

April 22, 2010

Home Health and Hospice Ask the Contractor Teleconference (ACT) Summary held March 23, 2010

On March 23, 2010, NHIC, Corp. hosted an ACT for home health and hospice providers. The majority of the call was reserved for the question and answer session. Prior to the question and answer portion of the call, the following information was shared with the home health and hospice provider community:

- Reminders about Change Request (CR) 6440
 - Reporting requirements mandatory effective 1/1/2010
 - Do not report visit and time data by non-hospice staff when a hospice patient is receiving Respite Care in a contract facility
 - For General Inpatient (GIP) care, reporting of visit intensity data is not required at this time
 - Continue to report the number of GIP visits in accordance with CR5567
 - Time associated with each visit/call should be rounded to the nearest 15-minute increment
 - Separate lines should be reported for all routine home care (RHC), continuous home care (CHC) and respite care services
- CMS Frequently Asked Questions (FAQs) on the CMS website
 - www.cms.hhs.gov
 - Click on 'Questions' in dark blue bar at top of page
 - Search by keyword(s) in search term field
 - FAQs specific to CR6440 can be found under FAQ IDs: 9887, 9915, 9916, 9970 and 9971 (These CMS FAQs will be attached to the end of this summary)
- CR6540 – effective for dates of services on or after 1/1/2010
 - Report the National Provider Identifier (NPI) of the attending physician/nurse practitioner (NP) in the “Attending Physician” field on the Notice of Election (NOE) and claim
 - Report the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course in the “Other Physician” field on the NOE and claim
- CR6791 – effective for hospice claims submitted on or after April 29, 2010

- Hospices should report separate line items for the level of care, each time the level of care changes.
- CR6757 – coding changes for home health claims effective for dates of service July 1, 2010 and forward
 - Condition Code 47 will be used to replace Point of Origin Code ‘B’
 - Point of Origin Code ‘B’ no longer used for transfer to another Home Health Agency (HHA)
 - Point of Origin Code ‘C’ will not be replaced – the Medicare system will recognize if the same HHA overlaps a previous episode when a RAP or no-RAP LUPA is submitted with dates of service that overlap a previous episode claim
 - Point of Origin Code ‘C’ no longer used for discharge/readmission to same HHA

Questions & Answers

The following questions were asked during the session. Questions and answers may have been rewritten for clarity.

Q1. Where can we find information in Change Request 6778?

- A1. Change Request (CR) 6778 revises existing Medicare standard systems edits to allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election; adds new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC); provides a technical correction to the Medicare Benefit Policy Manual regarding the requirement for nursing care related to hospice continuous home care; and provides manual clarification regarding ambulance transport on the date of a hospice election. More information on CR 6778 can be found in the MLN Matters Article Number MM6778.
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6778.pdf>

Q2. Can you clarify if a contracted aide is considered an employee and if the contracted aide visits have to be counted?

- A2. If the aide is contracted by the hospice, then yes they would have to count their visits as if they were an employee of the hospice. Change Request 6440 states, “All visits to provide care related to the palliation and management of the terminal illness or related conditions, whether provided by hospice employees or provided under arrangement,

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must be reported. The two exceptions are related to General Inpatient Care and Respite care. CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care or respite care in contract facilities.”

Q3. We have several home health claims that were billed as later episodes but paid as early episodes. Is there a system issue with processing early and later episodes?

A3. In most cases a system problem does not affect processing early and later home health episodes. There are times when the timing of episode claim submission may conflict with correction/submission of earlier billed episodes. When this happens, the later episodes may not originally pay as later episodes; however, FISS will eventually update claims based on the Common Working File (CWF) – these claims will show in FISS as a 3XG bill type. All claims processing circumstances are situational, so if you have any questions regarding claim processing, please call the provider contact center at 1-866-289-0423.

Q4. Is it true that Remarks are only read on a claim when it is in Medical Review or Appeals or is a timely filing consideration?

A4. The Remarks area can be used for several claim billing situations and can also be used for providers to further explain reasons for updating, adding or correcting information on a claim adjustment. This area is not reserved exclusively for Medical Review or Appeals. The provider comments in the Remarks area are read and considered whenever there is manual intervention from the Claims area or in specified billing situations (e.g. certain Medicare Secondary Payer claims).

The Centers for Medicare and Medicaid Services (CMS) Frequently Asked Questions (FAQ) related to CR 6440:

Below are the Centers for Medicare and Medicaid Services (CMS) Frequently Asked Questions (FAQ) related to CR 6440, including the revised CMS FAQ ID 9970, which are currently available on CMS’s Web site at www.cms.hhs.gov. In order to access the FAQs, click “*Questions*” in the dark blue bar on the CMS home page. This will bring you directly to the FAQ database. From here, you can search terms or access a specific FAQ by keying the ID number of the FAQ in the Search box.

Q. How should a hospice provider report the total charges field on the line item reporting a visit?

A. The total charges should be the hospice provider's total charges for the service billed on that line of the claim based on the provider's charge structure. What is placed in the charges is completely dependent on the provider and their own charge structure. If a provider charges \$100 per visit regardless of the length of the visit, then the charge would be \$100 on the line for the visit regardless of the number of units for the length of the visit. If the provider has a timed charge structure then they would report the total charge after calculating their rate for the length of the visit being reported on the claim. *(Resource: CMS FAQ ID 9971)*

Q. In CR 6440 CMS wrote that: "Report only social worker phone calls related to providing and or coordinating care to the patient and family, and documented as such in the clinical records." Does this sentence mean that only calls to the patient and family are to be considered for reporting?

A. Because of the nature of a social worker's job, social workers perform a portion of their work without face-to face contact with either the patient or their family, which is why CMS allowed social workers to record their phone calls as visits. For instance, off hours counseling of the patient and/or counseling of family members who live out of town, would be considered appropriate and necessary when provided via a phone conversation. However, it would be inappropriate to record every phone call that a social worker makes on behalf of a patient.

As stated in CR 6440, only social worker 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. Given the nature of a social worker's job responsibilities, we would expect that almost all social worker phone calls reported would be between the social worker and either the patient or the patient's family. It is feasible, however, that care coordination phone calls by a social worker to other than family members could be reportable. For example, if a SW facilitates alternate care arrangements for the patient in a scenario where the patient's primary caregiver suddenly becomes unavailable to provide care, those calls should be recorded. Clinical judgment should be applied to determine if a particular social worker phone call is reportable. In essence, report only social worker phone calls related to providing care to and/or coordinating care of the patient for the palliation and management of the

terminal illness and related conditions, as well as for the counseling of a patient's family, and document those phone calls as such in the clinical records (*Resource: CMS FAQ ID 9970-Revised 2/19/10*)

Q. Change Request (CR) 6440 requires reporting of the length of most hospice visits. Some providers have staff spend time documenting during the course of a visit. For example, those using electronic medical records may record patient data in the medical record as the patient is being assessed. Should this documentation time be backed out of the visit time reported when the documentation occurs during a visit?

A. To clarify the instructions in CR 6440, documentation time (such as the updating of medical records) which occurs during, and as part of, an otherwise covered and billable visit to a patient can be included in the time reported for the visit. Documentation time which occurs outside the context of such a visit is not reportable. (*Resource: CMS FAQ ID 9916*)

Q. Change Request (CR) 6440 requires reporting of allowable social worker phone calls, and the length of the call. When a social worker makes phone calls related to the patient's care during the course of a visit with the patient or his/her family, should those calls be reported, or should they be counted as part of the visit?

A. Phone calls made on behalf of a patient during the course of a visit with the patient or his family should not be reported on hospice claims. Only report phone calls that are not made during a reportable visit, and which meet the criteria given in CR 6440: "Only phone calls that are necessary to 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 placement) should be reported. Report only social worker phone calls related to providing and / or coordinating care to the patient and family, and documented as such in the clinical records." (*Resource: CMS FAQ ID 9915*)

Q. Change Request 6440 requires time reporting of most hospice visits on claims. How should hospice providers report the time for visits when the visit takes less than 15 minutes?



- A. All visits up to 15 minutes are reported as one 15-minute increment, regardless of the length of the visit. Visits longer than 15 minutes are rounded to the nearest 15-minute increment (up or down). For example, a five-minute visit is counted as one 15-minute increment, a 20 minute visit is counted as 1 increment, and a 25-minute visit is counted as two increments. (*Resource: CMS FAQ ID 9887*)