NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE/
HOSPICE ASSOCIATION OF AMERICA

ADDITIONAL DATA REPORTING REQUIREMENTS FOR HOSPICE CLAIMS
Comparison of CMS Proposed and Final Requirements

Change Request 8358/Transmittal 2747 (July 26, 2013)
MedLearn Matters Article MM8358
Version 4

CMS Proposed	HAA Comment (summary)	As Required by CR8358 MLM Article MM8358
		Implementation date: Jan.6, 2014 Effective dates: Jan 1, 2014 VOLUNTARY reporting April 1, 2014 MANDATORY reporting for claims with dates of service on or after April 1, 2014
We are considering collecting data on paid hospice chaplain and counselor visits and visit length (in 15-minute increments) on a line-item basis on hospice claims.	CHAPLAIN: Visit data on only paid hospice chaplains does not fully represent hospice visits/resource use for chaplain services since many chaplain services are provided on a volunteer basis. Hospices expenses for volunteers include administration, recruitment and retention. While the costs of a volunteer program are included in the hospice cost report, volunteer chaplain visits cannot be extracted. As a result, the data will underreport use of an important element of hospice care. COUNSELORS: HAA advises the separate identification of bereavement counselor visits to ensure that hospice programs are classifying counselor visits appropriately and accurately. CHAPLAIN/COUNSELORS: Activities related to chaplain and counseling services can be varied. Chaplain and spiritual and bereavement counseling "visits" may be conducted by phone; chaplains may conduct or attend memorial services to provide continuing support to family. These additional services should be reportable in some form as	NO COLLECTION SCHEDULED AT THIS TIME.

	visits.	
We are considering collecting line-item visit data, including length of visits in 15-minute increments, for nurses, aides, social workers, physical therapists, occupational therapists, speech-language pathologists, chaplains, and counselors providing GIP or respite care to hospice patients in nursing homes or hospitals.	As understood by HAA, this additional visit data does NOT include collection/reporting of facility staff visits. It would be helpful to clarify in final language that this applies to hospice employees only.	**Reporting of line-item visit data, including length of visits in 15-minute increments, for hospice staff including nurses, aides, social workers, physical therapists, occupational therapist, and speech-language pathologists providing GIP to hospice patients in a SNF, inpatient hospital, long term care hospital, or inpatient psychiatric facility. This includes certain calls made by social workers.** **NOTE: CMS WILL NOT REQUIRE COLLECTION OF VISIT DATA FOR CHAPLAINS AND COUNSELORS AT THIS TIME.**
We are considering collecting the NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving services, regardless of the level of care provided.	Collection of this information will require coordination by the hospices to secure NPIs from outside facilities; we would advise significant lead time for compliance.	**Reporting of NPI and other identifying information for any facility where the patient is receiving hospice services, regardless of level of care provided, when site of service is not the location of the billing hospice. If care is provided in more than one facility during the billing month, hospice reports NPI of facility where the patient was last treated. Failure to report will cause claim to RTP.**
With patient safety and quality of care in mind, we are considering reporting of visits and length of visits for nurses, aides, social workers, therapists, chaplains, and counselors which occur after the patient has passed away, on the	For hospice staff visits that begin on one calendar day and span into the next day, the hospice is to report one visit using the date the visit ended as the service date. Because patients often expire close to the end of the billing day (midnight) and the hospice staff visit on these occasions often spans into the next day, the hospice should report the entire length of the visit inclusive of the time of the visit that spans into the next day. This would provide CMS more accurate visit length and cost data at the end of hospice care and it follows the	**Reporting of visits and length of visits by hospice staff (nurses, aides, social workers, and therapists) on the date of death that occur post-mortem (regardless of patient's level of care or site of service) will be reported, with a "PM" modifier to distinguish them from visits occurring before death.** **Post-mortem visits subsequent to**

calendar day of death. Visits occurring after death would need to be reported using a modifier to differentiate them from visits occurring before death. Our thoughts are that post-mortem visits to patients who died while receiving GIP or respite in a hospice inpatient unit, or to their families, would be exempt from this requirement.	same data collection process for the post death visit as for all other visits that span two days. In many states the time of death by law is the time that the nurse or other qualified individual pronounces the patient as expired. In these situations, would the nurse be required to create two visit encounters – one to cover until the pronouncement and another to cover the post mortem time? This would be burdensome to the hospice. Adequate lead time would be needed to ensure that computer vendors are able to create and incorporate the codes to differentiate these visits.	**date of death are not to be reported due to systems limitations.**
We are considering collecting DME data on the claims by reporting the 29X revenue code series and the appropriate DME HCPCS code for the time period covered by the claim. This is similar to the DME reporting that occurs on home health claims.	The reporting of this data on hospice claims creates a significant burden on hospices. Many hospices do not have electronic data systems; manual extraction from medical records and/or invoices from the DME supplier would be required since the majority of hospices provide this through contract. Hospices do not have the manpower to do this. In addition, DME invoices typically arrive at the hospice weeks to months after the hospice claim has been submitted. Requiring the DME data on the claim would unnecessarily hold up hospice billing and create cash flow problems for hospices. It may lead to hospices submitting inaccurate DME data on the claims in order to submit claims timely. Moreover, many DME companies do not bill hospices by the piece, nor do they bill hospices for the same time period the claim covers. Many bills are based on per diem contracts. DME is often bundled into a package and the patient may or may not utilize all equipment in the package. If DME data were added to claims there would need to be a significant amount of lead time for DME companies and hospices to create the necessary data collection and sharing processes and, even with these in place, the burden on hospices is	**CMS will only require reporting of data on infusion pumps. NO OTHER DME DATA SUBMISSION WILL BE REQUIRED AT THIS TIME.**

	overwhelming. The majority of hospices are considered to be small to medium-sized (fewer than 100 patients per day, on average). Hospices of this size do not have the financial and human resources necessary to extract the level of detailed data required for this proposal. Adding this level of detail to hospice claims will require the hiring of additional staff. The majority of hospices do not have the financial resources to bear this additional cost nor do they have the financial resources to weather the delay in cash flow caused by having to hold claims until DME invoices are received.	
We are considering collecting data on claims for certain medical supplies by reporting revenue code 27X and 62X, with the supply charges totaled for the time period covered by the claim. By definition, routine supplies are typically used in small quantities for patients during the course of most visits (for example, gloves, alcohol wipes, adhesive or paper tape). Non-routine supplies, on the other hand, are those medically supplies which are needed to treat a patient's specific illness or injury in accordance with the physician's plan of care.	Routine supplies for hospice patients are very different from routine supplies for home health patients. For instance, gloves are considered routine supplies in home health and are mostly used in small quantities. Gloves in hospice are routine supplies used by the hospice staff but are not used in small quantities. This is because there are typically more visits to patients in hospice than in home health and because many hospices provide the patient with gloves for the caregiver's use. The definition of non-routine supplies as "those medical supplies which are needed to treat a patient's specific illness or injury in accordance with the physician's plan of care" could mean that supplies such as Chux would be a non-routine supply. Many supplies such as this would be considered non-routine because they are needed to treat a patient's specific illness or injury. The reporting of this data on hospice claims creates a tremendous burden on hospices. Many hospices do not have electronic data systems and, as with DME, manual extraction from medical records and/or invoices from the supplier would be required. Many hospices do not have the manpower to do this. In addition, supply invoices typically arrive at the hospice weeks to months after the hospice	**NO COLLECTION AT THIS TIME.**

Non-routine supply items are specifically identifiable to a particular patient, and are ordered by the physician and recorded in the plan of care. These definitions and procedures are similar to those used for home health claims. We are considering limiting the reporting of medical supplies to that of non-routine.	claim has been submitted. Requiring the non-routine data on the claim would unnecessarily hold up hospice billing and create cash flow problems for hospices. It may lead to hospices submitting inaccurate supply data on the claims in order to submit claims timely. Moreover, many supply companies do not bill hospices by the piece nor do they bill hospices for the same time period the claim covers. Instead the bills are based on per diem contracts with the hospice. The supplies are often bundled into a package that would include routine and non-routine supplies. If non-routine supply data were added to claims there would need to be a significant amount of lead time for supply companies and hospices to create the necessary data collection and data sharing processes and even with these in place, the burden to hospices is overwhelming. There should also be additional input from hospices on the definition of non-routine supplies if these are added to the hospice claim data. The majority of hospices are considered to be small to medium-sized (fewer than 100 patients per day, on average). Hospices of this size do not have the financial and human resources necessary to extract the level of detailed data required for this proposal. Adding this level of detail to hospice claims will require the hiring of additional staff, and most hospices do not have the financial resources to bear this additional cost, nor can they weather the delay in cash flow caused by having to hold claims until non-routine supply invoices are received.	
OTC Drugs, injectable drugs and non-injectable prescription drugs	As with DME and non-routine supplies, many hospices do not have electronic data systems; manual extraction from medical records and/or invoices from the supplier would be required. Many hospices do not have the manpower to do this. In addition, medication invoices typically arrive at the	**CMS will require reporting of injectable and non-injectable prescription drugs on a line-item basis per fill.** **Hospices will also be required to**

	hospice weeks to months after the hospice claim has been submitted. Requiring OTC drug data on the claim would unnecessarily hold up hospice billing and create cash flow problems for hospices. It may lead to hospices submitting inaccurate data on the claims in order to submit claims timely. If OTC drug data were added to claims there would need to be a significant amount of lead time for pharmacies and hospices to create the necessary data collection and data sharing processes and even with these in place, the burden on hospices would be significant. As mentioned previously, the majority of hospices are considered to be small to medium-sized (fewer than 100 patients per day, on average). Hospices of this size do not have the financial and human resources necessary to extract the level of detailed data required for this proposal. Adding this level of detail to hospice claims will require the hiring of additional staff. This would be financially prohibitive for most hospices. Most hospices would also have severe cash-flow difficulties that would result from holding claims until non-routine supply invoices were received and processed. Many hospices cover the costs of items such as homeopathic preparations. It is unclear how the reporting requirements would apply to these items.	**submit data on infusion pumps (see DME above).** **CMS WILL NOT REQUIRE REPORTING OF OTC DRUG INFORMATION AT THIS TIME.**