Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

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(Rev. 1352, 10-15-07)
(Rev. 1494, 04-29-08)

10 - Overview

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period. Election/termination dates are retained on CWF.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact.

See the Medicare Benefit Policy Manual, Chapter 9, for additional general information about the Hospice benefit.

See Chapter 29 of this manual for information on the appeals process that should be followed when an entity is dissatisfied with the determination made on a claim.

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

10.1 – Hospice Pre-Election Evaluation and Counseling Services

(Rev. 386, Issued: 12-03-04, Effective: 01-01-05, Implementation: 01-03-05)

Section 512 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amends sections 1812(a**),** 1814(i) and 1861(dd) of the Act, effective January 1, 2005, to allow payment to a hospice for specified hospice pre-election evaluation and counseling services when furnished by a physician who is either the medical director of or employee of the hospice.

This provision provides a one- time only Medicare payment on behalf of a beneficiary who is terminally ill, (defined as having a prognosis of 6 months or less if the disease follows its normal course), has no previous hospice elections, and has not previously received hospice pre-election evaluation and counseling services.

HCPCS code G0337 "Hospice Pre-Election Evaluation and Counseling Services" will be used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies will bill their Regional Home Health Intermediaries (RHHIs) directly using HCPCS G0337 with Revenue Code 0657. No other revenue codes may appear on the claim.

Claims for "Hospice Pre-Election and Counseling Services", HCPCS code G0337, will not be subject to the usual required editing to match the claim to an established hospice period. Further, contractors will not apply payments for hospice pre-election evaluation and counseling consultation services to the overall hospice cap amount.

Medicare must ensure that the Hospice Consultation occurs only one time per beneficiary by imposing safeguards to detect and prevent duplicate billing for similar services. If "new patient" physician services (HCPCS codes 99201-99205) are submitted by the carrier to CWF for payment authorization but HCPCS code G0337 (Hospice Pre-Election Evaluation and Counseling Services) has already been approved for an RHHI bill for the same beneficiary, for the same date of service, by the same physician, the physician service will be rejected by CWF and the service shall be denied as a duplicate. Generate MSN messages 16.8 and 16.45 and Remittance Advice reason code 97 and remark code M86. Likewise, if a "new patient" claim for HCPCS codes 99201-99205 has been approved and subsequently, a bill is submitted by the RHHI to CWF for payment authorization for HCPCS code G0337, (for same beneficiary, same date of service, same physician), CWF shall reject the claim and the RHHI shall deny the bill.

HCPCS code G0337 is only payable when billed by a hospice to its RHHI. Carriers shall not make payment for HCPCS code G0337. Carriers shall deny line items for HCPCS code G0337 and generate MSN message 17.9 and Remittance Advice code 109.

20 - Hospice Notice of Election

(Rev. 1, 10-01-03)

HSP-201

20.1 - Procedures for Hospice Election

(Rev. 1, 10-01-03)

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

20.1.1 - Notice of Election (NOE) - Form CMS-1450

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

When a Medicare beneficiary elects hospice services, hospices must complete FLs 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, 67, 82, 83, and 85 of the Uniform (Institutional Provider) Bill (Form CMS-1450), which is an election notice. In addition, the hospice must complete the Form CMS-1450 when the election is for a patient who has changed an election from one hospice to another.

Hospices must send the Form CMS-1450 Election Notice to the FI by mail, messenger, or direct data entry (DDE) depending upon the arrangements with the FI.

If a patient enters hospice care before the month he/she becomes entitled to Medicare benefits, e.g., before age 65, the hospice should not send the election notice before the first day of the month in which he/she becomes 65.

20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The following fields must be completed by the hospice on the Form CMS-1450 for the Notice of Election:

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number

The minimum entry for this item is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Enter the 3-digit numeric type of bill code: 81A, B, C, D, E or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital-Based)
2 - Hospice (Hospital-Based)

3rd Digit - Frequency

A - Hospice benefit period initial election notice
B - Termination/revocation notice for previously posted hospice election
C - Change of provider
D - Void/cancel hospice election
E - Hospice Change of Ownership

FL 12. Patient's Name

The patient's name is shown with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

FL 14. Patient's Birth Date

(If available.) Show the month, day, and year of birth numerically as MM-DD-YYYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

FL 15. Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FLs 51A, B, and C. Provider Number

This is the 6-digit number assigned by Medicare (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI). It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, C. Insured's Name

Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name exactly as it appears on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, C. Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67. Principal Diagnosis Code

The full ICD-9-CM diagnosis code is required. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. The CMS accepts only ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

FL 82. Attending Physician I.D.

Enter the UPIN and name of the physician currently responsible for certifying the terminal illness. The UPIN is shown in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Claims Where Physician Not Assigned a UPIN - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. In addition, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;

- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians; and
- OTH000 for all other unspecified entities not included above. The OTH000 ID may be audited.

FL 83. Other Physician I.D.

If the attending physician is a nurse practitioner, enter the UPIN and name of the nurse practitioner. The UPIN is shown in the first six positions followed by two spaces, the nurse practitioner's last name, one space, first name, one space, and middle initial.

The word "employee" or "nonemployee" must be entered here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under the hospice jurisdiction.

FL 85-6. Provider Representative Signature and Date

A hospice representative must make sure the required physician's certification, and a signed hospice election statement are in the records before signing the Form CMS-1450. A stamped signature is acceptable.

20.1.3 - FI Reply to Notice of Election

(Rev. 1, 10-01-03)
HSP-302.2

The reply to the notice of election is furnished according to hospice arrangements with the FI. Whether the reply is given by telephone, mail, or wire, it is based upon the FI's query to CMS master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

30 - Billing and Payment for General Hospice Services

(Rev. 1, 10-01-03)

30.1 - Levels of Care

(Rev. 1494, Issued: 04-29-08, Effective: 01-01-08 Systems Changes byHospice/07-01-08 Mandatory Service Reporting by Hospice, Implementation: 01-07-08)

With the exception of payment for physician services, Medicare payment for hospice care is made at one of four predetermined rates for each day that a Medicare beneficiary is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the application of the statutory **"**caps" on overall payments and on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

The four levels of care into which each day of care is classified:

Routine Home Care	Revenue code 0651
Continuous Home Care	Revenue code 0652
Inpatient Respite Care	Revenue code 0655
General Inpatient Care	Revenue code 0656

For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For continuous home care the amount of payment is determined based on the number of hours, reported in increments of 15 minutes, of continuous care furnished to the beneficiary on that day. For the other categories a single rate is applicable for the category for each day.

For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

A description of each level of care follows.

Routine Home Care - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

Continuous Home Care - The hospice is paid the continuous home care rate when continuous home care is provided. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15 minute increments and these increments are used in calculating the payment rate. Only patient care **provided** during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. *Units should only be rounded to the nearest increment.* Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g. meal beaks, report, education of staff). **Continuous home care is not intended to be used as respite care.**

The hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening, but care must reflect the

needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (*also known as a hospice aide*) services may be provided to supplement the nursing care.

Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.

For more detailed information on Continuous Home Care, see Pub. 100-02, Chapter 9, §40.2.1.

Inpatient Respite Care - The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than five days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided.

30.2 - Payment Rates

(Rev. 1352, Issued: 10-15-07, Effective: 01-01-08, Implementation: 01-07-08)
HSP-403, HSP-404, 9/5/01 ARA update memo, A-02-059

The CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. These rates must then be adjusted by the FI based on the beneficiary's locality.

National rates are issued as described below. These rates are updated annually and published in the "Recurring Update Notification." This example is the national rates for October 1, 2004, through September 30, 2005.

Description	Revenue Code	Daily Rate	Wage Amount	Non-weighted Component
Routine Home Care	0651	$121.98	$83.81	$38.17
Continuous Home	0652	$711.92	$489.16	$222.76

Description	Revenue Code	Daily Rate	Wage Amount	Non-weighted Component
Care Full Rate = 24 hours of care; $29.66 hourly rate				
Inpatient Respite Care	0655	$126.18	$68.30	$57.88
General Inpatient Care	0656	$542.61	$347.32	$195.29

These national rates are adjusted by FI as follows:

1. Rate Components

The rate is considered to have two components

A wage amount component
A non-weighted component

2. Adjustment to Wage Component

The wage amount component is adjusted (multiplied) by the wage index for the location of the place of service *for all levels of care*.

The hospice wage index is published in the **Federal Register** notice each year, and is effective October 1 of that year through September 30 of the following year. To select the proper index for the hospice area, first determine if the beneficiary is located in one of the Urban Areas listed in Table A of the **Federal Register** notice. If so, use the index shown for the area. If the beneficiary is not located in one of the Urban Areas, use the index number of the rural area for the State, listed in Table B of the **Federal Register** notice.

3. Adjusted Payment Rate

The adjusted wage component is then added to the non-weighted component. This is the payment rate for the year.

EXAMPLE I: If the wage index for the beneficiary's area is .87, a $78.47 national wage amount for routine home care would be multiplied by .87 to determine the wage amount,

and this amount ($68.27) would be added to the non-weighted component of $35.73 to provide a local rate of $104.00.

EXAMPLE II: If the wage index for the beneficiary's area is 0 .87, a $457.97 national wage amount for continuous home care would be multiplied by 0.87 to determine the wage amount, and this amount ($398.43) would be added to the non-weighted component of $208.55 to provide a local daily rate for revenue code 0652 of $606.98. Divide by 24 to get the local hourly rate of $25.29.

Similar calculations are done for the rates for the other revenue codes.

30.3 - Data Required on Claim to FI

(Rev. 1494, Issued: 04-29-08, Effective: 01-01-08 Systems Changes byHospice/07-01-08 Mandatory Service Reporting by Hospice, Implementation: 01-07-08)

See Pub. 100-02, Chapter 9, §§10 & 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. See section 20, of this chapter for information on Notice of Election (NOE) transaction types (81A,C,E and 82A,C,E).

Before billing, the hospice must submit an admission notice to the FI (see section 20). *The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing hospice services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

Because *claim formats serve* the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. Items not listed need not be completed although hospices may complete them when billing multiple payers.

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular benefit period. It is referred to as a **"**frequency" code.

Code Structure

1st Digit - Type of Facility
8 - Special facility (Hospice)

2nd Digit - Classification (Special Facility Only)
1 - Hospice (Nonhospital based)
2 - Hospice (Hospital based)

3rd Digit Frequency	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The **"**Through" date of this bill (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill. For additional information on late charge bills see Chapter 3.

3rd Digit Frequency	Definition
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

Statement Covers Period (From-Through)

The hospice shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). *The hospice does* not show days before the patient's entitlement began. Since the 12-month hospice "cap period" (see §80.2) ends each year on October 31, *hospices must* submit separate bills for October and November.

Patient Name/Identifier

The hospice enters the beneficiary's name exactly as it appears on the Medicare card.

Patient Address

Patient Birth date

Patient Sex

The hospice enters the appropriate address, date of birth and gender information describing the beneficiary.

Admission/*Start of Care* Date

The hospice enters the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

The admission date stays the same on all continuing claims for the same *hospice election*.

The hospice enters the month, day, and year numerically as MM-DD-YY.

Patient *Discharge* Status

This code indicates the patient's status as of the **"**Through" date (FL 6) of the billing period. *The hospice enters the most appropriate NUBC approved code.*

The codes most commonly used on hospice claims include:

01 Discharged to home or self care

30 Still patient

40 Expired at home

41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice

42 Expired - place unknown

50 *Discharged/Transferred to* Hospice - home

51 *Discharged/Transferred to* Hospice - medical facility

Condition Codes

The hospice enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.

Occurrence Codes and Dates

The hospice enters any appropriate NUBC approved code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) to record additional occurrences and dates.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

Code	Title	Definition
23	Cancellation of Hospice Election Period (FI USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an FI as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. *Note regarding transfers from one hospice to another hospice: If a patient is in the first certification period when they transfer to another hospice, the receiving hospice would use the same certification date as the previous hospice until the next certification period. However, if they were in the next certification at the time of transfer, then they would enter that date in the Occurrence Code 27 and date.*
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit, has been decertified or discharged. **It cannot** be used in transfer situations.

Occurrence Span Code and Dates

*The hospice enters any appropriate NUBC approved c*ode(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alphanumeric digits and dates are shown numerically as MM-DD-YY.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each. M2 is used when respite care is provided more than once during a benefit period.
77	Provider Liability – Utilization Charged	Code indicates From/Through dates for a period of non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).

Hospices must use occurrence span code 77 to identify days of care that are not covered by Medicare due to untimely physician recertification. *This is particularly important when the non-covered days fall at the beginning of a billing period.*

Value Codes and Amounts

The hospice enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

The most commonly used value codes on hospice claims *are* value codes 61 and G8, which are used to report the location of the site of hospice services. Otherwise, value codes are commonly used only to indicate Medicare is secondary to another payer. For detailed information on reporting Medicare secondary payer information, see the Medicare Secondary Payer Manual.

Code	Title	Definition
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	MSA or *Core-Based Statistical Area (CBSA)* number (or rural State code) of the location where the hospice service is delivered. A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care. Hospices must report value code 61 when billing revenue codes 0651 and 0652.
G8	Facility where Inpatient Hospice Service is Delivered (General	MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility

	Inpatient and Inpatient Respite Care).	where inpatient hospice services are delivered. Hospices must report value code G8 when billing revenue codes 0655 and 0656.

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. This applies for either routine home care and continuous home care (e.g., the beneficiary's residence changes between locations in different CBSAs) or for general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs).

Revenue Codes

The hospice assigns a revenue code for each type of service provided and enter the appropriate four-digit numeric revenue code to explain each charge.

For claims with dates of service before July 1, 2008, hospices only reported the revenue codes in the table below. Effective on claims with dates of service on or after January 1, 2008, additional revenue codes will be reported describing the visits provided under each level of care. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in this table.

Code	**Description**	**Standard Abbreviation**
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	CTNS Home A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (or less than 32 units) within a 24 hour period, then the care rendered would be covered as a routine home care day. Services provided by a nurse practitioner as the attending physician are not included in the CHC computation nor is care that is not directly related to the crisis included in the computation. CHC billing should reflect direct patient care during a period of crisis and should not reflect time related to staff working hours, time taken for meal breaks, time used for educating

Code	Description	Standard Abbreviation
		staff, time used to report etc.
0655***	Inpatient Respite Care	IP Respite
0656***	General Inpatient Care	GNL IP
0657**	Physician Services	PHY SER (must be accompanied by a physician procedure code)

- * Reporting of value code 61 is required with these revenue codes.
- **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.
- ***Reporting of value code G8 is required with these revenue codes.

NOTE: Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657. Procedure codes are required in order for the FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

Effective on claims with dates of service on or after July 1, 2008, hospices must report the number of visits that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes above. Charges for these codes will be reported on the appropriate level of care line. Total number of patient care visits is to be reported by the discipline (registered nurse, nurse practitioner, licensed nurse, home health aide (also known as a hospice aide), social worker, physician or nurse practitioner serving as the beneficiary's attending physician) for each week at each location of service. If visits are provided in multiple sites, a separate line for each site and for each discipline will be required. The total number of visits does not imply the total number of activities or interventions provided. If patient care visits in a particular discipline are not provided under a given level of care or service location, do not report a line for the corresponding revenue code.

To constitute a visit, the discipline, (as defined above) must have provided care to the beneficiary. Services provided by a social worker to the beneficiary's family also constitute a visit. For example, phone calls, documentation in the medical/clinical record, interdisciplinary group meetings, obtaining physician orders, rounds in a facility or any other activity that is not related to the provision of items or services to a beneficiary, do not count towards a visit to be placed on the claim. In addition, the visit 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.

Example 1: Week 1: A visit by the RN was made to the beneficiary's home on Monday and Wednesday where the nurse assessed the patient, verified effect of pain medications, provided patient teaching, obtained vital signs and documented in the medical record. A home health aide assisted the patient with a bath on Tuesday and Thursday. There were no social work or physician visits. Thus for that week there were 2 visits provided by the nurse and 2 by the home health aide. Since there were no visits by the social worker or by the physician, there would not be any line items for each of those disciplines.

Example 2: If a hospice patient is receiving routine home care while residing in a nursing home, the hospice would record visits for all of its physicians, nurses, social workers, and home health aides who visit the patient to provide care for the palliation and management of the terminal illness and related conditions, as described in the patient's plan of care. In this example the nursing home is acting as the patient's home. Only the patient care provided by the hospice staff constitutes a visit.

Hospices must enter the following revenue codes, when applicable:

055X Skilled Nursing	*Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.*
056X Medical Social Services	*Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.*
057X Home Health Aide	*Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.*

Hospices should follow NUBC coding guidelines for the use of the appropriate fourth position (the "X") when reporting these revenue codes.

Visits by registered nurses, licensed vocational nurses and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055X.

All visits to provide care related to the palliation and management of the terminal illness or related conditions, whether provided by hospice employees or provided under arrangement, must be reported. The one exception is related to General Inpatient Care. CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care in contract facilities. However, General Inpatient Care visits related to the palliation and management of the terminal illness or related conditions provided by hospice staff in contract facilities must be reported , and

all General Inpatient Care visits related to the palliation and management of the terminal illness or related conditions provided in hospice-owned facilities must be reported.

HCPCS/ *Accommodation* Rates/HIPPS Rate Codes

For services provided on or before December 31, 2006, HCPCS codes are required only to report procedures on service lines for attending physician services (revenue 657). Level of care revenue codes (651, 652, 655 or 656) do not require HCPCS coding.

For services provided on or after January 1, 2007, hospices must also report a HCPCS code along with each level of care revenue code *(651, 652, 655 and 656)* to identify the type of service location where that level of care was provided.

The following HCPCS codes will be used to report the type of service location for hospice services:

HCPCS Code	Definition
Q5001	HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE
Q5002	HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTCH)
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY
Q5009	HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)

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 patient's residence and another portion in an assisted living facility. In this case, report one revenue code 651 line with HCPCS code Q5001 and the number of days of routine home care provided in the residence and another revenue code 651 line with HCPCS code Q5002 and the number of days of routine home care provided in the assisted living facility.

Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay and nursing facility residents.

Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.

These service location HCPCS codes are not required on revenue code lines describing the visits provided under each level of care (e.g. 055X, 056X, 057X).

Service Date

The HIPAA standard 837 Institutional claim format requires line item dates of service for all outpatient claims. Medicare classifies hospice claims as outpatient claims (see Chapter 1, §60.4). For services provided on or before December 31, 2006, CMS allows hospices to satisfy the line item date of service requirement by placing any valid date within the FL 6 Statement Covers Period dates on line items on hospice claims.

For services provided on or after January 1, 2007, service date reporting requirements will vary between continuous home care lines (revenue code 652) and other revenue code lines.

Revenue code 652 – report a separately dated line item for each day that continuous home care is provided, reporting the number of hours, or parts of hours rounded to 15-minute increments, of continuous home care that was provided on that date.

Other *payment* revenue codes – report a separate line for each level of care provided at each service location type, as described in the instructions for HCPCS coding reported above. *Hospices report the earliest date that each level of care was provided at each service location. Attending physician services should be individually dated, reporting the date that each HCPCS code billed was delivered.*

Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

Service Units

The hospice enters the number of units for each type of service. Units are measured in days for revenue codes 651, 655, and 656, in hours for revenue code 652, and in procedures for revenue code 657. For services provided on or after January 1, 2007, hours for revenue code 652 are reported in 15-minute increments. *For services provided on or after January 1, 2008, units for visit discipline revenue codes are measured by the number of visits.*

Total Charges

The hospice enters the total charge for the service described on each revenue code line. This information is being collected for purposes of research and will not affect the amount of reimbursement.

Payer *Name*

The hospice identifies the appropriate payer(s) for the claim.

National *Provider Identifier – Billing Provider*

The hospice enters its own National Provider Identifier (NPI).

Principal Diagnosis Code

The hospice enters diagnosis coding as required by ICD-9-CM Coding Guidelines. Hospices may not report V-codes as the primary diagnosis on hospice claims. The principal diagnosis code describes the terminal illness of the hospice patient and V-codes do not describe terminal conditions.

Other Diagnosis Codes

The hospice enters diagnosis coding as required by ICD-9-CM Coding Guidelines.

Attending *Provider Name and Identifiers*

The hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

Other *Provider Name and Identifiers*

If the attending physician is a nurse practitioner, *the hospice enters the NPI* and name of the nurse practitioner.

40 - Billing and Payment for Hospice Services Provided by a Physician

(Rev. 1, 10-01-03)
HSP-406, B3-4175, B3-2020, B3-15513

40.1 - Types of Physician Services

(Rev. 1, 10-01-03)
HSP-406

Payment for physician services provided in conjunction with the hospice benefit is made based on the type of service performed.

40.1.1 - Administrative Activities

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group (IDG). Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.

40.1.2 - Patient Care Services

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Payment for physicians or nurse practitioner serving as the attending physician, who provide direct patient care services and who are hospice employees or under arrangement with the hospice**,** is made in the following manner:

- Hospices establish a charge and bill the FI for these services.

- The FI pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services or 85% of the fee schedule amount for nurse practitioner services. This payment is in addition to the daily hospice rates.

- Payment for physician and nurse practitioner services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.

- No payment is made for physician or nurse practitioner services furnished voluntarily. However, some physicians and nurse practitioners may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the physician or nurse practitioner for the services. A physician or nurse practitioner must treat Medicare patients on the same basis as other patients in the hospice; a physician or nurse practitioner may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.

- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.

  EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the FI and is paid for the service. Dr. Jones may not bill Medicare Part

B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.

40.1.3 - Attending Physician Services

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an **"**attending physician," who is not an employee of the designated hospice nor receives compensation from the hospice for those services. For purposes of administering the hospice benefit provisions, an **"**attending physician" means an individual who:

- Is a doctor of medicine or osteopathy or
- A nurse practitioner (for professional services related to the terminal illness that are furnished on or after December 8, 2003); and
- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

Even though a beneficiary elects hospice coverage, he/she may designate and use an attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an attending physician, who may be a nurse practitioner as defined in Chapter 9, that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services.

Where the service is considered a hospice service (i.e., a service related to the hospice patient's terminal illness that was furnished by someone other than the designated "attending physician" [or a physician substituting for the attending physician]) the physician or other provider must look to the hospice for payment.

Professional services related to the hospice patient's terminal condition that were furnished by the "attending physician", who may be a nurse practitioner, are billed to carriers. When the attending physician furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the carrier and looks to the hospice for payment for the technical component. Likewise, the attending physician, who may be a nurse practitioner, would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests). The remainder of this section explains this in greater detail.

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, who may be a nurse practitioner, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered "hospice services." These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice. The attending physician codes services with the GV modifier "Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. Carriers make payment to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

Payments for the services of attending physician are not counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Services provided by an independent attending physician who may be a nurse practitioner must be coordinated with any direct care services provided by hospice physicians.

Only the direct professional services of an independent attending physician, who may be a nurse practitioner, to a patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.

If another physician covers for a hospice patient's designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician who may be a nurse practitioner, the physician must look to the hospice for payment. In this situation the physicians' services are hospice services and are billed by the hospice to its FI.

Carriers must process and pay for covered, medically necessary Part B services that physicians furnish to patients after their hospice benefits are revoked even if the patient remains under the care of the hospice. Such services are billed without the GV or GW modifiers. Make payment based on applicable Medicare payment and deductible rules for each covered service even if the beneficiary continues to be treated by the hospice after hospice benefits are revoked.

The CWF response contains the period of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. Carriers use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

40.1.3.1 - Care Plan Oversight

(Rev. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

For a physician or NP employed by or under arrangement with a hospice agency, CPO functions are incorporated and are part of the hospice per diem payment and as such may not be separately billed.

For information on separately billable CPO services by the attending physician or nurse practitioner see Chapter 12, §180 of this manual.

40.2 - Carrier Processing of Claims for Hospice Beneficiaries

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Professional services of attending physicians, who may be nurse practitioners, furnished to hospice beneficiaries are coded with modifier GV. Attending physician not employed or paid under arrangement by the patient's hospice provider. This modifier must be retained and reported to CWF.

Local Part B carriers shall presume that hospice benefits are not involved unless the biller codes services on the claim to indicate that the patient is a hospice enrollee (e.g. the GV modifier is billed by the attending physician, who may be a nurse practitioner, or the GW modifier is billed for services unrelated to the terminal illness) or the trailer information on the CWF reply shows a hospice election. The carrier shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information.

For beneficiaries enrolled in hospice, carriers shall deny any services furnished on or after January 1, 2002, that are submitted without either the GV or GW modifier. For services furnished to a hospice patient prior to January 1, 2002, the attending physician is to include an attestation statement that is the written equivalent of the GV modifier and carriers are responsible for determining whether or not a service is related to the patient's terminal condition.

Deny claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician, who may be a nurse practitioner. Such claims include bills for any DME, supplies or independently practicing speech-language pathologists or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the FI.

See §110 for MSN and Remittance Advice (RA) coding.

40.2.1 - Claims After the End of Hospice Election Period

(Rev. 1, 10-01-03)

A3-3141.1

Upon revocation of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. After revocation, carriers process and pay for covered Part B services that hospice employed physicians may furnish. Services provided before the hospice termination date may not be paid.

40.2.2 - Claims From Medicare + Choice Organizations

(Rev. 1, 10-01-03)
B3-4175.3

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b).

A - Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an M+CO to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;

2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;

3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or

4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

B - Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X and 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment is not disrupted.

M + C organizations may bill the Medicare carrier for nonhospice services provided to M + C enrollees who elect hospice benefits. These claims should be submitted with a GV or GW (for services not related to the terminal condition) modifier as applicable. Carriers process these claims in accordance with regular claims processing rules.

Medicare physicians may also bill such services directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. **Revised requirements for such billing were set forth in Transmittal 1728 CR 1910 in Pub. 14-4 (Medicare Carriers Manual) effective April 2002 and specifies use of modifiers –GV and –GW.** When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

50 - Billing and Payment for Services Unrelated to Terminal Illness

(Rev. 1, 10-01-03)
HSP-303.2, B3-4175.2, AB-02-015

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the FI or carrier for non-hospice Medicare payment. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition" when submitted to a carrier or with condition code 07 "Treatment of Non-terminal Condition for Hospice" when submitted to an FI. Contractors process services coded with the GW modifier and "07" condition code in the normal manner for coverage and payment determinations. If warranted, contractors may conduct prepayment development or postpayment review to validate that services billed with the GW modifier or "07" condition code are not related to the patient's terminal condition. See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for physician type of services) for billing rules.

60 - Billing and Payment for Services Provided by Hospices Under Contractual Arrangements With Other Institutions

(Rev. 1, 10-01-03)
A-02-102

There may be circumstances in which another health care entity may wish to "purchase" some of the highly specialized staff time or services of a hospice to better meet the needs of their specific patient population. In these cases, the services are not "hospice" services

in terms of Medicare payment but become part of the service package of the provider under whose care the patient is. Examples of such circumstances are provided below.

EXAMPLE 1

A dually eligible Medicare/Medicaid beneficiary enrolled in the Program of All-Inclusive Care for the Elderly (PACE) program for approximately two years has been diagnosed with a life limiting terminal illness with a prognosis of six months or less. In the course of routine assessments, the PACE provider recognizes that the beneficiary would benefit from the specialized services of a pain management specialist or a grief counselor. The PACE provider would then enter into a contractual arrangement with a Medicare certified hospice to purchase these specialized services. The hospice provider would bill the PACE provider for the services, and the PACE provider would in turn pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which in this example are PACE services and included in the PACE provider's capitated rate). In this example, the PACE provider would maintain a medical record on the patient and the hospice provider would submit any documentation related to the care of the PACE patient to the PACE provider.

EXAMPLE 2

A Medicare beneficiary is receiving skilled services from a Medicare certified home health agency (HHA). The beneficiary has been diagnosed with a life limiting terminal illness, but chooses to continue curative treatments, thereby rendering him ineligible for the Medicare hospice benefit. The beneficiary is experiencing a period of intractable pain, and the HHA wishes to purchase specialized pain control services from the hospice provider. The HHA would then enter into a contractual arrangement with a Medicare certified hospice to purchase specialized nursing services. The hospice would bill the HHA and the HHA would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which, in this example, are home health services and therefore included in the HHA's episode payment). In this example, the HHA would maintain a medical record on the patient, and the hospice submits any documentation related to the pain management to the HHA.

EXAMPLE 3

A Medicare beneficiary (non-dual eligible) resides in a skilled nursing facility (SNF) and has a diagnosis of Alzheimer's disease. The beneficiary's disease process has progressed to a stage in which he/she can no longer ingest food or fluids. The beneficiary's family has been approached by the SNF regarding the placement of a feeding tube and has been told, "their loved one may not live much longer." The family is struggling with this concept and has requested assistance from the SNF regarding hospice care and grief counseling. The SNF has provided information about the Medicare hospice benefit to the family, but the patient's legal representative has made a decision not to elect hospice care at this time. The SNF does not have a trained grief counselor or full-time social worker on staff, but has a business relationship with a local hospice and has requested the services of a pastoral or grief counselor. The SNF and hospice enter into a contractual

arrangement for the provision of grief counseling to this beneficiary's family by a pastoral care counselor. The hospice provider would bill the SNF, and the SNF would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare Part A or B separately for the pastoral care services (which in this example are included in the Medicare's Resource Utilization Group or RUG payments to the SNF). The SNF maintains the medical record on this patient and the hospice provider would submit any documentation related to the pastoral care services provided to the SNF.

60.1 - Instructions for the Contractual Arrangement

(Rev. 1, 10-01-03)
A-02-102

A contractual agreement between both parties must be on file and available for review by the state survey agency responsible for conducting surveys on behalf of CMS to assess compliance with the relevant conditions of participation for the provider contracting for the hospice services. Where a PACE organization contracts with a hospice organization, the contract, which is reviewed by CMS, must meet the requirements specified in 42 CFR 460.70. The agreement must specify each of the services to be provided, the credentials required for any of the professionals providing the services, the billing method and payment amounts, and any required documentation.

60.2 - Clarification of the Payment for Contracted Services

(Rev. 1, 10-01-03)
A-02-102

In all of the examples provided above, the billing and payment for the services are between each of the providers. It is our expectation that Medicare will not be billed separately for any of the contracted services referred to in the examples provided above.

70 - Deductible and Coinsurance for Hospice Benefit

(Rev. 1, 10-01-03)
HSP 410

70.1 - General

(Rev. 1, 10-01-03)
A3-3142

There is no deductible.

The payment rates have been reduced by a coinsurance amount on outpatient drugs and biologicals, and inpatient respite care as required by law. No other coinsurance or deductibles may be imposed for services furnished to beneficiaries during the period of an election, regardless of the setting of the services. Hospices may charge beneficiaries for the applicable coinsurance amounts only for drugs and biologicals and for inpatient respite care.

The hospice is responsible for billing and collecting any coinsurance amounts from the beneficiary.

70.2 - Coinsurance on Outpatient Drugs and Biologicals
(Rev. 1, 10-01-03)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than $5, for each prescription furnished on an outpatient basis.

The hospice is not required to make this charge but may do so in accordance with the following.

- The hospice must establish a **"**drug copayment schedule" that specifies each drug and the copayment to be charged. The copayment charges included on the schedule must approximate 5 percent of the cost of the drugs or biologicals to the hospice, up to a $5 maximum. Additionally, the cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The hospice must submit this schedule to the FI in advance for approval.

70.3 - Coinsurance on Inpatient Respite Care
(Rev. 1, 10-01-03)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the amount CMS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences. This coinsurance is not counted toward the hospital deductible, but it is limited to the same amount.

EXAMPLE

Assume a wage adjusted inpatient respite care rate for the year (as provided by the FI) of $100. The maximum coinsurance rate would be $5. The hospice may charge any amount up to and including $5 for inpatient respite care only.

The total amount of coinsurance for inpatient respite care for any beneficiary during a hospice coinsurance period may not exceed the amount of the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. A hospice coinsurance period begins with the first day for which an election for hospice services is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on which no such election is in effect for the beneficiary.

EXAMPLE

Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care under an additional election period. Since these election periods were not

separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, the maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

No other coinsurance may be charged by the hospice.

80 - Caps and Limitations on Hospice Payments
(Rev. 1, 10-01-03)

80.1 - Limitation on Payments for Inpatient Care
(Rev. 1, 10-01-03)
HSP 405

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each year, at the end of the hospices' **"**cap period" (November 1 - October 31). The limitation is calculated by the FI as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2.

2. If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.

3. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

    - Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

    - Multiplying excess inpatient care days by the routine home care rate.

    - Adding together the amounts calculated in bullets 1 and 2 above.

    - Comparing the amount in bullet 3 above with interim payments made to the hospice for inpatient care during the **"**cap period."

Any excess reimbursement must be refunded by the hospice.

EXAMPLE: Assume that:

40,000 total hospice days - the maximum allowable in patient days would be 8000 days.

10,000 inpatient days were paid

The ratio of maximum allowable days to the number of actual days equals 8000 to 10000 or .8.

Assume the total reimbursement for inpatient care revenue codes 0655 and 0656 is $4,000,000. Multiplying $ 4 million times .8 is $3,200,000.

Multiply the 2000 excess inpatient care days by the routine home care rate of $110.56 results in $221,120

Add $3,200,000 (80% of $4, 000,000) and $221,120 results in $3,421,120.

Compare $3,421,120 cap with $4,000,000 paid for inpatient revenue codes.

The hospice must refund $578,880.

80.2 - Cap on Overall Hospice Reimbursement

(Rev. 1, 10-01-03)
HSP 407-407.1

Overall aggregate payments made to a hospice are subject to a **"**cap amount," calculated by the FI at the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicare beneficiaries during this period are compared to the **"**cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.

80.2.1 - Services Counted

(Rev. 1, 10-01-03)

"Total payment made for services furnished to Medicare beneficiaries during this period" refers to payment for services rendered during the cap year beginning November 1 and ending October 31, regardless of when payment is actually made. All payments made to hospices on behalf of all Medicare hospice beneficiaries receiving services during the cap year are counted, regardless of which year the beneficiary is counted in determining the cap. For example, payments made to a hospice for an individual electing hospice care on October 5, 1997, pertaining to services rendered in the cap year beginning November 1, 1996, and ending October 31, 1997, are counted as payments made during the first cap year (November 1, 1996 - October 31, 1997), even though that individual is not counted in the calculation of the cap for that year. (The individual is, however, to be counted in the cap calculation for the following year since the election occurred after September 27 - see below).

The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices must cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1997, runs from October 1, 1997 through October 31, 1998. Similarly, the first cap period for hospice providers entering the program after November 1, 1996, but before November 1, 1997, ends October 31, 1998.

The **"**cap amount" is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount (See §80.2 for an explanation of how this amount is obtained each year). The hospice cap amount for the cap year ending October 31, 2003, is $18, 661.29. This amount may be adjusted in future years to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers

Hospices that began operations before January 1, 1975, are eligible for an exception to the application of this cap. The hospice must apply and be approved to receive this waiver. Send applications to:

Centers for Medicare & Medicaid Services
Chronic Care and Purchasing Policy Group, CHPP
C5-02-23
7500 Security Boulevard
Baltimore, MD. 21244-1850

The computation and application of the **"**cap amount" is made by the FI at the end of the cap period. The material is presented here for the hospice benefit as an aid to planning. Hospices are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the FI. This must be done within 30 days after the end of the cap period.

Follow these rules in determining the number of Medicare beneficiaries who have elected hospice care during the period:

- The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

- The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicare beneficiary during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of beneficiaries to be counted in each cap period.

80.2.2 - Counting Beneficiaries for Calculation

(Rev. 1, 10-01-03)

Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)

When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary. It is inequitable to count the patient's stay in the hospices as equivalent if there were marked differences in the lengths of stay. Consequently, a calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay. The FI servicing the hospice program in which the beneficiary dies or revokes the hospice benefit is responsible for determining the proportionate lengths of stay for all preceding hospices. This FI is also responsible for disseminating this information to any other FI servicing hospices in which the beneficiary was previously enrolled. Each FI then adjusts the number of beneficiaries reported by these hospices based on the latest information available at the time the cap is applied.

EXAMPLE: John Doe, a Medicare beneficiary, initially elects hospice care from hospice A on September 2, 2001. Mr. Doe stays in hospice A until October 2, 2001 (30 days) at which time he changes his election and enters hospice B. Mr. Doe stays in hospice B for 70 days until his death on December 11, 2001. The FI servicing hospice B is responsible for determining the proportionate number of Medicare beneficiaries to be reported by each hospice that delivered hospice services to Mr. Doe. This FI determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in hospice A and 70 days in hospice B). Since Mr. Doe was in hospice A for 30 days, Hospice A counts .3 of a Medicare beneficiary for Mr. Doe in its hospice cap calculation (30 days/100 days). Hospice B counts .7 of a Medicare beneficiary in its cap calculation (70 days/100 days). The FI servicing hospice B makes these determinations and notifies the FI servicing hospice A of its determination. These FI are then responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

Readjustment of the hospice cap may be required if information previously unavailable to the FI at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the example above, if the FI servicing hospice A had calculated and applied the hospice cap on November 30, 2001, information would not have been available at that time to adjust the number of beneficiaries reported by hospice A, since Mr. Doe did not die until December 11, 2001. The FI servicing hospice A would have to recalculate and reapply the hospice cap to hospice A based on the information it later received from the FI servicing hospice B. The cap for hospice A after recalculation would then reflect the proper beneficiary count of .3 for Mr. Doe.

An additional step is required when more than one Medicare certified hospice provides care to the same individual, and the care overlaps two cap years. In this case, each FI must determine in which cap year the fraction of a beneficiary is reported. If the

beneficiary entered the hospice before September 28, the fractional beneficiary is included in the current cap year. If the beneficiary entered the hospice after September 27, the fractional beneficiary is included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, hospice A includes .3 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 2000, and ending October 31, 2001, since Mr. Doe entered hospice A before September 28, 2001. Hospice B includes .7 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 2001, and ending October 31, 2002, since Mr. Doe entered hospice B after September 27, 2001.

Where services are rendered by two different hospices to one Medicare patient, and one of the hospices is not certified by Medicare, no proportional application is necessary. The FI counts one patient and uses the total cap for the certified hospice.

80.2.3 - Adjustments to Cap Amount

(Rev. 1, 10-01-03)

The original cap amount of $6,500 per year is increased or decreased for accounting years that end after October 1, 1984, by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. The hospice cap is applied on the basis of a cap year beginning November 1 and ending the following October 31.

For example, for the cap amount for the period ending October 31, 1998, calculate using the March 1998 price level in the medical care expenditures category of 239.8 and divide by the March 1984 price level of 105.4 to yield an index of 2.275 (rounded). The new hospice cap amount is the product of $6500 (base year cap) multiplied by 2.275. Therefore, the cap amount for the period ending October 31, 1997, is $14,788.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.

EXAMPLE

10/01/97 - Hospice A is Medicare certified.

10/01/97 to 10/31/98 - First cap period (13 months) for hospice A.

Statutory cap for first Medicare cap year (11/01/96 - 10/31/97) = $14,394

Statutory cap for second Medicare cap year (11/01/97 - 10/31/98) = $14,788

Weighted average cap calculation for hospice A:

One month (10/01/97 - 10/31/97) at $14,394 = $ 14,394

12 months (11/01/97 - 10/31/98) at $14,788 = $177,456

13 month period $191,850 divided by 13 = $14,758 (rounded)

In this example, $14,758 is the weighted average cap amount used in the initial cap calculation for hospice A for the period October 1, 1997, through October 31, 1998.

NOTE: If hospice A had been certified in mid-month, a weighted average cap amount based on the number of **days** falling within each cap period is used.

90 - Frequency of Billing
(Rev. 1, 10-01-03)
HSP 303.5

The hospice will bill monthly. If the care is interrupted, e.g., an inpatient hospital admission for an unrelated condition, occurrence span code 74 is used to show the period not applicable to hospice care.

100 - Medical Review of Hospice Claims
(Rev. 1, 10-01-03)
HSP 304

See Chapter 6 of the Medicare Program Integrity Manual.

110 - Medicare Summary Notice (MSN) Messages/ASC X12N Remittance Advice Adjustment Reason and Remark Codes
(Rev. 1, 10-01-03)
B3-7012, Transmittal R64-HSP, Transmittal R1846-A3

The following messages apply specifically to Hospice beneficiaries. See Chapter 21 for a list of all messages. Note that administrative appeals processes are available to beneficiaries, physicians/suppliers, or providers dissatisfied with these determinations, see Chapter 29 for more information.

MSN Code	Message	ASC Code	Message
27.1	This service is not covered because you are enrolled in a hospice.	B9	Services are not covered because the patient is enrolled in a hospice.
27.2	Medicare will not pay for inpatient respite care when it	119	Benefit maximum for this time period has

MSN Code	Message	ASC Code	Message
	exceeds 5 consecutive days at a time.		been reached.
27.3	The physician certification requesting hospice services was not received timely.	B17 with MA54	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Physician certification or election consent for hospice care not received timely.
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate. (This would be shown on the RA to the hospice by payment for that date as billed by the hospice.)	No separate message would be needed. The payment rate would be shown as the allowed amount.	
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate. (The level of care being paid would be indicated by the allowed	57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this

MSN Code	Message	ASC Code	Message
	amount.)		dosage.
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	106 with MA54	Patient payment option/election not in effect. Physician certification or election consent for hospice care not received timely.
27.8	The documentation submitted does not support that your illness is terminal.	57 with zero payment for hospice.	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.11	The provider has billed in error for the routine home care items or services received.	97	Payment is included in allowance for the basic service/procedure.

MSN Code	Message	ASC Code	Message
27.12	The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate.	NA	
27.13	According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.	NA	

120 - Contractor Responsibilities for Publishing Hospice Information

(Rev. 1, 10-01-03)
B3-4175.1, B3-4175.6

Carriers must at least annually, include in newsletters and bulletins to physicians and suppliers an explanation of the hospice program and the requirements for billing for physicians who attend a hospice patient. Include information on the use of special modifiers that are in effect at that time.

Carriers may also publish related material on Web pages.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1494CP	04/29/2008	Reporting of Additional Data to Describe Services on Hospice Claims	01/07/2008	5567
R1447CP	02/12/2008	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1494	01/07/2008	5567
R1397CP	12/18/2007	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1447	01/07/2008	5567
R1372CP	11/02/2007	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1397	01/07/2008	5567
R1352CP	10/15/2007	Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished	01/07/2008	5745
R1304CP	07/20/2007	Reporting of Additional Data to Describe Services on Hospice Claims – Replaced by Transmittal 1372	01/07/2008	5567
R1011CP	07/28/2006	Instructions for Reporting Hospice Services in Greater Line Item Detail	01/02/2007	5245
R999CP	07/14/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
R993CP	06/23/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R771CP	12/02/2005	Revisions to PUB 100-04, Medicare	01/03/2006	4181

Rev #	Issue Date	Subject	Impl Date	CR#
		Claims Processing Manual in Preparation for the National Provider Identifier		
R606CP	07/15/2005	Medicare Program-Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2005	10/04/2004	3386
R458CP	01/28/2005	Hospice Physician Recertification Requirements	07/05/2005	3686
R386CP	12/03/2004	Hospice Pre-Election Evaluation and Counseling Services	01/03/2005	3585
R304CP	09/24/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	06/28/2004	3226
R271CP	08/04/2004	Medicare Program-Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2005	10/04/2004	3386
R264CP	07/30/2004	Medicare Program-Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2005	10/04/2004	3386
R205CP	06/15/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	06/28/2004	3226
R193CP	05/28/2004	Nurse Practitioner as Attending Physician In Hospice	06/28/2004	3226
R001CP	10/01/2003	Initial Publication of Manual	NA	NA