

# CMS Visit Reporting Guide

## THE HOSPICE LEADERS PROJECT

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## *CMS Visit Reporting Guide* *Revised 11/12/08*

Compliments of



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The Hospice Leaders Project is voluntary collaboration of information and technology companies focused on expediting the adoption of meaningful performance comparisons for the hospice industry. For more information, please send an email to [hlp@ocsys.com](mailto:hlp@ocsys.com).

## CMS Visit Reporting Guide

CMS is moving forward with a phased increase in data required of hospices, in order to improve hospice benefit payment accuracy and analyze the services provided in this evolving and growing benefit. The second phase of expanding required line-level detail on hospice claims is underway, as a result of a Change Request to the Medicare billing requirements (CR 5567). The reporting of additional data to describe services provided for each hospice level of care became mandatory on July 1, 2008.

This guide summarizes the requirements, provides direction regarding interpretation challenges and implementation priorities, and lists additional resources for information. Discussions with CMS on behalf of hospice providers are ongoing, and the regional home health intermediaries (RHHIs) continue to refining their specifications and education for CR 5567.

### The New Claims Data Reporting Requirements

On monthly patient claims, hospices must report the number of **visits** each **week** by **discipline** at each **location**, for each **level of care**, as well as the **charge** for each visit.

#### The Details

##### Level of care

Hospices continue to bill with a line for each level of care delivered, under existing codes.

##### Location of care

Visit data must be reported separately for each location of care at which the patient is served.

##### Not all disciplines?

Hospices must report visits of nurses (registered, licensed, and nurse practitioners), hospice aides, social workers, and physicians (or nurse practitioners serving as attending physician).

- CMS selected the disciplines, because there are existing codes for claims data capture.
- CMS recognizes that this does not represent all care provided under the hospice benefit.
- If no visits are made by a discipline to the beneficiary during a week, do not enter any information for that revenue code.
- Hospices using only licensed nurses (no home health aides) to provide care, should enter all licensed nurse visits as nursing visits, and report no hospice aide visits.

##### What is a week?

For consistency, CMS defines a week to begin on Sunday and end on Saturday.

- Hospices must report lines for each week on the monthly bill.
- If a patient is admitted or discharged mid-week, the week is reported like all others (likely with fewer visits than a full week).
- A week that is split across two months is reported on each month's bill, with the services delivered in each month on that month's bill.

##### What visits "count"?

- DO count 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.
- DO count visits where care is provided to the patient (beneficiary).
- DO count social worker visits to the beneficiary's family.
- DO count simultaneous visits by multiple providers providing appropriate services per DO #1, above, including when required to perform a single task (such as turning a difficult patient).
- DO count visits in a hospice facility staffed 24 hours, by creating a mechanism to capture appropriate visits (see more below).
- DO NOT count training or supervision.
- DO NOT count documentation without a visit.
- DO NOT count phone calls.
- DO NOT count IDG meetings.
- DO NOT count obtaining physician orders.
- DO NOT count visits by a physician not under contract with or employed by the hospice.
- DO NOT count rounds in a facility.

##### Charges

Charges are required as additional information.

- Charge data will not affect payment now, but may be used by MedPAC or others.
- Charges are like prices, not the same as costs.
- Charges should be based upon *actual* costs, including overhead; add a mark-up percentage to reflect gross charges.
- Charge structure should be the same for all payors for the same services
- For each line, calculate and submit charge per visit times number of visits

## Ongoing Interpretation and Reporting Challenges

### Calculating charges

There will be no single “formula” for all hospices. Hospices should know their costs per visit by discipline *in detail* and ensure that charges exceed the “fully-loaded” (including overhead allocation) costs. CMS has removed some flexibility, by specifying that charges may not vary by payer for the same services. NHPCO, NAHC and many consultants offer templates to direct hospices’ efforts to calculate visit costs.

### Counting visits in a facility staffed 24 hours a day

CMS has narrowed its reporting requirement for “visits” in a general inpatient facility to the services provided in a hospice-owned facility. Hospice providers must create a mechanism to determine the number of nursing, social work, hospice aide and physician “visits” in a hospice-owned inpatient facility. CMS-suggested methods include the use of a manual check list or “tally” and the use of an electronic point of care system to record weekly reportable visits. *Note: Only hospice staff visits must be reported in nursing homes or other facilities where the patient is receiving Routine Home Care. Hospices are encouraged to do their best to determine inpatient visit counts, and also to watch for developments from advocates and best practices of peer agencies.*

### Counting continuous care (CHC) visits

CMS has advised that CHC visits are counted in the same manner as Routine Home Care visits and has offered the following examples: An RN provides 4 hours of care in the morning and 4 more hours of care in the evening; 2 nursing visits would be counted. If 3 nurses (in 3 consecutive 8-hour shifts) and 1 aide provide 24 hours of CHC in a 24-hour period, 3 nursing visits and 1 aide visit would be counted. Hospices are encouraged to review CMS examples and consider CHC cases individually to determine appropriate visit counting protocols for the hospice’s unique model of CHC provision. RHHIs will also provide guidance. This is a very small percent of all hospice care provided, so hospices should do their best without over-investing in analysis.

## Implementation Priorities – Ensure Compliance and Take Strategic Advantage of the Data

Hospices are encouraged to review and refine the quality of visit data reported to CMS, and to strategically analyze data for all visits and all disciplines. Ongoing improvement of staffing management systems is important.

### Learn and provide education

- Follow evolving interpretation consensus through seminars, websites, open forums and networking.
- Ask questions about interpretation of the requirements as they relate to your hospice practices.
- Ensure billing accuracy, based upon audits against the Medicare Claims Processing Manual.
- Schedule ongoing training and discussion among clinical staff to ensure complete documentation, as well as compliance and consistency in determining “reportable” visits.
- Provide initial and ongoing training on new data systems and processes.

### Optimize data systems and processes

- Invest now in process and system upgrades ... process changes take longer than anticipated.
- Define each team member’s role in new management processes as they are implemented.
- If necessary, implement new or upgraded clinical information capture and reporting systems.
- Implement data capture processes for all disciplines and services, not just “reportable” visits.
- Create and strengthen internal review processes for visit documentation accuracy.
- Integrate “CR 5567-ready” visit data into data management system and process preparation for the Quality Assessment and Performance Improvement (QAPI) Condition of Participation, effective 12/2/08, with performance improvement project implementation by 2/2/09.

### Continue to provide high quality hospice care

- Do not alter care delivery practices for the purpose of inflating patient visit counts.
- Do use the newly-available visit data to analyze and improve patient care delivery practices.
- Participate in comparative benchmarking of patient-level visit data, both to pinpoint opportunities to improve patient care and to build a database that will illustrate the complete set of services hospices provide. This can be facilitated by members of The Hospice Leaders Project.

### Why Does CMS Want Hospice Visit Data?

Since the Medicare hospice benefit was implemented in 1983, the benefit has grown to have significant – and increasing – impact on the healthcare system. The government – beyond CMS – wants to evaluate utilization of the benefit, with a better understanding of the types and frequency of hospice services provided.

### Is This Good for Hospice?

It is important for hospice policy makers, payers, advocates, and agency leaders to have more comprehensive patient-level data for direction, decision-making, and the ongoing improvement in hospice care and services. Voluntary data submission will not build the necessary database quickly enough. There are challenges – and some risks – associated with the approach of CR 5567, and there remain questions about interpretation. However, hospices will benefit from the implementation of consistent documentation, data collection and reporting systems, *especially if processes are built to capture and understand all services provided* (not just those to be required for reporting on claims).

NHPCO and others successfully advocated for a delay from the originally-transmitted January 1, 2008 implementation date and the elimination of both the requirement to report non-hospice staff visits in contracted facilities and the term “medically reasonable and necessary”, when referring to reportable services. Although the requirement became mandatory on July 1, 2008, hospices should continue to refine, implement and test new processes and systems to ensure the highest level of accuracy and value in data captured. Further, hospices should take full advantage of the analysis (not just capture) of their own data, strengthening quality assessment and performance improvement efforts, while also understanding what CMS may learn from their data submission.

It is important to note that this will create a *partial* set of data, from which substantial regulatory and payment decisions cannot be well supported. NHPCO and other hospice advocates are working with legislators and policy-makers to move toward a well-designed, comprehensive data submission requirement that will build a solid, valuable base of information about hospice care and services.

### Additional Information Sources

CR 5567 Official Instructions to the Medicare RHHI (reissued 4/29/2008)

- [www.cms.hhs.gov/transmittals/downloads/R1494CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1494CP.pdf)

CMS Hospice Center, with links to most current information, including guidance on charge calculations

- [www.cms.hhs.gov/center/hospice.asp](http://www.cms.hhs.gov/center/hospice.asp)

MLN Matters (from Medicare Learning Network) article on CR 5567 (5/1/08)

- [www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf)

NHPCO Members Only regulatory center for CR5567

- [www.nhpc.org/i4a/pages/Index.cfm?pageID=5500](http://www.nhpc.org/i4a/pages/Index.cfm?pageID=5500)

NAHC Homecare & Hospice Financial Managers Association (HHFMA) Hospice Charge Worksheets

- [www.nahc.org/facts/](http://www.nahc.org/facts/) (*scroll down to links*)

Hospice Payment System Fact Sheet

- [www.cms.hhs.gov/MLNProducts/downloads/hospice\\_pay\\_sys\\_fs.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf)