CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1494	**Date: April 29, 2008**
	Change Request 5567

NOTE: This transmittal, dated April 29, 2008, rescinds and replaces Transmittal 1447 dated February 12, 2008. This transmittal temporarily suspends reporting of visit data from non-hospice staff in contract facilities providing General Inpatient Care. All other visit reporting requirements described in Transmittal 1447, dated February 12, 2008, remain unchanged. Additionally, CMS made minor edits to clarify some ambiguous language.

SUBJECT: REPORTING OF ADDITIONAL DATA TO DESCRIBE SERVICES ON HOSPICE CLAIMS

I. SUMMARY OF CHANGES: This instruction expands claim data reporting requirements for Medicare hospice claims.

New / Revised Material
Effective Date: January 1, 2008 for systems changes and for OPTIONAL visit reporting by hospices.
July 1, 2008 for mandatory visit reporting by hospices
Implementation Date: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	11/30.1/Levels of Care
R	11/30.3/Data Required on Claim to FI

III. FUNDING:
For Regional Home Health and Hospice Intermediaries (RHHI):
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1494	Date: April 29, 2008	Change Request: 5567

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SUBJECT: Reporting of Additional Data to Describe Services on Hospice Claims

Effective Date: **January 1, 2008, for systems changes and for OPTIONAL visit reporting by hospices.**
July 1, 2008, for mandatory visit reporting by hospices

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: Historically, billings by institutional providers to Medicare fiscal intermediaries contained limited service line information. Claim lines on a typical institutional claim in the 1980s or early 90s may have reported only a revenue code, a number of units, and a total charge amount. Over the last decade, legislated payment requirements have changed and Medicare has implemented increasingly complex payment methods. These changes have required more line item detail on claims for most institutional provider types, such as line item dated services, reporting HCPCS codes and modifiers, and submission of non-covered charges. This detail has supported the payment requirements of legislated payment systems and also improved the quality and richness of Medicare analytic data files.

Hospice claims have been an exception to this process. Since the inception of the hospice program in 1983, hospices have been required to submit on Medicare claims only a small number of service lines to report the number of days at each of the four hospice levels of care. HCPCS coding was required only to report procedures performed by the beneficiary's attending physician if that physician was employed by the hospice. This limited claims data has restricted Medicare's ability to ensure optimal payment accuracy in the hospice benefit, and to carefully analyze the services provided in this growing benefit.

Transmittal 1011 (Change Request 5245) was implemented effective January 1, 2007. That transmittal represented a first phase in the expansion of line level detail information requirements on hospice claims. It required HCPCS codes describing the location where hospice levels of care were delivered and created line item dating requirements for continuous home care level of care. This transmittal provides instructions for the next phase in the expansion of required data on hospice claims. As there appears to be some confusion among hospice providers in distinguishing nursing homes from skilled nursing facilities, we are clarifying that the site of service code Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay and nursing facility residents. The site of service code Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.

B. Policy: Hospice providers shall report data on their claims for Medicare payment, which describe the visits provided in the course of delivering each hospice level of care billed. For each week, beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of visits provided by nurses (registered, licensed and/or nurse practitioner), home health aides (also known as hospice aides), social workers, physicians, and nurse practitioners serving as the beneficiary's attending physician. Each line shall reflect the total number of patient care visits for each coverage category and not as an aggregate total for all. Each line shall indicate the appropriate code for the site where each visit is made. A visit constitutes care to the beneficiary to meet his or her needs related to the palliation and management of the terminal illness and related conditions, as described in the plan of care. An entry in a medical/clinical record without a visit does not constitute a visit and as such is not counted. Rounds in facilities do not constitute a visit and as such are not counted. Items and services provided within a visit are not counted as separate visits. Only the number of patient care visits is counted. Due to the nature of a social worker's functions, counseling or speaking with a patient's family or arranging for placement would constitute a visit. If the site of service changes, a separate line will be required to reflect the site where the patient care visit was made.

To be counted as a visit, the visit must be reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the plan of care. This applies in circumstances where separate billing occurs for a physician or nurse practitioner serving as the attending physician. For the nurse, home health aide and social worker, the weekly total of visits by discipline is not for the purpose of separate payment but to provide transparency into the visits that are being provided to beneficiaries who are electing the Medicare hospice benefit.

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.

Specific instructions regarding this data are included in revisions to the Claims Processing Manual, chapter 11, section 30.3 contained in this transmittal.

Beneficiaries are eligible for the Medicare hospice benefit if they have been certified to have a terminal diagnosis with a prognosis of six months or less if the disease runs its normal course. We have identified that claims are being submitted with an ICD-9 v codes identified as the terminal diagnosis. As v codes (for example, history of stroke, positive tuberculin test, physical therapy, palliative care and radiation therapy) are not intended to capture terminal diagnoses, we will no longer accept claims submitted with a v code for the principle diagnosis. These claims will be returned to the provider.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5567.1	Medicare systems shall allow revenue codes 055X, 056X and 057X on types of bill 81X and 82X.						X					
5567.2	Medicare systems shall require 055X, 056X and 057X revenue code lines reported on types of bill 81X and 82X to contain units and charges.						X	X				
5567.3	Medicare systems shall accept one or more 055X, 056X or 057X revenue code lines associated with each hospice level of care revenue code (651, 652, 655, 656).						X	X				
5567.3.1	Medicare systems shall accept that for each hospice level of care revenue code that there is one or more 055X, 056X or 057X revenue code lines each with a date of service equal to or greater than the date of that level of care revenue code and less than the date of the next level of care revenue code.						X	X				
5567.4	Medicare systems shall not make payment on 055X, 056X or 57X revenue code lines.						X	X				
5567.5	Medicare systems shall reflect the charges associated with each 055X, 056X or 57X revenue code as paid under the all-inclusive payment for the associated level of care revenue code line.						X	X				
5567.5.1	Medicare systems shall change any charges and units associated with each 055X, 056X or 57X revenue code to be non-covered.							X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5567.5.2	Medicare systems shall reflect bundling of services into level of care revenue codes on the remittance advice with reason code 97.						X	X				
5567.6	Medicare systems shall not allow reporting of V-codes as the principal diagnosis code on hospice claims.							X				
5567.6.1	Medicare systems shall return claims to the provider if a V-code is reported as the principal diagnosis.						X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5567.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within						X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5567.5.2	Reason code 97 is defined "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

B. For all other recommendations and supporting information, use the space below:

N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov for claims processing issues and Katie Lucas, 410-786-7723, katherine.lucas@cms.hhs.gov or Randy Throndset, 410-786-0131, randy.throndset@cms.hhs.gov for policy issues.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Regional Home Health and Hospice Intermediaries (RHHI):*
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

(Rev. 1494, 04-29-08)

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.

30.3 - 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

3rd Digit Frequency	Definition
	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.
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*

Code	Title	Definition
		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 Inpatient and Inpatient Respite Care).	MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility 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 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.