

# **National Association for Home Care & Hospice**

presents

## **Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?**

Audio Conference

**Wednesday, May 28, 2008**

2:30 PM – 4:00 PM Eastern

1:30 PM – 3:00 PM Central

12:30 PM – 2:00 PM Mountain

11:30 AM – 1:00 PM Pacific

Presented by:

**Callene Bentoncoury**

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## Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?

NAHC Teleconference  
May 28, 2008

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## Faculty

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NAHC, Washington, DC

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## History of Change Request 5567 Reporting of Additional Hospice Data

- Initially released July 20, 2007
    - January 1, 2008 effective date
  - September-NAHC requested 6-month delay
  - Hospices lobbied CMS for delay
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## History of CR 5567

- November 2, 2007 CMS Revises effective date to July 1, 2008
  - Ongoing – NAHC & hospices requested elimination of inpatient non-hospice employee visit counts
  - April 28, 2008 CMS revises CR to eliminate such counts
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## Reporting of Visits CR 5567

What are “visits” and how do we report them???

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### CMS Definition

- (Collect and Report) direct patient care visits that are reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care.
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## Which Visits?

- Skilled nursing: for routine home care, general inpatient, inpatient respite and continuous care.
  - Social worker: direct visits with patient or families
  - Home health aide: visits to provide services to the patient
  - Physician and Nurse Practitioner: medically reasonable and necessary
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## What is “reasonable and necessary”?

- The plan of care (POC) on a CHF patient indicates nursing visits 3 times weekly. The nurse visits 5 times during one week as the patient wants her to attend his birthday party (one visit). On another day, the patient complains of chest pain and the nurse makes an additional visit.
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## What is “reasonable and necessary”?

- A cancer patient is GIP for pain at a hospice home. The nurse has given pain med 30 minutes ago and she returns to the room to evaluate the patient’s response to the medication. An hour later she delivers water to the room.
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## What is “reasonable and necessary”?

- This same patient has increased pain with movement. The nurse assists the hospice aide with bathing the patient.
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## What is “reasonable and necessary”?

- A patient with ALS scheduled to receive continuous home care for withdrawal of a ventilator. The patient is alert and oriented. Two nurses are present to give medications and manage the event. Also on hand is a social worker as family has gathered to say goodbye.
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## What is a Visit?

- This same patient lives for 2 days following vent withdrawal. Nurses in shifts provide continuous home care to manage symptoms. One RN per 8-hour shift per day is present. A social worker visits both days to help the family with counseling.
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## What is a Visit?

- A dementia patient is recently admitted to a nursing facility for respite. The nurse visits to assess the patient in his new surroundings and to review the plan of care with facility staff. The facility's nurse and aide are turning the patient when the hospice nurse arrives.
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## What is “reasonable and necessary”?

- The plan of care on a patient with dementia indicates that the HCA will visit 3 times weekly to provide personal care. The patient develops diarrhea and the aide visits daily to assist with hygiene. On one day the aide makes an additional visit to the home to drop off briefs and under pads.
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## What is a Visit?

- A plan of care for a patient with a CVA, who resides in a nursing facility, indicates that the social worker will visit twice monthly. The social worker meets with family members in their home as there is conflict about care decisions. Later that week the social worker calls the family to check on progress.
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## What is a Visit?

- A hospice physician is visiting hospice patients in a skilled nursing facility. She sees a patient who has been having increased respiratory distress. While she is visiting the nurse asks for an order on another patient. The doctor reviews the chart on the second patient and writes the requested order.
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## What is a “Medically Reasonable and Necessary”?

- A patient is nearing time for recertification and the hospice Medical Director visits to determine continued eligibility.
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## What is “Medically Reasonable and Necessary”?

- A hospice Medical Director makes rounds twice a week at a facility that provides general inpatient care for hospice patients. On one day the doctor examines and writes orders on a newly admitted patient. While the physician is present, he stops in to see all the hospice patients in the facility.
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## Where to Start: Staff Education

- Home Care Clinical Staff:
    - New billing rules
    - What is a visit
    - Must turn in paperwork more quickly
    - Clear expectations
  - Ask for Suggestions
  - Typical Challenges:
    - Clinicians' focus is patients not business
    - How to get documentation to the office
      - Time, mileage and motivation
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## Where to Start: Clinical Staff Support (Home Care)

- Make it as easy as possible (use ideas)
    - Coding of visits (electronic records)
    - Coding of itineraries (paper records)
    - Drop-off points for paperwork
    - Faxing
    - Reminders at end of month
    - Give feedback and follow-up on performance
      - Reward compliance
      - Correct mistakes
      - Consequences for delinquent documenters
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## Where to Start: Staff Education

- Inpatient Clinical Staff:
    - New billing rules
    - What is a visit (new concept)
    - How to count
    - Clear expectations
  - Ask for Suggestions
  - Typical Challenges:
    - Clinicians' focus is patients not business
    - Distractions
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## Where to Start: Clinical Staff Support (Inpatient)

- Make it as easy as possible (use ideas)
    - Coding of visits (electronic records)
    - Counting tools (paper records)
    - Develop system for end of shift reporting
      - Make use of simple acuity system to verify count
      - Tie to current reporting (bed report?)
    - As much as possible, use clerical staff
    - Encourage team support of each other
  - Give feedback and follow-up on performance
    - Reward compliance
    - Correct mistakes
    - Consequences for delinquent documenters
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## Where to Start: Staff Education

- **Administrative Staff:**
    - New billing rules
    - What is a week: Sunday through Saturday
    - Timely and accurate data entry of visits
    - Verification of receipt of documentation
    - Clear expectations
  - **Ask for Suggestions**
  - **Typical Challenges:**
    - Labor intensive
    - Lack of technical supports
    - Lack of feedback
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## Where to Start: Admin Staff Support

- **Make it as reasonable as possible (use ideas):**
    - Electronic medical records
    - Feedback via electronic reports
      - Regularly scheduled
      - Check accuracy of entry- duplications or no entry
      - Synchronization reports
    - Ease communication
      - Information to management not clinical staff
      - Billing staff
    - Timely consistent feedback: reward and corrections
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## Where to Start: Staff Education

- Management
    - All that other staff has received (why, what, who, when and how)
    - Clear expectations/goals
    - Brainstorm
    - Hospice agency capabilities for support
      - Available technology
      - Human Resources
      - Budget
    - Typical Challenges
      - Added work load
      - Many distractions/ priorities
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## Where to Start: Support for Managers

- Make it as easy as possible (use ideas):
    - Use of technology (electronic or paper)
      - Concise scheduled reports
      - Reminders to give feedback
    - Delegate as much as is reasonable
      - Clerical support
    - Support communication
      - Be sure to make it safe
    - Follow-up on problems quickly
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## Summary

- Understand what CMS requires
  - Communicate and solicit feedback from the hospice team
  - Put systems in place to support
  - Follow-up
  - Celebrate success!
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## Hospice and Palliative Care Patient Visit Definitions

### Defining Patient Care Visits

- Includes care provided to the patient to meet his or her needs
  - Must be reasonable and necessary for the palliation and management of terminal illness and related conditions as described in the patient's plan of care
- Must be provided in-person by hospice and contract employees
  - **Exception: At this time, visit data reporting is not required for visits made by non-hospice staff providing GIP and inpatient respite care in contract facilities**

### Nurse

- Care 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
- Examples of patient care activities that count as a visit:
  - Assessment
  - Management of medications
  - Patient/family teaching
  - Symptom management
  - Nursing procedures
- Examples of patient related activities that *do not count* as a visit:
  - Phone calls, patient documentation, ICC meetings, obtaining physician orders, rounds in a facility, travel time, or any other activity that is not directly related to the provision of hospice and palliative care services
  - **Note:** After hours phone calls and other "on call" phone consultations do *not* count as patient visits.

### CNA

- Care 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
- Examples of patient care activities that count as a visit:
  - Assistance and delivery of personal care
  - Assistance with transfers and ambulation
  - Assistance with feeding
- Examples of patient related activities that *do not count* as a visit:
  - Delivery of water and food, checking in on patients without any care/assistance rendered, supply delivery, and friendly conversation that is not related to hospice and palliative care needs

### Social Worker

- Care 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
- Due to the nature of the functions of social work, contacts with family are allowed to be counted
- Examples of patient care activities that count as a visit:
  - Counseling with the patient and family
  - Speaking with the patient's family regarding patient needs
  - Arranging for placement
  - Financial counseling
  - Discussion of Health Care Directives
  - Mortuary planning
- Examples of patient related activities that *do not count* as a visit:
  - Phone calls to agencies or individuals on behalf of the patient or family
  - Phone calls to families who are out of town

## Visit Verification

### EXAMPLE

#### Level 1

##### RN

- Complex procedures (Vent/High Oxygen Delivery/Cont. Infusions)
- Hospice/palliative assessment every 1 hour or more
- Medication administration every 1 hour or more
- Symptom assessment/management every 1 hour or more
- Emotional support every 1 hour or more
- **RN visit range: 24 – 48 visits in a 24 hour period**

##### CNA

- Personal care every 1 hour or more
- Emotional support every 1 hour or more
- **CNA visit range: 24 – 48 visits in a 24 hour period**

#### Level 2

##### RN

- Hospice/palliative assessment every 1-2 hour(s)
- Medication administration every 1-2 hour(s)
- Symptom assessment/management every 1-2 hour(s)
- Emotional support every 1-2 hour(s)
- **RN visit range: 12 – 24 visits in a 24 hour period**

##### CNA

- Personal care approximately every 1-2 hour(s)
- Emotional support approximately every 1-2 hour(s)
- **CNA visit range: 12 - 24 visits in a 24 hour period**

#### Level 3

##### RN

- Hospice/palliative assessment every 2-3 hours
- Medication administration every 2-3 hours
- Symptom assessment/management every 2-3 hours
- Emotional support every 2-3 hours
- **RN visit range: 8 – 12 visits in a 24 hour period**

##### CNA

- Personal care approximately every 2-3 hours
- Emotional support approximately every 2-3 hours
- **CNA visit range: 8 – 12 visits in a 24 hour period**

#### Routine Care and Respite Care with Minimal Intervention

##### RN

- Hospice/palliative assessment every 4-8 hours
- Medication administration every 4-8 hours
- Symptom assessment/management every 4-8 hours
- Emotional support every 4-8 hours
- **RN visit range: 3-6 visits in a 24 hour period**

##### CNA

- Personal care every 2-3 hours
- Emotional support every 2-3 hours
- **CNA visit range: 8 -12 visits in a 24 hour period**

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## Hospice Programs Must Develop Charges By Discipline For Billing of Services Effective July 1, 2008

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May 28, 2008

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### Effective July 1, 2008

- Need to know costs and billable visits to develop charges on a per visit basis.
  - Effective with the July 1, 2008 date, if claims are received without reporting revenue codes (55X, 56X, 57X), units of service, or charges, the claim will be returned to the provider.
  - Remember this is also true if claims are submitted without site of service identified, they are currently being returned to the provider.
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## Hospices Must Enter the Appropriate Revenue Code, Unit of Service, and Charge on the Claim Form

- 055X Skilled Nursing-visits by registered nurses, licensed vocational nurses and nurse practitioners (unless acting as the attending physician) are reported under this code.
  - 056X Medical Social Services
  - 057X Home Health Aide
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## Next phase?

- Notice that revenue code reporting is not presently required for therapy disciplines (physical therapy, physical therapy assistant, occupational therapy, occupational therapy assistant or speech pathologist).
  - CMS states they will work with NAHC and others to determine what additional data to collect to reflect full hospice services.
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## Pub 100-04 Medicare Claims Processing CR 5567

- CMS has stated that the additional lines on hospice claims reporting visits per week do not currently affect payment, but are for data purposes only.
  - The charge information is for research purposes only.
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## Pub 100-04 Medicare Claims Processing CR 5567

- CMS states hospices are to report charges as accurately as possible. Charges are required to provide supplementary information and because many provider billing systems cannot generate service lines on a claim without a charge amount.
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## What Are Hospice Programs Doing To Meet This Requirement?

- Many hospice programs are presently seeking assistance from home care consultants and accountants to determine charges to be reported.
  - The information that follows will help to identify what information will be needed in order to develop cost and charge information.
  - Templates will be presented to help those that may want to develop charges on their own.
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## Where do we get the information?

- Hospice programs have much of the information to accomplish this challenge.
    - We are accumulating and reporting costs on appropriate cost report forms presently
  - Need to expand our data to include number of visits/services provided to beneficiaries by discipline.
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## Cost Information

- Cost information can be taken from:
    - Prior Cost report-(historical)
    - Current Year-to-Date Financial Statements, dependent upon the format (more current), pr
      - General Ledger Accounts-more current
      - Payroll Records-more current
    - Monthly cost report-more current
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## Visit Information

- Hospice programs have not been required to report visit information – (per day)
  - Hospice programs utilizing electronic health records can retrieve billable visit information from system
  - Hospice programs not using electronic health records may have to retrieve information from patient charts, productivity reports, projected visit summaries, schedules
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## To Address the New Requirements:

- Charge templates have been developed by members of the HHFMA of the National Association for Home Care & Hospice and are available from NAHC [www.nahc.org](http://www.nahc.org) under “Facts & Stats.”
  - Version 1-uses information from Medicare cost report and total hospice costs (includes overhead).
  - Version 2-uses information from Medicare cost report and is discipline specific (excludes overhead).
  - Version 3-More sophisticated format for those wanting to develop cost for all disciplines and services not limited to those included in new billing regulations.

## Markup is Considered Once Cost is Determined

- Determination of the markup factor should be determined by the individual hospice
  - You should consult your home care consultant or home care auditor for assistance if unsure what markup factor should be used in the calculation.
  - For **presentation purposes** markup factor of 1.2 was used to illustrate use of the forms.

### What mark-up factor should I use?

The mark up factor to be used is up to each individual agency, but should be based on a mark-up of the cost per visit.

Example: Fees = 1.2 X cost per visit & rounded to the nearest dollar.

In determining the mark-up factor, keep in mind the following:

- a. The costs are historic (possibly one or two years old) if you are using past cost report information. The fees are for current and future periods.
- b. The total allowable Hospice cost may exclude some true costs, such as marketing, etc...
- c. The future may have a number of unknown elements that may affect true costs, (i.e. new services, inflation of medical supply prices, wage increases, increased cost of transportation, other contingencies, ...)
- d. If using old cost reporting data to develop charges have you incurred any costs that are not included in that information (have you purchased a new information system, developed any new services or programs).
- e. Bring costs up to date.

### Many methods

- There is no "one right way" to calculate your charges. Once you've considered the various factors involved and determined your objectives for your pricing strategy, you need some way to crunch the actual numbers. Here are three ways to calculate charges that are available on the NAHC website.

## Review of the Templates

- Let's begin reviewing Version 3 as it is the most detailed and many may not be ready now to plug their numbers into this model but may wish to develop this model for future budgeting and analysis purposes.
- All templates presented will calculate by discipline once information is entered.

## Version 3

- More sophisticated costing model.
- Determines cost per visit for all disciplines not only those required in new regulation.
- Allows hospice program to cost out entire operations and determine cost and charges for all services.

## Version 3

- The template is quite large and includes much detail so is difficult to present on one slide.
- Information would be accumulated in the general ledger.
- Information would be detailed in nature and more like financial reporting under activity based costing methodology.

## Version 3

- Once visit and cost information is entered the calculation of cost by discipline and service is automatically calculated.
- Markup is entered as a separate factor and desired charge rate is calculated.

VERSION 3 –BILLABLE VISITS

DISCIPLINES	Routine Nursing	Continuous Nursing	Physical Therapy	Occupational Therapy	Speech Therapy
Billable Visits	_____				
	Medical Social Service	Home Health Aides	Continuous Home Health Aides	Physicians	TOTAL ALL DISCIPLINES
Billable Visits	_____				

Would include visits for physical therapy, occupational therapy, and speech therapy.

Expenses

Salaries-Supervisors

Salaries- Staff

Fringe Benefits - from Hospice Cost Report

(or Payroll Taxes from General Ledger)

(or Fringe Benefits - Premium Based from General Ledger)

(or Fringe Benefits - Retirement/Profit Sharing from General Ledger)

Workers' Compensation Insurance

Auto Reimbursement (Allowance)

Contract Personnel

TOTAL DISCIPLINE DIRECT COST

DIRECT COST PER VISIT

**TOTAL DIRECT COST OF DISCIPLINES**

**OTHER DIRECT EXPENSES**

Inpatient - General Care  
Inpatient - Respite Care  
Spiritual Counseling  
Drugs, Biologicals and Infusion  
Analgesics  
Sedatives / Hypnotics  
DME / Oxygen  
Patient Transportation  
Imaging Services  
Labs and Diagnostics  
Medical Supplies Charged to Patients  
Outpatient Services (ER, etc.)  
Radiation Therapy  
Other

**GENERAL SERVICE COST CENTER**

Capital Related Costs - Building & Fixtures  
Capital Related Costs - Movable Equipment  
Plant Operation and Maintenance  
Transportation  
Volunteer Service Coordination  
Administrative and General

**TOTAL GENERAL SERVICE COSTS**

**BEREAVEMENT PROGRAM COSTS**

**VOLUNTEER PROGRAM COSTS**

**OTHER**

**TOTAL NON-DIRECT COSTS**

**TOTAL COSTS**

TOTAL DISCIPLINE DIRECT COST

TOTAL DISCIPLINE NON-DIRECT COST

TOTAL DISCIPLINE COST

BILLABLE VISITS

TOTAL COST PER VISIT

DESIRED % MARK-UP OVER TOTAL COST (.00)

CALCULATED CHARGE RATES

ROUNDING TO EVEN DOLLARS

DESIRED CHARGE RATES

For each discipline you would use these factors to determine cost per visit then Multiply any desired markup and achieve charge per visit for each discipline.

## Version 1-includes overhead

- Freestanding Hospices-obtains data from Worksheet B column 7 of the Medicare Cost Report.
- Provider Based Hospices-obtains data from Worksheet K-5, Part I, Column 8 of the Medicare Cost Report.
- *Same process for calculation only difference is where data is obtained.*
- Markup calculation is the same for both freestanding and provider based hospice programs.

Version 1 - Information obtained from the Medicare cost report  
 Visits obtained from clinical records of services charged for direct patient care  
 And includes overhead factor in calculation.

Crosswalk in determining cost to set agency charges  
 Charges Covering Entire Hospice

**Freestanding Hospices: (CMS Form 1984)**

In order to establish charges the agency must first develop a cost per visit.  
 The cost per visits will be obtained utilizing the following lines from Worksheet B, Column 7  
 of the Medicare cost report and dividing them by the total number of visits obtained from your records.  
 Column C below is obtained by multiplying the ratio in Column B, Line 12 by each cell of Column B, Lines 1 to 9.

		A	B	C	D
		VISITS	DIRECT COST	TOTAL COST	
		(from records)	OF SERVICES	OF SERVICES	COST PER VISIT
			(from cost report)	(Col B, L12 X L1 to L9)	(Col C/Col A)
1	Line 15- Physician Services	200	16,000	40,479	202.40
2	Line 16- Nursing Care	2,881	328,567	831,260	288.53
3	Line 16.2- Nursing Care-Continuous HC	640	18,400	46,551	72.74
4	Line 17- Physical Therapy	29	4,739	11,989	413.41
5	Line 18- Occupational Therapy	1	270	683	683.00
6	Line 19- Speech/Language Pathology	3	788	1,994	664.67
7	Line 20- Medical Social Service	996	98,014	247,972	248.97
8	Line 24- Home Health Aid & Homemaker	4,282	127,196	321,800	75.15
9	Line 24.2 HHA & HM-Continuous Care	0	0	0	0.00
10	Total Visits & Cost (Sum of lines 1 to 9)	9,032	593,974	1,502,728	
11	Total Hospice Allowable Cost (W/S D, Col 4, Ln 1)		1,502,728		
12	Ratio of Total to Direct Cost (Col B, Ln 11/Ln 10)		2.52995586		

BEFORE ANY MARKUP—COST OF SERVICES  
 Freestanding Hospices

Version 1 - Information obtained from the Medicare cost report  
 Visits obtained from clinical records of services charged for direct patient care  
 And includes overhead factor in calculation.

**Provider Based Hospices: (CMS Form 1728)**

In order to establish charges the agency must first develop a cost per visit.  
 The cost per visits will be obtained utilizing the following lines from Worksheet K-5, Part 1, Column 8  
 of the Medicare cost report and dividing them by the total number of visits obtained from your records.  
 Column C below is obtained by multiplying the ratio in Column B, Line 12 by each cell of Column B, Lines 1 to 9.

		A	B	C	D
		VISITS	DIRECT COST	TOTAL COST	
		(from records)	OF SERVICES	OF SERVICES	COST PER VISIT
			(from cost report)	(Col B, L12 X L1 to L9)	(Col C/Col A)
1	Line 4- Physician Services	200	16,000	40,479	202.40
2	Line 5- Nursing Care	2,881	328,567	831,260	288.53
3	Line 5.2- Nursing Care-Continuous HC	640	18,400	46,551	72.74
4	Line 6- Physical Therapy	29	4,739	11,989	413.41
5	Line 7- Occupational Therapy	1	270	683	683.00
6	Line 8- Speech/Language Pathology	3	788	1,994	664.67
7	Line 9- Medical Social Service	996	98,014	247,971	248.97
8	Line 13- Home Health Aid & Homemaker	4,282	127,196	321,800	75.15
9	Line 13.2 HHA & HM-Continuous Care	0	0	0	0.00
10	Total Visits & Cost (Sum of lines 1 to 9)	9,032	593,974	1,502,727	
11	Total Hospice Allowable Cost (W/S K-6, Col 4, Ln1)		1,502,728		
12	Ratio of Total to Direct Cost (Col B, Ln 11/Ln 10)		2.52995586		

BEFORE ANY MARKUP—COST OF SERVICES  
 Provider Based Hospices

Total charges by discipline with Markup  
Version 1 template on NAHC website

**Provider Based Hospices: (CMS Form 1728)**

**Freestanding Hospices: (CMS Form 1984)**

In order to establish charges the agency must first develop a cost per visit.

The cost per visits will be obtained utilizing the following lines from Worksheet B, Column 7 of the Medicare cost report and dividing them by the total number of visits obtained from your records.

Column C below is obtained by multiplying the ratio in Column B, Line 12 by each cell of Column B, Lines 1 to 9.

		D	E	F
		COST PER VISIT	MARK-UP	FEES
		(Col C/Col A)	FACTOR	(Col D X Col E)
1	Line 15- Physician Services	202.40	1.2	243
2	Line 16- Nursing Care	288.53	1.2	346
3	Line 16.2- Nursing Care-Continuous HC	72.74	1.2	87
4	Line 17- Physical Therapy	413.41	1.2	496
5	Line 18- Occupational Therapy	683.00	1.2	820
6	Line 19- Speech/Language Pathology	664.67	1.2	798
7	Line 20- Medical Social Service	248.97	1.2	299
8	Line 24- Home Health Aid & Homemaker	75.15	1.2	90
9	Line 24.2 HHA & HM-Continuous Care	0.00	1.2	0
10	Total Visits & Cost (Sum of lines 1 to 9)			
11	Total Hospice Allowable Cost (W/S D, Col 4, Ln 1)			
12	Ratio of Total to Direct Cost (Col B, Ln 11/Ln 10)			

## Version 2-direct cost only

- Freestanding obtains data from Worksheet B column 7 of the Medicare Cost Report.
- Provider Based Program obtains data from Worksheet K-5, Part I, Column 8 of the Medicare Cost Report.
- Markup calculation is the same for both freestanding and provider based hospice programs.

Version 2 - Information obtained from the Medicare cost report  
 Visits obtained from clinical records of services charged for direct patient care  
 Excludes any overhead factor in calculation.

Crosswalk in determining cost to set agency charges  
 Charges Covering Specific Disciplines Only

**Provider Based Hospices: (CMS Form 1728)**

In order to establish charges the agency must first develop a cost per visit.  
 The cost per visits will be obtained utilizing the following lines from Worksheet K-5, Part 1, Column 8  
 of the Medicare cost report and dividing them by the total number of visits obtained from your records.  
 Column C below is obtained by multiplying the ratio in Column B, Line 9 by each cell of Column B, Lines 1 to 7.

		A	B	D
		VISITS	DIRECT COST	
		OF SERVICES	OF SERVICES	COST PER VISIT
		(from records)	(from cost report)	(Col C/Col A)
1	Line 4- Physician Services	200	16,000	80.00
2	Line 5- Nursing Care	2,881	328,567	114.05
3	Line 5.2- Nursing Care-Continuous HC	640	18,400	28.75
4	Line 6- Physical Therapy	29	4,739	163.41
5	Line 7- Occupational Therapy	1	270	270.00
6	Line 8- Speech/Language Pathology	3	788	262.67
7	Line 9- Medical Social Service	996	98,014	98.41
8	Line 13- Home Health Aid & Homemaker	4,282	127,196	29.70
9	Line 13.2 HHA & HM-Continuous Care	0		0.00
10	Total Visits & Cost (Sum of lines 1 to 9)	9,032	593,974	

Crosswalk in determining cost to set agency charges  
 Charges Covering Specific Disciplines Only

**Freestanding Hospices: (CMS Form 1984)**

In order to establish charges the agency must first develop a cost per visit.  
 The cost per visits will be obtained utilizing the following lines from Worksheet B, Column 7  
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		A	B	D
		VISITS	DIRECT COST	
		OF SERVICES	OF SERVICES	COST PER VISIT
		(from records)	(from cost report)	(Col C/Col A)
1	Line 15- Physician Services	200	16,000	80.00
2	Line 16- Nursing Care	2,881	328,567	114.05
3	Line 16.2- Nursing Care-Continuous HC	640	18,400	28.75
4	Line 17- Physical Therapy	29	4,739	163.41
5	Line 18- Occupational Therapy	1	270	270.00
6	Line 19- Speech/Language Pathology	3	788	262.67
7	Line 20- Medical Social Service	996	98,014	98.41
8	Line 24- Home Health Aid & Homemaker	4,282	127,196	29.70
9	Line 24.2 HHA & HM-Continuous Care	0	0	0.00
10	Total Visits & Cost (Sum of lines 1 to 9)	9,032	593,974	

**Crosswalk in determining cost to set agency charges  
Charges Covering Specific Disciplines Only**

**Freestanding Hospice Agencies  
Provider Based Hospices: (CMS Form 1728)**

In order to establish charges the agency must first develop a cost per visit.  
The cost per visits will be obtained utilizing the following lines from Worksheet K-5, Part 1, Column 8 of the Medicare cost report and dividing them by the total number of visits obtained from your records.  
Column C below is obtained by multiplying the ratio in Column B, Line 9 by each cell of Column B, Lines 1 to 7.

		D	E	F
		COST PER VISIT	MARK-UP	FEES
		(Col C/Col A)	FACTOR	(Col D X Col E)
			(see instructions below)	
1	Line 4- Physician Services	80.00	1.2	96
2	Line 5- Nursing Care	114.05	1.2	137
3	Line 5.2- Nursing Care-Continuous HC	28.75	1.2	35
4	Line 6- Physical Therapy	163.41	1.2	196
5	Line 7- Occupational Therapy	270.00	1.2	324
6	Line 8- Speech/Language Pathology	262.67	1.2	315
7	Line 9- Medical Social Service	98.41	1.2	118
8	Line 13- Home Health Aid & Homemaker	29.70	1.2	36
9	Line 13.2 HHA & HM-Continuous Care	0.00	1.2	0
10	Total Visits & Cost (Sum of lines 1 to 9)			

# Medicare Claims Processing Hospice Benefit

Pub 100-04 Medicare Claims Processing Transmittal 1494 dated 4/29/08 Change Request 5567

Effective date: January 1, 2008, for system changes and for OPTIONAL service reporting by hospices.  
July 1, 2008, for MANDATORY services reporting by hospices

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## General Information

- Since the inception of the hospice program in 1983, hospices have been only required to submit on claim forms the number of days at each of the four hospice levels of care.
    - Routine Home Care
    - Continuous Home Care
    - Inpatient Respite Care
    - General Inpatient Care
  - HCPCS coding was required only to report procedures performed by the beneficiary's attending physician if that physician was employed by the hospice.
- 

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## January 1, 2007

- Transmittal 1011 (CR 5245) was implemented.
  - First phase-requiring hospices to denote through coding the location where hospice levels of care were delivered and created line item dating requirements for continuous levels of care.
-

## HCPCS/Accommodation Rates/HIPPS Rate Codes

- Q5001 Hospice Care Provided in Patients Home/Resident
- Q5002 Hospice Care Provided in Assisted Living Facility
- Q5003 Hospice Care Provided in Nursing Long Term Care Facility (LTC) or Non-Skilled Facility (NF)
- Q5004 Hospice Care Provided in Skilled Nursing Facility
- Q5005 Hospice Care Provided in Inpatient Hospital
- Q5006 Hospice Care Provided in Inpatient Hospice
- Q5007 Hospice Care Provided in Long Term Care Hospital
- Q5008 Hospice Care Provided in Inpatient Psychiatric Facility
- Q5009 Hospice Care Provided In Place Not Otherwise Specified (NOS)

Interim Claim Form-Not admission form locator #44				SP CODE	UNRECORDED AMOUNT	CD CODE	UNRECORDED AMOUNT	X1 CODE	UNRECORDED AMOUNT
				61	5190.00	G8	0875.00		
					cbsa		cbsa		
PRECED	PRECED #	HIPPS RATE	HIPPS CODE	HIPPS RATE	HIPPS RATE	TOTAL AMOUNT	UNRECORDED AMOUNT		
0651	Routine Home Care	Q5001	010108	014	1750.00				

Q5001 Hospice Care Provided in Patients Home/Residence  
 Q5002 Hospice Care Provided in Assisted Living Facility  
 Q5005 Hospice Care Provided in Inpatient Hospital  
 Q5006 Hospice Care Provided in Inpatient Hospice Facility  
 Q5007 Hospice Care Provided in Long Term Care Hospital  
 Q5008 Hospice Care Provided in Inpatient Psychiatric Hospital  
 Q5009 Hospice Care Provided in Place Not Otherwise Spec.

Q5003 Hospice Care Provided in L-T Care Facility or Non Skilled Facility  
 Q5004 Hospice Care Provided in Skilled Nursing Facility

001 PAGE OF CREATION DATE 051608 TOTALS 9070.00

## Further Clarification in Transmittal Concerning These Two Codes:

- Q5003 Hospice Care Provided in Nursing Long Term Care Facility (LTC) or Non-Skilled Nursing Facility-*is to be used for skilled nursing facility residents in a NON-Medicare covered stay and nursing facility residents.*
- Q5004 Hospice Care Provided in Skilled Nursing Facility (SNF)-*is to be used for skilled nursing facility residents in a Medicare covered stay.*

## What if Location of Service Delivery Changes During the Month?

- If care is rendered at multiple locations, each location is to be identified on the claim with a corresponding HCPCS code.
  - For example: Routine home care may be provided for a portion of the billing period in the patients residence and another portion in an assisted living facility.
  - Revenue Code 651 Q5001 with # of days
  - Revenue Code 651 Q5002 with # of days

## What Next?

Effective July 1, 2008

### Effective July 1, 2008

- Once the calculation of charges for each discipline and service are complete develop a charge master of all billing rates. If electronic billing system enter charges for appropriate billing.
- Must collect visit information by discipline for all billable services provided to a hospice patient that need to be reported on the claim form.
- Discipline item detail must be included on claim submitted for payment.

## Medicare Reporting Week.

- Each week, beginning on Sunday and ending on Saturday, providers must indicate the number of services/visits provided by nurses (rn, lpn and/or nurse practitioner), home health aides, social workers, physicians, nurse practitioners serving as the beneficiaries attending physician. The date of the first visit performed by each discipline will be output in form locator 45 on the claim.

Interim Claim Form-Not admission				SP CODE	UNL RECORDED AMOUNT	CD CODE	UNL RECORDED AMOUNT	ST CODE	UNL RECORDED AMOUNT
				61	5190.00	G8	0875.00		
DISPENSE #	DISPENSE #	WEEK DATE	WEEK DATE	DISP. DATE	DISP. UNITS	DISP. UNITS	TOTAL CHARGES	DISPENSED CHARGES	
0651	Routine Home Care	Q5001		010108	014		1750.00		# units times charge Per visit
0550	Skilled Nursing			010308	002		200.00		
0570	Home Health Aide	Week 12/30-1/5		010508	001		60.00		
0550	Skilled Nursing			010608	004		400.00		
0570	Home Health Aide	Week 1/6-1/12		010608	007		420.00		
0550	Skilled Nursing			011308	001		100.00		
0570	Home Health Aide			011308	002		120.00		
0656	General Inpatient	Q5005		011508	005		2500.00		
0550	Skilled Nursing			011508	003		300.00		
0570	Home Health Aide	Week 1/13-1/19		011508	005		300.00		
0651	Routine Home Care	Q5001		012008	012		1500.00		
0550	Skilled Nursing			012008	004		400.00		
0570	Home Health Aide	Week 1/20-1/26		012008	007		420.00		
0550	Skilled Nursing			012708	003		300.00		
0570	Home Health Aide			012708	005		300.00		
<p>Visit information is aggregated by week with the first date of service by each discipline entered in the service date column and the number of visits for the week entered in the service units column</p>									
001	PAGE	OF	CREATION DATE	051608	TOTALS		9070.00		

Interim Claim Form-Not admission		61	5190.00	G8	0875.00		
62 RECD	63 RECEIPT #	64 RPTD / RATE / RPTD CODE	65 DRG / RATE	66 DRG / UNITS	67 TOTAL CHARGES	68 NON-COVERED CHARGES	69
0651	Routine Home Care	Q5001	010108	014	1750.00		
0550	Skilled Nursing		010308	002	200.00		
0570	Home Health Aide		010508	001	60.00		
0550	Skilled Nursing		010608	004	400.00		
0570	Home Health Aide		010608	007	420.00		
0550	Skilled Nursing		011308	001	100.00		
0570	Home Health Aide		011308	002	120.00		
0656	General Inpatient	Q5005	011508	005	2500.00		
0550	Skilled Nursing		011508	003	300.00		
0570	Home Health Aide		011508	005	300.00		
0651	Routine Home Care	Q5001	012008	012	1500.00		
0550	Skilled Nursing		012008	004	400.00		
0570	Home Health Aide		012008	007	420.00		
0550	Skilled Nursing		012708	003	300.00		
0570	Home Health Aide		012708	005	300.00		
					<b>TOTALS</b>	9070.00	

The total reflects total of All items entered

## Payment of Claims

- Medicare systems will not make payment on 055X, 056X, or 57X revenue code lines.
- Medicare systems shall change any charges and units associated with each 055X, 056X, or 57X revenue code to be non-covered the provider does not have to denote that on the claim.

## Other items requiring attention:

- Patient discharge status codes
  - #50 Discharged/Transferred to Hospice – home
  - #51 Discharges/Transferred to Hospice – medical facility.
  - If Hospice services are provided to the beneficiary in more than one CBSA area during the billing period the hospice reports the CBSA that applies at the end of the billing period.
  - Hospices may not report V-codes as primary diagnosis on hospice claims.

## Other items requiring attention:

- If late visits are identified remember to void and replace a prior claim form so that the services can be accumulated in the statistics.
- Thank you.
  - Remember:
    - Talk to your vendor
    - Put systems in place to capture information needed

**To: Sign In Sheet Manager/NAHC Teleconference Proctor**  
**Please note Procedures have changed**  
**Read Carefully**

**National Association for Home Care & Hospice**  
**Teleconference Proctor Instructions**

In order to serve you better, NAHC has instituted new steps allowing participants to receive their certificates immediately after the conclusion of the teleconference. To do this, the Sign-In Sheet Manager will act as a NAHC Teleconference Proctor and follow these steps:

**Prior to the Teleconference:**

- Download the PowerPoint Presentation, photocopy as necessary, and distribute to the attendees.
- Circulate the Attendance/Sign-in sheet for the teleconference session. Make sure names are legible and that signatures are provided. Nurses should put RN after their names and accountants put CPA and state of licensure.
- Distribute the Program Evaluation to all Attendees.
- Verify that the attendee completed the session(s) before providing a certificate. The Teleconference is a ninety minute session.

**Following completion of the Teleconference:**

- Prepare and distribute certificates (include name and Agency Name). There is a nursing CE certificate ; an accountant CPE certificate and a general certificate of attendance for the ninety minute educational session. Be sure to select the appropriate certificate for each attendee.
- Return the following via U.S. mail to: NAHC Education Dept., 228 Seventh Street SE, Washington, DC 20003.  
(A) sign-in sheets with signed oath (B) program evaluations and (C) **Copies of all certificates issued.**

*If no certificates are needed, please send in the sign-in sheet and evaluations.*

Should you have any questions regarding these steps, please call Wanda Allen, NAHC Education Department, at (202) 547-7424.

**SIGN-IN FOR CONTINUING EDUCATION CREDIT FOR NURSES and ACCOUNTANTS**

**Teleconference May 28, 2008 2:30-4:00 ET**

**Title: Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?**

Nursing CEs 1.5  
Accountant CPE 1.0

The sign-in sheet manager/NAHC Teleconference Proctor for this teleconference is responsible for mailing (A) sign-in sheet(s) with signed oath, (B) program evaluations required for all participants requesting certificates, and (C) copies of all certificates issued: Send to: NAHC Education Dept, 228 7<sup>th</sup> Street SE, Washington, DC 20003. Phone (202) 547-7424.

These materials must be mailed in the same package. No faxes will be accepted.

**Sign-In Sheet Manager/NAHC Proctor Oath**

I affirm that I proctored this NAHC Teleconference and verify that certificates distributed were for only the professionals who attended this 90 minute session.

**PLEASE DO NOT FOLD THE MATERIALS.**

THE FOLLOWING INFORMATION IS REQUIRED AND MUST BE PRINTED

Proctor/Sign-in Sheet Manager \_\_\_\_\_

NAHC Member ID# \_\_\_\_\_ Phone: \_\_\_\_\_ Fax \_\_\_\_\_

Agency: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Proctor  
Signature \_\_\_\_\_

Mail the sign-in sheet and evaluation forms and copies of certificates to: NAHC Education Dept, 228 7<sup>th</sup> Street, SE, Washington, DC, 20003. The sign-in sheet(s) w/signed oath and evaluation forms must be mailed (within 30 days of teleconference) in the same package. **DO NOT FOLD MATERIALS.**

**Print Name**  
*(If name is illegible certificate can't be produced.)*

**Signature**

**RN or CPA**

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

National Association for Home Care & Hospice  
Teleconference Sign-In Sheet

3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____

National Association for Home Care & Hospice  
 Teleconference:  
 Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?  
 May 28, 2008 2:30 to 4:00 pm ET

Faculty: **Callene Bentoncoury and Donna Gouveia**

**Overall Evaluation**

		Excellent	Good	Fair	Poor
1.	Overall usefulness				
2.	Increased your body of knowledge on this topic				
3.	Consistency and accuracy of content with objectives				
4.	Program room accommodations				
5.	Appropriate pre-requisites (if applicable)				

**Program Objectives**

		Met	Partially Met	Not Met
1.	Determine which visits should be counted			
2.	Complete a hospice bill with appropriate coding			
3.	Determine per visit charges using templates developed by NAHC's Homecare and Hospice Financial Manager's Association			

**Faculty Evaluation**

**Callene Bentoncoury**

**Donna Gouveia**

		Yes	No			Yes	No
				Would you attend another program on a similar topic by this speaker in the future?			
				The speaker refrained from commercialization or selling during the presentation.			

Excellent	Good	Fair	Poor		Excellent	Good	Fair	Poor
				Overall presentation skills				
				Knowledge of subject				
				Teaching methods				
				Organization of content				
				Choice of content area				
				Responsiveness to questions				
				Integration and Effectiveness of AV				
				Time allotted to learning activity				

**Comments:**

**National Association for Home Care & Hospice  
228 Seventh Street SE  
Washington, DC 20003 - 202/547-7424  
Teleconference**

**Continuing Education Certificate for Nurses**

*“Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?”*

**May 28, 2008, 2:30pm to 4:00pm**

**CE credit: 1.5**

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**State License #:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

The National Association for Home Care & Hospice is an approved provider (Code No. PN06-821-821) of continuing nursing education by the Maryland Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. This certificate must be retained by the licensee for a period of five years.



Val J. Halamandaris, President  
National Association for Home Care & Hospice

National Association for Home Care & Hospice  
228 Seventh Street SE  
Washington, DC 20003 - 202/547-7424  
Teleconference

**Continuing Professional Education Certificate for Accountants**

*“Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?”*

**May 28, 2008, 2:30pm to 4:00pm**

**Field of Study: Regulatory/Ethics**

**CPE credit: 1.0**

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**State License #** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, zip:** \_\_\_\_\_

The National Association for Home Care & Hospice is registered with the National Association of State Boards of Accountancy (NASBA) as a sponsor of continuing professional education on the National Registry of CPE Sponsors (104616). In accordance with the standards of the National Registry of CPE Sponsors, CPE credits are granted based on a 50 minute hour. State boards of accountancy have final authority on acceptance of individual courses for CPE credit. The workshop is presented in group-live format.



President  
National Association for Home Care & Hospice



National Association for Home Care & Hospice  
228 Seventh Street SE  
Washington, DC 20003 - 202/547-7424  
Teleconference

**Certificate of Attendance**

*“Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?”*  
**May 28, 2008, 2:30pm to 4:00pm**

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

This is a general certificate of attendance provided by the National Association for Home Care & Hospice for individuals who do not require CEs for licensure.



**Val J. Halamandaris, President**  
**National Association for Home Care & Hospice**

# National Association for Home Care

## Meeting the CMS July 1 Deadline to Report Hospice Visits/Charges: Are You Ready?

May 28, 2008

If you prefer to submit your evaluation online, please go to: <http://eval.krm.com/eval.asp?id=14108>



	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1. Overall rating .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Content .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Audio quality .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ease of registration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Presenter: Overall Effectiveness

5. Callene Bentoncoury.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Donna Gouveia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

7. Would you participate in another virtual seminar? .....  YES  NO

What was your overall impression of the event and the virtual seminar format? Any additional comments?

PLEASE KEEP WRITTEN COMMENTS WITHIN BOX

Name (optional): \_\_\_\_\_