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Eli's Hospice Insider

Billing: Get Your Billing Straight For Looming Claims Data Deadline

MAC offers more info on burdensome new requirement.

With all the new data you'll have to report on hospice claims in the new year, exceeding the 450-line claim limit isn't out of the question but hospices aren't sure how to deal with the problem.

Reminder: This past summer, the Centers for Medicare & Medicaid Services issued a transmittal instructing hospices to report a slew of new data by April 1, 2014 (see Eli's HOP, Vol. 6, No. 9). That includes "visit reporting for general inpatient care, reporting the facility NPI where the care was provided when not provided at the billing hospice facility, and reporting of infusion pumps and prescription drugs," CMS describes.

"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," the agency details in July 26 Transmittal 2747 (CR 8358). "It also includes certain calls by hospice social workers ... on a line-item basis, with call and call length reported as is done for the home levels of care."

The number of lines used for medications especially may push claims over the 450-line limit, observers expect. But CMS and its contractors aren't offering hospices any solutions on how to deal with the problem.

"A system edit now enforces monthly billing for hospices; one claim, per month, per patient," says HHH Medicare Administrative Contractor CGS in a recently posted Frequently Asked Question document from an October Ask the Contractor Teleconference on the topic. "CMS expects the instance of going over that 450 revenue code cap to be a rare instance. If a provider hits that cap, the provider should ensure they are reporting their visits appropriately."

Splitting a beneficiary's monthly claim into two will not work, CGS explains in a separate FAQ. "There are edits in place to prevent a claim from processing when the patient status code indicates that patient is still a patient, but the 'TO' date of the claim is not the last day of the month," CGS explains. "In addition, there are edits in place to reject claims with the same dates of service."

Note: See more of the 34 FAQs at www.cgsmedicare.com/hhh/education/faqs/act/act_qa10171.html. The transmittal, including coding instructions, is at www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2747CP.pdf. The MLN Matters article is at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8358.pdf.

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