Interdisciplinary Team Visit Data Required on the Hospice Claim for Submission to Medicare Administrative Contractor (MAC) for Medicare Payment

The Requirements

CR 8358 - Additional Data Reporting Requirements for Hospice Claims, issued July 26, 2013 and effective January 6, 2014 (Voluntary reporting from January 1, 2014 through March 31, 2014. Mandatory reporting on or after April 1, 2014.)

- Hospice staff visits for General Inpatient (GIP) in a SNF or hospital - Hospice providers are required to 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 the home levels of 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 the home levels of care.
  - Exception: 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.

- NPI number reported - Hospices shall report the National Provider Identifier (NPI) of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving services, regardless of the level of care provided, when the site of service is not the billing hospice.
  - The billing hospice must report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice’s location.
  - When the patient has received care in more than one facility during the billing month, the hospice reports 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.

- 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.
  - Visits occurring after death, and on the date of death, would need to be reported using a PM modifier to differentiate them from visits occurring before death.
    - The reporting of post-mortem visits, on the date of death, should occur regardless of the patient’s level of care or site of service.
  - Exception: Post mortem visits occurring on a date subsequent to the date of death are not to be reported.

- Prescription drugs (injectable, non-injectable and infusion pumps):
  - Hospice agencies shall report injectable and non-injectable prescription drugs on their claims. Both injectable and non-injectable prescription drugs should be reported on claims on a line-item basis per fill. Over-the-counter drugs are not to be reported at this time.
  - Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump order and for each medication refill. DME other than infusion pumps and medical supplies are not to be reported at this time.

CR 6440 (Revised) - Additional Data Reporting Requirements for Hospice Claims, issued in May 15, 2009 and effective January 1, 2010

- **Visits for level of care** - Hospice providers are required to report all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite care billing. Medicare hospice claims should report each visit 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, on a separate line.

- **Therapy visits** - Providers are also required to report each RHC, CHC, and Respite visit performed by physical therapists, occupational therapists, and speech-language therapists, and their associated time per visit in the number of 15 minute increments on a separate line.

- **Social work phone calls** - Social worker phone calls made to the patient or the patient’s family should be reported. 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.
  - 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.
  - When recording any visit or social worker phone call time, providers should sum the time for each visit or call, rounding to the nearest 15 minute increment.
  - Providers should not include travel time or documentation time in the time recorded for any visit or call.\(^1\)

- **General Inpatient Care (GIP) or respite visits** - GIP or respite care related to the palliation and management of the terminal illness or related conditions provided in hospice-owned facilities must be reported. Hospices should not record a visit every time a staff member enters the patient's room. Hospices should not record visits which are part of room and board services provided to a RHC patient residing in a facility. Room and board services may include, but are not limited to, delivery of meals, changing bed linens, housekeeping tasks, etc.
  - **Exception:** Hospice providers are not required to report time for visits made by non-hospice staff providing General Inpatient Care or respite care in contract facilities.\(^2\)


CR 5567 (Revised) issued February 12, 2008 and effective July 1, 2008

- **Visit reporting** - 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, must be reported on the hospice claim. The total number of patient care visits is to be reported by the discipline (registered nurse, nurse practitioner, licensed nurse, home health aide (also known as a hospice aide), social worker, physician or nurse practitioner serving as the beneficiary’s attending physician) for each week at each location of service.
  - Visits by registered nurses, licensed vocational nurses and nurse practitioners (unless the nurse practitioner is acting as the beneficiary’s attending physician) are reported under revenue code 055x

- **Visits in multiple sites** - If visits are provided in multiple sites, a separate line for each site and for each discipline will be required. The total number of visits does not imply the total number of activities or interventions provided.

- **Visit defined** - To constitute a visit, the discipline, must have provided care to the beneficiary. The visit must

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be reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care.

**Activities that should not be reported:**

- Phone calls, documentation in the medical/clinical record, interdisciplinary group meetings, obtaining physician orders, rounds in a facility or any other activity that is not related to the provision of items or services to a beneficiary, do not count towards a visit to be placed on the claim.
- 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.


### CMS FAQ’s related to Additional Data on the Hospice Claim Form

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<th>Hot Link to FAQ</th>
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<td>How should a hospice provider count visits when Respite Care is provided in a contract facility?</td>
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<td>2347</td>
<td>How should hospice providers count patient care visits in a facility that is staffed 24 hours a day?</td>
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<tr>
<td>2349</td>
<td>What constitutes a hospice patient care visit that is reasonable and necessary?</td>
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<td>2359</td>
<td>Are attending physician visits by a physician not employed by or under contract with a hospice included</td>
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<td>2361</td>
<td>Hospice services have always been paid on a per diem basis? Does the weekly reporting of services change...</td>
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<tr>
<td>2487</td>
<td>Change Request (CR) #5567 provided instructions for the expanded claims data reporting requirements ...(charges)</td>
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<tr>
<td>7625</td>
<td>What constitutes a hospice patient care visit that is reasonable and necessary?</td>
</tr>
<tr>
<td>2355</td>
<td>If a hospice only uses licensed nurses to provide care, how will the home health aide visits be counted?</td>
</tr>
<tr>
<td>2357</td>
<td>Do phone calls and “on-call” phone consultations constitute a visit for hospice services?</td>
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<tr>
<td>7631</td>
<td>How should hospice providers count patient care visits in a facility that is staffed 24 hours a day?</td>
</tr>
<tr>
<td>7635</td>
<td>Will each hospice visit need to be billed as a separate line item on the claim, showing the time duration...</td>
</tr>
<tr>
<td>2353</td>
<td>How are visits counted for continuous home care (CHC)?</td>
</tr>
<tr>
<td>7627 and 2351</td>
<td>If multiple health care providers are providing hospice care at the same time, does each count as a visit?</td>
</tr>
<tr>
<td>7629</td>
<td>Do phone calls and “on-call” phone consultations constitute a visit for hospice services?</td>
</tr>
</tbody>
</table>

### CMS Frequently Asked Questions (Hot link)

Visit revenue codes

Codes required per CR 8358 with dates of service on or after April 1, 2014

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>Required HCPCS</th>
<th>Required Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250 Non-injectable Prescription Drugs</td>
<td>N/A</td>
<td>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.</td>
</tr>
<tr>
<td>029X Infusion pumps</td>
<td>Applicable HCPCS</td>
<td>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.</td>
</tr>
<tr>
<td>0636 Injectable Drugs</td>
<td>Applicable HCPCS</td>
<td>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).</td>
</tr>
</tbody>
</table>

Modifiers

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.

- How to code:
  - Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>Required detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>0657** Physician</td>
<td>Hospice providers use revenue code 0657 to identify hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657. Procedure codes are required in order for the Medicare contractor to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the Medicare contractor. **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner. ***Reporting of value code G8 is required with these revenue codes</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Revenue code</th>
<th>Required HCPCS</th>
<th>Required Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>042x Physical Therapy</td>
<td>G0151</td>
<td>Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.</td>
</tr>
<tr>
<td>043x Occupational Therapy</td>
<td>G0152</td>
<td>Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.</td>
</tr>
<tr>
<td>044x Speech Therapy Language Pathology</td>
<td>G0153</td>
<td>Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.</td>
</tr>
<tr>
<td>055x Skilled Nursing</td>
<td>G0154</td>
<td>The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description. ★ Does not require a service location HCPCS code.</td>
</tr>
<tr>
<td>056x Medical Social Services</td>
<td>G0155</td>
<td>The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description. ★ Does not require a service location HCPCS code.</td>
</tr>
<tr>
<td>0569 Other Medical Social Services</td>
<td>G0155</td>
<td>Each social service phone call is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the call defined in the HCPCS description. HCPCS G-code G0155 is for the length of the call.</td>
</tr>
<tr>
<td>057x Home Health Aide</td>
<td>G0156</td>
<td>The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description. ★ Does not require a service location HCPCS code.</td>
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</tbody>
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### HCPCS codes required to report the type of service location for hospice services

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Q5001</td>
<td>Hospice Care Provided In Patient’s Home/Residence</td>
</tr>
<tr>
<td>Q5002</td>
<td>Hospice Care Provided In Assisted Living Facility</td>
</tr>
<tr>
<td>Q5003</td>
<td>Hospice Care Provided In Nursing Long Term Care Facility (LTC) Or Non Skilled Nursing Facility (NF)</td>
</tr>
<tr>
<td></td>
<td>- Q5003 is to be used for hospice patients in an unskilled nursing facility (NF) or hospice patients in the NF portion of a dually certified nursing facility, who are receiving <em>unskilled</em> care from the facility staff.</td>
</tr>
<tr>
<td></td>
<td>- Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. When a patient is in the NF portion of a dually certified nursing facility, and receiving only unskilled care from the facility staff, Q5003 should be reported.</td>
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<tr>
<td></td>
<td>★ <em>Requires NPI number of facility</em></td>
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<tr>
<td>Q5004</td>
<td>Hospice Care Provided In Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td></td>
<td>- Q5004 is to be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff.</td>
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<tr>
<td></td>
<td>- Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. For Q5004 to be used, the facility would have to be certified as a SNF.</td>
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<td>★ <em>Requires line item visit reporting in units of 15 minute increments for hospice staff</em></td>
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<tr>
<td></td>
<td>★ <em>Requires NPI number of facility</em></td>
</tr>
<tr>
<td>Q5005</td>
<td>Hospice Care Provided In Inpatient Hospital</td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires line item visit reporting in units of 15 minute increments for hospice staff</em></td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires NPI number of facility</em></td>
</tr>
<tr>
<td>Q5006</td>
<td>Hospice Care Provided In Inpatient Hospice Facility</td>
</tr>
<tr>
<td>Q5007</td>
<td>Hospice Care Provided In Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires line item visit reporting in units of 15 minute increments for hospice staff</em></td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires NPI number of facility</em></td>
</tr>
<tr>
<td>Q5008</td>
<td>Hospice Care Provided In Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires line item visit reporting in units of 15 minute increments for hospice staff</em></td>
</tr>
<tr>
<td></td>
<td>★ <em>Requires NPI number of facility</em></td>
</tr>
<tr>
<td>Q5009</td>
<td>Hospice Care Provided In Place Not Otherwise Specified (NOS)</td>
</tr>
<tr>
<td>Q5010</td>
<td>Hospice Home Care Provided in a Hospice Facility</td>
</tr>
</tbody>
</table>

#### Coding required on or after April 1, 2014:

- **General Inpatient (GIP) in a SNF or hospital** - Hospice providers are required to 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 the home levels of 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 the home levels of care.

- **NPI** - 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 must obtain the NPI for the facility where the patient is receiving care and report the facility’s name, address and NPI on the 837I version 5010A2 837I version 5010A2 of the electronic claim record 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.

**Multiple locations of care** - 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. In this case, report one revenue code 651 line with HCPCS code Q5001 and the number of days of routine home care provided in the residence and another revenue code 651 line with HCPCS code Q5002 and the number of days of routine home care provided in the assisted living facility.

**Note:** GIP care that is provided in a nursing facility can only be given in a SNF (using HCPCS code Q5004), because GIP requires a skilled level of care.

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