Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

PHYSICIAN NOTES: Hospices--Shore Up Your Claims Data

Starting in July, CMS requires claims to be a lot more detailed

According to MLN Matters article MM5567, hospice providers will have to -describe the services provided in the course of delivering each hospice level of care billed- as of July 1.

Starting then, hospice providers will have to indicate on their claims the number of services/visits provided to each Medicare patient. In addition, the hospice claim should demonstrate the total number of direct patient care visits per category -and not as an aggregate total for all,- the article states.

In the article, CMS also outlines what does not constitute a patient visit. For example, a medical record entry without a visit doesn't count as one, nor do -rounds in facilities.- Plus, a single visit encompasses all services and items provided within it--additional services during the visit do not count as additional visits.

CMS also notes in the article that Medicare will not accept a V code as a primary diagnosis on hospice claims.

To read the full article, visit www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf.

In Other News:

- **CMS has added 70 new geographic areas to its competitive bidding program**, allowing Medicare beneficiaries to lower their out-of-pocket costs and giving the Feds an opportunity to keep unscrupulous providers out of the Medicare program.

-Competitive bidding means that Medicare beneficiaries will have access to these products at substantially lower costs,- said Acting **CMS Administrator Kerry Weems** in a Jan. 8 statement. In fact, CMS expects the competitive bidding program to save beneficiaries and Medicare about $1 billion a year after the program launches nationwide.

The program now covers 10 categories, including power wheelchairs, walkers, oxygen supplies and equipment, hospital beds, and other devices.

To read more about the competitive bidding program, go online to www.cms.hhs.gov/CompetitiveAcqforDMEPOS/.

- **Want to know which facilities qualify as ASCs,** how your radiology reimbursement in the ASC is calculated, and who should reimburse your neck brace claims? This information and a lot more is available in a new MLN Matters product sheet titled -Ambulatory Surgical Center Fee Schedule,- part of CMS- Payment System Fact Sheet Series.

The publication lists several examples of covered ASC services, and offers a chart to show where you should send your claims for items and services not included in surgical or ancillary ASC payments.

To read the full article, visit www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508.pdf.

CPT® 2023 American Medical Association. All rights reserved.