CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1352	**Date: October 15, 2007**
	Change Request 5745

Subject: Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished

I. SUMMARY OF CHANGES: This transmittal provides billing instructions for hospices regarding the location where inpatient levels of hospice care are provided.

New / Revised Material
Effective Date: January 1, 2008
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	11/30.2/Payment Rates
R	11/30.3/Data Required on Claim to FI

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their 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: 1352	Date: October 15, 2007	Change Request: 5745

SUBJECT: Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: Currently, not all Medicare payments for hospice services are wage adjusted based on the location where the service is furnished. For Routine Home Care (RHC) and Continuous Home Care (CHC) levels of care (revenue codes 651 and 652), Medicare uses the Core Based Statistical Area (CBSA) for the beneficiary's residence as the basis for wage adjustment. There may be circumstances where RHC and CHC are provided in inpatient settings, as these settings may serve as the beneficiary's place of residence. The CBSA for the beneficiary's residence, whether or not it is an inpatient setting, is reported on the claim using value code 61. This code is currently defined by the National Uniform Billing Committee (NUBC) as "Location Where Service is Furnished (HHA and Hospice)."

For inpatient hospice levels of care, Medicare currently uses the CBSA on the provider file for the hospice facility as the basis for wage adjustment. This assumes that any inpatient levels of care are provided at an inpatient facility either at the hospice itself or under arrangements with a facility within the same CBSA.

The FY 2008 Hospice Wage Index regulation, effective January 1, 2008, requires the use of the CBSA of the location where hospice care is provided for all levels of care, including inpatient levels of care. The current definition of value code 61 is broad enough to include this use, as the code itself does not distinguish between home and facility locations. However, hospice providers frequently bill both home and inpatient levels of care on the same claim. If multiple instances of value code 61 were reported, the claim would not distinguish which CBSA code corresponded to which level of care.

It would be possible to resolve this problem without a code change by requiring hospices to bill separately for home vs. inpatient levels of care. While this would meet Medicare's need in terms of making accurate payment, it could create unnecessary administrative burden on hospices. Also, by artificially increasing the number of hospice claims, it would increase administrative costs for the Medicare program.

To avoid these impacts, CMS requested the NUBC approve a new value code to distinguish a facility CBSA from the currently reported residence CBSA. Such a code allows hospices to continue the current practice of billing all hospice services on a single monthly claim while allowing the Medicare program to wage adjust the services on that claim accurately under the new regulation. The NUBC approved this new code, value code G8, effective January 1, 2008. The NUBC has also redefined value 61 to make clear that it applies to residence locations only. Similar to CBSA code reporting for home levels of care, if multiple inpatient locations with differing CBSAs are used in a billing period, the last CBSA shall be reported for payment.

B. Policy: Hospices shall report the CBSA for the location where services are furnished for all levels of hospice care, including inpatient hospice levels of care, on Medicare claims. Hospices shall report the CBSA for inpatient levels of care in value code G8, for services provided on or after January 1, 2008.

II. BUSINESS REQUIREMENTS TABLE

Shall denotes 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	
5745.1	Regional Home Health Intermediaries shall instruct hospices to report the CBSA of the location where hospice inpatient levels of care are furnished, as described in the Claims Processing Manual, chapter 11, section 30.3.						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	
5745.2	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 1 week of the availability of the provider education article. In addition, the provider education						X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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:
Should denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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 or Wendy Tucker, 410-786-3004 for claims processing issues; Terri Deutsch, 410-786-9462, terri.deutsch@cms.hhs.gov for policy issues

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For *Fiscal Intermediaries and Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MACs):*
N/A

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

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(Rev. 1352, 10-15-07)

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 Care Full Rate = 24 hours of care; $29.66 hourly rate	0652	$711.92	$489.16	$222.76
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. 1352, Issued: 10-15-07, Effective: 01-01-08, 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

3rd Digit Frequency	Definition
	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 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 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 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

Code	Title	Definition
		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 code(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* 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 place of residence where 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).*

The hospice enters the five digit CBSA, with two trailing zeroes, in the "amount" field (i.e., if the CBSA is 10180, enter 1018000).

Revenue Codes

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

For claims with dates of service before January 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 services

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 January 1, 2008, hospices must report the services 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 direct patient care services is to be reported by the discipline (registered nurse, nurse practitioner, licensed nurse, nurse's aide, social worker, physician or nurse practitioner serving as the beneficiary's attending physician) for each week at each location of service. If services are provided in multiple sites, a separate line for each site and for each discipline will be required. The total number of services indicates the total number of visits and does not imply the total number of activities or interventions provided. If direct patient care services 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 **direct** care to the beneficiary. 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 directly related to the provision of items or services to a beneficiary, does not count towards a visit to be placed on the claim. In addition, the visit must be medically reasonable and necessary for the provision of care required by the beneficiary.

Example: 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 services/visits provided by the Nurse and 2 for the Home Health Aide. Since there were no services/visits by the social worker or by the physician, there would not be any line items for each of those disciplines. If in this example, 2 nurses made a visit simultaneously; the total would still remain as 2 since there were only 2 visits. However, multiple visits in a day would be counted. If in this example, the RN returned later on Monday, the amount would be 3.

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.

Services of 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 services, whether provided by hospice employees or provided under arrangement, 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 or 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 services 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 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.

Payer Name

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

National Provider Identifier – Billing Provider

The hospice enters their 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.