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# Eli's Hospice Insider

## Reimbursement: CMS Heeds Industry's Pleas For Relief On Drug Reporting

**Your claims reporting should get easier, but it comes at a price.**

The **Trump** administration asked for the industry's suggestions for regulatory relief, and it actually appears to have listened - at least in one area.

In the 2019 proposed rule for hospice payment and CR 10573, both released April 27, the **Centers for Medicare & Medicaid Services** grants many hospices' wishes by removing the requirement to report detailed drug data on the hospice claim.

Effective Oct. 1, "CMS no longer requires hospices to report a charge total and amount dispensed per drug, CMS no longer requires hospices to report injectable drugs using revenue code 0636, and CMS no longer requires hospices to report HCPCS codes for DME infusion pumps or DME drugs," the agency says in the transmittal.

**Background:** "We initially began asking for this information via Hospice Change Request 8358 in support of hospice payment reform," CMS recalls in the proposed rule published in the May 8 Federal Register. Then when CMS asked for ideas for regulatory relief in last year's payment rule, "commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices," the agency continues.

"After determining that this information is not currently used for quality, payment, or program integrity purposes, we are removing this requirement effective October 1, 2018," the rule says. "We ... believe this could result in a significant reduction of burden to Medicare hospices, potentially reducing the number of line items on hospice claims by approximately 21.5 million, in aggregate."

**Instead:** "We will allow hospices two options for reporting hospice drug information," CMS says in the rule. "Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items. This submission option will no longer be mandatory. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim." The flexibility to use either of those options should reduce burden, CMS concludes in the rule.

This change has many hospice providers "dancing in the streets," says **Judi Lund Person** with the **National Association for Hospice & Palliative Care**. The process of reporting drugs on the claim is "very laborious," Lund Person notes. "That's a really exciting change."

**The problem:** "In addition to the drug name, hospices have been required to include the dosage, the National Drug Code (NDC) and the hospice for each fill," the **National Association for Home Care & Hospice** explains. "This has been a significant burden on hospice programs and the Medicare Administrative Contractors (MACs), and has been particularly burdensome in cases where hospices contract for General Inpatient Care (GIP) and must secure the list of drugs from the facility and input the information for each drug by hand. In many cases this has delayed billing and payments for care, and has required increased hospice staffing," the trade group says in its newsletter.

"The less time and effort spent on non-beneficial regulatory reporting, the more time and effort available for patient care and other goals and objectives of the hospice," cheers **The Health Group** in Morgantown, West Virginia, in its newsletter.

**Remember:** "Regardless of these changes, it remains incumbent on [hospices] to ensure that their charges reasonably reflect the cost of providing items and services," NAHC reminds providers.

The downside of the changes is that the information won't be collected, Lund Person adds.

**Shot down:** Numerous commenters on the 2018 rule also asked CMS to eliminate sequential billing requirements for hospices. "While we are always evaluating ways to make operational improvements, sequential billing for hospice claims is required because of how hospice benefit periods are constructed in statute," CMS notes in the proposed rule. "Sequential billing ensures that Medicare systems create and exhaust each period before creating a later period, maintaining the statutorily required sequence."

**Plus:** "Payment for routine home care now varies depending on length of stay (a higher rate for days 1-60 and a lower rate for days 61+) making the sequential billing of hospice claims necessary to accurately pay claims and ensure the system applies benefit periods," CMS adds. "Sequential billing ensures correct payments are made and to providers, minimizes the need to resubmit claims or face claims denials, and ultimately reduces burden. As a result, we are not able to eliminate the sequential billing requirement for hospice claims."

CMS's load-lightening may not be over yet. The agency will "consider whether future regulatory or sub-regulatory changes are warranted to reduce unnecessary burden," the agency pledges in the rule.