such in the clinical records.

When recording any visit or social worker phone call time, you should sum the time for each visit or call, rounding to the nearest 15-minute increment and report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. Do not include travel time or documentation time in the time recorded for any visit or call. Additionally, you may not include interdisciplinary group time in time and visit reporting.

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The following table displays these new reporting requirements.

Data Collection Requirements for Hospices Delivering Routine Home Care, Continuous Home Care, and Respite Care Effective January 1, 2010		
Revenue Code	Required HCPCS Code	Required Detail
042x Physical Therapy	G0151	Identify each visit, or social worker phone call, on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
043x Occupational Therapy	G0152	
044x Speech Therapy – Language Pathology	G0153	
055x Skilled Nursing	G0154	
056x Medical Social Services	G0155	
056x Other Medical Social Services	G0155	
057x Aide	G0156	

Note: Effective January 1, 2010, Medicare contractors will return your claims that do not contain Revenue Codes 0655 and 0656, but DO contain one or more of visit revenue codes 042x, 043x, 044x, 055x, 056x, or 57x without the appropriate HCPCS code. They will also return claims containing revenue code 0569 when billed without HCPCS code G0155.

Additional Key Points in CR6440

- Charges associated with the reported Revenue Codes 42x, 43x, 44x, 55x, 56x, and 57x are covered under the hospice bundled payment and are reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines. These visit charges will be identified on the provider remittance advice notice with reason code 97 ("Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated.") and code CO (Contractual Obligation).

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- If a hospice patient is receiving Respite care in a contract facility, you should not report visit and time data by non-hospice staff.
- Billing of physician visits to hospice patients is not changing, and is unaffected by CR 6440.
- Data on claims for chaplains/spiritual counselors or volunteers will not be collected at this time, but reporting of this data will be in a future phase of the data collection.
- For General Inpatient (GIP) care, the reporting of visit intensity data is not required at this time. Providers should continue to report the number of GIP visits in accordance with CR 5567. Additionally, the units for visits under GIP level of care continue to reflect the number of visits per week, and visit reporting by non-hospice staff is exempted when hospice patients in a contract facility are receiving GIP

Additional Information

You can find more information about the additional data collection requirements on hospice claims by going to CR 6440, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1738CP.pdf* on the CMS website. You will find the updated *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.3 (Data Required on Claim to FI) as an attachment to that CR.

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

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