# *2014 Hospice Billing Changes: New Data Requirements*

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BKD LLP
CPAs & Advisors

**M. Aaron Little,** CPA
Managing Director | Springfield, MO
mlittle@bkd.com

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## NEW CLAIM REQUIREMENTS

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## NEW CLAIM REQUIREMENTS

// Centers for Medicare & Medicaid Services (CMS) ***Change Request** (CR) **8358***

// Original document dated July 26, 2013

// http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Transmittals-Items/Hospice-CR8358-R2747CP.html

// Revised document dated January 31, 2014

// http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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## NEW CLAIM REQUIREMENTS

// Latest information available through Medicare Administrative Contractors (MACs)

// CGS

// http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

// Palmetto GBA

// http://www.palmettogba.com/palmetto/providers.nsf/ls/Jurisdiction%2011%20Home%20Health%20and%20Hospice~9H3NHM8217?opendocument&utm_source=J11HHHL&utm_campaign=J11HHHLs&utm_medium=email

// NGS

// http://www.ngsmedicare.com/ngs/wcm/connect/295b3338-c5b6-42fd-bd63-9d26bb13c8de/1530_0314_CR_8358_QA_Summary_Final_508.pdf?MOD=AJPERES&useDefaultText=0&useDefaultDesc=0

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## NEW CLAIM REQUIREMENTS

// Voluntary reporting began with claim dates of service ***January 1, 2014***

// Mandatory reporting effective for claims with dates of service ***April 1, 2014*** & thereafter

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## NEW CLAIM REQUIREMENTS

// General inpatient care (GIP) visits

// Inpatient facility identification

// Port-mortem visits

// Injectable drugs

// Non-injectable drugs

// Infusion pumps

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## GIP VISITS

- Claims must now itemize billable visits & calls provided to patients receiving GIP
  - Only by hospice employed personnel
  - Includes all billable disciplines of service
    - Nurses, aides, social worker visits & phone calls, & physical, occupational & speech therapy
      - No changes to visit definitions
- ***Exception***: Does not apply to visits & calls performed in hospice inpatient facility during GIP
  - No changes to current GIP service reporting requirements
    - Visits & calls remain reported in summary totals by week by discipline
- New requirements do not impact claim payment

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# GIP VISITS

// New claim coding requirements

- // Visits & calls must be itemized in 15-minute increments when occurring in billable GIP locations
  - // Applies when GIP level of care is billed with the following HCPCS location codes
    - // Q5004 skilled nursing facility (SNF), patient receiving skilled care
    - // Q5005 inpatient hospital
    - // Q5007 long term care hospital
    - // Q5008 inpatient psychiatric facility
- // ***Does not*** apply when GIP billed during inpatient hospice facility stay
  - // HCPCS location code Q5006

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# GIP VISITS

**B. Policy:** Medicare hospices shall 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 CR 6440, Transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for routine home care and continuous home 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.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than General Inpatient (GIP) care in 15 minute increments using the following revenue codes and associated HCPCS. *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 routine home care and continuous home care. This also includes certain calls by hospice social workers (as described further below).*

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http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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# GIP VISITS

// Claim example one

// GIP billed during non-inpatient hospice facility stay

// Visits itemized by line by service date

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0656 | GIP - hospital | Q5005 | 040114 | 3 | 2100: 00 |
| 2 | 0551 | SN visit - employed | G0154 | 040114 | 4 | 200: 00 |
| 3 | 0551 | SN visit - employed | G0154 | 040214 | 6 | 200: 00 |
| 4 | 0551 | SN visit - employed | G0154 | 040314 | 7 | 200: 00 |
| 5 | 0001 | Total charges | | | 20 | 2700: 00 |

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# GIP VISITS

// Claim example two

// GIP billed during inpatient hospice facility stay

// No change to claim reporting

// Visits still summarized by week by discipline

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0656 | GIP - hospital | Q5006 | 040114 | 3 | 2100: 00 |
| 2 | 0551 | SN visit - employed | | 040114 | 3 | 600: 00 |
| 3 | 0001 | Total charges | | | 6 | 2700: 00 |

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# GIP VISITS

## // Frequently asked questions (FAQs)

3. Does the visit reporting discussed in CR8358 only apply to GIP services or does it also include RHC services?

**Answer:** The visit reporting rules for RHC, CHC, and inpatient respite levels of care are outlined in CR6440. The visit reporting rules in CR8358 apply to the GIP level of care in a skilled nursing facility (SNF) or hospital. You will continue to follow CR5567 when providing GIP in an inpatient hospice unit. Per CR5567, for GIP visits provided in an inpatient hospice unit, you will report the total number of visits performed by nurses, aides, and social workers who are employed by the hospice for each week while in the GIP level of care. Below is a chart to assist you in the appropriate reporting rules for GIP visits based on service location:

| HCPCS | Definition | CR | Visit Reporting Description |
|---|---|---|---|
| Q5004 | Hospice care provided in SNF | 8358 | Report each visit with associated HCPCS G-code |
| Q5005 | Hospice care provided in inpatient hospital | 8358 | Report each visit with associated HCPCS G-code |
| Q5006 | Hospice care provided in inpatient hospice facility | 5567 | Report total number of visits per week (no HCPCS G-code) |
| Q5007 | Hospice care provided in long term care hospital (LTCH) | 8358 | Report each visit with associated HCPCS G-code |
| Q5008 | Hospice care provided in inpatient psychiatric facility | 8358 | Report each visit with associated HCPCS G-code |

13 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# GIP VISITS

8. For GIP provided in SNFs or hospitals, hospices must report visits. If we are using an inpatient unit run by a different hospice, do we have to report these visits following CR8358 as well?

CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (Q5006). You will continue to report the total number of visits per week performed by nurses, aides, and social workers, who are employed by the hospice following the instructions implemented in CR5567.

9. Do we have to report therapy visits by employed and contracted therapists? Or only visits provided by employed therapists?

You will report the therapy visits for hospice-employed therapists and contracted therapists. You will not report visits by non-hospice staff when provided in a contracted facility.

10. Social worker phone calls will be reported regardless of length of phone call. I'm assuming that is only if the social worker spoke to someone and will not be reported if they left a voice mail. Is this correct?

CR6440 states, "Only phone 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) should be reported." Since the social worker wasn't able to make contact with the needed party, the call should not be reported.

14 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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## INPATIENT FACILITY IDENTIFICATION

- Claims must now report inpatient facility identifying information, when applicable
  - Applies to all levels of care when patient receives hospice care in inpatient facility
- ***Exception***: Does not apply if hospice submitting claim has same provider number as inpatient facility
- New requirements do not impact claim payment

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# INPATIENT FACILITY IDENTIFICATION

- New claim coding requirements
  - Varies whether submitting HIPAA compliant 837 file or entering claim directly into Direct Data Entry (DDE)/Fiscal Intermediary Standard System (FISS)
    - HIPAA compliant 837 claim requirements
      - Facility National Provider Identifier (NPI) number
      - Facility name & address
      - Reported in HIPAA 5010 electronic claim format 'Other Provider Location Loop 2310 E'
    - DDE/FISS claim requirements
      - NPI number only

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# INPATIENT FACILITY IDENTIFICATION

- Applies to all claims billed with inpatient HCPCS locations codes
  - 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 different from hospice submitting claim
  - Q5007 long term care hospital
  - Q5008 inpatient psychiatric facility

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# INPATIENT FACILITY IDENTIFICATION

- Claims billed with HCPCS codes indicating hospice services were provided in inpatient facility will be returned (RTP'd) for corrections if inpatient facility identifying information is not coded on claim
  - Includes
    - Q5003 NF, patient receiving unskilled care
    - Q5004 SNF, patient receiving skilled care
    - Q5005 inpatient hospital
    - Q5007 long term care hospital
    - Q5008 inpatient psychiatric facility
  - ***Excludes***
    - Q5006 inpatient hospice facility

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# INPATIENT FACILITY IDENTIFICATION

*Hospices shall report the 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. The billing hospice shall obtain the NPI for the facility where the patient is receiving care and report the facility's name, address and NPI on the 837I electronic claim format in loop 2310 E Service Facility 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. Failure to report this information for claims reporting place of service HCPCS Q5003 (long term care nursing facility), Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5007 (long term care hospital) and Q5008 (inpatient psychiatric facility) with dates of service on or after April 1, 2014, will result in the claim being returned to the provider.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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# INPATIENT FACILITY IDENTIFICATION

// New DDE/FISS data entry field

```
MAP1713   PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052 01/21/14
          SC               INST CLAIM INQUIRY                C201413F 08:01:49
HIC                TOB 821  S/LOC S B9099  PROVIDER
NDC CODE                                                OFFSITE ZIPCD:
 CD  ID    PAYER                      OSCAR        RI AB          EST AMT DUE
A Z        MEDICARE                                  Y Y                0.00
B                                                                       0.00
C                                                                       0.00
DUE FROM PATIENT          0.00         0.00   SERV FAC NPI  1033296397
MEDICAL RECORD NBR                      COST RPT DAYS      NON COST RPT DAYS
DIAG CODES 01 3310       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 00  ADJUSTMENT REASON CODE     REJECT CODE          NONPAY CODE
ATT PHYS         NPI                 I                   F FREDERIC  M     SC 38
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 DAVID     M     SC 11
      PROCESS COMPLETED   ---    PLEASE CONTINUE
     PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV   PF8-NEXT
```

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# INPATIENT FACILITY IDENTIFICATION

// FAQs

14. If we enter our claims directly in the Fiscal Intermediary Standard System (FISS)/Direct Data Entry (DDE) the NPI reporting is not required, correct?

The NPI is required on the 5010 Electronic Claim in loop 2310E (the NPI qualifier goes in data element NM108 and the NPI goes in NM109). The NPI is also required in DDE. Note that a new field has been added to claim page 3 to accommodate this new reporting requirement (see screenshot below). However, this is not a requirement for paper claims (UB04).

```
MAP1713  PAGE 03
 XXX1111  SC                INST CLAIM ENTRY
 HIC XXXXXXXXXA   TOB 8X2   S/LOC S B0100   PROVIDER XXXXXX
                                                 OFFSITE ZIPCD:
  CD  ID   PAYER                    OSCAR        RI AB          EST AMT DUE
A Z        MEDICARE                                X
B
C
DUE FROM PATIENT
                                                SERV FAC NPI XXXXXXXXX
MEDICAL RECORD NBR                      COST RPT DAYS    NON COST RPT DAYS
DIAGNOSIS CODES  1 XXXXX     2            3            4            5
      6              7            8            9              END OF POA IND
ADMITTING DIAGNOSIS          E CODE             HOSPICE TERM ILL IND
IDE
PROCEDURE CODES AND DATES  1                  2
 3                  4                5                6
NDC CODE
ESRD HOURS      ADJUSTMENT REASON CODE      REJECT CODE          NONPAY CODE
ATT PHYS         NPI XXXXXXXXXX    LN DOCTOR                FN  IMA      MI SC 99
OPR PHYS         NPI               LN                       FN           MI SC
OTH PHYS         NPI XXXXXXXXXX    LN PHYSICIAN             FN  ISA      MI SC

PROCESS COMPLETED --- PLEASE CONTINUE
                PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT
```

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# INPATIENT FACILITY IDENTIFICATION

15. What will happen if you report the NPI of a hospice inpatient unit that is the same as the hospice facility?

If the patient is in your own inpatient-hospice unit, the NPI should not be reported. The claim will still process through if you report the NPI of your own inpatient facility.

16. Does the NPI need be reported for all levels of care provided at a nursing facility (NF), SNF, Hospital, or Hospice Inpatient facility?

Under CR8358, regardless of the level of care provided, you will report the NPI, facility name, and address of any SNF, NF, hospital, or hospice inpatient facility where the patient is receiving services when the service is not performed at the same location as the billing hospice's location (i.e., your own hospice-inpatient facility). This is required for any hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 (when not the same as the billing hospice), Q5007 and Q5008, unless it is a paper claim.

17. I was informed that one of the hospitals we contract with does not have an NPI as they only accept commercial insurance patients. How do handle this since there is no NPI to report?

NPIs are assigned for every provider, regardless of the payer source. They are a HIPAA requirement and an industry standard. Additionally, per the 42 Code of Federal Regulations (CFR) Chapter IV, Part 418, section 418.108- *Condition of participation: Short-term inpatient care*, inpatient care must be available for pain control, symptom management, and respite purposes, AND must be provided in a participating Medicare or Medicaid facility. A hospice cannot contract with a hospital that is not Medicare/Medicaid certified.

18. Do we report the NPI of our own hospice inpatient facility if it isn't at the same physical location as our hospice agency?

For hospice inpatient facilities, you will only report the NPI if you are using another hospice agency's inpatient hospice facility. If your hospice agency owns the hospice inpatient facility, then you will NOT report an NPI, regardless of where the hospice inpatient facility is physically located.

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# POST-MORTEM VISITS

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## POST-MORTEM VISITS

- Claims must now identify post-mortem visits occurring on day of death after time of death
  - Does not apply to visits or calls occurring on day(s) ***after*** death
- Does ***not*** require presence of patient's body
  - Recently confirmed by CMS

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## POST-MORTEM VISITS

- Includes all billable visits & calls
  - Visits performed by hospice employed nurses, aides, social workers, & therapists, including social worker calls
  - Regardless of site of service or level of care
    - ***Exception***: Requirement does ***not*** apply to visits & social worker calls performed during GIP provided in hospice inpatient facility since those visits are not itemized on claim
- New requirements do not impact claim payment

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# POST-MORTEM VISITS

- New claim coding requirements
  - Visits must continue to be reported in 15-minute increments
  - Visits must report HCPCS modifier code "PM"
  - Requires split visit billing if death occurs during visit
    - Visit would be reported as two separate visits
      - Visit time occurring prior to time of death coded without "PM" modifier
      - Visit time occurring after time of death coded with "PM" modifier

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# POST-MORTEM VISITS

*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 shall not be reported. 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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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# POST-MORTEM VISITS

// Claim example one

// Visit occurred after time of death

// Patient receiving routine home care

// Skilled nursing visit occurred after time of death on day of death

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0551 | SN visit - post-mortem | G0154 PM | 040314 | 7 | 200 00 |
| 5 | 0001 | Total charges | | | 20 | 1050 00 |

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# POST-MORTEM VISITS

// Claim example two

// Death occurred during visit

// Patient receiving routine home care

// Skilled nursing visit initiated on 04/03/14 at 10:15 p.m. & concluded at 1:30 a.m. on 04/14/14

// Death occurred at 11:15 p.m.

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0551 | SN visit | G0154 | 040314 | 4 | 200 00 |
| 5 | 0551 | SN visit - post-mortem | G0154 PM | 040314 | 3 | 200 00 |
| 6 | 0001 | Total charges | | | 20 | 1250 00 |

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# POST-MORTEM VISITS

// Claim example three

// Death occurred during GIP level of care during inpatient hospice facility stay

// No change to claim reporting

// Visits still summarized by week by discipline

// No "PM" modifier necessary

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0656 | GIP - hospital | Q5006 | 040114 | 3 | 2100: 00 |
| 2 | 0551 | SN visit - employed | | 040114 | 3 | 600: 00 |
| 3 | 0001 | Total charges | | | 6 | 2700: 00 |

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# POST-MORTEM VISITS

// FAQs

4. If patient dies prior to midnight and the visit extends to next day, do we split the visit pre/post mortem? How do we handle the portion of the visit after the date of death?

   If a patient dies during a visit, the visit needs to be split. Report the length of the visit while the patient was alive without a PM modifier. Report the length of the visit after death and prior to midnight with the PM modifier. Due to system limitations, you will not report visit time after midnight.

5. For post mortem visits, if the nurse arrived at 9am and the patient dies at 10am and doesn't leave until 11 am, should this 1 continuous visit require the PM modifier?

   In the scenario above, the visit time would be split. One visit line item will have the length of time while the patient was alive without the PM modifier, and another visit line will have the length of time after the patient's death with a PM modifier.

6. What if the patient dies shortly before midnight and is not pronounced until early the next day – should we record all services done on the day the patient is pronounced?

   Post mortem services should only be reported for the day of death, using the date of death recorded on the death certificate.

7. How is the billing department supposed to know how to split a visit when the patient dies during that visit?

   It is strongly recommended that each hospice organization implement a process to differentiate the time associated with visits pre- and post-mortem.

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**Source**
http://www.cmsmedicare.com/hhh/education/faqs/COPE24969.html

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# POST-MORTEM VISITS

9. Do we have to report therapy visits by employed and contracted therapists? Or only visits provided by employed therapists?

   You will report the therapy visits for hospice-employed therapists and contracted therapists. You will not report visits by non-hospice staff when provided in a contracted facility.

10. Social worker phone calls will be reported regardless of length of phone call. I'm assuming that is only if the social worker spoke to someone and will not be reported if they left a voice mail. Is this correct?

    CR6440 states, "Only phone 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) should be reported." Since the social worker wasn't able to make contact with the needed party, the call should not be reported.

11. This question is regarding rounding of minutes for use of the PM modifier. In this example the registered nurse (RN) arrives at the home at 9:25 am and leaves at 10:45 am. The patient dies at 10:06 am. The total number of minutes for the visit is 80. Based on the time reporting requirements, 80 minutes = 5 units if this was reported as a single visit. However, since the death occurred during the visit, all of the MACs have advised me to split the visit and then round if a patient dies during the visit. Given that, the time the patient was alive would be reported with 3 units (9:25 – 10:06 am = 41 minutes = 3 units) and the time after death would be reported with 3 units (10:06-10:45 am = 39 minutes = 3 units). So we will now be reporting a total of 6 units for this 80 minute visit that was split in order to report the PM modifier. I just want to ensure that this is correct.

    Yes, this is correct.

33 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# POST-MORTEM VISITS

12. For post-mortem visits, does the patient's body need to be present to report the PM visit? Based on the definition of a visit in the Medicare Claims Processing Manual, we believe the answer is 'no' for most disciplines; however, a social worker visit/phone call could still be reported as a PM visit without the patient's body being present. Please confirm if this is correct.

    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.

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?

    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.

34 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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## INJECTABLE DRUGS

- // Claims must now report injectable prescription drugs
- // Excludes over-the-counter (OTC) drugs & vaccines
- // Applies to all sites of service & all levels of care
- // Only applies to hospice covered medications for which hospice is financially responsible
- // New requirements do not impact claim payment

# INJECTABLE DRUGS

// New claim coding requirements

- // Requires line-item reporting on claim per fill based on amount dispensed
  - // ***Exception***: Medication management systems summarize "fills" per drug
  - // No claim requirements to report or account for unused drugs
- // Requires revenue code 0636

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# INJECTABLE DRUGS

- // Requires applicable injectable drug HCPCS codes
  - // Often, but not limited to, "J" & "Q" codes
  - // http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Downloads/DRUG2014.pdf
- // Requires applicable units
  - // Should represent amount filled based on drug & HCPCS definition
- // Requires charge amount
  - // See slide 82

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# INJECTABLE DRUGS

| | | |
|---|---|---|
| *0636 Injectable Drugs* | *Applicable HCPCS* | *Required detail: Report on a line item basis per fill with units representing the amount filled. (i.e. Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2).* |

*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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf



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# INJECTABLE DRUGS

// Claim example one

// Medication fill of 20 mg

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0636 | Inject - mphin sulft, 10mg | J2270 | 040314 | 2 | 50 00 |
| 5 | 0001 | Total charges | | | 15 | 900 00 |

J2270 = Injection, morphine sulfate, up to 10 mg
2 billable units = 20 mg fill

**The following additional data is to be reported in accordance with Change Request 8358. This data is optional for services beginning January 1, 2014, and required for services on/after April 1, 2014.**

For 0636 (injectable drugs), units = amount filled based on the HCPCS description.

Source
http://www.cgsmedicare.com/hhh/education/materials/claim_page_2.html



HEALTHCARE first

# INJECTABLE DRUGS

// Special claim coding considerations

// Medication management systems

// Often used by inpatient facilities

// Each administration considered a 'fill' for hospice patients

// Report monthly total for each drug along with total dispensed

// Total for period covered by claim

*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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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HEALTHCARE first

# INJECTABLE DRUGS

// Claim example two

// Daily administration through medication management system of 10 mg injections

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 30 | 4500 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0636 | Inject - mphin sulft, 10mg | J2270 | 040114 | 30 | 750 00 |
| 5 | 0001 | Total charges | | | 70 | 5650 00 |

J2270 = Injection, morphine sulfate, up to 10 mg
30 billable units = 30 daily administrations of 10 mg

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HEALTHCARE first

# INJECTABLE DRUGS

## // FAQs

21. Where can we find a list of the drug Healthcare Common Procedure Coding System (HCPCS) codes?

    The Table of Drugs is available on the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.gov (Medicare > Coding: HCPCS Release & Code Sets > Alpha-Numeric HCPCS Items > Details for Year).

22. Per pharmacy regulations, to "dispense a drug" means to fill a prescription on a patient-specific basis with patient-specific labeling, etc. In some states, pharmacy regulations allow us to operate a special class of Pharmacy that does not require medications to be "dispensed" prior to the nurse administering the med. In accordance with our Pharmacy license, medications are not "dispensed" in our inpatient centers. Our nursing staff is able to obtain a medication order, go to the inpatient center pharmacy, and obtain a single patient dose of the medication from a stock med bottle and/or use a Pyxis system. They then administer the medication and document it on the Medication Administration Record (MAR). What would be considered a "fill" in this situation? Any suggestions?

    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.

25. What is the intent of the per fill listing for drugs? What happens if they do not use the entire fill? Do we have to change the quantity?

    Drug reporting is required so that Medicare can see what it's paying for, and to help CMS better understand non-labor costs during a hospice election. Report prescription drugs based on the fill, using the amount dispensed. Do not report drugs based upon what the patient actually uses because the hospice bears the cost of the entire amount dispensed, whether the patient uses all the medication or not.

43 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# INJECTABLE DRUGS

27. Are we required to report medications dispensed at the hospital for our patients? If so, given the fact that we do not receive documentation from our contracted hospitals in a timely manner (sometimes receiving the bills months later), can we submit our initial claims to Medicare without this data and submit an adjusted claim afterwards once we get the detail from the hospital?

    Report all prescription medications provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with your contracted providers, who may need to modify their billing to accommodate this new requirement. If you are notified of medications that were administered after you have submitted your claim, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

28. Will all hospice patients, regardless of the level of care, now require the reporting of injectable and non-injectable prescriptions drugs?

    Yes, the reporting of injectable and non-injectable prescription drugs will be required for all hospice patients regardless of the level of care.

29. Are flu shots and anti-coagulants, such as Lovenox, considered injectable drugs?

    Medicare covered vaccines are preventive services, and are outside of the hospice benefit. They are billed to Part B on a professional claim, not to Part A on a hospice claim, and therefore would not be reported on hospice claims. Lovenox would be reported on a hospice claim if related to the terminal illness.

30. Do we have to have dollar amounts on the drug or pump lines of service on the electronic claim and/or the UB-04?

    All reported line items require that a provider charge be submitted.

44 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# INJECTABLE DRUGS

31. Is CMS aware of the burden it places on agencies around the reporting of medications? How will the billing departments get this information?

Industry representatives have encouraged CMS to collect non-labor data to better understand hospice resource usage, and to assist in reforming the hospice payment system. The Affordable Care Act also allows CMS, and by extension, MACs, to collect additional data needed for payment reform. Until recently, hospices have historically not reported much information on their claims. We appreciate that any new requirement is a change, but we also recognize that it is a normal part of doing business in much of the healthcare industry. We trust that the hospice billing department will be able to work with other providers and suppliers to get the needed data in a timely fashion.

32. If our electronic medical records (EMR) vendor is not ready to put medications on claims, will there be a manual way to enter?

Yes, claims can be submitted via DDE.

34. Do we report only the hospice-covered medications?

Only report medications for the palliation and management of the terminal illness and related conditions. Therefore, you will only report medications covered under the hospice benefit.

36. Providers are having issues with EMR vendors as they are not willing to support medication reporting on claims. Have you or CMS heard this from other providers? What do we do if our vendors won't do this reporting?

This is a business issue between a provider and its software vendor. Other Medicare provider types have not experienced this problem.

37. Some of our pharmacies are slow on getting us information on refills. We will discover medication refills after the claims have been submitted. Will we need to do bill corrections on these additional medications?

Yes, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

45 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# INJECTABLE DRUGS

38. Could you suggest to CMS that drugs be captured through Cost Reporting vs. on the claims?

This suggestion will be forwarded to CMS. In the meantime, you should follow the instructions in CR8358.

41. Will there be a specific list of drugs that need to be reported, so we know which are required and/or excluded?

All prescription drugs, injectable and non-injectable, are to be reported.

49. Hospitals utilize different billing systems that do not use the same revenue or HCPCS codes that CMS requires hospices to use and those billing systems are not designed to provide NDC numbers. How does CMS propose that hospices obtain all the required information that needs to go on the claims per CR8358?

We strongly suggest that all hospices work with their contracted hospitals to ensure the hospitals are aware of this additional data reporting requirement.

46 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# INJECTABLE DRUGS

43. How are charges for drugs reported when the hospice pays a capitated rate for all drugs?

With regards to guidance to hospices on how to report charges on the hospice claim, we refer hospices to three areas of CMS's manuals.

1. The CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75.5 states, "This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

2. The CMS IOM Publication 100-00, Provider Reimbursement Manual, Part 1, Chapter 22, section 2203 states, "Provider Charge Structure as Basis for Apportionment", that to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program." In Section 2204 of the same chapter CMS further states that the Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)

3. In Section 2202, "Definitions", at 2202.4 "Charges", CMS states that charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# NON-INJECTABLE DRUGS

HEALTHCARE first

## NON-INJECTABLE DRUGS

- Claims must now report non-injectable prescription drugs
- Excludes OTC drugs
- Applies to all sites of service & all levels of care
- Only applies to hospice covered medications for which hospice is financially responsible
- New requirements do not impact claim payment



HEALTHCARE first

## NON-INJECTABLE DRUGS

- Clam coding requirements
  - Requires line-item reporting on claim per fill based on amount dispensed
    - ***Exception***: Medication management systems summarize "fills" per drug
    - No claim requirements to report or account for unused drugs
  - Requires revenue code 0250



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# NON-INJECTABLE DRUGS

- // Requires National Drug Code (NDC) information
  - // http://www.fda.gov/drugs/informationondrugs/ucm142438.htm
- // HCPCS code not required
- // Requires applicable units
  - // Should represent appropriate units of fill based on NDC definition
- // Requires charge amount

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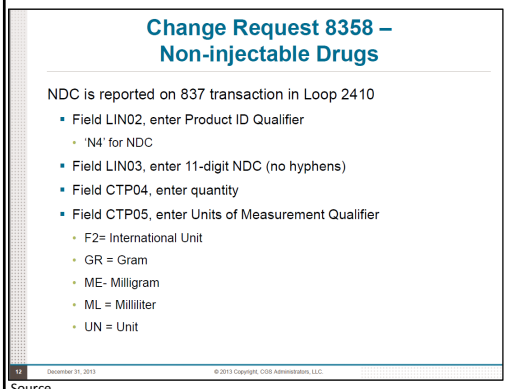
HEALTHCARE first

| | | |
|---|---|---|
| *0250 Non-injectable Prescription Drugs* | *N/A* | *Required detail: 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.* |

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf




Source
http://www.cgsmedicare.com/hhh/education/materials/pdf/8358_adr_handout.pdf

| 837i Loop 2410 | |
|---|---|
| **Segment ID Reference** | **Description** |
| LIN02* | 'N4' for NDC qualifier |
| *LIN03*** | *11-digit NDC without hyphens (xxxxx-xxxx-xx)* |
| *CTP04*** | *NDC quantity* |
| *CTP05*** | *NDC quantity qualifier: 'F2', 'GR', 'ME', 'ML', 'UN'* |
| * | *Data only required in 837 electronic file* |
| ** | *Data also required in DDE/FISS* |

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HEALTHCARE first

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0250 | No-injc - dexamethasone | | 040314 | 1 | 50 00 |
| 5 | 0001 | Total charges | | | 15 | 1050 00 |

**0054-4182-31 | Dexamethasone (Dexamethasone) | TABLET | 1.5 mg/1**

**Product NDC**: 0054-4182
**Proprietary Name**: Dexamethasone
**Non-Proprietary Name**: Dexamethasone
**Product Type Name**: HUMAN PRESCRIPTION DRUG
**Market Category Name** : ANDA
**Application Number**: ANDA084610
**Route Name**: ORAL
**Substance Name**: DEXAMETHASONE
**Package Description** : 1000 TABLET in 1 BOTTLE, PLASTIC (0054-4182-31)
**Pharm Class**: N/A
**DEA**: N/A
**Labeler Name**: Roxane Laboratories, Inc
**Start date**: 07-07-2006 / **End date**: N/A

Source
http://www.accessdata.fda.gov/scripts/cder/ndc/dsp_searchresult.cfm

**1 service unit = 1 bottle of 1,000 tablets, 1.5 mg per tablet**

| 837i Loop 2410 | | |
|---|---|---|
| **Segment ID Reference** | **Description** | **Value** |
| LIN02* | 'N4' for NDC qualifier | N4 |
| *LIN03*** | *11-digit NDC (xxxxx-xxxx-xx)* | *00054418231* |
| *CTP04*** | *NDC quantity* | *1* |
| *CTP05*** | *NDC quantity qualifier 'F2', 'GR', 'ME', 'ML', 'UN'* | *UN* |
| * | *Data only required in 837 electronic file* | |
| ** | *Data also required in DDE/FISS* | |

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HEALTHCARE first

```
MAP171E   PAGE 02          J11 MAC SC/HHH UAT #11001          ACMFA891 12/28/12
          SC                INST CLAIM ENTRY                 C201312F 17:46:04
                                                        NDC CD PAGE 01
HIC                TOB      S/LOC S B0100   PROVIDER

          CL   NDC FIELD        NDC QUANTITY    QUALIFIER
           1
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
           6
LLR NPI                  L
           7
LLR NPI                  L

      PROCESS COMPLETED   ---
PRESS PF2-1712 PF3-EXIT PF5-
```

**F11 key**

| Field Name | UB-04 X-Ref. | Description |
|---|---|---|
| NDC CD PAGE 01 | | There are a total of 33 pages to account for 450 revenue lines. |
| HIC | 60 | The beneficiary's Medicare Health Insurance Claim number. |
| TOB | 4 | The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values. |
| S/LOC | | The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system. |
| PROVIDER | | This field displays the provider identification number. |
| CL 1 - 7 | | This field identifies the claim line number. |
| NDC FIELD | | This field identifies the National Drug Code (NDC). |
| NDC Quantity | | This field identifies the NDC quantity. |
| QUALIFIER | | This field identifies the NDC quantity qualifier. |
| LLR NPI | | This field identifies the line level rendering physician's NPI number. |
| L | | The last name of the rendering physician. |
| F | | The first name of the rendering physician. |
| M | | The middle initial of the rendering physician. |
| SC | | This field identifies the Critical Access Hospital Physician/Non-Physician specialty code. |

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Source
http://www.palmettogba.com/Palmetto/Providers.nsf/files/DDE_Manual.pdf/$File/DDE_Manual.pdf

HEALTHCARE first

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| 4 | 0250 | No-injc - dexamethasone | | 040314 | 1 | 50 00 |
| 5 | 0001 | Total charges | | | 15 | 1050 00 |

```
MAP171E   PAGE 02          J11 A/B MAC SC/HHH #11001          ACPFA391 03/03/14
XK53878   SC                INST CLAIM ENTRY                   C201413P 12:03:04
                                                    NDC CD PAGE 01
HIC 111111111A    TOB 813  S/LOC S B0100  PROVIDER 2222222222

          CL   NDC FIELD        NDC QUANTITY    QUALIFIER
           1
LLR NPI                  L                 F           M    SC
           2
LLR NPI                  L                 F           M    SC
           3
LLR NPI                  L                 F           M    SC
           4  00054418231        1                  UN
LLR NPI 3333333333  L SMITH              F JOHN      M    SC
           5
LLR NPI                  L
           6
LLR NPI                  L
           7
LLR NPI                  L

     PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DN PF7-PRE PF8-NXT PF9-UPDT PF10-LT PF11-RT
```

F11 key

1 NDC unit = 1 bottle of 1,000 tablets, 1.5 mg per tablet

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HEALTHCARE first

**CEFTRIAXONE SODIUM | 0409-7338-01 | Ceftriaxone Sodium (Ceftriaxone Sodium) | INJECTION, POWDER, FOR SOLUTION | 500 mg/1**

**Product NDC**: 0409-7338
**Proprietary Name**: Ceftriaxone Sodium
**Non-Proprietary Name**: Ceftriaxone Sodium
**Product Type Name**: HUMAN PRESCRIPTION DRUG
**Market Category Name** : ANDA
**Application Number**: ANDA065169
**Route Name**: INTRAMUSCULAR; INTRAVENOUS
**Substance Name**: CEFTRIAXONE SODIUM
**Package Description** : 10 VIAL, SINGLE-USE in 1 CARTON (0409-7338-01) > 1 INJECTION, POWDER, FOR SOLUTION in 1 VIAL, SINGLE-USE
**Pharm Class**: N/A
**DEA**: N/A
**Labeler Name**: Hospira, Inc
**Start date**: 05-09-2005 / **End date**: N/A

| 837i Loop 2410 | | |
|---|---|---|
| **Segment ID Reference** | **Description** | **Value** |
| LIN02* | 'N4' for NDC qualifier | N4 |
| *LIN03*** | *11-digit NDC (xxxxx-xxxx-xx)* | *00409733801* |
| *CTP04*** | *NDC quantity* | *2* |
| *CTP05*** | *NDC quantity qualifier 'F2', 'GR', 'ME', 'ML', 'UN'* | *UN* |
| * | *Data only required in 837 electronic file* | |
| ** | *Data also required in DDE/FISS* | |

*A patient received a 1,000 mg fill of Ceftriaxone where two 500 mg vials of powder were reconstituted*

```
          CL   NDC FIELD        NDC QUANTITY    QUALIFIER
           1
LLR NPI                  L                 F           M
           2
LLR NPI                  L                 F           M
           3
LLR NPI                  L                 F           M
           4
LLR NPI                  L                 F           M
           5
LLR NPI                  L                 F           M
           6
LLR NPI                  L                 F           M
           7
LLR NPI                  L                 F           M
```

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HEALTHCARE first

# NON-INJECTABLE DRUGS

// Special claim coding considerations

- // Medication management systems
  - // Often used by inpatient facilities
  - // Each administration considered a 'fill' for hospice patients
  - // Report monthly total for each drug along with total dispensed
    - // Total for period covered by claim

*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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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HEALTHCARE first

# NON-INJECTABLE DRUGS

// Multi-ingredient compound prescription drugs

- // Each ingredient of compound must be reported along with each NDC, appropriate units of measure & prescription or linkage number

*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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

**1.11.2 Compound Drug Billing**

An 837 for a multiple ingredient compound will have one 2400 loop for each ingredient with the HCPCS code in SV202-2, the provider's charge for that ingredient in SV203, and the associated units in SV205. When required by situational rules, the 2410 loop is sent with the NDC number in LIN03 with the associated quantity in CTP04. Loop ID-2410 REF02 must have the same prescription number, or the same linkage number if provided without a prescription, for each ingredient of the compound to enable the payer to differentiate and link the ingredients to a single compound.

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# NON-INJECTABLE DRUGS

// Prescription drugs in a comfort kit/pack

// Must report NDC of each prescription drug within package in accordance with non-injectable prescriptions

*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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

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HEALTHCARE first

# NON-INJECTABLE DRUGS

// FAQs

22. Per pharmacy regulations, to "dispense a drug" means to fill a prescription on a patient-specific basis with patient-specific labeling, etc. In some states, pharmacy regulations allow us to operate a special class of Pharmacy that does not require medications to be "dispensed" prior to the nurse administering the med. In accordance with our Pharmacy license, medications are not "dispensed" in our inpatient centers. Our nursing staff is able to obtain a medication order, go to the inpatient center pharmacy, and obtain a single patient dose of the medication from a stock med bottle and/or use a Pyxis system. They then administer the medication and document it on the Medication Administration Record (MAR). What would be considered a "fill" in this situation? Any suggestions?

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.

25. What is the intent of the per fill listing for drugs? What happens if they do not use the entire fill? Do we have to change the quantity?

Drug reporting is required so that Medicare can see what it's paying for, and to help CMS better understand non-labor costs during a hospice election. Report prescription drugs based on the fill, using the amount dispensed. Do not report drugs based upon what the patient actually uses because the hospice bears the cost of the entire amount dispensed, whether the patient uses all the medication or not.

23. How is that national drug code (NDC) going to work on the electronic submission of claims? Is there a field in the electronic claim to enter the NDC?

The NDC goes in the 5010 loop 2410 (drug identification). Within the loop, the following data elements are required: LIN02 - Qualifier (which would equal N4), LIN03 - National Drug Code, CTP04 – Quantity, and CTP05 – Unit of Measure Qualifier (F2=International Unit, GR = Gram, ME = Milligram, ML = Millimeter, UN=Unit).

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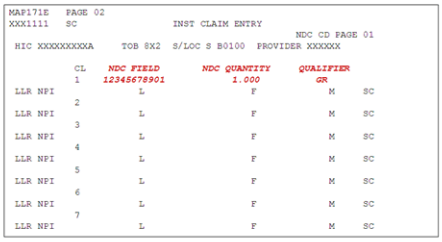
**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# NON-INJECTABLE DRUGS

24. Where do I report the NDC in DDE?

The NDC is reported in the first right view of claim page 02 in DDE. To add an NDC, press the <F11>/ <PF11> key to view the right side of CLAIM PAGE 02. Note that you will have to keep track of the claim line number when entering the NDCs as the NDC line must be the same claim line as the 0250 revenue code. When entering the quantity, units must be entered with the decimal point (e.g., 50 units would be reported in the Quantity field as "50.0"; DDE will automatically add the remaining two trailing zeros).



```
MAP171E   PAGE 02
XXX1111   SC                    INST CLAIM ENTRY
                                                    NDC CD PAGE 01
 HIC XXXXXXXXXA      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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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# NON-INJECTABLE DRUGS

27. Are we required to report medications dispensed at the hospital for our patients? If so, given the fact that we do not receive documentation from our contracted hospitals in a timely manner (sometimes receiving the bills months later), can we submit our initial claims to Medicare without this data and submit an adjusted claim afterwards once we get the detail from the hospital?

Report all prescription medications provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with your contracted providers, who may need to modify their billing to accommodate this new requirement. If you are notified of medications that were administered after you have submitted your claim, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

28. Will all hospice patients, regardless of the level of care, now require the reporting of injectable and non-injectable prescriptions drugs?

Yes, the reporting of injectable and non-injectable prescription drugs will be required for all hospice patients regardless of the level of care.

30. Do we have to have dollar amounts on the drug or pump lines of service on the electronic claim and/or the UB-04?

All reported line items require that a provider charge be submitted.

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# NON-INJECTABLE DRUGS

31. Is CMS aware of the burden it places on agencies around the reporting of medications? How will the billing departments get this information?

Industry representatives have encouraged CMS to collect non-labor data to better understand hospice resource usage, and to assist in reforming the hospice payment system. The Affordable Care Act also allows CMS, and by extension, MACs, to collect additional data needed for payment reform. Until recently, hospices have historically not reported much information on their claims. We appreciate that any new requirement is a change, but we also recognize that it is a normal part of doing business in much of the healthcare industry. We trust that the hospice billing department will be able to work with other providers and suppliers to get the needed data in a timely fashion.

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Yes, claims can be submitted via DDE.

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34. Do we report only the hospice-covered medications?

Only report medications for the palliation and management of the terminal illness and related conditions. Therefore, you will only report medications covered under the hospice benefit.

35. We have heard that the NDC can be different based upon the drug manufacturer. How do we accurately and timely include this data on the claim?

The NDC code varies by manufacturer and is on the prescription received from the pharmacy. The NDC codes are also available in the NDC directory at http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday.

63 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# NON-INJECTABLE DRUGS

36. Providers are having issues with EMR vendors as they are not willing to support medication reporting on claims. Have you or CMS heard this from other providers? What do we do if our vendors won't do this reporting?

This is a business issue between a provider and its software vendor. Other Medicare provider types have not experienced this problem.

37. Some of our pharmacies are slow on getting us information on refills. We will discover medication refills after the claims have been submitted. Will we need to do bill corrections on these additional medications?

Yes, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

39. CMS wants the quantity of the non-injectable drugs that are filled, is that part of the NDC, or do we need to report that in the Units field on the claim?

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. Hospices should follow the 5010 billing guidance and requirements.

40. My understanding is that the NDC is not issued until after the fill, sometimes long after. How will we process timely claims given this reality?

The NDC code should be on the medication received from the pharmacy. The NDC is issued by the drug manufacturer. To link to an Excel file showing all NDC codes, go to http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday. If the NDC is not available at the time of the claim submission, you will have to submit an adjustment (Type of bill 8X7) to add the medication information once it is received.

41. Will there be a specific list of drugs that need to be reported, so we know which are required and/or excluded?

All prescription drugs, injectable and non-injectable, are to be reported.

64 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

HEALTHCARE first

# INJECTABLE DRUGS

43. How are charges for drugs reported when the hospice pays a capitated rate for all drugs?

With regards to guidance to hospices on how to report charges on the hospice claim, we refer hospices to three areas of CMS's manuals.

1. The CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75.5 states, "This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

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3. In Section 2202, "Definitions", at 2202.4 "Charges", CMS states that charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

65 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# NON-INJECTABLE DRUGS

44. What is the definition of the NDC? Is it just the drug name dosage and quantity or is it the manufacturer's code?

The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. The 3 segments of the 11-digit NDC identify the labeler, the product, and the commercial package size. The first set of numbers in the NDC identifies the labeler (manufacturer, repackager, or distributer). The second set of numbers is the product code, which identifies the specific strength, dosage form (e.g., capsule, tablet, liquid) and formulation of a drug for a specific manufacturer. Finally, the third set is the package code, which identifies package sizes and types. In addition to the actual NDC, you will also have to report the qualifier (electronic claims only), the quantity dispensed, and the unit qualifier. Below is an example of NDC reporting for both electronic claims and FISS/DDE claims:

| **NDC breakdown for 5010 electronic claims Qualifier + NDC Code + UOM + Quantity** | | **NDC breakdown for FISS/DDE claims NDC Code + Quantity + UOM** | |
|---|---|---|---|
| Example: N4 + 12345678901 + ML + 5 | | Example: 12345678901 + 5.0 + ML | |
| Qualifier | N4 (always report N4) | National Drug Code (NDC Field) | NDC format (5-4-2) |
| National Drug Code (NDC) | NDC format (5-4-2) | Drug unit quantity (NDC Quantity field) | Dispensing quantity |
| Drug Unit of Measure (UOM) | Valid unit of measures are:<br>F2 (international unit)<br>GR (gram)<br>ME (milligram)<br>ML (milliliter)<br>UN (unit) | Drug Unit of Measure (Qualifier field) | Valid unit of measures are:<br>F2 (international unit)<br>GR (gram)<br>ME (milligram)<br>ML (milliliter)<br>UN (unit) |
| Drug unit quantity | Dispensing quantity | | |

66 **Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# NON-INJECTABLE DRUGS

45. Can you clarify the definition for non-injectable drugs?

Any prescription drug that is not injected or administered via the infusion pump would be reported as a non-injectable drug.

46. If the dosing is by unit, does not have an itemized charge, and the NDC number is not listed on the invoice, how do we obtain the NDC information?

The NDC code varies by manufacturer and is on the prescription received from the pharmacy. The NDC codes are also available in the NDC directory at http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday.

47. Does the NDC number that we are going to be asked to report have to match the actual NDC of the product dispensed?

Yes, you must report the NDC for the drug actually dispensed.

48. The CR says that the NDC is to be reported and it will represent the quantity of drug filled. This creates an issue when the NDC represents a bottle of #100 and a pharmacy is only dispensing #30 at a time for example. How would they report a quantity less than the pack size of the bottle?

The actual NDC identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. In addition to the actual NDC, you will also have to report the quantity dispensed. Please see Q/A 44 for additional information.

49. Hospitals utilize different billing systems that do not use the same revenue or HCPCS codes that CMS requires hospices to use and those billing systems are not designed to provide NDC numbers. How does CMS propose that hospices obtain all the required information that needs to go on the claims per CR8358?

We strongly suggest that all hospices work with their contracted hospitals to ensure the hospitals are aware of this additional data reporting requirement.

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# INFUSION PUMPS

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## INFUSION PUMPS

- Claims must now report infusion pumps & related medication necessary for effective use of pump
  - Excludes OTC drugs & nutrition
  - Only applies to hospice covered medications for which hospice is financially responsible
- Applies to all sites of service & all levels of care
- New requirements do not impact claim payment

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## INFUSION PUMPS

- New claim coding requirements
  - Infusion pumps
    - Requires line-item reporting on claim per each pump order
    - Requires revenue code 029X
      - 0290 for general equipment classification
      - 0291 for rental
      - 0292 for purchase of new equipment
      - 0293 for purchase of used equipment
    - Requires applicable HCPCS code
    - Requires applicable units
    - Requires charge amount

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# INFUSION PUMPS

// Prescription infusion medications

- // Requires line-item reporting per infusion medication fill
- // Requires revenue code 0294
- // Requires applicable HCPCS code
- // Requires applicable units
  - // Should represent amount filled based on drug definition
- // Requires charge amount

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# INFUSION PUMPS

| | | |
|---|---|---|
| *029X Infusion pumps* | *Applicable HCPCS* | *Required detail: 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.* |

*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 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.*

Source
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf

Enter the revenue code 029X (X=appropriate 4th digit) to report infusion pump equipment.

- A separate revenue code line is required for each pump order.

Enter the revenue code 0294 to report infusion medications.

- A separate revenue code line is required for medication fill.

For 029X, units = as appropriate.

For 0294, units = amount filled based on the HCPCS description.

Source
http://www.cgsmedicare.com/hhh/education/materials/claim_page_2.html

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# INFUSION PUMPS

## // Claim example

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES |
|---|---|---|---|---|---|---|
| 1 | 0651 | Routine home care - home | Q5001 | 040114 | 3 | 450 00 |
| 2 | 0551 | SN visit | G0154 | 040114 | 4 | 200 00 |
| 3 | 0551 | SN visit | G0154 | 040214 | 6 | 200 00 |
| | 0291 | Infusion pump - rental | E0783 | 040114 | 1 | 150 00 |
| | 0294 | Infusion - saline 1000cc | J7030 | 040114 | 1 | 50 00 |
| 6 | 0001 | Total charges | | | 15 | 1050 00 |

E0783 = Infusion pump system, implantable, programmable (includes all components, *e.g.*, pump, catheter, connectors, *etc.*)

J7030 = Infusion, normal saline solution, 1000cc
1000cc = 1 unit

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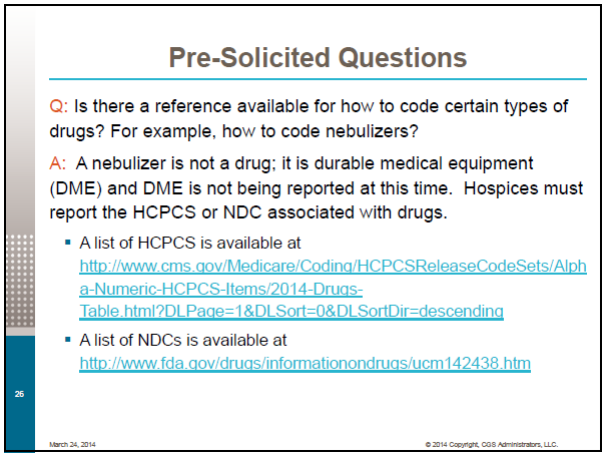
# INFUSION PUMPS

## // FAQs

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**Source**
http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# INFUSION PUMPS

19. When billing for the pump, do we bill the equipment charge once a month or each time there is an injection?

CMS reissued CR8358 on January 31, 2014. The revised CR states, "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 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."

20. How do we report infusion pump and medication in a GIP setting when it's included in the GIP rate we pay to the hospital with which we contract?

Report all prescription medications and infusion pumps provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with those providers you contract with, as they may need to modify their billing to the hospice to assist the hospice in meeting this new requirement. Since the hospice is still responsible for its patients receiving GIP in a contracted facility, it should know what medications were provided and if an infusion pump was used.

22. Per pharmacy regulations, to "dispense a drug" means to fill a prescription on a patient-specific basis with patient-specific labeling, etc. In some states, pharmacy regulations allow us to operate a special class of Pharmacy that does not require medications to be "dispensed" prior to the nurse administering the med. In accordance with our Pharmacy license, medications are not "dispensed" in our inpatient centers. Our nursing staff is able to obtain a medication order, go to the inpatient center pharmacy, and obtain a single patient dose of the medication from a stock med bottle and/or use a Pyxis system. They then administer the medication and document it on the Medication Administration Record (MAR). What would be considered a "fill" in this situation? Any suggestions?

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.

75 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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# INFUSION PUMPS

25. What is the intent of the per fill listing for drugs? What happens if they do not use the entire fill? Do we have to change the quantity?

Drug reporting is required so that Medicare can see what it's paying for, and to help CMS better understand non-labor costs during a hospice election. Report prescription drugs based on the fill, using the amount dispensed. Do not report drugs based upon what the patient actually uses because the hospice bears the cost of the entire amount dispensed, whether the patient uses all the medication or not.

26. What will we do about the infusion pumps that we own and have the patient use? They have to have an order to use the infusion pump, but we don't have a bill.

According to CR 8358, "hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump order and for each medication refill." In this case, report a reasonable charge for the pump on the claim when a pump is provided to the patient.

27. Are we required to report medications dispensed at the hospital for our patients? If so, given the fact that we do not receive documentation from our contracted hospitals in a timely manner (sometimes receiving the bills months later), can we submit our initial claims to Medicare without this data and submit an adjusted claim afterwards once we get the detail from the hospital?

Report all prescription medications provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with your contracted providers, who may need to modify their billing to accommodate this new requirement. If you are notified of medications that were administered after you have submitted your claim, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

30. Do we have to have dollar amounts on the drug or pump lines of service on the electronic claim and/or the UB-04?

All reported line items require that a provider charge be submitted.

76 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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Yes, you will have to submit an adjustment (Type of Bill 8X7) to add the medication information.

41. Will there be a specific list of drugs that need to be reported, so we know which are required and/or excluded?

All prescription drugs, injectable and non-injectable, are to be reported.

42. Does total parenteral nutrition (TPN) need to be reported? What if drugs are added to the TPN?

Medicare considers TPN to be a prosthetic, and not to be a drug or DME. It should not be reported on claims. If drugs are added, the drug should be reported.

49. Hospitals utilize different billing systems that do not use the same revenue or HCPCS codes that CMS requires hospices to use and those billing systems are not designed to provide NDC numbers. How does CMS propose that hospices obtain all the required information that needs to go on the claims per CR8358?

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78 **Source** http://www.cgsmedicare.com/hhh/education/faqs/COPE24969.html

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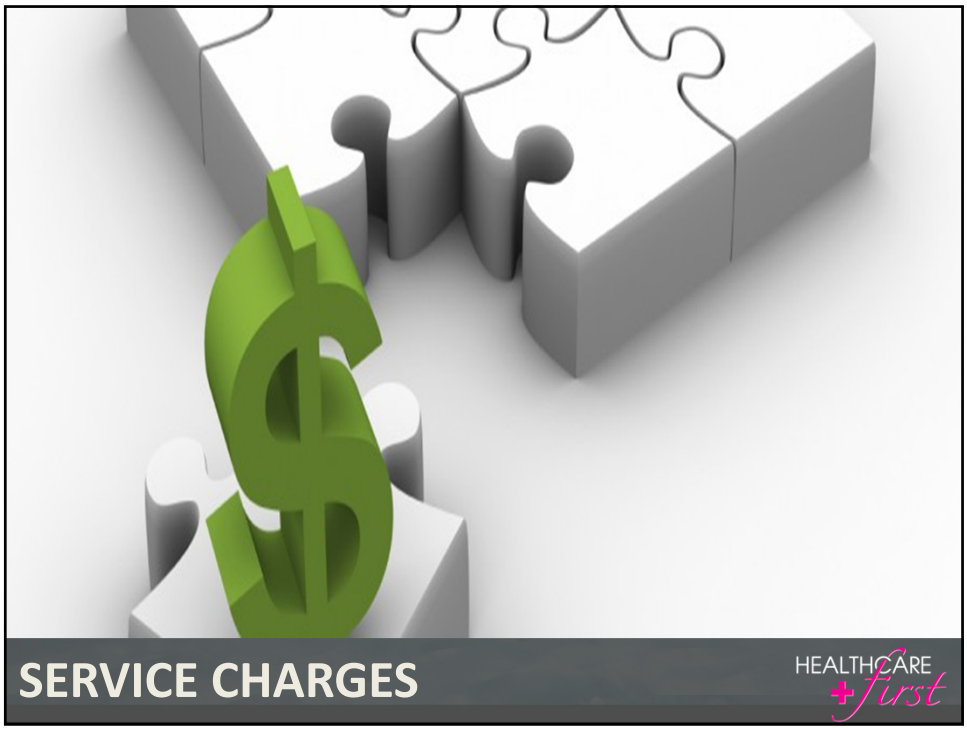

# SERVICE CHARGES

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## SERVICE CHARGES

// Charges required on all billed services

- // Required for services described on each revenue code line
- // Information collected for purposes of research & does not affect payment
- // Should include consideration of all costs
  - // Direct & indirect costs

Provider Reimbursement Manual, Part 1, Ch. 22

*Section 2202* defines "charges" as "the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions."

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## SERVICE CHARGES

// National Association for Home Care & Hospice

- // Home Care & Hospice Financial Managers Association
  - // New task force created under direction of Payment & Reimbursement Committee
  - // Tasked with creating guidance on calculating costs & offering information on assessing charges in relation to costs
  - // Watch for information to be available in near future…

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## ASSESS READINESS

### New FISS Edits Related to CR 8358

| Reason Code | Issue | Result |
|---|---|---|
| 17712 | Service facility NPI cannot be equal to billing provider NPI | Return to provider (RTP) |
| 32102 | Invalid service facility NPI | Return to provider (RTP) |
| 32511 | Ensures all NDC information is reported (incl. NDC code, quantity, and quantity qualifier) | Return to provider (RTP) |
| 32513 | Ensures value of NDC quantity qualifier is F2, GR, ME, ML, or UN | Return to provider (RTP) |
| 34952 | Claim includes Q5003, Q5004, Q5005, Q5007, or Q5008, and the service facility NPI is blank of invalid | Return to provider (RTP) |

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March 24, 2014



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## ASSESS READINESS

// Assess vendor readiness

- // How will pharmacy vendors provide itemized NDC information for all drugs, including compounded drugs & comfort kits
- // How will inpatient facilities provide drugs administered/"filled" through medication management systems?
- // How will infusion vendor provide HCPCS information for pumps & medications?
- // How promptly will vendors be able to provide invoices to correspond with timing of monthly Medicare billing?
- // Can vendors provide electronic invoices that can be imported directly into billing software?

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## ASSESS READINESS

// Evaluate processes & documentation

- // How might processes need to be altered to capture new information for billing purposes?
  - // GIP visits
    - // Inpatient hospice vs. non-inpatient hospice
  - // Inpatient facility identifying information
  - // Post-mortem visits
  - // Injectable & non-injectable prescription drugs
  - // Infusion pumps & related medications

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***2014 Hospice Billing Changes: New Data Requirements***

April 8, 2014, 10:30 – 11:30 CT

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BKD LLP
CPAs & Advisors

**M. Aaron Little,** CPA
Managing Director | Springfield, MO
mlittle@bkd.com

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