CR 6440: Additional Documentation on Hospice Claims

CR 6440 effective date = January 1, 2010
For services provided on or after January 1, 2010

WHAT ARE THE REPORTING REQUIREMENTS OF CR 6440?

As of January 1, 2010, CMS requires hospices to report additional data on their claims for Medicare payment that describes the time intensity of services provided in the course of delivering routine home care, continuous home care, and respite care. With the implementation of CR 6440, hospices must also report visits by physical therapists, occupational therapists, speech language pathologists, and some social worker phone calls.

HOW TO REPORT A VISIT:

- 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 5 minute visit is counted as 1 15-minute increment, a 20 minute visit is counted as 1 increment, and a 25 minute visit is counted as 2 increments.

- Interdisciplinary group (IDG) meeting time is not reported.

- Documentation time: 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.

- Rounding visits:
  - Transmittal1738, dated May 15, 2009 rescinds and replaces Transmittal 1713 issued April 24, 2009, to change “rounding up to the nearest 15 minute increment” to “rounding to the nearest 15 minute increment.”
    - Example #1: Visit time by nurse equals 8 minutes. One 15 minute increment or unit is entered for that visit on the line of the claim.
    - Example #2: Visit time by nurse equals 47 minutes. Three 15 minute increments or units are entered for that visit on the line of the claim.

- The total number of visits does not imply the total number of activities or interventions provided. If patient care visits in a particular discipline are not provided under a given level of care or service location, do not report a line for the corresponding revenue code.

- Reporting care by multiple health care providers at the same time: These visits should be recorded on the claim form as long as the visits are required for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care and are not listed for the purposes of increasing the number of visits.
  - For example, a nurse teaching another nurse to perform a procedure would not comprise 2 visits. A nurse and an aide turning a difficult patient would constitute one visit each (though there would likely be other tasks performed as part of those visits).

- If a hospice receives late information about reportable visits for any reportable discipline other than physicians, it will adjust the previously submitted claim to add the required information that was omitted. If a hospice receives late information about separately billable physician
visits, it may either adjust the previously submitted claim or submit a separate late charge claim (type of bill 815 or 825) for the visits.

- If revenue code lines reporting visits (revenue codes 55x, 56x or 57x) are received without units or charges, the claim will be returned to the provider. Please note that this is also true for the reporting of site of service Healthcare Common Procedure Coding System (HCPCS) codes on hospice level of care revenue code lines (revenue codes 651, 652, 655 and 656). Claims submitted without the site of service HCPCS codes are currently returned to the provider.

REPORT VISITS BY DISCIPLINE:

- Medicare hospice claims should report each visit to an individual patient, performed by nurses, aides, and social workers who are employed by the hospice, and their associated time per visit in the number of 15 minute increments.

- Visits performed by physical therapists, occupational therapists, and speech language pathologists were added as of January 1, 2010. Some social worker phone calls can also be counted.

- Report visits on a separate line (line-item billing) regardless of the location of the patient or the level of care provided, if the visit is necessary for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Visit revenue code</th>
<th>HCPCS G-code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses (RN’s, LPN’s, NP’s if acting in the role of a nurse)</td>
<td>055x Skilled Nursing</td>
<td>G0154</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>056x Medical Social Services</td>
<td>G0155</td>
</tr>
<tr>
<td>Hospice Aide</td>
<td>057x Home Health Aide</td>
<td>G0156</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>042x Physical Therapy</td>
<td>G0151</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>043x Occupational Therapy</td>
<td>G0152</td>
</tr>
<tr>
<td>Speech Language Therapy</td>
<td>044x Speech Language Therapy</td>
<td>G0153</td>
</tr>
</tbody>
</table>

Physicians or NPs acting as the attending physician

★ No changes to reporting requirements for physicians in CR 6440

(CR 5567 - The physician visits on the hospice claims are for reasonable and necessary visits by the hospice medical director or a physician who is employed by or under contract with the hospice.)

- Physician visits are to be reported daily, at a procedure code level.
- For every day a physician provides a visit, there should be a separate line item.
- If a physician provided multiple visits for a given beneficiary on a given day, as the procedure codes were different, there should be a separate line item for each procedure code on that day.
- If the physician visits provided on a given day were the same procedure code, the visits would be reported on a single line item, showing more than one visit for that procedure code on that day.

(REvised)

REPORT VISITS THAT ARE REASONABLE AND NECESSARY:

- A reasonable and necessary patient care visit means a visit to provide care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions as
described in the patient’s plan of care. Hospices should count the number of visits, not the number of services performed during a single visit.

- **Example:** if a nurse visits to auscultate a patient’s chest but auscultation is not necessary or warranted, it would not constitute a patient care visit.

- **Reasonable and necessary for social work visits:** *This a visit that is reasonable and necessary* for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care. Due to the nature of a social worker’s functions, counseling or speaking with a patient’s family or arranging for placement, would constitute a visit.

- **How to decide whether a visit is reported in a facility:** When making the determination as to whether or not a particular visit should be reported, a hospice should consider whether the visit would have been reported, and how it would have been reported, if the patient were receiving RHC in his or her private home. If a group of tasks would normally be performed in a single visit to a patient living in his or her private home, then the hospice should count the tasks as a single visit for the patient residing in a facility. Hospices should not record a visit every time a staff member enters the patient’s room. Hospices should use clinical judgment in counting visits and summing time.

---

**REPORT VISITS BY LEVEL OF CARE:**

**Routine Home Care:**

Count visits for Routine Home Care (RHC) as follows:

1. **Patient resides in their own home**
   - Hospice providers report all visits by staff employed by the hospice and contracted staff in 15 minute increments on the claim form.

2. **Patient resides in a facility**
   - a. **Hospice owned facility**
     - Record visits by staff employed by the hospice and contracted staff in 15 minute increments on the claim form.
     - Visits which are part of **room and board services** and which are provided to a RHC patient residing in a facility should **NOT** be reported on hospice claims to Medicare (regardless of whether those services are being provided by hospice staff or facility staff not employed by the hospice).
   - b. **Non-hospice owned facility**
     - Hospices are **not** required to count visits by non-hospice staff to hospice patients receiving RHC in contract facilities.
     - Hospices are **are** required to count visits by hospice staff in a non-hospice owned facility.

- **Description of room and board services:** Room and board services may include, but are not limited to, delivery of meals, changing bed linens, housekeeping tasks, etc. Hospices should only report visits which are reasonable and necessary for the palliation and management of the terminal illness and related conditions.

  - Hospices should not:
    - Record a visit every time a staff member enters the patient’s room.
CONTINUOUS HOME CARE:

Count visits for Continuous Home Care (CHC) as follows:

1. Patient resides in their own home
   - Hospice providers report all visits by staff employed by the hospice and contracted staff in 15 minute increments on the claim form.

2. Patient resides in a facility
   a. Hospice owned facility
      - Record visits by staff employed by the hospice and contracted staff in 15 minute increments on the claim form.
      - Visits which are part of room and board services and which are provided to a CHC patient residing in a facility should **NOT** be reported on hospice claims to Medicare (regardless of whether those services are being provided by hospice staff or facility staff not employed by the hospice).
      - The visits are counted based upon the number of times that are needed to constitute a CHC visit.

      - **Examples:**
        A nurse (RN) provides 4 hours of care in the morning and 4 in the afternoon = 2 RN visits.

        If 3 nurses and one aide provide 24 hrs of CHC continuously in a 24 hour visit = 1 RN visit and 1 aide visit. Please see Section 40.2.1 of the Medicare Benefit Policy Manual for additional explanations and examples

        - Nursing must be the majority of the care, so the total 15 minute increments billed in a 24 hour period must have more nursing increments than aide increments.

   b. Non-hospice owned facility
      - Hospices are **not** required to count visits by non-hospice staff to hospice patients receiving CHC in contract facilities.

INPATIENT RESPITE CARE:

Count visits for inpatient Respite Care as follows:

1. Patient receives care in a Hospice owned facility
   - Record visits by staff employed by the hospice and contracted staff in 15 minute increments on the claim form.
   - Visits which are part of room and board services should **NOT** be reported on hospice claims to Medicare (regardless
2. Patient receives care in a non-hospice owned facility
   • Hospices are not required to count visits by non-hospice staff to hospice patients receiving respite care in contract facilities.

GENERAL INPATIENT CARE:

Count visits for General Inpatient Care (GIP) as follows:

1. Patient is receives care in a Hospice owned facility
   • Reporting of visit intensity data is NOT required at this time. Providers should continue to report the number of GIP visits in accordance with CR 5567. Additionally, the units for visits under GIP level of care continue to reflect the number of visits per week.
   • Mechanism for Counting Visits: Hospice providers should create a mechanism that allows for counting how many times a hospice nurse, home health aide (also known as a hospice aide), social worker, physical or occupational therapist, speech language pathologist, or physician visits a patient, or the number of times a social worker makes certain types of phone calls, for the purpose of providing care necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care.
   • Visits which are part of room and board services should NOT be reported on hospice claims to Medicare (regardless of whether those services are being provided by hospice staff or facility staff not employed by the hospice).

2. Patient is receives care in a non-hospice owned facility
   • Hospices are not required to count visits by non-hospice staff to hospice patients receiving GIP in contract facilities.

ALL LEVELS OF CARE: SOCIAL WORKER TELEPHONE CALLS

• 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, in certain circumstances, their phone calls as visits. For instance, 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.
  
  o 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. However, it would be inappropriate to record every phone call that a social worker makes on behalf of a patient.

- Report each telephone call that social workers make 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) in 15 minute increments on the claim form.

- Each call should be a separate line item.

- With the implementation of CR 6440 on January 1, 2010, hospices may report some social worker calls using revenue code 0569. Please see CMS Hospice Q&A #9970 for more details. Hospices may not report any other types of phone calls. (Revised)

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Revenue code</th>
<th>HCPCS G-code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Social Services telephone calls</td>
<td>0569</td>
<td>G0155</td>
</tr>
</tbody>
</table>

**HOW TO REPORT CHARGES ON THE CLAIM FORM:**

- Charges associated with the reported Revenue Codes 42x, 43x, 44x, 55x, 56x, and 57x are covered under the hospice bundled payment and are reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines.

- These visit charges will be identified on the provider remittance advice notice with reason code 97 (“Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated.”) and code CO (Contractual Obligation).

- 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.

★ **NHPCO Recommendation:** Work to develop a per-unit charge structure and report charges based on the unit charge multiplied by the amount of time, in 15 minute increments.

**DATA FOR OTHER HOSPICE IDG MEMBERS:**

**CMS Comment:** Data on claims for chaplains/spiritual counselors or volunteers are not required to be collected at this time, but CMS has stated that reporting this data will be included in a future phase of the data collection.

**NHPCO Recommendation:** Although CMS is not requiring visits and time intensity for disciplines other than those listed above, NHPCO recommends that all disciplines begin reporting visits and visit time for each patient in software systems or timesheets. This data could be vitally important in future discussions with CMS about the services hospices offer and how to restructure hospice rates.
STRATEGIES FOR IMPLEMENTATION:

- Ensure that your software vendor has completed the necessary updates to guarantee compliance with CR 6440.

- Determine whether you will implement a per-unit charge structure so that your charges will vary depending on the length of a visit. Implement the charge structure so that charges reflect 15-minute increments, rather than a total, all-inclusive charge. [NHPCO Recommendation]

- If you operate your own hospice facility, determine a system for counting visits for patient contacts for visits that reasonable and necessary for the palliation of the terminal illness.

- Ensure that all staff in a hospice owned facility understands what care is considered room and board care so that it not recorded on the claim form as a visit.

- Educate appropriate staff about the requirements and your process for collecting the data.

REFERENCES


Centers for Medicare and Medicaid Services, Hospice Q&A’s, http://questions.cms.hhs.gov/app/answers/list