Hospice Change Request (CR) 8358 Questions and Answers

CR8358 General Questions

1. **Will the Centers for Medicare & Medicaid Services (CMS) extend an invitation to hospice providers to participate in testing the changes associated with 8358 prior to April 2014?**

   Answer: There will be a voluntary reporting period for hospice providers. Voluntary reporting will be implemented on claims with through dates on or after January 1, 2014 through March 31, 2014.

2. **How would a provider submit a claim where they have exceeded the 450 line cap?**

   Answer: The 450 line limitation is rarely exceeded in any Medicare benefit. It could be hospices are reporting visits incorrectly, based on the number of times someone enters the patients room rather than what qualifies as a visit. For general inpatient (GIP) care or respite care in contract facilities, only report visits by hospice staff. Visits which are part of room and board services and which are provided to a routine home care (RHC) or continuous home care (CHC) patient residing in a facility should not be reported on hospice claims to Medicare (regardless of whether those services are being provided by hospice staff or facility staff not employed by the hospice). Room and board services may include, but are not limited to, delivery of meals, changing bed linens, housekeeping tasks, etc. Hospices should only report visits which are reasonable and necessary for the palliation and management of the terminal illness and related conditions.

   When making the determination as to whether or not a particular visit should be reported, a hospice should consider whether the visit would have been reported, and how it would have been reported, if the patient were receiving RHC in his or her private home. If a group of tasks would normally be performed in a single visit to a patient living in his or her private home, then the hospice should count the tasks as a single visit for the patient residing in a facility. Hospices should not record a visit every time a staff member enters the patient's room. Hospices should use clinical judgment in counting visits and summing time.

CR8358 Visit Reporting Questions

1. **Does the visit reporting discussed in CR8358 only apply to GIP services or does it also include RHC services?**

   Answer: The visit reporting rules for RHC, CHC, and inpatient respite levels of care are outlined in CR6440. The visit reporting rules in CR8358 apply to the GIP level of care in a skilled nursing facility (SNF) or hospital. You will continue to follow CR5567 when providing GIP in an inpatient hospice unit. Per CR5567, for GIP visits provided in an inpatient hospice unit, you will report the total number of visits performed by nurses, aides, and social workers who are employed by the hospice for each week while in the GIP level of care. Below is a chart to assist you in the appropriate reporting rules for GIP visits based on service location:

HCPCS	Definition	CR	Visit Reporting Description
Q5004	Hospice care provided in SNF	8358	Report each visit with associated HCPCS G-code
Q5005	Hospice care provided in inpatient hospital	8358	Report each visit with associated HCPCS G-code
Q5006	Hospice care provided in inpatient hospice facility	5567	Report total number of visits per week (no HCPCS G-code)
Q5007	Hospice care provided in long term care hospital (LTCH)	8358	Report each visit with associated HCPCS G-code
Q5008	Hospice care provided in inpatient psychiatric facility	8358	Report each visit with associated HCPCS G-code

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2. **If patient dies prior to midnight and the visit extends to next day, do we split the visit pre/post mortem? How do we handle the portion of the visit after the date of death?**

   Answer: If a patient dies during a visit, the visit needs to be split. Report the length of the visit while the patient was alive without a PM modifier. Report the length of the visit after death and prior to midnight with the PM modifier. Due to system limitations, you will not report visit time after midnight.

3. **For post mortem visits, if the nurse arrived at 9am and the patient dies at 10am and doesn't leave until 11 am, should this 1 continuous visit require the PM modifier?**

   Answer: In the scenario above, the visit time would be split. One visit line item will have the length of time while the patient was alive without the PM modifier, and another visit line will have the length of time after the patient's death with a PM modifier.

4. **What if the patient dies shortly before midnight and is not pronounced until early the next day – should we record all services done on the day the patient is pronounced?**

   Answer: Post mortem services should only be reported for the day of death, using the date of death recorded on the death certificate.

5. **How is the billing department supposed to know how to split a visit when the patient dies during that visit?**

   Answer: It is strongly recommended that each hospice organization implement a process to differentiate the time associated with visits pre- and post-mortem.

6. **For GIP provided in SNFs or hospitals, hospices must report visits. If we are using an inpatient unit run by a different hospice, do we have to report these visits following CR8358 as well?**

   Answer: CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (Q5006). You will continue to report the total number of visits per week performed by nurses, aides, and social workers, who are employed by the hospice following the instructions implemented in CR5567.

7. **Do we have to report therapy visits by employed and contracted therapists? Or only visits provided by employed therapists?**

   Answer: You will report the therapy visits for hospice-employed therapists and contracted therapists. You will not report visits by non-hospice staff when provided in a contracted facility.

8. **Social worker phone calls will be reported regardless of length of phone call. I'm assuming that is only if the social worker spoke to someone and will not be reported if they left a voice mail. Is this correct?**

   Answer: CR6440 states, "Only phone calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care (such as counseling or speaking with a patient's family or arranging for a placement) should be reported." Since the social worker wasn't able to make contact with the needed party, the call should not be reported.

9. **This question is regarding rounding of minutes for use of the PM modifier. In this example the registered nurse (RN) arrives at the home at 9:25 am and leaves at 10:45 am. The patient dies at 10:06 am. The total number of minutes for the visit is 80. Based on the time reporting requirements, 80 minutes = 5 units if this was reported as a single visit. However, since the death occurred during the visit, all of the MACs have advised me to split the visit and then round if a patient dies during the visit. Given that, the time the patient was alive would be reported with 3 units (9:25 – 10:06 am = 41 minutes = 3 units) and the time after death would be reported with 3 units (10:06-10:45 am = 39 minutes = 3 units). So we will now be reporting a total of 6 units for this 80 minute visit that was split in order to report the PM modifier. I just want to ensure that this is correct.**

   Answer: Yes, this is correct.

10. **For post-mortem visits, does the patient's body need to be present to report the PM visit? Based on the definition of a visit in the Medicare Claims Processing Manual, we believe the answer is 'no' for most disciplines; however, a social worker visit/phone call could still be reported as a PM visit without the patient's body being present. Please confirm if this is correct.**

    Answer: The patient's body does not need to be present to report a post-mortem visit. While hospice staff may have to deal with the patient's body during a post-mortem visit, hospice care is also provided post-mortem to the family. This includes all visit disciplines that are currently reported by hospice providers.

11. **Do we have to report post mortem visits for patients who die while in the GIP level of care at a hospice inpatient facility?**

Answer: The system does not allow the reporting of modifiers without a HCPCS code. For GIP visit reporting in a hospice inpatient facility (Q5006), you will continue to follow the instructions in CR5567. This means that the visits are reported weekly (Sunday-Saturday) and do NOT utilize the HCPCS G-codes. By definition, the HCPCS G-codes state "per 15 minutes". They are timed HCPCS codes and cannot be used when reporting weekly visits.

For example, if a patient was in GIP at a hospice inpatient facility for three days and had six skilled nursing visits, the visit line would be reported with "6" units to tell the system the patient had six separate visits. If a HCPCS G-code was added to that visit line, then the claim would be telling the system that there was one visit totaling six 15-minute increments.

Therefore, post mortem visits cannot be reported when a patient dies in GIP while in a hospice inpatient facility since HCPCS G-codes are not reported in this situation and there would be no way to report the –PM modifier on the claim.

12. **Please confirm if a billable Social Work Phone call should be reported after death, on the day of death, with a post mortem code.**

    Answer: Yes, the post mortem reporting requirement applies to all of the disciplines that currently require visit reporting.

13. **If the nurse arrives to home at 9 am but does not record time of death until 9:10. Do we count the first 10 minutes as a regular visit and the rest as a post mortem visit?**

    Answer: Yes, post mortem visit reporting does not begin until the actual time that the patient is pronounced, which is the official time of death as recorded on the pronouncement of death.

14. **If a patient dies at a facility, the facility nurse pronounces the patient, but the hospice nurse notifies the family (by phone), contacts the funeral home, attends to the patient's personal belongings-does this constitute a post mortem visit?**

    Answer: Only phone calls by social workers are reportable. However, the time the nurse tended to the patient's belongings, or any other time the nurse is present with the family or the patient's body would be reportable with the PM modifier. For example, a nurse gathers a deceased patient's belongings to return to the family; this would be reported as a PM visit, as it was provided after the patient's death, on the day of death, and involved tending to the deceased patient and/or their family.

CR8358 National Provider Identifier (NPI) Reporting Questions

1. **If we enter our claims directly in the Fiscal Intermediary Standard System (FISS)/Direct Data Entry (DDE) the NPI reporting is not required, correct?**

   Answer: The NPI is required on the 5010 Electronic Claim in loop 2310E (the NPI qualifier goes in data element NM108 and the NPI goes in NM109). The NPI is also required in DDE. Note that a new field has been added to claim page 3 to accommodate this new reporting requirement (see screenshot below). However, this is not a requirement for paper claims (UB04).

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MAP1713  PAGE 03
 XXX1111  SC                    INST CLAIM ENTRY
 HIC XXXXXXXXXA   TOB 8X2   S/LOC S B0100   PROVIDER XXXXXX
                                              OFFSITE ZIPCD:
  CD  ID   PAYER                   OSCAR      RI AB       EST AMT DUE
A Z        MEDICARE                           X
B
C
DUE FROM PATIENT
                                        SERV FAC NPI XXXXXXXXX
MEDICAL RECORD NBR               COST RPT DAYS    NON COST RPT DAYS
DIAGNOSIS CODES  1 XXXXX     2        3         4          5
     6          7        8        9              END OF POA IND
ADMITTING DIAGNOSIS        E CODE        HOSPICE TERM ILL IND
IDE
PROCEDURE CODES AND DATES  1              2
  3            4           5                6
NDC CODE
ESRD HOURS    ADJUSTMENT REASON CODE    REJECT CODE     NONPAY CODE
ATT PHYS      NPI XXXXXXXXXX   LN DOCTOR          FN  IMA    MI SC 99
OPR PHYS      NPI          LN                     FN         MI SC
OTH PHYS      NPI XXXXXXXXXX   LN PHYSICIAN       FN  ISA    MI SC

PROCESS COMPLETED --- PLEASE CONTINUE
              PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT
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2. **What will happen if you report the NPI of a hospice inpatient unit that is the same as the hospice facility?**

   Answer: If the patient is in your own inpatient-hospice unit, the NPI should not be reported. The claim will still process through if you report the NPI of your own inpatient facility.

3. **Does the NPI need be reported for all levels of care provided at a nursing facility (NF), SNF, Hospital, or Hospice Inpatient facility?**

   Answer: Under CR8358, regardless of the level of care provided, you will report the NPI, facility name, and address of any SNF, NF, hospital, or hospice inpatient facility where the patient is receiving services when the service is not performed at the same location as the billing hospice's location (i.e., your own hospice-inpatient facility). This is required for any hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 (when not the same as the billing hospice), Q5007 and Q5008, unless it is a paper claim.

4. **I was informed that one of the hospitals we contract with does not have an NPI as they only accept commercial insurance patients. How do handle this since there is no NPI to report?**

   Answer: NPIs are assigned for every provider, regardless of the payer source. They are a HIPAA requirement and an industry standard. Additionally, per the 42 Code of Federal Regulations (CFR) Chapter IV, Part 418, section 418.108-*Condition of participation: Short-term inpatient care*, inpatient care must be available for pain control, symptom management, and respite purposes, AND must be provided in a participating Medicare or Medicaid facility. A hospice cannot contract with a hospital that is not Medicare/Medicaid certified.

5. **Do we report the NPI of our own hospice inpatient facility if it isn't at the same physical location as our hospice agency?**

   Answer: For hospice inpatient facilities, you will only report the NPI if you are using another hospice agency's inpatient hospice facility. If your hospice agency owns the hospice inpatient facility, then you will NOT report an NPI, regardless of where the hospice inpatient facility is physically located.

6. **Electronic claims require us to report the ZIP+4 code for nursing homes and hospitals. Will the ZIP+4 codes still be required once we start reporting the NPI for these facility types?**

   Answer: Yes, all billing providers must submit 9 digit zip codes. Claims containing facility information also require the 9 digit zip codes for the facility address.

7. **For facilities that have multiple NPI numbers listed, does it matter what one we enter? We have looked up nursing facilities in NPPES and found some have two or three NPIs.**

   Answer: Yes, consult with the facility to determine which NPI is appropriate.

8. **Do we need to report NPIs for intermediate care facilities (ICF)?**

   Answer: No, you will only report the NPI when reporting site of service HCPCS codes Q5003, Q5004, Q5005, Q5006 (when not the same as the billing hospice), Q5007 and Q5008, which are the NF,SNF, hospital, and hospice inpatient facility location codes.

CR8358 Drug and Infusion Pump Reporting Questions

1. **When billing for the pump, do we bill the equipment charge once a month or each time there is an injection?**

   Answer: CMS reissued CR8358 on January 31, 2014. The revised CR states, "Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump and for each medication fill and refill. The hospice claim shall reflect the total charge for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems so long as, in total, the claim reflects the charges for the pump for the time period of that claim."

2. **How do we report infusion pump and medication in a GIP setting when it's included in the GIP rate we pay to the hospital with which we contract?**

   Answer: Report all prescription medications and infusion pumps provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with those providers you contract with, as they may need to modify their billing to the hospice to assist the hospice in meeting this new requirement. Since the hospice is still responsible for its patients receiving GIP in a contracted facility, it should know what medications were provided and if an infusion pump was used.

3. **Where can we find a list of the drug Healthcare Common Procedure Coding System (HCPCS) codes?**

Answer: The Table of Drugs is available on the Centers for Medicare & Medicaid Services (CMS) Web site at www.cms.gov (Medicare > Coding: HCPCS Release & Code Sets > Alpha-Numeric HCPCS Items > Details for Year).

4. Per pharmacy regulations, to "dispense a drug" means to fill a prescription on a patient-specific basis with patient-specific labeling, etc. In some states, pharmacy regulations allow us to operate a special class of Pharmacy that does not require medications to be "dispensed" prior to the nurse administering the med. In accordance with our Pharmacy license, medications are not "dispensed" in our inpatient centers. Our nursing staff is able to obtain a medication order, go to the inpatient center pharmacy, and obtain a single patient dose of the medication from a stock med bottle and/or use a Pyxis system. They then administer the medication and document it on the Medication Administration Record (MAR). What would be considered a "fill" in this situation? Any suggestions?

   Answer: When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a system (such as Pyxis) where each administration of a hospice medication is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.

5. How is that national drug code (NDC) going to work on the electronic submission of claims? Is there a field in the electronic claim to enter the NDC?

   Answer: The NDC goes in the 5010 loop 2410 (drug identification). Within the loop, the following data elements are required: LIN02 - Qualifier (which would equal N4), LIN03 - National Drug Code, CTP04 – Quantity, and CTP05 – Unit of Measure Qualifier (F2=International Unit, GR = Gram, ME = Milligram, ML = Millimeter, UN=Unit).

6. Where do I report the NDC in DDE?

   Answer: The NDC is reported in the first right view of claim page 02 in DDE. To add an NDC, press the <F11>/ <PF11> key to view the right side of CLAIM PAGE 02. Note that you will have to keep track of the claim line number when entering the NDCs as the NDC line must be the same claim line as the 0250 revenue code. When entering the quantity, units must be entered with the decimal point (e.g., 50 units would be reported in the Quantity field as "50.0"; DDE will automatically add the remaining two trailing zeros).

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MAP171E    PAGE 02
XXX1111    SC                        INST CLAIM ENTRY
                                                     NDC CD PAGE 01
  HIC XXXXXXXXXA      TOB 8X2   S/LOC S B0100   PROVIDER XXXXXX


             CL      NDC FIELD       NDC QUANTITY      QUALIFIER
             1      12345678901         1.000            GR
  LLR NPI            L                  F                M      SC
             2
  LLR NPI            L                  F                M      SC
             3
  LLR NPI            L                  F                M      SC
             4
  LLR NPI            L                  F                M      SC
             5
  LLR NPI            L                  F                M      SC
             6
  LLR NPI            L                  F                M      SC
             7
  LLR NPI            L                  F                M      SC
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7. What is the intent of the per fill listing for drugs? What happens if they do not use the entire fill? Do we have to change the quantity?

   Answer: Drug reporting is required so that Medicare can see what it's paying for, and to help CMS better understand non-labor costs during a hospice election. Report prescription drugs based on the fill, using the amount dispensed. Do not report drugs based upon what the patient actually uses because the hospice bears the cost of the entire amount dispensed, whether the patient uses all the medication or not.

8. What will we do about the infusion pumps that we own and have the patient use? They have to have an order to use the infusion pump, but we don't have a bill.

   Answer: According to CR 8358, "hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump order and for each medication refill." In this case, report a reasonable charge for the pump on the claim when a pump is provided to the patient.

9. Are we required to report medications dispensed at the hospital for our patients? If so, given the fact that we do not receive documentation from our contracted hospitals in a timely manner (sometimes receiving the bills

months later), can we submit our initial claims to Medicare without this data and submit an adjusted claim afterwards once we get the detail from the hospital?

Answer: Report all prescription medications provided under the hospice benefit, regardless of level of care or site of service. We suggest you coordinate with your contracted providers, who may need to modify their billing to accommodate this new requirement. Hospices are expected to submit completed claims. Provider-submitted adjustments (Type of Bill 8X7) are allowable during the timely filing period, but hospices should not make claims adjustments their standard practice. The UB-04 form states, "Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete." We would be concerned if a hospice routinely submitted incomplete claims and then later routinely submitted adjustments to those claims.

10. **Will all hospice patients, regardless of the level of care, now require the reporting of injectable and non-injectable prescriptions drugs?**

    Answer: Yes, the reporting of injectable and non-injectable prescription drugs will be required for all hospice patients regardless of the level of care.

11. **Are flu shots and anti-coagulants, such as Lovenox, considered injectable drugs?**

    Answer: Medicare covered vaccines are preventive services, and are outside of the hospice benefit. They are billed to Part B on a professional claim, not to Part A on a hospice claim, and therefore would not be reported on hospice claims. Lovenox would be reported on a hospice claim if related to the terminal illness.

12. **Do we have to have dollar amounts on the drug or pump lines of service on the electronic claim and/or the UB-04?**

    Answer: All reported line items require that a provider charge be submitted.

13. **Is CMS aware of the burden it places on agencies around the reporting of medications? How will the billing departments get this information?**

    Answer: Industry representatives have encouraged CMS to collect non-labor data to better understand hospice resource usage, and to assist in reforming the hospice payment system. The Affordable Care Act also allows CMS, and by extension, MACs, to collect additional data needed for payment reform. Until recently, hospices have historically not reported much information on their claims. We appreciate that any new requirement is a change, but we also recognize that it is a normal part of doing business in much of the healthcare industry. We trust that the hospice billing department will be able to work with other providers and suppliers to get the needed data in a timely fashion.

14. **If our electronic medical records (EMR) vendor is not ready to put medications on claims, will there be a manual way to enter?**

    Answer: Yes, claims can be submitted via DDE.

15. **How will we report compounded medications?**

    Answer: When reporting compounded medications, hospices should report each prescription drug that is part of the compound on a separate line item using revenue code 0250 along with the NDC. For electronic claims, the segment REF – Prescription or Compound Drug Association Number must also be reported. When a compound drug is reported, each component will have the same prescription number in order for the payer to match all components to the prescription. If there is no prescription number, a "link sequence number" is reported, which is a provider assigned number that is unique for the claim. The link sequence number matches the components, similar to the prescription number. Note that the prescription number reporting is only required on electronic claims. There is no field available in FISS/DDE to report the prescription number.

16. **Do we enter the pharmacy prescription numbers as well as the NDCs for the non-injectable prescription medications?**

    Answer: The prescription number is only reported when reporting compounded drugs on electronic claims. Please see QA 38 for more information.

17. **Do we report only the hospice-covered medications?**

    Answer: Only report medications for the palliation and management of the terminal illness and related conditions. Therefore, you will only report medications covered under the hospice benefit.

18. **We have heard that the NDC can be different based upon the drug manufacturer. How do we accurately and timely include this data on the claim?**

Answer: The NDC code varies by manufacturer and is on the prescription received from the pharmacy. The NDC codes are also available in the NDC directory at http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday.

19. **Providers are having issues with EMR vendors as they are not willing to support medication reporting on claims. Have you or CMS heard this from other providers? What do we do if our vendors won't do this reporting?**

    Answer: This is a business issue between a provider and its software vendor. Other Medicare provider types have not experienced this problem.

20. **Some of our pharmacies are slow on getting us information on refills. We will discover medication refills after the claims have been submitted. Will we need to do bill corrections on these additional medications?**

    Answer: We suggest you coordinate with your pharmacies, which may need to modify their billing to accommodate this new requirement. Hospices are expected to submit completed claims. Provider-submitted adjustments (Type of Bill 8X7) are allowable during the timely filing period, but hospices should not make claims adjustments their standard practice. The UB-04 form states, "Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete." We would be concerned if a hospice routinely submitted incomplete claims and then later routinely submitted adjustments to those claims. However, if you are informed of a fill after claim submission, you will have to submit an adjustment (Type of bill 8X7) to add the medication information once it is received.

21. **Could you suggest to CMS that drugs be captured through Cost Reporting vs. on the claims?**

    Answer: This suggestion will be forwarded to CMS. In the meantime, you should follow the instructions in CR8358.

22. **CMS wants the quantity of the non-injectable drugs that are filled, is that part of the NDC, or do we need to report that in the Units field on the claim?**

    Answer: Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and should be reported as the unit measure. Hospices should follow the 5010 billing guidance and requirements.

23. **My understanding is that the NDC is not issued until after the fill, sometimes long after. How will we process timely claims given this reality?**

    Answer: The NDC code should be on the medication received from the pharmacy. The NDC is issued by the drug manufacturer. To link to an Excel file showing all NDC codes, go to http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday. Hospices are expected to submit completed claims. Provider-submitted adjustments (Type of Bill 8X7) are allowable during the timely filing period, but hospices should not make claims adjustments their standard practice. The UB-04 form states, "Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete." We would be concerned if a hospice routinely submitted incomplete claims and then later routinely submitted adjustments to those claims. However, if you are informed of a fill after claim submission, you will have to submit an adjustment (Type of bill 8X7) to add the medication information once it is received.

24. **Will there be a specific list of drugs that need to be reported, so we know which are required and/or excluded?**

    Answer: All prescription drugs, injectable and non-injectable, are to be reported.

25. **Does total parenteral nutrition (TPN) need to be reported? What if drugs are added to the TPN?**

    Answer: Medicare considers TPN to be a prosthetic, and not to be a drug or DME. It should not be reported on claims. If drugs are added, the drug should be reported.

26. **How are charges for drugs reported when the hospice pays a capitated rate for all drugs?**

    Answer: With regards to guidance to hospices on how to report charges on the hospice claim, we refer hospices to three areas of CMS's manuals.

    1. The CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75.5 states, "This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill

Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

2. The CMS IOM Publication 100-00, Provider Reimbursement Manual, Part 1, Chapter 22, section 2203 states, "Provider Charge Structure as Basis for Apportionment", that to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program." In Section 2204 of the same chapter CMS further states that the Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)

3. In Section 2202, "Definitions", at 2202.4 "Charges", CMS states that charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

27. **What is the definition of the NDC? Is it just the drug name dosage and quantity or is it the manufacturer's code?**

Answer: The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. The 3 segments of the 11-digit NDC identify the labeler, the product, and the commercial package size. The first set of numbers in the NDC identifies the labeler (manufacturer, repackager, or distributer). The second set of numbers is the product code, which identifies the specific strength, dosage form (e.g., capsule, tablet, liquid) and formulation of a drug for a specific manufacturer. Finally, the third set is the package code, which identifies package sizes and types. In addition to the actual NDC, you will also have to report the qualifier (electronic claims only), the quantity dispensed, and the unit qualifier. Below is an example of NDC reporting for both electronic claims and FISS/DDE claims:

NDC breakdown for 5010 electronic claims Qualifier + NDC Code + UOM + Quantity		NDC breakdown for FISS/DDE claims NDC Code + Quantity + UOM	
Example: N4 + 12345678901 + ML + 5		Example: 12345678901 + 5.0 + ML	
Qualifier	N4 (always report N4)	National Drug Code (NDC Field)	NDC format (5-4-2)
National Drug Code (NDC)	NDC format (5-4-2)	Drug unit quantity (NDC Quantity field)	Dispensing quantity
Drug Unit of Measure (UOM)	Valid unit of measures are: F2 (international unit) GR (gram) ME (milligram) ML (milliliter) UN (unit)	Drug Unit of Measure (Qualifier field)	Valid unit of measures are: F2 (international unit) GR (gram) ME (milligram) ML (milliliter) UN (unit)
Drug unit quantity	Dispensing quantity		

28. **Can you clarify the definition for non-injectable drugs?**

Answer: Any prescription drug that is not injected or administered via the infusion pump would be reported as a non-injectable drug.

29. **If the dosing is by unit, does not have an itemized charge, and the NDC number is not listed on the invoice, how do we obtain the NDC information?**

Answer: The NDC code varies by manufacturer and is on the prescription received from the pharmacy. The NDC codes are also available in the NDC directory at http://www.fda.gov/drugs/informationondrugs/ucm142438.htm. This file is updated every weekday.

30. **Does the NDC number that we are going to be asked to report have to match the actual NDC of the product dispensed?**

    Answer: Yes, you must report the NDC for the drug actually dispensed.

31. **The CR says that the NDC is to be reported and it will represent the quantity of drug filled. This creates an issue when the NDC represents a bottle of #100 and a pharmacy is only dispensing #30 at a time for example. How would they report a quantity less than the pack size of the bottle?**

    Answer: The actual NDC identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. In addition to the actual NDC, you will also have to report the quantity dispensed. Please see Q/A 44 for additional information.

32. **Hospitals utilize different billing systems that do not use the same revenue or HCPCS codes that CMS requires hospices to use and those billing systems are not designed to provide NDC numbers. How does CMS propose that hospices obtain all the required information that needs to go on the claims per CR8358?**

    Answer: We strongly suggest that all hospices work with their contracted hospitals to ensure the hospitals are aware of this additional data reporting requirement.

33. **The CR states hospice agencies should report infusion pumps on a line-item basis for each pump and for each medication fill and refill. What is the quantity to be reported for the infusion pump?**

    Answer: You will always report a separate line item with one unit for each separate pump used in the month.

34. **If entering a claim in FISS, do I enter the quantity of the revenue code 250 in the total units as well as the NDC quantity field?**

    Answer: Yes, you will enter the quantity in the units field on the revenue code 0250 line as well as in the NDC quantity field.

35. **Since the NDC reporting instructions in CR8358 are for data collection purposes only, does CMS consider it acceptable to always use the unit of measure qualifier "UN" (Unit)?**

    Answer: The container label also displays the appropriate unit of measure for that drug. The unit of measure is by weight (grams: GR), volume (milliliter: ML) (milligram: ME) or count (unit: UN). Each dispensed dose must be converted into one of these, following the manufacturer's unit of measure. International units (F2) must be converted to standard measurements (GR, ML, ME and UN). Examples of proper unit measures include:
    - For drugs that come in a vial in powder form that needs to be reconstituted before administration, bill each vial (UN).
    - For drugs that comes in a vial in liquid form, bill in milliliters (ML).
    - For topical forms of medicine (e.g., cream, ointment, bulk powder in a jar), bill in grams (GR or ME).

36. **If an over-the-counter (OTC) drug is ordered by a physician is it reported on the claim?**

    Answer: OTC drugs are not reported on the claim. This would include OTC drugs ordered by a physician. Only prescription drugs should be reported on the claim. Per the Food and Drug Administration's Prescription Drugs and Over-the-Counter (OTC) Drugs: Questions and Answers article, prescription drugs are prescribed by a doctor and only obtained through a pharmacy. OTC drugs are drugs that do not require a doctor's prescription and can be bought off-the-shelf in stores.

37. **Do we report the charges for the drugs and infusion pumps as covered or non-covered?**

    Answer: The charges should be reported as covered charges.

38. **Do we report all prescription drugs found in the home when we admit a patient to the Medicare hospice benefit, or only those are prescribed after admission and as part of the plan of care?**

    Answer: Prescription drugs that were filled prior to the patient electing the Medicare hospice benefit would not be reported. Once the patient elects the Medicare hospice benefit, you will report all medications prescribed for the palliation and management of the terminal illness and related conditions.

39. **Is oxygen reported as a non-injectable prescription medication for the purposes of the NDC reporting requirements on hospice claims?**

    Answer: No, oxygen is not reported on hospice claims.

40. **Do we need to report a HCPCS code with revenue code 0250 for the non-injectable prescription drugs? Do we need to report and NDC with revenue code 0636 for the injectable prescription drugs?**

Answer: No, per CR8358, non-injectable prescription drugs are reported with revenue code 0250 and the NDC. Injectable prescription drugs are reported with revenue code 0636 and the HCPCS code. Below is a chart to assist you in the appropriate reporting rules for drugs:

| Type of Drug | FISS/DDE Claim Page 2 | | | | | Right View of Claim Page 2 |
	Revenue Code	HCPCS Code	Units	Charges	Service Date	NDC Code
Injectable	0636	Required	Required, see QA#42	Required	Required, date of fill	None
Non-injectable	0250	None	Required, see QA#48	Required	Required, date of fill	Required
Infusion pump medications	0294	Required	Required, see QA#42	Required	Required, date of fill	None

41. **How do we report micrograms?**

    Answer: You will have to convert micrograms to a reportable measure (i.e., milligrams or grams). For example, 1 microgram (mcg) is 1000th of a milligram:
    - 1 mcg= 0.001 mg
    - 10 mcg =0.01mg
    - 100 mcg = 0.1 mg
    - 1000 mcg = 1.0 mg

42. **How do we report fractional units for injectable prescription drugs? For example, the HCPCS code definition is for 100 mg, or 200 mg, but the physician prescribed 125 mg. How are units for this reported?**

    Answer: Providers are required to report this in "whole number" units on the revenue code line. Therefore, if your definition of a "unit" as per the HCPCS code is 100 mg, then 125 mg would be "2" HCPCS units since it is more than 100 mg but not more than 200 mg (which would be the upper limit of reporting for 2 HCPCS units).

43. **If fifty 15 mg tablets are dispensed, is the NDC quantity "50" and the unit of measure "UN"?**

    Answer: Yes, the NDC quantity would be "50", and the unit of measure would be "UN". The NDC quantity for tablets or capsules is always the number of tablets or capsules dispensed. The actual NDC that is reported identifies the dosage of the tablet itself.

44. **Are injectable medications that are given by a non-routine route, for example, a narcotic is administered by nebulization instead of injection reported as an injectable meds, or is it reported as a non-injectable because of the way it is administered?**

    Answer: The means by which the medication is administered will determine how it is reported. <Sent to CMS for clarification to confirm how hospice should handle drugs dispensed via other DME>

45. **When we bill for an injectable medication, is it reported differently if it is injected or if it is administered via an infusion pump?**

    Answer: Yes, if it is administered via an infusion pump, it will be reported as an infusion pump drug, using revenue code 029X for the equipment and 0294 for the drugs, along with the appropriate HCPCS.

46. **Can we report durable medical equipment (DME) other than infusion pumps (e.g., nebulizers, hospital beds, wheel chairs)?**

    Answer: No, the only DME that can be reported is infusion pumps. Do not report any other DME on your hospice claims.

47. **If the patient owns the pump, does it belong on the claim if they are receiving infusion drugs?**

    Answer: CR8358 requires the reporting of infusion pumps provided by the hospice, so a patient-owned pump would not be reported. There is no cost to the hospice for such a pump.

48. **If we are reporting "50" in the NDC quantity field for 50 tablets, what should we be reporting in the revenue code unit field?**

Answer: The 0250 revenue code line only requires a valid value in whole numbers as the actual units (quantity) are reported in the NDC field. Providers can report a unit of "1" or any other value that may assist them internally.

49. Can we report "fillers" used with infusion pump drugs (e.g., saline, sodium chloride)?

    Answer: No, solutions or diluents used to mix with prescription drugs for use in an infusion pump are not to be reported. These "fillers" are not prescription drugs.

50. We ordered a non-injectable on 4/4, but the pharmacy did not fill it until 4/5, and we then received it on 4/6. The patient died on 4/5. Would we report this drug and if so, what service date would be reported on the revenue code 0250 line?

    Answer: You will report the drug along with the date that it was filled. In this example, you would report 4/5.

51. We routinely order medications the day before the actual admission and we pick it up before the actual date of admission. Would we report this medication since we ordered it and received it the day before the actual hospice admission? If so, what service date would be reported on the revenue code 0250 line?

    Answer: Yes, you should report the medication since it is part of the plan of care. However, your line item dates of service cannot be prior to the actual admission date. In this scenario, you should report the date of admission on the drug line.

Version History

Version	Date	Section	Revisions/New QAs
V1.3	1/6/2015	Visits	Revised: None New: #14
		NPIs	Revised: None New: None
		Drugs/Infusion Pumps	Revised: #40 New: #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51
V1.2	3/31/2014	Visits	Revised: #11 New: #12, #13
		NPIs	Revised: None New: #6, #7, #8
		Drugs/Infusion Pumps	Revised: #9, #15, #20, #23 New: #16, #33, #34, #35, #36, #37, #38, #39, #40