Medicare Hospice Billing 2016 & Beyond! Part 2

Presented By:

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Sequential Claim Billing

The NOE must be in S/LOC P B9997 prior to submitting the first claim.

- Claims must be submitted sequentially. This means that the prior claim must be processed and in S/LOC P, D or R. A suspended claim (in S/LOC "S") does not meet the sequential billing requirement.
- Claims must be consecutive. This means there cannot be a skip in days between the prior claim and the subsequent claim.
- Claims must be submitted monthly. The Medicare Claims Processing Manual (Pub. 100-04), Chapter 11, Section 90 states **"Hospices must bill for their Medicare beneficiaries on a monthly basis."** This will significantly reduce errors related to sequential billing.

Levels of Care

Description	Revenue Code	Unit=Time
Routine Home Care	0651	1 unit = 1 day
Continuous Home Care	0652	1 unit = 15 minutes
Inpatient Respite Care	0655	1 unit = 1 day
General Inpatient Care	0656	1 unit = 1 day

Routine Home Care (RHC)

- Hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care
  - paid without regard to the volume or intensity

2016 Hospice Payment Reform

Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.
5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘High’ Rate upon the new hospice election

Continuous Home Care

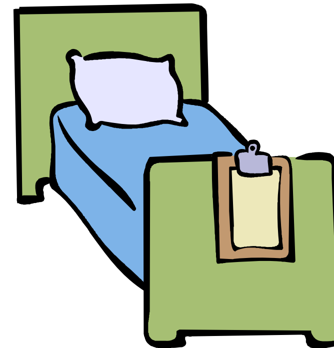
- CHC is provided during periods of crisis as needed to maintain the patient in their home.
- To qualify as CHC, a minimum of 8-hours of care must be provided in a 24-hour period, beginning and ending at midnight.
    - The care does not need to be continuous.
- Care can be provided by nurses (RN or LPN) and home health aides; however, at least half (50%) of the care must be provided by a nurse.
- When billing CHC, units are billed to indicate the number of 15-minute increments provided in each 24-hour period of CHC. Example: 8 hours of CHC = 32 units
- If these criteria are not met (e.g. only 7 hours of care was provided), routine home care must be billed.

Inpatient Respite Care

- Respite care is provided in a hospital, skilled nursing facility, or other inpatient facility, to provide temporary relief to the patient's family members or other caregivers.
- Respite care should be used on a short-term, occasional basis, when necessary to relieve the caregiver.
- Respite is payable for up to 5 consecutive days. Days beyond day 5 are billed at the routine rate.
- More than one respite stay in a billing period is allowed.
- The day of admission to respite is billed as a respite day. The day of discharge is billed as a routine home care day. If the patient dies while in respite, the day of death is billed as respite.

General Inpatient Care (GIP)

- GIP is provided in an inpatient setting to control the patient's pain or manage the symptoms of their terminal illness that cannot feasibly be provided in another setting.
- The day of admission to GIP is billed as a GIP day. The day of discharge is billed as a routine home care day. If the patient dies while in GIP, the day of death is billed as GIP.



2016 Hospice Payment Reform

Service Intensity Add-On Payment (SIA)

Effective for hospice services with " dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment if the following criteria are met:

1. The day is an RHC level of care day.
2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).
3. Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a social worker via telephone.

Sequential Claim Billing

- ✓ **HIC – *Required*:** Enter the beneficiary's Health Insurance Claim Number (HICN)
- ✓ **TOB – *Required:*** Type of bill (system generated). FISS Page 01 defaults the type of bill (TOB) to 81A.
  - You may need to change this depending on the TOB you are entering.

    1st Digit
    8 — Hospice

    2nd Digit
    1 — Hospice (nonhospital based)
    2 — Hospice (hospital based)

    3rd Digit
    1—Admit through discharge; 2—Interim–first claim
    3—Interim–continuing claim; 4—Interim–last claim
- ✓ **NPI – *Required:*** Enter your Hospice National Provider Identifier.
- ✓ **PAT.CNTL# - *Optional:*** Up to 20 digits are available for you to enter your internal account number for tracking purposes. This number will display on your Remittance Advice or your Electronic Remittance Advice

Sequential Claim Billing

- ✓ **STMT DATES FROM – *Required:*** Enter the begin and end dates of the billing period
- ✓ **LAST – *Required:*** Enter the beneficiary's last name exactly as it appears on the Medicare card or the beneficiary's eligibility file, including any spaces, apostrophes, hyphens or suffixes.
- ✓ **FIRST – *Required:*** Enter the beneficiary's first name exactly as it appears on the Medicare card or the beneficiary's eligibility file.
- ✓ **MI – *Optional:*** Enter the beneficiary's middle initial.
- ✓ **DOB – *Required:*** Enter the beneficiary's date of birth.
- ✓ **ADDR 1-6 – *Required:*** Enter the beneficiary's full mailing address, including street name and number, post office box number or RFD, city and state.
- ✓ **ZIP – *Required:*** Enter the beneficiary's 5- or 9- digit zip code.
- ✓ **SEX – *Required:*** Enter the beneficiary's gender using the appropriate alpha character. M = Male F= Female

Sequential Claim Billing

- ✓**MS – *Optional:*** Beneficiary's marital status
- ✓**ADMIT DATE – *Required:*** Enter the effective date of the hospice election or date of hospice transfer. (must match the Admit date on the NOE or Change)
- ✓**HR – *Required (DDE ONLY):*** Hour of Admission — Enter the hour of admission (based on a 24-hour clock). If the hour of admission is unknown, enter '01'.
- ✓**TYPE – *Required:*** Enter the Priority (Type) of Admission code. 1 — Emergency; 2 — Urgent; 3 — Elective; 4 — Newborn 5 — Trauma; 9 — Information not available
- ✓**SRC – *Required:*** Enter a Point of Origin (Source of Admission) code
  - ✓1 — Non-health care facility; 2 — Clinic or Physician's office; 4 — Transfer from hospital (different facility); 5 — Transfer from skilled nursing facility (SNF) or intermediate care facility (ICF); 6 — Transfer from another health care facility; 8 — Court/Law enforcement; 9 — Information not available
- ✓**STAT – Required:** Enter the beneficiary's Discharge Status Code as of the "TO" date on this claim.

Discharge STAT Codes

PATIENT DISCHARGE CODES AND DESCRIPTIONS

Code	Description
01	Discharged to home or self-care. **This code should not be used for patients who die while under hospice care.**
30	Still a hospice patient - hospice services continue to be provided.
40	Expired at home.* Note: When patient status code '40' is reported, an occurrence code 55 and the date of death must also be reported.
41	Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF) or freestanding hospice.* Note: When patient status code '41' is reported, an occurrence code 55 and the date of death must also be reported.
42	Expired – place unknown.* Note: When patient status code '42' is reported, an occurrence code 55 and the date of death must also be reported.
50	Discharged/transferred to hospice – home. Use this code when a patient transfers to another hospice under routine or continuous care.
51	Discharged/transferred to hospice – medical facility. Use this code when a patient transfers to another hospice under respite or general inpatient care.

*Ensure the "TO" date on the claim is the date of death.

Occurrence & Condition Codes

Occurrence Codes (FL 31-34)	
27	Date of certification or recertification
42	Date of revocation (ONLY)
55	Date of death (when patient status = 40, 41 or 42)
CMS Pub. 100-04, Chapter 11, Section 30.3	

Occurrence Span Codes (FL 35-36)	
77	Noncovered days due to untimely recertification (Not for FTF)
M2	Multiple respite stays, From/To dates of each stay
CMS Pub. 100-04, Chapter 11, Section 30.3	

Occurrence code 32 and date are required when the Advance Beneficiary Notice (ABN) was provided to the beneficiary, and the beneficiary requested the services provided be billed to Medicare. The date reflects the date the ABN was provided to the beneficiary.

Occurrence & Condition Codes

Discharge Reason	Occurrence Code	Condition Code	Patient Status Code
Patient revokes	42	None	Appropriate code
Patient transfers hospices	None	None	50 or 51
Patient no longer terminal	None	None	Appropriate code
Patient discharged for cause	None	H2	Appropriate code
Patient moves out of service area	None	52	Appropriate code
Death	55	None	40, 41, or 42

Condition code 52 - required to report a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient.

Condition code H2 - required when a patient is discharged by the hospice for cause.

Sequential Claim Billing

- ✓ **FAC.ZIP – *Required:*** Facility ZIP code of the provider or the subpart (5- or 9-digit). The ZIP code entered must match the ZIP code in the Master Address field of the provider's address file at Medicare MAC
- ✓ **Value Codes – Amounts – *Required:***
  - ✓ Value code 61 and the core based statistical area (CBSA) code are required when billing routine (revenue code 0651) and/or continuous home care (revenue code 0652).
  - ✓ Value code G8 and the CBSA code are required when billing respite (revenue code 0655) and/or general inpatient care (revenue code 0656).

Revenue Codes - Visits

Discipline Visit Description	REV	HCPCS, Modifiers (PM if post-mortem on/after 1/1/14)
Physical therapy	**0421**	G0151, PM
Occupational therapy	**0431**	G0152, PM
Speech language pathology	**0441**	G0153, PM
Skilled nursing	**0551**	G0154, PM
Medical social service (visit)	**0561**	G0155, PM
Medical social service (phone call)	**0569**	G0155, PM
Home health aide	**0571**	G0156, PM

Location Codes

<table>
<tr><th>Levels of Care Description</th><th>REV</th><th>HCPCS (Place of Service)</th></tr>
<tr><td>Routine home care (Q5001-Q5010)</td><td>0651</td><td rowspan="4">Q5001 – Home
Q5002 – Assisted living facility
Q5003 – LTC or non-skilled NF (receiving unskilled care)
Q5004 – Skilled nursing facility (receiving skilled care)
Q5005 – Inpatient hospital
Q5006 – Inpatient hospice facility
Q5007 – Long term care hospital
Q5008 – Inpatient psychiatric facility
Q5009 – Place not otherwise specified
Q5010 – Hospice residential facility</td></tr>
<tr><td>Continuous home care (Q5001-Q5003, Q5009-Q5010)</td><td>0652</td></tr>
<tr><td>Respite care (Q5003-Q5009)</td><td>0655</td></tr>
<tr><td>General inpatient care (Q5004-Q5009)</td><td>0656</td></tr>
</table>

Location Codes

Allowed Place of Service (HCPCS) Codes for Levels of Care (Revenue) Codes	Routine 651	CHC 652	Respite 655	GIP 656
Q5001 – Home	Y	Y	N	N
Q5002 – Assisted living facility	Y	Y	N	N
Q5003 – LTC or non-skilled NF (unskilled care)	Y	Y	Y	N
Q5004 – Skilled nursing facility (skilled care)	Y	N	Y	Y
Q5005 – Inpatient hospital	Y	N	Y	Y
Q5006 – Inpatient hospice facility	Y	N	Y	Y
Q5007 – Long term care hospital	Y	N	Y	Y
Q5008 – Inpatient psychiatric facility	Y	N	Y	Y
Q5009 – Place not otherwise specified	Y	Y	Y	Y
Q5010 – Hospice residential facility	Y	Y	N	N

Multiple Location Codes

- If care is rendered at multiple locations, each location is to be identified on the claim with a corresponding HCPCS code
  - For example, routine home care may be provided for a portion of the billing period in the patient's residence and another portion in an assisted living facility
    - Report one revenue code 651 line with HCPCS code Q5001 and another revenue code 651 line with HCPCS code Q5002

Time Reporting Units

< means less than

Units	Minutes
1	< 23 minutes
2	= 23 minutes to < 38 minutes
3	= 38 minutes to < 53 minutes
4	= 53 minutes to < 68 minutes
5	= 68 minutes to < 83 minutes
6	= 83 minutes to < 98 minutes
7	= 98 minutes to < 113 minutes
8	= 113 minutes to < 128 minutes
9	= 128 minutes to < 143 minutes
10	= 143 minutes to < 158 minutes

Claim Form Locators

R = required   C = conditional   N = not required   O = optional

FISS Pg	FISS Field Name	UB FL	Data Entered	NOE	Claim
2	Tot Unit	46	Total units	N	R
2	Cov Unit	46	Covered units	N	R
2	Tot Charge	47	Total charges	N	R
2	Ncov Charge	48	Noncovered charges	N	C
2	Serv Date	45	Service date	N	R
3	CD	50	Payer code	R	R
3	Payer	50	Payer name	R	R
3	RI	52	Release of information	R	R
3	SERV FAC NPI	N/A	NPI of Facility	N	C[7]
3	Medical Record Nbr	3b	Medical Record Number	O	O
3	Diag Codes	67	Diagnosis codes	R	R
3	Att Phys NPI	76	Attending physician's NPI	R	R
3	L	76	Attending physician's last name	R	R
3	F	76	Attending physician's first name	R	R

[7] Required when patient in nursing facility, hospital, hospice inpatient facility.

*Attending Physician Update

- CMS will amend the regulations at §418.24(b)(1) **and require the election statement to include the patient's choice of attending physician**

- **Information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or NP was designated as the attending physician.** Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in §418.24(b) are met.

- **Language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient's (or representative's) choice.**

*Attending Physician Update

- **If a patient (or representative) wants to change his or her designated attending physician**, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, **the patient (or representative) must file a signed statement, with the hospice, that identifies the new attending physician in enough detail so that it is clear which physician or NP was designated** as the new attending physician.

- **The statement needs to include the date the change is to be effective, the date that the statement is signed, and the patient's (or representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or representative's) choice**. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

*Attending Physician Update

- CMS provides clarification that attending physician status need not change when a patient enters GIP. If attending physician is not available, hospice physician fills in.
- Hospice should document in medical record situations where attending is no longer willing or available to follow patient. Hospice should inform patient or representative that new attending may be chosen.
- CMS will issue educational materials to alert hospices and treating physicians about inappropriate use of attending physician modifier on claim and update beneficiary materials.

New Hospice Claim Requirements

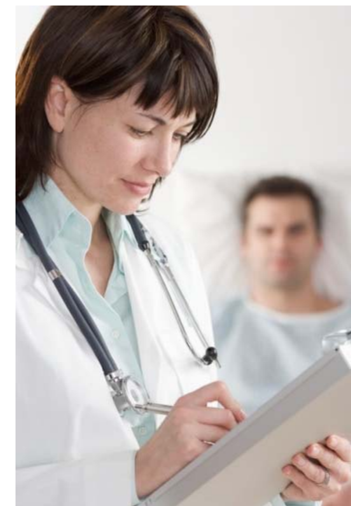
- **General Inpatient Care (GIP) Visits**
- **Inpatient Facility Identification**
- **Post-Mortem Visits**
- **Injectable Drugs**
- **Non-Injectable Drugs**
- **Infusion Pumps**

General Inpatient (GIP) Visit Changes

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

General Inpatient (GIP) – Q5006

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



GIP UB04 Claim Detail - 2014

GIP - Facility OTHER THAN Hospice Inpatient Facility

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

GIP - Hospice Inpatient Facility

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

Inpatient Facility Identification

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

Inpatient Facility Identification

- Reported in HIPAA 5010 electronic claim format - 'Other Provider Location Loop 2310 E'
- Claims billed with inpatient facility location codes will be returned (RTP) ("T" Status) for corrections if inpatient facility identifying information missing
- When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

Page 3 – DDE Entry Hospice

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

Post–Mortem Visits

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

Post–Mortem Visits

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

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

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

CGS 2014 Q&A – Reviewed 11/30/13

- **Q&A #28 -** If a post-mortem nurse visit begins at 11:15 pm and lasts until 12:30 am, would that be counted as 5 increments of 15 minutes then, because it started on the date of death even though it extended into the following day?

- **Answer:** Post-mortem visits should reflect the duration of the visit that occurred on the date of death. Any visit time for the day **following the date of death cannot be reported**. So in this example, the post-mortem visit would be reported as 3 units, which is equivalent of 45 minutes – from 11:15 p.m. until midnight.

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

CMS 2014 Q&A – Revised

- **Q&A #12-** Does the patient's body have to be present to report a post-mortem visit?

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

CMS 2014 Q&A – Revised

- **Question #13: Do we have to report post mortem visits for patients who die while in the GIP level of care at a hospice inpatient facility?**

- **Answer:** For visit reporting for GIP in a hospice inpatient facility, you will continue to follow the instructions in CR5567. These visits are reported weekly (Sunday-Saturday) and do not utilize the HCPCS G-codes. Since line item visit reporting is not applicable for GIP in a hospice inpatient facility (Q5006), post mortem visits would not be reported either.

GIP UB04 Claim Detail - 2014

GIP - Facility with Post-Mortem Visit

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

GIP - Facility with SPLIT Post-Mortem Visit

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

Injectable Drugs

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

GIP UB04 Claim Detail - 2014

GIP - Facility with Injectable Drugs

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

Non-Injectable Drugs

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

GIP UB04 Claim Detail - 2014

GIP - Facility with Non-Injectable & Injectable Drugs

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

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

Keying Non-Injectable Drugs in DDE

```
MAP171E   PAGE 02
XXX1111   SC                      INST CLAIM ENTRY
                                                        NDC CD PAGE 01
 HIC 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
```

Infusion Pumps

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

Infusion Pumps

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

GIP UB04 Claim Detail - 2014

GIP - Facility with Injectable Drugs & Infusion Pump

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

ICD-9-CM/ICD-10-CM codes that may not be used as primary diagnoses	▪ Diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines. ▪ Diagnosis codes which require further compliance with various ICD-9-CM/ICD-10-CM coding conventions. ▪ Codes that have principal diagnosis code sequencing or etiology/manifestation guidelines. ▪ Diagnosis codes listed under the classification of Symptoms, Signs, and Ill-defined Conditions are not to be used as principal diagnoses when a related definitive diagnosis has been established or confirmed by the provider. ▪ "Debility" (799.3, 780.79/R53.81) and "adult failure to thrive" (783.7/R62.7) are not to be used as principal hospice diagnoses on the hospice claim form. ▪ Diagnosis codes in Attachment A
Return to provider claims	▪ When the above diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

ICD-9-CM/ICD-10-CM Dementia Coding Guidelines:

ICD-9-CM/ICD-10-CM dementia codes that may not be used as primary diagnoses	▪ **Codes that have principal diagnosis code sequencing guidelines.**
	  ○ Most of these dementia codes are those found under the ICD-9-CM/ICD-10-CM classification, *"Mental, Behavioral, and Neurodevelopmental Disorders"* as these are typically manifestations from an underlying physiological condition.
	▪ **Diagnosis codes 294.10/F02.80.**
	  ○ "Dementia in diseases classified elsewhere without behavioral disturbance," and 294.11/F02.81, "Dementia in diseases classified elsewhere with behavioral disturbance."

Unspecified codes	▪ These codes are only to be used when the medical record, at the time of the encounter, is insufficient to assign a more specific code. ○ it is recognized that the underlying neurologic condition causing dementia may be difficult to code because the medical record may not provide sufficient information. ▪ There are codes listed under "Diseases of the Nervous System" that do provide for appropriate principal code selection under these circumstances and hospice providers are encouraged to look at the coding conventions under that classification for coding dementia conditions on hospice claims.
Return to provider claims	▪ When the above diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Coding Guidelines – Hospice

- The principal diagnosis listed is the diagnosis most contributory to the terminal prognosis.

Non-reportable Principal Diagnosis Codes to be returned to the provider for correction:

- Hospices may not report ICD-10-CM z-codes as the principal diagnosis on hospice claims.
- Hospices may not report debility, failure to thrive, or dementia codes classified as unspecified as principal hospice diagnoses on the hospice claim.
- Hospices may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines or require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing guidelines.

Coding Guidelines – Hospice

ICD-9-CM/ICD-10-CM Coding Guidelines

The principal diagnosis reported on the claim is the diagnosis most contributory to the terminal prognosis. Hospice providers must follow the ICD-9-CM/ICD-10-CM Coding Guidelines. CMS will implement a Medicare Code Editor edit beginning October 1, 2014 as a "Manifestation code as principal diagnosis" edit in the Integrated Outpatient Code Editor (IOCE). Additionally, new edits for the codes in Attachment A will be implemented, as these codes are part of sequencing or other coding convention in ICD-9-CM/ICD-10-CM coding guidelines.

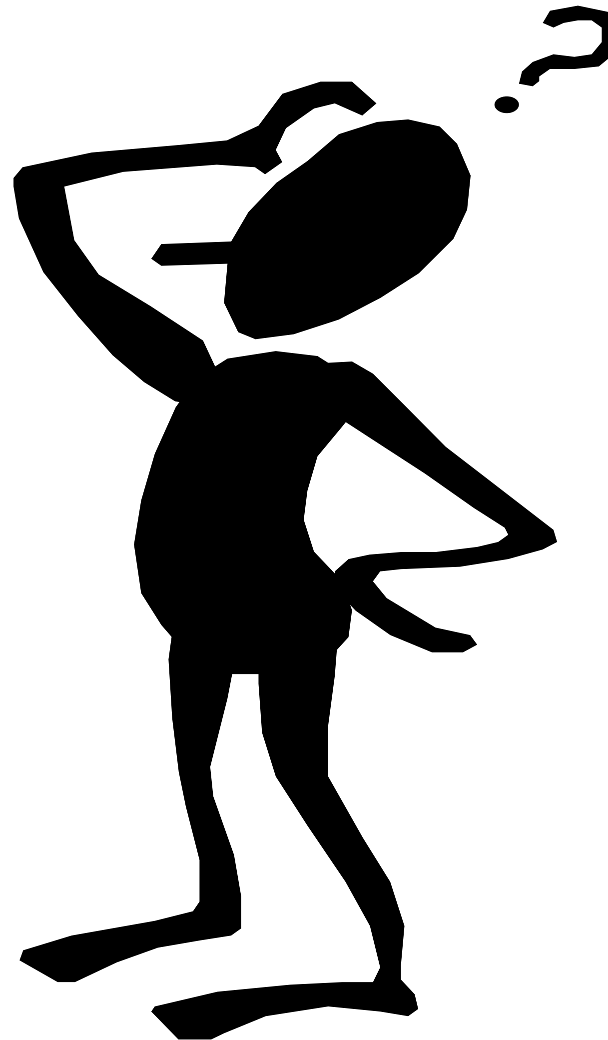
ICD-9-CM/ICD-10-CM codes that may not be used as primary diagnoses	• Diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines. • Diagnosis codes which require further compliance with various ICD-9-CM/ICD-10-CM coding conventions. • Codes that have principal diagnosis code sequencing or etiology/manifestation guidelines. • Diagnosis codes listed under the classification of Symptoms, Signs, and Ill-defined Conditions are not to be used as principal diagnoses when a related definitive diagnosis has been established or confirmed by the provider. • "Debility" (799.3, 780.79/R53.81) and "adult failure to thrive" (783.7/R62.7) are not to be used as principal hospice diagnoses on the hospice claim form. • Diagnosis codes in Attachment A
Return to provider claims	• \When the above diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Coding Guidelines – Hospice

- Specifically, all diagnoses affecting the plan of care for the individual, which is in line with the hospice coverage requirements which state that hospices are to provide services for the palliation and management of the terminal illness and related conditions, are to be reported on the hospice claim.

- http://www.cgsmedicare.com/hhh/education/materials/msp.html
- http://www.cgsmedicare.com/hhh/education/materials/MSPResources.html
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf

Questions



Thank You For Listening!

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