

# Medicare Claims Processing Manual

## Chapter 11 - Processing Hospice Claims

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*(Rev. 2410, 02-03-12)*  
*(Rev. 2482, 06-01-12)*

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## **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. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

Effective January 1, 2005, Medicare allows 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.

Medicare covers a one-time only 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” is used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies bill their Medicare contractor with home health and hospice jurisdiction 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, are not subject to the editing usually required on hospice claims to match the claim to an established hospice period. Further, contractors do not apply payments for hospice pre-election evaluation and counseling consultation services to the overall hospice cap amount.

Medicare must ensure that this counseling service 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 a Medicare contractor to CWF for payment authorization but HCPCS code G0337 (Hospice Pre-Election Evaluation and Counseling Services) has already been approved for a hospice claim 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. Medicare contractors use the following messages in this case:

MSN messages: 16.8: “Payment is included in another service received on the same day” and

16.45: “You cannot be billed separately for this item or service. You do not have to pay this amount.”

Claim adjustment reason code (CARC) 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”

Remittance advice remark code (RARC) M86:

Likewise, if a “new patient” claim for HCPCS codes 99201-99205 has been approved and subsequently, a hospice claim is submitted 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 contractor shall deny the bill and use the messages above.

HCPCS code G0337 is only payable when billed on a hospice claim. Contractors shall not make payment for HCPCS code G0337 on professional claims. Contractors shall deny line items on professional claims for HCPCS code G0337 and use the following messages:

MSN message 17.9: “Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor.”

CARC 109: “Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor .”

## **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. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)**

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 Medicare contractor by mail, messenger, or direct data entry (DDE) depending upon the arrangements with the Medicare contractor. The NOE should be filed as soon as possible after a patient elects the hospice benefit.

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. 2326, Issued: 10-27-11, Effective: 04-01-12, Implementation: 04-02-12)**

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election.

**NOTE:** Information regarding the form locator numbers that correspond to these data element names can be found in chapter 25.

### **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.

### **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

### **Patient's Name**

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

### **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.

### **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.

### **Patient's Sex**

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

### **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.

### **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).

### **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.

### **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 enter the patient's HICN. For example, if Medicare is the primary payer, enter this information. 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.

### **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.

### **Attending Physician I.D.**

For notice of elections effective prior to January 1, 2010, 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.

The reporting requirement optional for notice of elections effective on or after January 1, 2010 and required reporting on or after April 1, 2010 establishes that the hospice enters the NPI and name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.

### **Other Physician I.D.**

For notice of elections effective prior to January 1, 2010, if the attending physician is a nurse practitioner, enter the NPI and name of the nurse practitioner.

For notice of elections with dates of service on or after January 1, 2010, the hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying the terminal illness. When the attending physician is also the physician certifying the terminal illness, only the attending physician is required to be reported.

### **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 - Medicare Contractor Reply to Notice of Election**



**(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)**

The reply to the notice of election is furnished according to hospice arrangements with the Medicare contractor. Whether the reply is given by telephone, mail, or wire, it is based upon the Medicare contractor'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 Data Required on the Institutional Claim to Medicare Contractor**

**(Rev. 1907; Issued: 02-05-10; Effective Date: For claims submitted on or after July 6, 2010; Implementation Date: 07-06-10)**

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 in the patient's home. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay. 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 8 hours must be provided. Nursing care must be provided for more than 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 8 hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 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 5 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 5 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. Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF.

**General Inpatient Care** - Payment at the inpatient rate is made when general inpatient care is provided at a Medicare certified hospice facility, hospital, or skilled nursing facility.

### 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 the Institutional Claim to Medicare Contractor** *(Rev. 2410, Issued: 02-03-12, Effective: 07-01-12, Implementation: 07-02-12)*

See Pub. 100-02, Chapter 9, §§10 & 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the Medicare contractor. See section 20, of this chapter for information on NOE transaction types.

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

<b>1st Digit - Type of Facility</b>
8 - Special facility (Hospice)

<b>2nd Digit - Classification (Special Facility Only)</b>
1 - Hospice (Nonhospital based)
2 - Hospice (Hospital based)

<b>3rd Digit – Frequency</b>	<b>Definition</b>
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - 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.

<b>3rd Digit – Frequency</b>	<b>Definition</b>
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 is the discharge date, transfer date, or date of death.
5 - Late Charges	<p>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.</p> <p>Effective April 1, 2012, hospice late charge claims are no longer accepted by Medicare. Providers should use type of bill frequency 7. See below.</p>
7 - Replacement of Prior Claim	<p>This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or “new” bill.</p> <p>For additional information on replacement bills see Chapter 3.</p>
8 - Void/Cancel of a Prior Claim	<p>This code is used to cancel a previously processed claim.</p> <p>For additional information on void/cancel bills see Chapter 3.</p>

**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.

### **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 National Uniform Billing Committee (NUBC) approved code.

Note that patient discharge status code 20 is not used on hospice claims. If the patient has died during the billing period, use codes 40, 41 or 42 as appropriate.

Medicare regulations at 42 CFR 418.26 define three reasons for discharge from hospice care:

- 1) The beneficiary moves out of the hospice's service area or transfers to another hospice,
- 2) The hospice determines that the beneficiary is no longer terminally ill or
- 3) The hospice determines the beneficiary meets their internal policy regarding discharge for cause.

Each of these discharge situations requires different coding on Medicare claims.

Reason 1: A beneficiary may move out of the hospice's service area either with, or without, a transfer to another hospice. In the case of a discharge when the beneficiary moves out of the hospice's service area without a transfer, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation *and appends condition code 52*. The hospice does not report occurrence code 42 on their

claim. This discharge claim will terminate the beneficiary’s current hospice benefit period as of the “Through” date on the claim. The beneficiary may re-elect the hospice benefit at any time as long they remain eligible for the benefit.

In the case of a discharge when the beneficiary moves out of the hospice’s service area and transfers to another hospice, the hospice uses discharge status code 50 or 51, depending on whether the beneficiary is transferring to home hospice or hospice in a medical facility. The hospice does not report occurrence code 42 on their claim. This discharge claim does not terminate the beneficiary’s current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary’s hospice benefit is not affected.

Reason 2: In the case of a discharge when the hospice determines the beneficiary is no longer terminally ill, the hospice uses the NUBC approved discharge status code that best describes the beneficiary’s situation. The hospice *does not* report occurrence code 42 on their claim. This discharge claim will terminate the beneficiary’s current hospice benefit period as of the *Through” date on the claim.*

Reason 3: In the case of a discharge for cause, the hospice uses the NUBC approved discharge status code that best describes the beneficiary’s situation. The hospice does not report occurrence code 42 on their claim. Instead, the hospice reports condition code H2 to indicate a discharge for cause. The effect of this discharge claim on the beneficiary’s current hospice benefit period depends on the discharge status.

If the beneficiary is transferred to another hospice (discharge status codes 50 or 51) the claim does not terminate the beneficiary’s current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary’s hospice benefit is not affected. If any other appropriate discharge status code is used, this discharge claim will terminate the beneficiary’s current hospice benefit period as of the “Through” date on the claim. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future and are willing to be compliant with care.

*If the beneficiary has chosen to revoke their hospice election, the provider uses the NUBC approved discharge patient status code and the occurrence code 42 indicating the date the beneficiary revoked the benefit.* The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future.

<i>Discharge Reason</i>	<i>Coding Required in Addition to Patient Status Code</i>
<i>Beneficiary Revokes</i>	<i>Occurrence Code 42</i>
<i>Beneficiary Transfers Hospices</i>	<i>Patient Status Code 50 or 51; no other indicator</i>



<i>Beneficiary No Longer Terminally Ill</i>	<i>No other indicator</i>
<i>Beneficiary Discharged for Cause</i>	<i>Condition code H2</i>
<i>Beneficiary Moves Out of Service Area</i>	<i>Condition code 52</i>

### Untimely Face-to-Face Encounters and Discharge

When a required face-to-face encounter occurs prior to, but no more than 30 calendar days prior to, the third benefit period recertification and every benefit period recertification thereafter, it is considered timely. A timely face-to-face encounter would be evident when examining the face-to-face attestation, which is part of the recertification, as that attestation includes the date of the encounter. If the required face-to-face encounter is not timely, the hospice would be unable to recertify the patient as being terminally ill, and the patient would cease to be eligible for the Medicare hospice benefit. In such instances, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes.

When a discharge from the Medicare hospice benefit occurs due to failure to perform a required face-to-face encounter timely, the claim should include the most appropriate patient discharge status code. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, we would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

Occurrence span code 77 does not apply to the above described situations when the face-to-face encounter has not occurred timely.

While the face-to-face encounter itself must occur no more than 30 calendar days prior to the start of the third benefit period recertification and each subsequent recertification, its accompanying attestation must be completed before the claim is submitted.

### **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 the NUBC manual.

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.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause.  Note: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause.
52	<i>Out of Hospice Service Area</i>	<i>Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.</i>

### 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 the occurrence span code fields 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 the NUBC manual.

Code	Title	Definition
23	Cancellation of Hospice Election Period (Medicare contractor USE ONLY)	Code indicates date on which a hospice period of election is cancelled by a Medicare contractor as opposed to revocation by the beneficiary.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
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. It is not used in transfer situations.

Occurrence code 27 is reported on the claim for the billing period in which the certification or re-certification was obtained. When the re-certification is late and not obtained during the month it was due, the occurrence span code 77 should be reported with the through date of the span code equal to the through date of the claim.

### **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 the NUBC manual.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients to

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		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.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
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. For routine home care and continuous home care (e.g., the beneficiary's residence changes between locations in different CBSAs), report the CBSA of the beneficiary's residence at the end of the billing period. For general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs), report the CBSA of the latest facility that served the beneficiary. If the beneficiary receives both home and inpatient care during the billing period, the latest home CBSA is reported with value code 61 and the latest facility CBSA is reported with value code G8.

## 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 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.

Hospice claims are required to report separate line items for the level of care each time the level of care changes. This includes revenue codes 0651, 0655 and 0656. For example, if a patient begins the month receiving routine home care followed by a period of general inpatient care and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care. Each routine home care line reports a line item date of service to indicate the first date that level of care began for that consecutive period. This will ensure visits and calls reported on the claim will be associated with the level of care being billed.

<b>Code</b>	<b>Description</b>	<b>Standard Abbreviation</b>
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 do 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

Code	Description	Standard Abbreviation
		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)
<ul style="list-style-type: none"> <li>• * Reporting of value code 61 is required with these revenue codes.</li> <li>• **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.</li> <li>• ***Reporting of value code G8 is required with these revenue codes.</li> </ul>		

**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 Medicare contractor to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the Medicare contractor.

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 visit revenue codes, when applicable as of July 1, 2008:

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.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than General Inpatient (GIP) care in 15 minute increments using the following revenue codes and associated HCPCS:

Revenue Code	Required HCPCS	Required Detail
042x Physical Therapy	G0151	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
043x Occupational Therapy	G0152	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
044x Speech Therapy – Language Pathology	G0153	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
055x Skilled Nursing	G0154	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
056x Medical Social Services	G0155	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
0569 Other Medical Social Services	G0155	Required detail: Each social service phone call is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the call defined in the HCPCS description.



057x Aide	G0156	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description.
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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 two exceptions are related to General Inpatient Care and Respite care. CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care or respite care in contract facilities. However, General Inpatient Care or respite 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 and respite care visits related to the palliation and management of the terminal illness or related conditions provided in hospice-owned facilities must be reported.

Charges associated with the reported visits are covered under the hospice bundled payment and reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines. The visit charges will be identified on the provider remittance advice notice with remittance code 97 “Payment adjusted because the benefit for this service is included in the payment / allowance for another service/procedure that has already been adjudicated.”

Effective January 1, 2010, Medicare will require hospices to report additional detail for visits on their claims. For all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite care billing, Medicare hospice claims should report each visit performed by nurses, aides, and social workers who are employed by the hospice, and their associated time per visit in the number of 15 minute increments, on a separate line. The visits should be reported using revenue codes 055x (nursing services), 057x (aide services), or 056x (medical social services), with the time reported using the associated HCPCS G-code in the range G0154 to G0156. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description.

Additionally, providers should begin reporting each RHC, CHC, and Respite visit performed by physical therapists, occupational therapists, and speech-language therapists and their associated time per visit in the number of 15 minute increments on a separate line. Providers should use existing revenue codes 042x for physical therapy, 043x for occupational therapy, and 044x for speech language therapy, in addition to the appropriate HCPCS G-code for recording of visit length in 15 minute increments. HCPCS G-codes G0151 to G0153 will be used to describe the therapy discipline and visit

time reported on a particular line item. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. If a hospice patient is receiving Respite care in a contract facility, visit and time data by non-hospice staff should not be reported.

Social worker phone calls made to the patient or the patient’s family should be reported using revenue code 0569, and HCPCS G-code G0155 for the length of the call, with each call being a separate line item. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. Only phone calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care (such as counseling, or speaking with a patient’s family or arranging for a placement) should be reported. Report only social worker phone calls related to providing and or coordinating care to the patient and family and documented as such in the clinical records.

When recording any visit or social worker phone call time, providers should sum the time for each visit or call, rounding to the nearest 15 minute increment. Providers should not include travel time or documentation time in the time recorded for any visit or call. Additionally, hospices may not include interdisciplinary group time in time and visit reporting.

**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)
Q5010	Hospice home care provided in a hospice facility

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 hospice patients in an unskilled nursing facility (NF) or hospice patients in the NF portion of a dually certified nursing facility, who are receiving unskilled care from the facility staff.

Q5004 is to be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff.

**NOTE:** Q5003 should be used for hospice patients located in a NF; many of these patients may also have Medicaid. Q5004 should be used when the hospice patient is in a SNF, and receiving skilled care from the facility staff, such as would occur in a GIP stay. For Q5004 to be used, the facility would have to be certified as a SNF. Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. When a patient is in the NF portion of a dually certified nursing facility, and receiving only unskilled care from the facility staff, Q5003 should be reported. Note that GIP care that is provided in a nursing facility can only be given in a SNF, because GIP requires a skilled level of care.

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 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.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than GIP care as separate line items for each with the appropriate line item date of service. GIP visit reporting has not changed with the January 2010 update. GIP visits will continue to be reported as the number of visits per week.

For service visits that begin in one calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

### **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.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than GIP care as a separate line item with the appropriate line item date of service and the units as an increment of 15 minutes. GIP visit reporting has not changed with the January 2010 update. The units for visits under GIP level of care continue to reflect the number of visits per week.

Report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description.

### **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**

For claims with dates of service before January 1, 2010, 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.

For claims with dates of service on or after January 1, 2010 the hospice shall enter the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

### **Other Provider Name and Identifiers**

For claims with dates of service before January 1, 2010, if the attending physician is a nurse practitioner, the hospice enters the NPI and name of the nurse practitioner.

For claims with dates of service on or after January 1, 2010, the hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note:

Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying the terminal illness. When the attending physician is also the physician certifying the terminal illness, only the attending physician is required to be reported.

### **30.4 - Claims From Medicare Advantage Organizations** (Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice. These regulations are found 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). Medicare Fee for Service retains payment responsibility for all hospice and non-hospice related claims beginning on the date of the hospice election.

#### **A - Covered Services**

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, or a provider treating an illness not related to the terminal condition, to a fee-for-service contractor of CMS. These claims are 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 bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage just as they do for beneficiaries with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X or 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.

Medicare physicians may also bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors 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. MA plan 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.

## **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 - Hospice Attending Physician Services** (Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)

Under the Medicare hospice benefit, an attending physician is defined as 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) who is identified by the patient, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his or her medical care. Payment for physicians or nurse practitioners serving as the attending physician, who provide direct patient care services and who are hospice employees or working under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill the Medicare contractor for these services under Medicare Part A.
- The Medicare contractor pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services or 85 percent 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 Medicare contractor 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 - Independent Attending Physician Services**

**(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**



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 independent 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.

Hospices should reiterate with patients that they must not see independent physicians for care related to their terminal illness other than their independent attending physician unless the hospice arranges it.

Even though a beneficiary elects hospice coverage, he/she may designate and use an independent 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 independent 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 Medicare Part A hospice services.

Where the service is related to the hospice patient’s terminal illness but 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 an independent attending physician, who may be a nurse practitioner, are billed to the Medicare contractor through Medicare Part B. When the independent 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 Medicare contractor on a professional claim and looks to the hospice for payment for the technical component. Likewise, the independent 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 Medicare Part A "hospice services." These independent attending physician services are billed through Medicare Part B to the Medicare contractor, provided they were not furnished under a payment arrangement with the hospice. The independent 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. The Medicare contractor makes payment to the independent attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

Payments for the services of an independent attending physician are not counted in determining whether the hospice cap amount has been exceeded because Part B 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 (i.e., by a non-independent physician/nurse practitioner), the physician must look to the hospice for payment. In this situation the physicians' services are Part A hospice services and are billed by the hospice to its Medicare contractor.

Medicare contractors 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 periods of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. Medicare contractor 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.

### **40.1.4 - Reserved**

## **40.2 - Processing Professional Claims for Hospice Beneficiaries**

**(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

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.

Medicare contractors processing professional claims 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 contractor shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information.

For beneficiaries enrolled in hospice, contractors shall deny any services on professional claim that are submitted without either the GV or GW modifier. Contractors shall 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 institutional claim.

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

### **40.2.1 - Claims After the End of Hospice Election Period**

**(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

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, Medicare contractors process and pay professional claims for covered Part B services that hospice employed physicians may furnish.

## **50 - Billing and Payment for Services Unrelated to Terminal Illness** **(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

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 using professional or institutional claims for non-hospice Medicare payment. On professional claims, these services are coded with the GW modifier “service not related to the hospice patient’s terminal condition.” On institutional claims, these services are coded with condition code 07 “Treatment of Non-terminal Condition for Hospice.” Contractors process services coded with the GW modifier or condition code 07 in the normal manner for coverage and payment determinations. See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for physician services) for billing instructions. If warranted, contractors may conduct prepayment development or postpayment review to validate that services billed with the GW modifier or condition code 07 are not related to the patient’s terminal condition.

## **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. 2482, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)*

*For information regarding caps and limitations on hospice payments, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 90.*

## **90 - Frequency of Billing and Same Day Billing**

**(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing should conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months.

In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

## **100 - Billing for Hospice Denials**

**(Rev. 2410, Issued: 02-03-12, Effective: 07-01-12, Implementation: 07-02-12)**

### **100.1 – Billing for Denial of Hospice Room and Board Charges**

**(Rev. 2410, Issued: 02-03-12, Effective: 07-01-12, Implementation: 07-02-12)**

*Hospice providers wishing to receive a line item denial for room and board charges may submit the charges as non-covered using revenue code 0659 with HCPCS A9270 and modifier GY on an otherwise covered hospice claim.*

## **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.

<b>MSN Code</b>	<b>Message</b>	<b>ASC Code</b>	<b>Message</b>
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 exceeds 5 consecutive days at a time.	119	Benefit maximum for this time period has 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



MSN Code	Message	ASC Code	Message
			<p>physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.</p> <p>Physician certification or election consent for hospice care not received timely.</p>
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 amount.)	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 dosage.
27.7	According to Medicare hospice requirements, the hospice election consent was	106 with MA54	Patient payment option/election not in effect.

<b>MSN Code</b>	<b>Message</b>	<b>ASC Code</b>	<b>Message</b>
	not signed timely.		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.
27.12	The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth	NA	

MSN Code	Message	ASC Code	Message
	day will be paid at the routine home care rate.		
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. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)**

Medicare contractors processing professional claims shall, 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 serve as the attending physician to a hospice patient. These contractors shall include information on the use of special modifiers that are in effect at that time. These contractors may also publish related material on Web pages.

## Transmittals Issued for this Chapter

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<a href="#">R2482CP</a>	06/01/2012	Updates to Caps and Limitations on Hospice Payments	07/02/2012	7838
<a href="#">R2410CP</a>	02/03/2012	New Hospice Condition code for Out of Service Area Discharges	07/02/2012	7677
<a href="#">R2391CP</a>	01/25/2012	New Hospice Condition code for Out of Service Area Discharges – Rescinded and replaced by Transmittal 2410	07/02/2012	7677
<a href="#">R2326CP</a>	10/27/2011	Discontinuation of Hospice Late Charge Claims	04/02/2012	7556
<a href="#">R2316CP</a>	10/07/2011	Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely	01/09/2012	7478
<a href="#">R2258CP</a>	07/29/2011	Correction to Processing of Hospice Discharge Claims	01/03/2012	7473
<a href="#">R1955CP</a>	04/28/2010	New Hospice Site of Service Code	10/04/2010	6905
<a href="#">R1907CP</a>	02/05/2010	Medicare Systems Edit Refinements Related to Hospice Services	07/06/2010	6778
<a href="#">R1897CP</a>	01/29/2010	Associating Hospice Visits to the Level of Care	04/29/2010	6791
<a href="#">R1885CP</a>	12/23/2009	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness	01/04/2010	6540
<a href="#">R1870CP</a>	12/11/2009	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness – Rescinded and replaced by Transmittal 1885	01/04/2010	6540
<a href="#">R1863CP</a>	11/27/2009	Hospice Reporting Requirements for the Attending Physician and the Hospice	01/04/2010	6540

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
		Physician Certifying the Terminal Illness – Rescinded and replaced by Transmittal 1870		
<u>R1738CP</u>	05/15/2009	Additional Data Collection on Hospice Claims	10/05/2009	6440
<u>R1713CP</u>	04/24/2009	Additional Data Collection on Hospice Claims – Rescinded and replaced by Transmittal 1738	10/05/2009	6440
<u>R1708CP</u>	04/03/2009	Hospice Cap Calculations Letters and Administrative Appeals	07/06/2009	6400
<u>R1673CP</u>	01/30/2009	Correction to the Common Working File (CWF) for Late Recertification	07/06/2009	6332
<u>R1558CP</u>	07/18/2008	Hospice Discharge for Cause	01/05/2009	6115
<u>R1494CP</u>	04/29/2008	Reporting of Additional Data to Describe Services on Hospice Claims	01/07/2008	5567
<u>R1447CP</u>	02/12/2008	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1494	01/07/2008	5567
<u>R1397CP</u>	12/18/2007	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1447	01/07/2008	5567
<u>R1372CP</u>	11/02/2007	Reporting of Additional Data to Describe Services on Hospice Claims - Replaced by Transmittal 1397	01/07/2008	5567
<u>R1352CP</u>	10/15/2007	Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished	01/07/2008	5745
<u>R1304CP</u>	07/20/2007	Reporting of Additional Data to Describe Services on Hospice Claims – Replaced by Transmittal 1372	01/07/2008	5567

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<u>R1011CP</u>	07/28/2006	Instructions for Reporting Hospice Services in Greater Line Item Detail	01/02/2007	5245
<u>R999CP</u>	07/14/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
<u>R993CP</u>	06/23/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
<u>R980CP</u>	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
<u>R941CP</u>	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
<u>R771CP</u>	12/02/2005	Revisions to Pub 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier	01/03/2006	4181
<u>R606CP</u>	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
<u>R458CP</u>	01/28/2005	Hospice Physician Recertification Requirements	07/05/2005	3686
<u>R386CP</u>	12/03/2004	Hospice Pre-Election Evaluation and Counseling Services	01/03/2005	3585
<u>R304CP</u>	09/24/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	06/28/2004	3226
<u>R271CP</u>	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
<u>R264CP</u>	07/30/2004	Medicare Program-Update to the Hospice Payment Rates, Hospice Cap, Hospice	10/04/2004	3386

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
		Wage Index and the Hospice Pricer for FY 2005		
<u>R205CP</u>	06/15/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	06/28/2004	3226
<u>R193CP</u>	05/28/2004	Nurse Practitioner as Attending Physician In Hospice	06/28/2004	3226
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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