Newly Medicare Certified Hospice Billing Guide

Providing quality software solutions, allowing care providers to focus on what matters most.
Newly Medicare Certified Hospices

Once a newly certified hospice site has a confirmed date of MEDICARE CERTIFICATION they may begin the process of preparing their patients for Medicare billing. Please be aware even if the Hospice has been caring for a patient and their family for several months they will need to discharge and re-admit the patient in Consolo so that the PATIENT CERTIFICATION matches the HOSPICE CERTIFICATION DATES. If the dates are not accurate on the claims the Hospice may have delayed payments.

For the Claims to be accurate for billing purposes, they must contain the following:

- **Admission Date**—Must be the same or after the Hospice’s Certification Date
- **Certifications**—Must begin on or after the Hospice’s Certification Date
- **Medical Record Number**—Must be entered in the Hospice Assignment Screen
- **ICD9 Code**—Must be Added in the Clinical Indicator and Diagnosis Screen
- **Visit Dates and Times**—Must be entered in Consolo (as defined by CMS)

*Please see the steps in the following pages to help guide the process.*
In order to create an accurate Medicare claim, “patients” start of care date and certification dates must be the same or after the Hospices Medicare certification date. This means in Consolo you must discharge and readmit a patient, if the Hospice was caring for the patient prior to the “Hospice’s” Medicare Certification.

Click View Summary to discharge patient.

Click New Care Change to select Discharge Type.
Select Discharge—Revocation to discharge patient.

Click Create to begin the discharge process.
Discharging Patient

Make sure to click each tab prior to saving.

It is optional to use this screen but it must still be opened.
Discharging Patient

Click Discharge next, to open the Discharge Screen.

Enter Date that is one day prior to the Hospice’s Medicare Certification (include a note if necessary).

Click Disposition tab, nothing is required to be modified in this screen.

Then click on Create to Save.
This is a summary of the Discharge information that was just saved.

Click on Patient Name to return the main Patient Home Page.
Next the patient needs to be re-admitted on the first day the Hospice was Medicare certified.

Click on Re-Admit Patient.

Admission Date should be the first day the Hospice was Medicare certified. Also select appropriate Office (add a note if necessary), then Save.
Next the Hospice Certification for the patient will need to match the date the Hospice was Medicare Certified (for those patients being cared for prior to the Hospice’s Certification). The patient may already have certifications in Consolo that may be left in the system.

Click on Hospice Certification and Plan of Treatment.

Click on Certification History to view a listing of Certifications already in Consolo.

NOT SIGNED not used
Click on New Certification to add a certification (if you want to keep existing certifications from a patient on service prior to the Hospice’s Certification).

If a certification was not created then click the edit icon.

The Benefit Period Number should match the Medicare Common Working File. (The Benefit Period will be #1 unless they have used their Medicare Hospice Benefit at another Medicare Certified Hospice).

Dates should be the Dates that the Hospice was Medicare Certified for patients being cared for prior to the Hospice’s Certification Date (Unless a patient was transferred). A Certification Signed Date Must be Entered for a Claim to be Sent Electronically.

Select a Nursing Assessment to associate with this Certification, and click Create to Save.
This page is a display of the Hospice Certification. If you would like to see a summary of the Certifications that have been saved, click on Certification History or click the Patient Name to return to the Home Page.
The Medical Record Number is required on the claim, if it has not been entered add it to the Hospice Assignment screen.

The Effective Date needs to be Hospice’s Certification date or prior. Add the MRN to the Medical Record Number field if needed. Update to Save.
In order for claims to be properly created for patients who were cared for prior to the Hospice Certification, Medicare should be set up as a Payer on or prior to the Medicare Hospice Certification Date.

If Medicare has not been entered, add it to the Payer Information Screen.

If Medicare is not set up in a Payer Group Create a New Payer Group.
Medicare needs to be in Consolo with an Effective Date, the same as Hospice’s Certification or prior (for patients being cared for Prior to the Hospice’s Certification).

This page is a display of the Payer Group that was just saved. If you would like to see a summary of the Payer Groups that have been saved, click on Payer Group History or click the Patient Name to return to the Home Page.
The Diagnosis Code is required on the claim, if it has not been entered add it to the Clinical Indicators & Diagnosis screen.

The Diagnosis Code must have an Indicator Date of the Hospice’s Certification or prior to properly appear on the claim (for those patients “receiving care” for prior to the Hospice’s Certification). Patients admitted after the Hospice’s Certification, should use an Indicator Date on or prior to their Admission Date).

Edit if the Diagnosis Code is in the system and Date needs modification or select New Indicator to add Diagnosis information.
The only two required fields for Medicare Claims processing are the Indicator Date and the Primary ICD9 Code (other fields are optional). Update to save.
CMS Requirements for Visits on the Claim

Visit Requirements

- Visit “Units” are billed in 15-minute increments
- Reporting of Nursing, Social Work, Hospice Aide and Therapy Visits (Physical, Speech and Occupational)
- Reporting of some Social Worker Phone Calls, is required:
  - Phone Calls necessary for Palliation and Management of Terminal Illness, Related Conditions as Described in Plan of Care
  - Phone Calls Related to Providing/Coordinating Care to Patient, Family and Documented in Clinical Record
- When Recording any Visit or Social Worker Phone Call Time, Consolo will sum the time for each visit or call, rounding up to the nearest 15 minute increment – **Consolo will not include travel time or documentation time** in the time recorded for any visit or call.

Summary of How the Consolo Claims will Appear:

- Each Visit for Nursing, Social Work and Hospice Aide will be billed on a separate Revenue Code Line
- Each Visit Lists Time in 15-minute Increments / Units
- Required HCPCS / G-Codes:
  - Nursing 55X G0154 / 15-min increments / Visit date
  - Social Worker 56X G0155 / 15-min increments / Visit date
  - Aide 57X G0156 / 15-min increments / Visit date
  - Social Worker Phone Calls to Patient / Family 569 G0155 / 15-min increments / Call date
  - Therapies (Physical / Occupational / Speech):
    - Physical Therapy 42X G0151 / 15-min increments / Visit date
    - Occupational 43X G0152 / 15-min increments / Visit date
    - Speech-Language Therapy 44X G0153 / 15-min increments / Visit date

*Please see the pages that follow for specific instructions on entering and verifying visits*
Clinical Time Entry

ENTERING CLINICAL TIME (Within the Patient Clinical Charting Screen)

- **Clinical Time Entry** is completed at the bottom of Clinical Documentation.
- **Enter Time** in Military Format.

Medicare Regulation requires the entry of Time In and Time Out for every billable Medicare visit.

* Indicator to count as a visit on Medicare Claims.

Effective Date / Date In / Date Out should all be the same unless the time being entered passes midnight.

See full list of Visit Types and Clinical Care Types on Next page.
<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>CLINICAL CARE TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement</td>
<td>2nd Shift Visit</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>3rd Shift Visit</td>
</tr>
<tr>
<td>E.C.F./Group Home *</td>
<td>48-Hour Visit</td>
</tr>
<tr>
<td>Email</td>
<td>Admission</td>
</tr>
<tr>
<td>Fax</td>
<td>After Hours Visit</td>
</tr>
<tr>
<td>Funeral/Memorial</td>
<td>Backup Weekend Visit</td>
</tr>
<tr>
<td>Home *</td>
<td>Bereavement Group</td>
</tr>
<tr>
<td>Hospital *</td>
<td>Bereavement Hourly</td>
</tr>
<tr>
<td>LPN/LVN On Call Notes</td>
<td>Bereavement Visit</td>
</tr>
<tr>
<td>Mail</td>
<td>Complex Visit</td>
</tr>
<tr>
<td>Phone Call to MD/DO</td>
<td>Continuous Care Visit</td>
</tr>
<tr>
<td>Missed Visit *</td>
<td>Discharge - Death</td>
</tr>
<tr>
<td>Nursing Home *</td>
<td>Discharge - Alive</td>
</tr>
<tr>
<td>Other</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Pain Assessment Phone Call</td>
<td>GIP Visit</td>
</tr>
<tr>
<td>Personal Care Home *</td>
<td>Initial Certification</td>
</tr>
<tr>
<td>Phone Call</td>
<td>Introductory Visit</td>
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<tr>
<td>Physician's Order</td>
<td>No Charge</td>
</tr>
<tr>
<td>Physician's IDT</td>
<td>On Call Admit</td>
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<tr>
<td>Physician's VISIT</td>
<td>On Call Discharge - Death</td>
</tr>
<tr>
<td>PRN *</td>
<td>On Call Evaluation</td>
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<tr>
<td>RN On-Call Notes</td>
<td>On Call Discharge - Alive</td>
</tr>
<tr>
<td>SNF *</td>
<td>On Call Standby</td>
</tr>
<tr>
<td>Phone Call SW *</td>
<td>On Call Visit</td>
</tr>
<tr>
<td>Therapy Visit</td>
<td>Phone Call</td>
</tr>
<tr>
<td>Triage - After hours Phone Call</td>
<td>PRN Visit</td>
</tr>
<tr>
<td>Triage - During hours Phone Call</td>
<td>Re-Admission</td>
</tr>
</tbody>
</table>

* Indicator to Count as a Visit on Medicare Claims

**NOTE:** The use of Visit Types and Clinical Care Types is defined internally, based on Hospice Team Policies and Procedures.
Social Work Phone Call Entry

Moore, Stiedemann and Stark
Welcome test! (logout)

Editing Social Note

Dashboard > Search Patients > Abler, Allyson > Social Note Summary > View Note

General Social Note Details

Effective Date: 11/17/2009
Visit Type: Phone Call SW *
Note Summary: Spoke with Patient and Caregiver regarding....

Interventions

PCG Response

Symptom Notes

Safety Notes

Patient Time

Leave times blank to ignore time entry.

Date In: 11/17/2009
Date Out: 11/17/2009
Time In: 12:00
Time Out: 12:30

Make sure that the entered times are in 24-hour format, i.e., 07:00 and 15:00.

Comments
Clinical Care Type
Mileage
Travel Start Time
Travel Stop Time
Out Of Pocket Expense

Phone call Time In and Time Out must be recorded.

Social worker Phone Calls to patient/family are counted as visits (with Time):

» Only when necessary for Palliation and Management of Terminal Illness, Related Conditions as described in Plan of Care
» Only related to Providing/Coordinating Care to Patient, Family and Documented in Clinical Record

(Choose Phone Call SW *)
To Bill for Therapy Visits, Therapist need to be entered as users, and have appropriate role selected.
For Therapist visits to count on the claim they must be entered by someone with a Therapy Role in the Therapy Notes Screen.

Select appropriate Therapy type

Remember times must be recorded.
The Chart Audit Report (a clinical report) may be run to verify, Visits, Visit Types and Time that will be captured on Medicare claims.

* Visit Types and Phone Calls (for Social Work) as well as assessments will be counted on claims for Nursing, Social Work, Therapists, and Hospice Aides.

Billable Units are the # of 15 minute increments that will display on the claim.

Click to Sort by Chart Type to make verification easier.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Office</th>
<th>Effective Date</th>
<th>User</th>
<th>Role</th>
<th>Chart Type</th>
<th>Visit Type</th>
<th>Care Type</th>
<th>Billable Units</th>
<th>Hospice Payer</th>
<th>Diagnosis Code</th>
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</thead>
<tbody>
<tr>
<td>Abler, Allyson</td>
<td></td>
<td>11/12/2009</td>
<td>Admin, Greg</td>
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<td>Nurse Note</td>
<td>Home *</td>
<td>12</td>
<td>Medicare</td>
<td></td>
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<td>11/12/2009</td>
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<td>9</td>
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<tr>
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<td>Nicola, Lisa</td>
<td>Admin</td>
<td>Nurse Note</td>
<td>Phone Call</td>
<td>12</td>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abler, Allyson</td>
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<td>11/17/2009</td>
<td>Administrator, Consolo</td>
<td>Admin</td>
<td>Social Note</td>
<td>Phone Call</td>
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<td></td>
</tr>
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<td>Admin</td>
<td>Social Note</td>
<td>Home *</td>
<td>8</td>
<td>Medicare</td>
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<td>Abler, Allyson</td>
<td></td>
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<td>Merage, Stephen</td>
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<td>Assessment</td>
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<td>Merage, Stephen</td>
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<td>Assessment</td>
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<td>11/11/2009</td>
<td>Nicola, Lisa</td>
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<td>Home</td>
<td>4</td>
<td>Medicare</td>
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<td></td>
</tr>
</tbody>
</table>

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The Active Patient Summary (a Clinical Report) shows all active patients and daily level of care for a given time period and various other statistical information that may be used to verify patient data.

If you would like data on discharged patients, select **Include Discharged**

---

**Active Patient Summary**

**Filter Options**

- **Date Range**
  - Range
  - Month
  - Week
  - Select Month: Last Month
- **Office**
- **Facility**
- **Location**
- **Payer**
- **Discharge Reason**
- **Include Discharged?**
- **Only Discharged?**
- **Show Level of Care details?**
- **Group By Payer?**
- **Physician**
- **Medical Director**
- **County**
- **Disaster Acuity**
- **Team**
- **DME Provider**
- **Pharmacy**
- **Hospital Avoidance?**

**Generate Report**

Continued on next page...
Note: This is only a portion of the actual report. This report is a great tool for data verification, if a patient is listed more than one time, the system is displaying a data change (such as: Multiple Admissions, Facility Move, ICD9 Change, etc.).

Click on any column header to sort data.

Note: Missing data will appear at the top—This is an excellent way to find missing Medical Record Numbers, Diagnosis and Payer information.
The Certification Report (a Clinical Report) shows active, unsigned, expired and expiring patient certifications that are displayed for verification.

| Certification Report |

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**Filter Options**

- **Office**
- **Include Active, Unsigned Certifications?**
- **Include Last 90 Days Of Discharged Patients?**
- **Team**

**Generate Report**

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**Expired Certifications**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Office</th>
<th>Team</th>
<th>Certification Period</th>
<th>Certification Begin Date</th>
<th>Certification End Date</th>
<th>Certification Signed Date</th>
<th>Begin Next Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA\DA1\AA1</td>
<td>ATestTX</td>
<td>1</td>
<td>01/14/2009</td>
<td>04/13/2009</td>
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**Unsigned Active Patient Certifications**

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<th>Certification Period</th>
<th>Certification Begin Date</th>
<th>Certification End Date</th>
<th>Certification Signed Date</th>
<th>Begin Next Period</th>
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<tbody>
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<td>Adelson, Lynn F</td>
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<td>02/01/2009</td>
<td>11/04/2009</td>
<td>11/03/2009</td>
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</table>

**Expiring Certifications**

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<thead>
<tr>
<th>Patient Name</th>
<th>Office</th>
<th>Team</th>
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<th>Certification Begin Date</th>
<th>Certification End Date</th>
<th>Certification Signed Date</th>
<th>Begin Next Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey, Mery F</td>
<td>Holland</td>
<td>H\OHuser</td>
<td>2</td>
<td>10/02/2009</td>
<td>01/23/2010</td>
<td>10/08/2009</td>
<td>01/24/2010</td>
</tr>
</tbody>
</table>
Billable Service Units are the # of 15 minute increments that will display on the claim.