

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

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(Rev. 3326, 08-14-15)
(Rev. 3378, 10-16-15)

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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 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. 3118, Issued: 11-06-14, Effective: 10-01-14, Implementation: 04-06-15)

When a Medicare beneficiary elects hospice services, hospices must complete form locators identified in section 20.1.2 for 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.

Timely-filed hospice NOEs shall be filed within 5 calendar days after the hospice admission date. A timely-filed NOE is a NOE that is submitted to the Medicare contractor and accepted by the Medicare contractor within 5 calendar days after the hospice admission date. While a timely-filed NOE is one that is submitted to and accepted by the Medicare contractor within 5 calendar days after the hospice election, posting to the CWF may not occur within that same time frame. The date of posting to the CWF is not a reflection of whether the NOE is considered timely-filed. In instances where a NOE is not timely-filed, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days shall be a provider liability, and the provider shall not bill the beneficiary for them. The hospice shall report these non-covered days on the claim with an occurrence span code 77, and charges for all claim lines reporting these days shall be reported as non-covered, or the claim will be returned to the provider.

If a hospice fails to file a timely-filed NOE, it may request an exception which, if approved, waives the consequences of filing a NOE late. The four circumstances that

may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the hospice admission date are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
2. an event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;
3. a newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor; or,
4. other circumstances determined by the Medicare contractor or CMS to be beyond the control of the hospice.

If one of the four circumstances described above prevents a hospice from filing a timely-filed NOE, the hospice may request an exception which, if approved, would waive the consequences of filing the NOE late.

Even if a hospice believes that exceptional circumstances beyond its control are the cause of its late-filed NOE, the hospice shall file the associated claim with occurrence span code 77 used to identify the non-covered, provider liable days. The hospice shall also report a KX modifier with the Q HCPCS code reported on the earliest dated level of care line on the claim. The KX modifier shall prompt the Medicare contractor to request the documentation supporting the request for an exception. Based on that documentation, the Medicare contractor shall determine if a circumstance encountered by a hospice qualifies for an exception.

If the request for an exception is approved by the Medicare contractor, the Medicare contractor shall process the claim with the CWF override code and remove the submitted provider liable days, which will allow payment for the days associated with the late-filed NOE. If the Medicare contractor finds that the documentation does not support allowing an exceptional circumstance, the Medicare contractor shall process the claim as submitted.

The provider liable days on these claims will receive the following remittance advice codes:

Business Scenario	Group Code	CARC	RARC
3	CO	96	MA54

Hospices may appeal the contractor's determination that an exceptional circumstance did not apply.

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. 3326, Issued: 08-14-15, Effective: 01-01-16, Implementation: 01-04-16)

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election. Data elements that are not shown are not required.

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 appropriate 3-digit numeric type of bill code, according to the following 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

Statement Covers Period (From-Through)

On a Notice of Termination/Revocation (NOTR), the hospice enters the start date of the hospice benefit period in which the notice is effective in the “From” date field. The hospice enters the date the termination/revocation is effective in the “Through” date field.

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

The hospice enters the admission date, which must *be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the election date cannot be the same as the revocation or discharge date.* 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. On a NOTR, the hospice enters the start date of the hospice benefit period in which the discharge or revocation is effective, not the initial hospice admission date.

EXAMPLE

The hospice election date (admission) is January 1, 2014. The physician’s certification is dated January 3, 2014. The hospice date for coverage and billing is January 1, 2014. The first hospice benefit period ends 90 days from January 1, 2014.

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

Provider Number

The hospice enters 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. *To ensure accuracy and prevent a delay in posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice 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

CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes, which were updated annually through October 1, 2013, are posted at <http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

The official annual updates to ICD-10-CM and ICD-10-PCS codes are posted at <http://www.cms.gov/Medicare/Coding/ICD10/index.html> .

Use full diagnosis codes including all applicable digits, up to five digits for ICD-9-CM and up to seven digits for ICD-10-CM.

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.

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.

NOTE: for electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

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. 3326, Issued: 08-14-15, Effective: 01-01-16, Implementation: 01-04-16)

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 claims with date of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. See section 30.2 of this chapter for additional instructions on the high and low RHC rates.

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 breaks,

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. 3378, Issued: 10-16-15, Effective: 01-01-16, Implementation: 01-01-16)

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 A/B MAC (A) 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

For claims with dates of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. Medicare systems count 60 days from the date of admission regardless of whether some days are covered or non-covered.

For a hospice patient that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the patient. If the hospice patient is discharged from hospice care for more than 60 days a new election to hospice will initiate a reset of the patient's 60-day window, paid at the RHC high rate upon the new admission.

Example:

- Patient elected hospice for the first time on 01/10/XX.
- The patient revoked hospice on 01/30/XX.
- The patient re-elected hospice on 02/16/XX.
- The patient discharged deceased from hospice care on 03/28/XX.

Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.

RHC provided during first election from 01/10 to 01/30 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27.

Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.

Extending the example above, if the March claim for this patient consisted entirely of RHC days at home, the payment line item would look like this:

Revenue Code	HCPCS	Line Item Date of Service	Units
0651	Q5001	03/01/XX	31

Medicare systems would:

- calculate the dates from 3/01 to 3/26 at the high RHC rate,
 - calculate the dates from 3/27 to 3/31 at the low RHC rate, and
- sum these two amounts in the payment applied to this line item.

30.2.1 – Payments to Hospice Agencies That Do Not Submit Required Quality Data

(Rev. 2696, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.

Penalties for Failure to Report

For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.

Medicare will provide contractors with a Technical Direction Letter (TDL) prior to each fiscal year, identifying hospice agencies not meeting the quality data reporting requirements. Contractors must update the quality indicator in the Provider Outpatient Specific File for each identified, hospice agency subject to the payment reduction.

30.2.2 – Service Intensity Add-on (SIA) Payments

(Rev. 3378, Issued: 10-16-15, Effective: 01-01-16, Implementation: 01-01-16)

Effective for hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment.

The SIA payment amount is calculated by multiplying the continuous home care (CHC) rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

EXAMPLE CLAIM: End of Life (EOL) 7 day SIA:

Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40

RHC in home, discharged deceased.

Revenue Code	HCPCS	Line Item Date of Service	Units
0651	Q5001	12/01/XX	9
0551	G0154	12/01/XX	4
0571	G0156	12/02/XX	6
0561	G0155	12/05/XX	4
0571	G0156	12/05/XX	3
0551	G0299	12/06/XX	3
0571	G0156	12/06XX	4
0551	G0299	12/09/XX	4
0561	G0155	12/09/XX	6
0571	G0156	12/09/XX	2

*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.

Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.

Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.

Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4.

Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/06/XX UNITS 3.

Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.

Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.

Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/09/XX UNITS 4.

30.3 - Data Required on the Institutional Claim to Medicare Contractor

(Rev. 3378, Issued: 10-16-15, Effective: 01-01-16, Implementation: 01-01-16)

See Pub. 100-02, Medicare Benefit Policy Manual, 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 format required for billing hospice services is the ASC X12 837 institutional claim transaction. Since the data structure of this 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 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 is found in Chapter 25.

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

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

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

Code Structure

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

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

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

3rd Digit – Frequency	Definition
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.

Discharge Reason	Coding Required in Addition to Patient Status Code
Beneficiary Revokes	Occurrence Code 42
Beneficiary Transfers Hospices	Patient Status Code 50 or 51; no other indicator
Beneficiary No Longer Terminally Ill	No other indicator
Beneficiary Discharged for Cause	Condition code H2
Beneficiary Moves Out of Service Area	Condition code 52

If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice shall file a timely-filed Notice of Election Termination / Revocation (NOTR) using type of bill 8xB, unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to the Medicare contractor and accepted by the Medicare contractor within 5 calendar days after the effective date of discharge or revocation. While a timely-filed NOTR is one that is submitted to and accepted by the Medicare contractor within 5 calendar days after the hospice election, posting to the CWF may not occur within that same timeframe. The date of posting to the CWF is not a reflection of whether the NOTR is considered timely-filed. A NOTR (type of bill 8xB) is entered via Direct Data Entry in the same way as an NOE (type of

bill 8xA). Hospices continue to have 12 months from the date of service in which to file their claims timely.

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, CMS 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	Out of Hospice Service Area	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.

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.
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

Code	Title	Definition
		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.

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

Respite care is payable only for periods of respite up to 5 consecutive days. Claims reporting respite periods greater than 5 consecutive days will be returned to the provider. Days of respite care beyond 5 days must be billed at the appropriate home care rate for payment consideration.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed 5 days, including consecutive respite periods.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6 and later returns to respite care from July 15 to July 18, and completes the month on routine home care, the provider must report two separate line items for the respite periods and two occurrence span code M2, as follows:

Revenue Line items:

- Revenue code 0655 with line item date of service 07/01/XX (for respite period July 1 through July 5) and line item units reported as 5
- Revenue code 0651 with line item date of service 07/06/XX (for routine home care July 6 through July 14) and line item units reported as 9
- Revenue code 0655 with line item date of service 07/15/XX (for respite period July 15 through 17th) and line item units reported as 3
- Revenue code 0651 with line item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line item units reported as 14.

Occurrence Span Codes:

- M2 0701XX – 0705XX
- M2 0715XX – 0717XX

Provider Liability Periods Using Occurrence Span Code 77: 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 other than the initial certification period.
- Late-filing of a Notice of Election (NOE). A timely-filed NOE is a NOE that is submitted to the Medicare contractor and accepted by the Medicare contractor within 5 calendar days after the hospice admission date. When the hospice files a NOE late, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to and accepted by the Medicare contractor. The date the NOE is submitted to and accepted by the Medicare contractor is an allowable day for payment.

Example:

Admission date is 10/10/2014 (Fri).

Day 1 = Sat. 10/11/2014

Day 2 = Sun. 10/12/2014
 Day 3 = Mon. 10/13/2014
 Day 4 = Tues. 10/14/2014
 Day 5 = Weds. 10/15/2014 10/15/2014 is the NOE Due Date.

IF NOE Receipt date is 10/16/2014, the hospice reports 10/10- 10/15 as non-covered days using occurrence span code 77 or CWF rejects the claim back to FISS. The contractor returns the claim to the provider for correction.

Value Codes and Amounts

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

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

Code	Title	Definition
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	<p>MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered.</p> <p>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.</p> <p>Hospices must report value code 61 when billing revenue codes 0651 and 0652.</p>
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care).	<p>MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility where inpatient hospice services are delivered.</p> <p>Hospices must report value code G8 when billing revenue codes 0655 and 0656.</p>

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.

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	CTNS Home A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care 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 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

Code	Description	Standard Abbreviation
		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"> • * Reporting of value code 61 is required with these revenue codes. • **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner. • ***Reporting of value code G8 is required with these revenue codes. • *** The date of discharge from general or respite inpatient care is paid at the appropriate home care rate and must be billed with the appropriate home care revenue code unless the patient is deceased at time of discharge in which case, the appropriate inpatient respite or general care revenue code should be used. 		

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. Hospices shall report line-item visit data for hospice staff providing general inpatient care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for routine home care and continuous home care. This also includes certain calls by hospice social workers (as described further below).

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 <i>(before 01/01/2016)) G0299 or G0300 (on or after 01/01/2016)</i>	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.

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."

Medicare requires 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.

Effective January 1, 2016, Medicare requires hospices to use G0299 for "direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting" and G0300 "direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting." G0154 is retired as of 12/31/2015.

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.

Hospice agencies shall report injectable and non-injectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injectable prescription drugs shall be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy.

When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a medication management system where each administration of a hospice medication is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.

Hospices shall report multi-ingredient compound prescription drugs (non-injectable) using revenue code 0250. The hospice shall specify the same prescription number for each ingredient of a compound drug according to the 837i guidelines in loop 2410. In addition, the hospice shall provide the NDC for each ingredient in the compound; the NDC qualifier represents the quantity of the drug filled (meaning the amount dispensed) and shall be reported as the unit measure.

When reporting prescription drugs in a comfort kit/pack, the hospice shall report the NDC of each prescription drug within the package, in accordance with the procedures for non-injectable prescriptions.

Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump and for each medication fill and refill. The hospice claim shall reflect the total charge for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems, so long as in total, the claim reflects the charges for the pump for the time period of that claim.

Revenue code reporting required for claims with dates of service on or after April 1, 2014:

0250 Non-injectable Prescription Drugs	N/A	Required detail: Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and should be reported as the unit measure.
029X Infusion pumps	Applicable HCPCS	Required detail: Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.
0636 Injectable Drugs	Applicable HCPCS	Required detail: Report on a line item basis per fill with units representing the amount filled. (i.e., Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2).

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.

Q5004 shall be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually-certified nursing facility. There are 4 situations where this would occur:

- 1) If the beneficiary is receiving hospice care in a solely-certified SNF.
- 2) If the beneficiary is receiving general inpatient care in the SNF.
- 3) If the beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition unrelated to the terminal illness and related conditions, and is receiving hospice routine home care; this is uncommon.
- 4) If the beneficiary is receiving inpatient respite care in a SNF.

If a beneficiary is in a nursing facility but doesn't meet the criteria above for Q5004, the site shall be coded as Q5003, for a long term care nursing facility.

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).

General inpatient care provided by hospice staff requires line item visit reporting in units of 15 minute increments when provided in the following sites of service: Skilled Nursing Facility (Q5004), Inpatient Hospital (Q5005), Long Term Care Hospital (Q5007), Inpatient Psychiatric Facility (Q5008).

Modifiers

The following modifier is required reporting for claims with dates of service on or after April 1, 2014:

PM – Post-mortem visits. Hospices shall report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Post mortem visits occurring on a date subsequent to the date of death are not to be reported. The reporting of post-mortem visits, on the date of death, should occur regardless of the patient's level of care or site of service. Date of death is defined as the date of death reported on the death certificate. Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.

For example, assume that a nurse arrives at the home at 9 pm to provide routine home care (RHC) to a dying patient, and that the patient passes away at 11 pm. The nurse stays with the family until 1:30 am. The hospice should report a nursing visit with eight 15-minute time units for the visit from 9 pm to 11 pm. On a separate line, the hospice should report a nursing visit with a PM modifier with four 15-minute time units for the portion of the visit from 11 pm to midnight to account for the 1 hour post mortem visit. If the patient passes away suddenly, and the hospice nurse does not arrive until after his death at 11:00 pm, and remains with the family until 1:30 am, then the hospice should report a line item nursing visit with a PM modifier and four 15-minute increments of time as the units to account for the 1 hour post mortem visit from 11:00 pm to midnight.

The following modifier may be used to identify requests for an exception to the consequences of not filing the NOE timely for claims with dates of service on or after October 1, 2014:

KX - Requirements specified in the medical policy have been met. This modifier is used to indicate that the hospice has documentation indicating an exception condition applies. The hospice reports the KX modifier with the Q HCPCS code on the earliest dated level of care revenue code line on the claim (revenue code 0651, 0652, 0655 or 0656). When this modifier is present, the Medicare contractor will request the documentation from the hospice (see section 20.1.1).

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.

Any service dates that fall within an occurrence span code 77 period must be reported with non-covered charges.

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.

When days are non-covered due to not filing a timely NOE, the hospice reports two lines for the affected level of care. For example, if a billing period contains 31 days of routine home care and the first 5 days are non-covered due to not filing a timely NOE:

- The hospice reports one revenue code 0651 line containing the earliest non-covered date of service, 5 units and all non-covered charges
- The hospice reports a second revenue code 0651 line containing the first covered date of service, 26 units and all covered charges.

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.

Non-Covered Charges

The hospice enters a charge amount equal to the Total Charges for any revenue code line with a Service Date within a non-covered period (e.g., an occurrence span code 77 period).

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 / ICD-10-CM Coding Guidelines.

CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes, which were updated annually through October 1, 2013, are posted at

<http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

The official annual updates to ICD-10-CM and ICD-10-PCS codes are posted at

<http://www.cms.gov/Medicare/Coding/ICD10/index.html> .

Use full diagnosis codes including all applicable digits, up to five digits for ICD-9-CM and up to seven digits for ICD-10-CM.

The principal diagnosis listed is the diagnosis most contributory to the terminal prognosis.

Non-reportable Principal Diagnosis Codes to be returned to the provider for correction:

- Hospices may not report ICD-9CM v-codes and ICD-10-CM z-codes as the principal diagnosis on hospice claims.
- Hospices may not report debility, failure to thrive, or dementia codes classified as unspecified as principal hospice diagnoses on the hospice claim.
- Hospices may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM or ICD-10-CM Coding Guidelines or require further compliance with various ICD-9-CM or ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing guidelines.

Other Diagnosis Codes

The hospice enters diagnosis coding as required by ICD-9-CM and ICD-10-CM Coding Guidelines. All of a patient's coexisting or additional diagnoses that are related to the terminal illness and related conditions should be reported on the hospice claim.

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.

NOTE: for electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

Hospices shall report the NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice. The billing hospice shall obtain the NPI for the facility where the patient is receiving care and report the facility's name, address and NPI on the 837 Institutional claim format in loop 2310 E Service Facility Location. When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated. Failure to report this information for claims reporting place of service HCPCS Q5003 (long term care nursing facility), Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5007 (long term care hospital) and Q5008 (inpatient psychiatric facility) with dates of service on or after April 1, 2014, will result in the claim being returned to the provider.

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.

40.2 - 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. 2642, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing must 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. Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned beginning on dates of service July 1, 2013. The only exception to this requirement is in the case of the beneficiary being discharged or revoking the benefit and then later re-electing the benefit during the same month. The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8 to August 31 and a separate claim is submitted with dates of service September 1 to September 1. Hospice claims should not span multiple months. Any hospice claim spanning multiple months will be returned to the provider for correction.

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. 2748, Issued: 07-26-13, Effective: 01-01-14, Implementation: 01-06-14)

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.

100.2 – Demand Billing for Hospice General Inpatient Care

(Rev. 2748, Issued: 07-26-13, Effective: 01-01-14, Implementation: 01-06-14)

The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by the hospice to Medicare beneficiaries in situations where Medicare payment is

expected to be denied. ABN issuance is mandatory when the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C). When a Medicare hospice beneficiary has been receiving covered general inpatient care (GIP) and the hospice determines that continued hospice GIP care is not reasonable and medically necessary, the provider must issue an ABN. Billing instructions for demand bills associated with ABN issuance are provided in this manual in Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32).

Hospices should be aware Medicare may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN. Medicare contractors reviewing GIP reported on a hospice claim with an ABN provided may conclude the care is not reasonable and medically necessary. When the Medicare contractor makes the non-coverage determination, they must non-cover the GIP line item(s) on the claim. Hospices may be paid the routine home care (RHC) rate in lieu of the denied GIP service. The Medicare contractor adds a line item for RHC (revenue code 0651) for each denied GIP line. The charges associated with the added RHC line should be the RHC charges the hospice reports on their claim or in the absence of a hospice submitted RHC line item, the contractor shall enter the applicable RHC base rate.

These instructions are not applicable when the beneficiary is not questioning the Medicare coverage but needs a Medicare denial for a secondary payer. In those cases, the provider should submit a non-covered claim with the condition code 21.

110 - Medicare Summary Notice (MSN) Messages/ASC X12N Remittance Advice Adjustment Reason and Remark Codes
(Rev. 3015, Issued: 08-07-14, Effective: ICD- Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: ICD- Upon Implementation of ICD-10, ASC-X12: 09-08-14)

The following messages apply specifically to Hospice beneficiaries. See Chapter 21 for a list of all MSN messages. See Chapter 22 sections 60§§ and 80§§ for instructions about selection of CARC, RARC, and CAGC codes, and application of CAQH CORE operating requirements in selection of these codes.

Also see <http://www.caqh.org/CORECodeCombinations.php> for the latest version of criteria for selecting CARC, RARC, and CAGC codes.

Note that administrative appeals processes are available to beneficiaries, physicians/suppliers, or providers dissatisfied with these determinations, see Chapter 29 for more information.

MSN Code	Message	ASC X12 835 Adjustment Codes	Message
27.1	This service is not covered because you are enrolled in a hospice.	B9	Services are not covered because the patient is enrolled in a

MSN Code	Message	ASC X12 835 Adjustment Codes	Message
			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 physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Physician certification or election consent for hospice care not received timely.
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate. (This would be shown on the RA to the hospice by payment for that date as billed by the hospice.)	No separate message would be needed. The payment rate would be shown as the allowed amount.	
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate. (The level of care being paid would be indicated by the allowed 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	106 with MA54	Patient payment

MSN Code	Message	ASC X12 835 Adjustment Codes	Message
	requirements, the hospice election consent was not signed timely.		option/election not in effect. Physician certification or election consent for hospice care not received timely.
27.8	The documentation submitted does not support that your illness is terminal.	57 with zero payment for hospice.	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.11	The provider has billed in error for the routine home care items or services received.	97	Payment is included in allowance for the basic service/procedure.
27.12	The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate.	NA	
27.13	According to Medicare hospice	NA	

MSN Code	Message	ASC X12 835 Adjustment Codes	Message
	requirements, this service is not covered because the service was provided by a non-attending physician.		

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

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R3378CP</u>	10/16/2015	Additional G-Codes Differentiating RNs and LPNs in the Home Health and Hospice Settings	01/01/2016	9369
<u>R3326CP</u>	08/14/2015	Implementation of the Hospice Payment Reforms	01/04/2016	9201
<u>R3118CP</u>	11/06/2014	Correction to Remittance Messages When Hospice Claims are Reduced Due to Late Filing of the Notice of Election	04/06/2014	8923
<u>R3032CP</u>	08/22/2014	Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election. This CR rescinds and fully replaces CR 8777.	10/01/2014	8877
<u>R3015CP</u>	08/07/2014	Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	09/08/2014	8648
<u>R2973CP</u>	06/06/2014	Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election – Rescinded and replaced by CR 8877	10/01/2014	8777
<u>R2929CP</u>	04/10/2014	Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12 – Rescinded and replaced by Transmittal 3015	10/01/2014	8648
<u>R2928CP</u>	04/10/2014	Enforcement of the 5 day Payment Limit for Respite Care Under the Hospice Medicare Benefit	07/07/2014	8569
<u>R2910CP</u>	03/14/2014	Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating	10/01/2014	8648

Rev #	Issue Date	Subject	Impl Date	CR#
		ICD-10 and ASC X12 – Rescinded and replaced by Transmittal 2929		
<u>R2867CP</u>	02/05/2014	Enforcement of the 5 day Payment Limit for Respite Care Under the Hospice Medicare Benefit – Rescinded and replaced by Transmittal 2928	07/07/2014	8569
<u>R2864CP</u>	01/31/2014	Additional Data Reporting Requirements for Hospice Claims	01/06/2014	8358
<u>R2748CP</u>	07/26/2013	Demand Billing of Hospice General Inpatient Level of Care	01/06/2014	8371
<u>R2747CP</u>	07/26/2013	Additional Data Reporting Requirements for Hospice Claims – Rescinded and replaced by Transmittal 2864	01/06/2014	8358
<u>R2696CP</u>	05/03/1013	Implementation of the Hospice Quality Reporting Required by the Affordable Care Act (ACA) Section 3004	10/07/2013	8241
<u>R2642CP</u>	01/31/2013	Hospice Monthly Billing Requirement	07/01/2013	8142
<u>R2482CP</u>	06/01/2012	Updates to Caps and Limitations on Hospice Payments	07/02/2012	7838
<u>R2448CP</u>	04/26/2012`	Medicare System Update to Include Claim Level Referring Physician Data and Insuring Hospice Certifying Physician Identifiers Are Fully Processed	10/01/2012	7755
<u>R2410CP</u>	02/03/2012	New Hospice Condition code for Out of Service Area Discharges	07/02/2012	7677
<u>R2391CP</u>	01/25/2012	New Hospice Condition code for Out of Service Area Discharges – Rescinded and replaced by Transmittal 2410	07/02/2012	7677
<u>R2326CP</u>	10/27/2011	Discontinuation of Hospice Late Charge Claims	04/02/2012	7556

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R2316CP</u>	10/07/2011	Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely	01/09/2012	7478
<u>R2258CP</u>	07/29/2011	Correction to Processing of Hospice Discharge Claims	01/03/2012	7473
<u>R1955CP</u>	04/28/2010	New Hospice Site of Service Code	10/04/2010	6905
<u>R1907CP</u>	02/05/2010	Medicare Systems Edit Refinements Related to Hospice Services	07/06/2010	6778
<u>R1897CP</u>	01/29/2010	Associating Hospice Visits to the Level of Care	04/29/2010	6791
<u>R1885CP</u>	12/23/2009	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness	01/04/2010	6540
<u>R1870CP</u>	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
<u>R1863CP</u>	11/27/2009	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness – Rescinded and replaced by Transmittal 1870	01/04/2010	6540
<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	07/06/2009	6332

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		(CWF) for Late Recertification		
<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
<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

Rev #	Issue Date	Subject	Impl Date	CR#
<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 Wage Index and the Hospice Pricer for FY 2005	10/04/2004	3386
<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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