MEDICARE HOSPICE BILLING 2014 & BEYOND!

New Hospice Claims Data Requirements & Clarifications

New Hospice Claim Requirements

- General Inpatient Care (GIP) Visits
- Inpatient Facility Identification
- Post-Mortem Visits
- Injectable Drugs
- Non-Injectable Drugs
- Infusion Pumps

General Inpatient (GIP) Visit Changes

- Claims must report line item visits provided to patients receiving GIP
  - Only by hospice employed personnel
  - Includes visits by all billable disciplines of service:
    - Nurses, aides, social workers, social worker phone calls, & physical, occupational & speech-language pathologists
    - *Visit reporting the same as for routine & continuous home care*
- Includes visits provided to patients in billable GIP locations
  - Q5004 skilled nursing facility (SNF)
  - Q5005 inpatient hospital
  - Q5007 long term care hospital
  - Q5008 inpatient psychiatric facility
- Visits must be reported in 15-minute increments

General Inpatient (GIP) – Q5006

- **Inpatient hospice facility** patients receiving GIP excluded from line-item reporting requirement
  - Q5006 = HCPCS location code
  - No changes to current visit reporting requirements
    - Visits remain reported by week

GIP UB04 Claim Detail - 2014

GIP - Facility OTHER THAN Hospice Inpatient Facility

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2

GIP - Hospice Inpatient Facility

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- Inpatient Hospice	Q5006	060114	2
0551	Skilled Nursing	G0154	060114	2

Inpatient Facility Identification

- **Claims must report inpatient facility NAME, ADDRESS & National Provider Identifier (NPI) number**
  - Only when facility is different than provider submitting claim
- **Includes claims billed with inpatient locations:**
  - Q5003 Nursing facility (NF), patient receiving unskilled care
  - Q5004 SNF, patient receiving skilled care
  - Q5005 inpatient hospital
  - Q5006 inpatient hospice facility, only if facility is not same as hospice submitting claim
  - Q5007 long term care hospital
  - Q5008 inpatient psychiatric facility

Inpatient Facility Identification

- Reported in HIPAA 5010 electronic claim format - 'Other Provider Location Loop 2310 E'
- Claims billed with inpatient facility location codes will be returned (RTP) ("T" Status) for corrections if inpatient facility identifying information missing
- 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.

Page 3 – DDE Entry Hospice

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MAP1713   PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
AB01CD    SC               INST CLAIM ENTRY                  C201413F HH:MM:SS
 HIC               TOB       S/LOC          PROVIDER
 NDC CODE                                                   OFFSITE ZIPCD:
  CD ID     PAYER                    OSCAR        RI AB                EST AMT DUE
 A
 B
 C
 DUE FROM PATIENT                             SERV FAC NPI
 MEDICAL RECORD NBR                     COST RPT DAYS       NON COST RPT DAYS
 DIAG CODES 01            02            03            04            05
 06             07            08            09                END OF POA IND
 ADMITTING DIAGNOSIS            E CODE            HOSPICE TERM ILL IND
 IDE
 PROCEDURE CODES AND DATES 01                 02
 03                 04                 05                 06
 ESRD HOURS      ADJUSTMENT REASON CODE     REJECT CODE       NONPAY CODE
 ATT PHYS        NPI                L                     F           M    SC
 OPR PHYS        NPI                L                     F           M    SC
 OTH OPR         NPI                L                     F           M    SC
 REN PHYS        NPI                L                     F           M    SC
 REF PHYS        NPI                L                     F           M    SC
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Inpatient Facility Identification

- **Q&A #15 -**Slide 13 (ACT teleconference) indicates claims billed with HCPCS Q5003, Q5004, Q5005, Q5007 or Q5008, will be returned when a facility NPI is not reported. What about Q5006?

- **Answer:** This Change Request requires a facility NPI when the service is not performed at the same location as the billing hospice's location. The HCPCS Q5006 indicates "hospice care provided in inpatient hospice facility", which could be the billing hospice's facility. Therefore, claims will not be returned if the NPI is not reported with the HCPCS Q5006.

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

Post–Mortem Visits

- Claims must report post-mortem visits when occurring **on date** of death - after **time** of death
  - *Date of death is defined as the date of death that is reported on the death certificate*
  - Includes visits performed by hospice employed nurses, aides, social workers & therapists
    - **Regardless of level of care or site of service**
  - Requires visits to be reported in 15-minute increments

Post–Mortem Visits

- Requires modifier code "PM"
- Requires split visit billing if death occurs during visit
  - *Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.*
- Excludes visits occurring on dates after the date of death

- **Q&A #5 -** Would an on call nurse pronouncement visit be considered a post-mortem visit?
- **Answer:** Any time prior to the pronouncement would be reported as an actual visit. Time from the pronouncement and beyond would be reported as a post-mortem visit.

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

CGS 2014 Q&A – Reviewed 11/30/13

- **Q&A #28 -** If a post-mortem nurse visit begins at 11:15 pm and lasts until 12:30 am, would that be counted as 5 increments of 15 minutes then, because it started on the date of death even though it extended into the following day?
- **Answer:** Post-mortem visits should reflect the duration of the visit that occurred on the date of death. Any visit time for the day **following the date of death cannot be reported**. So in this example, the post-mortem visit would be reported as 3 units, which is equivalent of 45 minutes – from 11:15 p.m. until midnight.

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

CMS 2014 Q&A – Revised

- **Q&A #12**- Does the patient's body have to be present to report a post-mortem visit?
- **Answer:** The patient's body does not need to be present to report a post-mortem visit. While hospice staff may have to deal with the patient's body during a post-mortem visit, hospice care is also provided post-mortem to the family. This includes all visit disciplines that are currently reported by hospice providers.

CMS 2014 Q&A – Revised

- **Question #13: Do we have to report post mortem visits for patients who die while in the GIP level of care at a hospice inpatient facility?**
- **Answer:** For visit reporting for GIP in a hospice inpatient facility, you will continue to follow the instructions in CR5567. These visits are reported weekly (Sunday-Saturday) and do not utilize the HCPCS G-codes. Since line item visit reporting is not applicable for GIP in a hospice inpatient facility (Q5006), post mortem visits would not be reported either.

GIP UB04 Claim Detail - 2014

GIP - Facility with Post-Mortem Visit

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2
0551	Skilled Nursing-Post-Mortem	G0154PM	060314	5

GIP - Facility with SPLIT Post-Mortem Visit

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2
0551	Skilled Nursing	G0154	060314	2
0551	Skilled Nursing-Post-Mortem	G0154PM	060314	3

Injectable Drugs

- Claims must report injectable prescription drugs
  - Requires line-item reporting on claim per fill
  - Requires revenue code 0636
  - Requires applicable HCPCS code
  - Requires applicable units
    - Should represent amount filled based on drug & HCPCS definition
  - Requires charge amount
- Excludes over-the-counter (OTC) drugs

GIP UB04 Claim Detail - 2014

GIP - Facility with Injectable Drugs

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2
0636	Inj – Lorazepam, 2 mg	J2060	060214	2

CGS 2014 Q&A – Reviewed 11/30/13

- **Q&A #19** - Are we required to report all the injectable drugs and PO drugs, and show the breakdown of the cost for the drugs?
- **Answer:** Hospice are required to report injectable and non-injectable drugs provided to the patient, along with a charge that reflects the associated costs to your agency for providing that drug. A drug given by mouth would be considered a non-injectable drug.

- **Q&A #3** - Do we have to report any drugs taken by a patient that the hospice is not paying for?
- **Answer:** No, if the patient is taking a drug that was not supplied by the hospice, the hospice would not report the drug on the claim.

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

Non-Injectable Drugs

- Claims must report non-injectable prescription drugs (excludes OTC drugs)
  - Requires line-item reporting on claim per fill
  - Requires revenue code 0250
  - Requires National Drug Code (NDC) qualifier
  - HCPCS code not required
  - Requires applicable units
    - Should represent **amount filled** based on drug definition
  - Requires charge amount

GIP UB04 Claim Detail - 2014

GIP - Facility with Non-Injectable & Injectable Drugs

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2
0636	Inj – Lorazepam, 2 mg	J2060	060214	2
0250	N400172375760UN100	(not applicable)	060214	1

- Begin by entering the qualifier N4 immediately followed by the 11-digit NDC code.
- The NDC codes must be in the 5-4-2 format required by HIPAA guidelines, do not report hyphens. It may be necessary to pad NDC numbers with zeroes in order to report eleven digits.
- Next enter the two digit unit of measurement qualifier immediately followed by the. numeric quantity administered to the patient (amount of fill). **Measurement Qualifiers:**
  F2 International Unit - - GR Gram - - ML Milliliter - - UN Units

Keying Non-Injectable Drugs in DDE

```
MAP171E   PAGE 02
XXX1111   SC                    INST CLAIM ENTRY
                                                    NDC CD PAGE 01
 HIC XXXXXXXXXXA     TOB 8X2   S/LOC S B0100   PROVIDER XXXXXX

            CL     NDC FIELD        NDC QUANTITY      QUALIFIER
            1     12345678901            1.000            GR
 LLR NPI                L                   F              M     SC
            2
 LLR NPI                L                   F              M     SC
            3
 LLR NPI                L                   F              M     SC
            4
 LLR NPI                L                   F              M     SC
            5
 LLR NPI                L                   F              M     SC
            6
 LLR NPI                L                   F              M     SC
            7
 LLR NPI                L                   F              M     SC
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CR 8358 Revisions – 01/31/14

- **Q&A #14 -** How are drugs billed when they are dispensed individually from a med room at a facility? (CGS Q&A)
- **Answer:** *When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a medication management system 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. (CMS - CR 8358 – 01/31/14)*
- ***New Clarification*** *- 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.*

CR 8358 Revisions – 01/31/14

- ***New Clarification*** *- 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 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.*

Infusion Pumps

- Claims must report infusion pumps
  - Requires line-item reporting on claim per each pump order
  - Requires revenue codes 029X
    - 0290 for general equipment classification
    - 0291 for rental
    - 0292 for purchase of new equipment
    - 0293 for purchase of used equipment
    - 0299 for other equipment
  - Requires applicable HCPCS code
  - Requires applicable units
  - Requires charge amount

Infusion Pumps

- Claims must also report related medication necessary for effective use of pump
  - Requires line-item reporting per medication fill
  - Requires revenue code 0294
  - Requires applicable HCPCS code
  - Requires applicable units
    - Should represent amount filled based on drug definition
  - Requires charge amount
- Excludes OTC drugs & nutrition

GIP UB04 Claim Detail - 2014

GIP - Facility with Injectable Drugs & Infusion Pump

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS	45 SERV. DATE	46 SERV. UNITS
0656	GIP- SNF	Q5004	060114	2
0551	Skilled Nursing	G0154	060114	3
0551	Skilled Nursing	G0154	060214	2
0636	Inj – Lorazepam, 2 mg	J2060	060214	2
0291	Infusion Pump Rental	E0738	060214	1
0294	Infusion – Saline 1000cc	J7030	060214	1

CGS 2014 Q&A – Reviewed 11/30/13

- **Q&A #17 -** I understand that we do not have to report TPN, but do we report the pump used to administer the TPN?
- **Answer:** The CR states that "hospice agencies shall report infusion pumps." If you are using an infusion pump to administer the TPN, the infusion pump should be reported.
- **Q&A #16** - Is DME required to be reported with this Change Request?
- **Answer:** This CR states "DME other than infusion pumps, and medical supplies are not to be reported at this time."

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

Hospice Coding Edits & Issues

Symptoms, Signs & Ill-Defined Conditions

- CMS has stated that the following are NOT acceptable as Primary Diagnosis for Hospice (edits in place 10/01/14)
  - 783.41 Failure to thrive
  - 783.7 Adult failure to thrive
  - 799.3 Debility Unspecified
  - 799.89 Other ill-defined conditions
  - 799.9 Other unknown and unspecified cause of morbidity or mortality
- "Symptoms, Signs, and Ill-Defined Conditions", such as "debility" or "adult failure to thrive," does not encompass the comprehensive, holistic nature of the assessment and care to be provided under the Medicare hospice benefit.

Coding Edits for Primary Diagnosis

- "claims received with these codes in the principal diagnosis field will be returned to the provider for more definitive coding of the principal diagnosis and additional diagnoses, effective for claims dated on or after October 1, 2014. This will not affect claims submitted before October 1, 2014. "Debility" and "adult failure to thrive" may be reported on the hospice claims as additional diagnoses in the appropriate claim fields. Although claims will not be returned to the provider until the start of FY 2015, we remind hospices that they are currently, and have always been, required to code *all* related diagnoses in the additional coding fields on the hospice claim and thus should be doing so now."

*Federal Register Center for Medicare & Medicaid Services42 CFR Part 418 Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Final Rule

Related Conditions Defined

- Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness.

  *Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615

- CMS' Hospice Claims Processing manual requires that hospice claims include other diagnoses "as required by ICD-9-CM Coding Guidelines" (IOM 100-04, chapter 11, section 30.1, available at): *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf*

Coding Guidelines – Hospice

- "Other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:
  - Clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.

  *Official Guidelines for Coding and Reporting

- Hospices should report on hospice claims all coexisting or additional diagnoses *that are related to* the terminal illness; they should not report coexisting or additional diagnoses that are unrelated to the terminal illness.

  *Coding Clinic - AHIMA

CGS – Widespread Edit - Hospice

Edit Number	Description
5037T	This edit selects hospice claims with revenue code 0651 (Routine) and a length of stay of greater than 730 days.
5057T	This edit selects hospice claims with revenue code 0656 (General Inpatient Services [GIP]) with at least seven or more days in a billing period.
5091T	This edit selects hospice claims with HCPC codes Q5003 (Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)) and Q5004 (Hospice care provided in skilled nursing facility (SNF)), ***for any non-oncologic diagnosis code*** and a length of stay greater than 180 days.
5118T	This edit selects hospice claims for beneficiaries in identified states with length of stay between 150-365 days and non-oncologic diagnosis codes.
59BX9	This edit selects hospice claims due to previous denials for selected beneficiary.

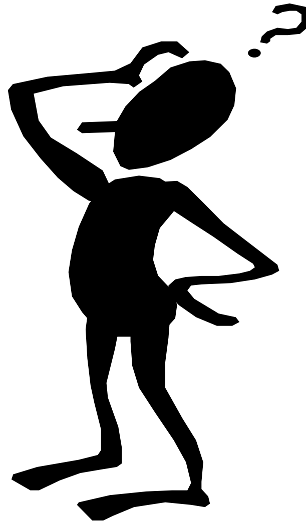
****Previous edit **5091T** targeted at "debility, unspecified" had highest denial rate last quarter (2013) of 61% for reason 5PTER, six-month terminal prognosis not supported. Edit now targets all non-oncologic diagnosis codes.

Source: CGS
http://www.cgsmedicare.com/hhh/medreview/med_review_edits.html

Coding Hospice Update - 2014

- Review all clinical documentation
- Consult hospice physicians to determine whether more appropriate principal diagnosis code should be used
- Implement processes & claim edits for ongoing monitoring of primary diagnosis coding

Questions



Thank You For Coming!

Please fill out evaluation forms!

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