

CMS Visit Reporting Guide

THE HOSPICE LEADERS PROJECT

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The Hospice Leaders Project is voluntary collaboration of information and technology companies focused on expediting the adoption of meaningful performance comparisons for the hospice industry. For more information, please send an email to hlp@ocsys.com.

CMS Visit Reporting Guide – NHPCO CTC Edition

CMS is moving forward with a phased increase in data required of hospices, in order to improve hospice benefit payment accuracy and analyze the services provided in this evolving and growing benefit. With a Change Request to the Medicare billing requirements (CR 5567), CMS has begun the second phase of expanding required line level detail on hospice claims. CR 5567 requires additional data to describe services provided for each hospice level of care, mandatory beginning July 1, 2008.

This guide summarizes the new requirements, provides direction regarding interpretation challenges and implementation priorities, and lists additional resources for information. Discussions with CMS on behalf of hospice providers are ongoing, and the regional home health intermediaries (RHHIs) are refining their specifications for CR 5567. This document will be updated as appropriate.

The New Claims Data Reporting Requirements

On monthly patient claims, hospices will need to report the number of **visits** each **week** by **discipline** at each **location**, for each **level of care**, as well as the **charge** for each visit. The requirements become effective for Medicare claims with dates of service beginning on or after July 1, 2008. Hospices may elect to begin reporting this information on January 1, 2008.

The Details

Level of care

Hospices continue to bill with a line for each level of care delivered, under existing codes.

Location of care

Visit data must be reported separately for each location of care at which the patient is served.

Not all disciplines?

Hospices must report visits of nurses (registered, licensed, and nurse practitioners), home health aides, social workers, and physicians (or nurse practitioners serving as attending physician).

- CMS selected the disciplines, because there are existing codes for claims data capture.
- CMS recognizes that this does not represent all care provided under the hospice benefit.
- If no visits are made by a discipline to the beneficiary during a week, do not enter any information for that revenue code.
- Hospices using only licensed nurses (no home health aides) to provide care, should enter all licensed nurse visits as nursing visits, and report no home health aide visits.

What is a week?

For consistency, CMS defines a week to begin on Sunday and end on Saturday.

- Hospices will report lines for each week on the monthly bill.
- If a patient is admitted or discharged mid-week, the week is reported like all others (likely with fewer visits than a full week).
- A week that is split across two months is reported on each month's bill, with the services delivered in each month on that month's bill.

What visits "count"?

"The total number of services indicates the total number of visits [for each discipline] and does not imply the total number of activities or interventions provided."

- DO count visits where direct care is provided to the patient (beneficiary).
- DO count "medically reasonable and necessary" visits (see more below).
- DO count simultaneous visits by multiple providers, if each visit is medically reasonable and necessary.
- DO count multiple simultaneous visits when two providers are required to perform a single task (such as turning a difficult patient).
- DO count visits in a facility staffed 24 hours, by creating a mechanism to capture appropriate visits (see more below).
- DO NOT count training or supervision.
- DO NOT count documentation without a visit.
- DO NOT count phone calls.
- DO NOT count IDG meetings.
- DO NOT count obtaining physician orders.
- DO NOT count visits by a physician not under contract with or employed by the hospice.
- DO NOT count rounds in a facility.

Charges

Charges are required as additional information.

- Charge data will not affect payment now, but may be used by MedPAC or others.
- Charges are not the same as costs.
- Charges should be based upon actual costs, including overhead, with a percent mark up.

NOTE: NHPCO has created a template to use Medicare Cost Report data to calculate charges.

Ongoing Interpretation and Reporting Challenges

What is “medically reasonable and necessary”?

Services (visits) reported must 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. Tasks should not be distributed across multiple visits for the purpose of inflating the patient's visit count. CMS has clarified that, for social workers, counseling or speaking with a patient's family or arranging for placement would constitute a visit.

Counting visits in a facility staffed 24 hours a day

Hospice providers should create a mechanism to count the number of times a day a reportable discipline sees a patient to provide a necessary direct patient service. Hospices must gather visit counts from their own facilities, as well as those providing services under contract. Viable methods include the use of a manual check list or “tally” and the use of an electronic point of care system to record daily reportable visits. *Note: NHPCO and others are advocating for CMS to exempt the general inpatient and respite levels of care from this requirement, on the basis of its low percent of all hospice care provided and the complexity and unlikelihood of comparability in determining the number of visits.*

Counting continuous care (CHC) visits

A CMS clarification states: “Visits are counted based upon the number of times that are needed to constitute a CHC visit”. Examples illustrate the situation-specificity of counting visits for CHC. (See web address for *Additional Questions and Answers about CR 5567 in the list of Additional Information Sources.*) Hospices are encouraged to review CMS examples and consider CHC cases individually to determine appropriate visit counting protocols for the hospice's unique model of CHC provision. RHHIs will also provide guidance. This is a very small percent of all hospice care provided, so hospices should do their best without over-investing in analysis.

Implementation Priorities – Ensure Compliance and Take Strategic Advantage of the Data

Hospices are encouraged to proactively prepare for this new data reporting requirement, aiming for “CR 5567-ready” documentation and internal data capture and reporting, beginning January 1, 2008.

Learn and provide education

- As interpretation consensus is evolving, take advantage of seminars, websites, open forums and networking opportunities, through NHPCO, RHHIs, state associations, consultants, and vendors.
- Ask questions about interpretation of the requirements as they relate to your hospice practices.
- Ensure that the billing staff prepares for the revenue code changes, listed in the Medicare Claims Processing Manual.
- Schedule ongoing training and discussion among clinical staff to ensure compliance and consistency in determining “reportable” visits.
- Provide initial and ongoing training on new data systems and processes.

Optimize data systems and processes

- Start now...process changes take longer than anticipated.
- Define each team member's role in the new management processes as they are implemented.
- Confirm readiness of your MIS Vendor and RHHI to capture and process visit data appropriately.
- If necessary, implement new or upgraded clinical information capture and reporting systems.
- Implement visit data capture processes for all disciplines and visits, not just “reportable” visits.
- Begin capturing and reporting “CR 5567-ready” visit data internally as soon as practical.
- Create and strengthen internal review processes for visit documentation accuracy.
- Integrate “CR 5567-ready” visit data into data management system and process preparation for the Quality Assessment and Performance Improvement (QAPI) Condition of Participation.

Continue to provide high quality hospice care

- Do not alter care delivery practices for the purpose of inflating patient visit counts.
- Do use the newly-available visit data to analyze and improve patient care delivery practices.
- Participate in comparative benchmarking of patient-level visit data, both to pinpoint opportunities to improve patient care and to build a database that will illustrate the complete set of services hospices provide. This can be facilitated by a member of The Hospice Leaders Project.

Why Does CMS Want Hospice Visit Data?

Since the Medicare hospice benefit was implemented in 1983, the benefit has grown to have significant – and increasing – impact on the healthcare system. The government – beyond CMS – wants to evaluate utilization of the benefit, with a better understanding of the types and frequency of hospice services provided.

Why Is This Good for Hospice?

It is important for hospice policy makers, payers, advocates, and agency leaders to have more comprehensive patient-level data for direction, decision-making, and the ongoing improvement in hospice care and services. Voluntary data submission will not build the necessary database quickly enough. There are challenges – and some risks – associated with the approach of CR 5567, and there remain questions about interpretation. However, hospices will benefit from the implementation of consistent documentation, data collection and reporting systems, *especially if processes are built to capture and understand all services provided* (not just those to be required for reporting on claims).

NHPCO and others have successfully advocated for a delay from the originally-transmitted January 1, 2008 implementation date. With the requirement becoming mandatory on July 1, 2008 and optional data submission beginning January 1, 2008, hospices have time to implement and test new processes and systems to ensure the highest level of accuracy and value in data captured. Further, hospices have time to analyze their own data, strengthening quality assessment and performance improvement efforts, while also understanding what CMS may learn from their data submission.

Additional Information Sources

CR 5567 Official Instructions to the Medicare RHHI (revised 11/2/07)

- www.cms.hhs.gov/transmittals/downloads/R1372CP.pdf

CMS Website, Hospice Center – for links to the most current information

- www.cms.hhs.gov/center/hospice.asp

Questions and Answers about CR 5567

- www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/downloads/Questions_and_Answers_About_CR5567.pdf

Additional Questions and Answers about CR 5567 (11/16/07)

- www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/downloads/Questions_and_Answers_About_CR5567v2.pdf

MLN Matters (from Medicare Learning Network) article on CR 5567 (11/2/07)

- www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf

NHPCO Members Only Webpage for CR5567 with a complete set of resources

- <http://www.nhpc.org/login.cfm?nextpage=/i4a/pages/index.cfm?pageid=5320>