CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3866	**Date: September 26, 2017**
	Change Request 10064

Transmittal 3813, dated July 27, 2017, is being rescinded and replaced by Transmittal 3866, dated, September 26, 2017 to revise the condition and occurrence codes in the manual. All other information remains the same.

SUBJECT: Accepting Hospice Notices of Election via Electronic Data Interchange

I. SUMMARY OF CHANGES: This Change Request will allow the submission of Notices of Election (NOEs) to be accepted via Electronic Data Interchange (EDI).

EFFECTIVE DATE: January 1, 2018 - Transactions received on or after January 1, 2018.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/Table of Contents
R	11/20.1/Procedures for Hospice Election and Related Transactions
R	11/20.1.1/Notice of Election (NOE)
R	11/20.1.2/Notice of Termination/Revocation (NOTR)
R	11/20.1.3/Change of Provider/Transfer Notice
N	11/20.1.4/Cancellation of an Election
N	11/20.1.5/Change of Ownership Notice
R	11/30.3/Data Required on the Institutional Claim to A/B MAC (HHH)
R	11/40.1.3/Independent Attending Physician Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3866	Date: September 26, 2017	Change Request: 10064

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SUBJECT: Accepting Hospice Notices of Election via Electronic Data Interchange

EFFECTIVE DATE: January 1, 2018 - Transactions received on or after January 1, 2018.
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IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: To be covered by the Medicare hospice benefit, a beneficiary must sign an election statement, indicating their choice of hospice care instead of curative treatment. The hospice notifies the Medicare program that a beneficiary's election is on file by submitting a Notice of Election (NOE). The NOE is a submitted like a claim. The hospice key-enters the NOE information into the Medicare contractor's Direct Data Entry (DDE) screens. The NOE processes through Medicare claims systems, which updates beneficiary records and later uses the information to adjudicate hospice claims.

Currently, hospices may only submit NOEs using DDE or paper claim submissions. The hospice industry has requested that Medicare implement submission of NOEs via electronic data interchange (EDI). Receipt of NOEs via EDI would support Medicare business needs, since prompt and error-free NOEs are increasingly important to a variety of payment policies. EDI transmission of NOEs would reduce, and potentially eliminate, problems with NOEs that result from errors during the Direct Data Entry process. Hospices could export data from their electronic medical record or other software system into the EDI format without human intervention.

B. Policy: Medicare contractors and hospices may develop trading partner agreements to exchange NOE and related transaction data using a non-standard implementation of the 837I transaction. Medicare will develop a companion guide for NOE transmissions. This guide will provide hospices instructions for how to complete data elements that are required by the 837I transaction but are not required by an NOE. Hospices may voluntarily agree to adopt the companion guide and submit non-standard 837I transactions.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10064.1	The contractor shall accept hospice notice of election data, and related transactions, by electronic submisson of the 837I. This includes types of bill 8XA, 8XB, 8XC, 8XD, and			X		X				CCEM

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	8XE.									
10064.2	The contractor shall remove all claim information received on an electronic NOE that is not required for NOE processing. The information will be removed prior to placing the NOE into FISS.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charles Nixon, Charles.Nixon@cms.hhs.gov , Wilfried Gehne, Wilfried.Gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims
Table of Contents
(Rev.3866, Issued: 09-26-17)

20.1 - Procedures for Hospice Election *and Related Transactions*
(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

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)
(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

When a Medicare beneficiary elects hospice services, hospices must complete form locators identified below for the Uniform (Institutional Provider) Bill (Form CMS-1450), which is an election notice.

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 A/B MAC (HHH) and accepted by the A/B MAC (HHH) 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 A/B MAC (HHH) 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 A/B MAC (HHH). 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 A/B MAC (HHH) 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 A/B MAC (HHH); or,

4. other circumstances determined by the A/B MAC (HHH) 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.

When an NOE is submitted within the five day timely filing period, but the NOE contains inadvertent errors (such as a beneficiary identifier that has recently changed), the error does not trigger the NOE to be immediately returned to the hospice for correction. In these instances, the hospice must wait until the incorrect information is fully processed by Medicare systems before the NOE is returned to the hospice for correction.
There are other NOE errors, such as an incorrect admission date, that will not be returned for correction and instead must be finalized and posted by the Medicare systems before the hospice can correct the NOE. Only the hospice is aware of the error. Such delays in Medicare systems could cause the NOE to be late.

Delays due to Medicare system constraints are outside the control of the hospice and may qualify for an exception to the timely filing requirement.

Medicare contractors shall grant an exception for the late NOE if the hospice is able to provide documentation showing:

(1) When the original NOE was submitted;

(2) When the NOE was returned to the hospice for correction or was accepted and available for correction and;

(3) Evidence the hospice resubmitted the returned NOE within two business days of when it was available for correction or cancelled an accepted NOE within two business days and submitted the new NOE within two business days after the date that the cancellation NOE finalized.

The hospice shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the case. If the remarks are not sufficient, Medicare contractors shall request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above.

Medicare contractors shall not grant exceptions if:

- *the hospice can correct the NOE without waiting for Medicare systems actions*
- *the hospice submits a partial NOE to fulfill the timely-filing requirement, or*
- *hospices with multiple provider identifiers submit the identifier of a location that did not actually provide the service*

In the great majority of cases, the five day timely filing period allows enough time to submit NOEs on a day when Medicare systems are available (i.e. the period allows for ("dark days"). Additionally, the receipt date is typically applied to the NOE immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, f the hospice can provide documentation showing an NOE is submitted on the day before a dark day period and the NOE does not receive a receipt date until the day following the dark days, the contractor shall grant an exception to the timely filing requirement. CMS expects these cases to be very rare.

Hospices must send the Form CMS-1450 Election Notice to the A/B MAC (HHH) by mail, *electronic data interchange (EDI)*, or direct data entry (DDE) depending upon the arrangements with the A/B MAC (HHH). 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.

Hospices complete the following data elements when submitting an NOE.

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:

81A - Hospice (Nonhospital-Based) Initial Election Notice
82A - Hospice (Hospital-Based) Initial Election Notice

Statement Covers Period *(From-Through)*

The hospice enters the From date of this hospice election. A Through date is not required on NOEs.

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

Show the month, day, and year of birth numerically as MM-DD-YYYY.

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. *When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the new admission date cannot be the same as the revocation or discharge date of the previous benefit period.*

The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is January 1, 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.

Condition Codes

Condition codes are not required on an original NOE. If the hospice is correcting an election date using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the NOE will be returned to the hospice.

Occurrence Codes and Dates

The hospice reports occurrence code 27 and the date of certification. This date must match the FROM date and ADMIT DATE.

Hospices may submit an NOE that corrects an election date previously submitted in error. In this case, the hospice reports the correct election date in the From and Admission Date fields and reports the original election date using occurrence code 56.

Release of Information

Valid values are:

I *- Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes*

Y *- Yes, provider has a signed statement permitting release of information.*

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

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.

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.

20.1.2 - *Notice of Termination/Revocation (NOTR)*

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

NOTR is used when the hospice beneficiary is discharged alive from the hospice or revokes the election of hospice services. An NOTR should not be used when a patient is transferred.

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), unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) 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 A/B MAC (HHH) 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.

Type of Bill

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

81B- Hospice (Nonhospital-Based) NOTR
82B- Hospice (hospital-Based) NOTR

***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.

Note: If the beneficiary transferred to your hospice during the benefit period, the From date should reflect the date of transfer.

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

Show the month, day, and year of birth numerically as MM-DD-YYYY.

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.

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

Facility Zip Code

Enter the hospice's ZIP code (9-digit). The ZIP code entered must match the ZIP code in the Master Address field of the provider's address file.

Condition Codes

Condition codes are not required on an original NOTR. If the hospice is correcting a revocation date using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the NOTR will be returned to the hospice.

Occurrence Codes and Dates

Hospices may submit an NOTR that corrects a revocation date previously submitted in error. In this case, the hospice reports the correct revocation date in the Through Date field and reports the original revocation date using occurrence code 56.

Release of Information

Valid values are:

I - *Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes*

Y - *Yes, provider has a signed statement permitting release of information*

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

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– *Change of Provider/Transfer Notice*

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

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. The 8XC does not get submitted until after the other provider has finalized their billing.

Type of Bill

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

81C - Hospice (Nonhospital-Based) Change of provider
82C - Hospice (Hospital-Based) Change of provider

Statement Covers Period *(From-Through)*

The "From" date would be the date the change is effective. No through date is required.

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

Show the month, day, and year of birth numerically as MM-DD-YYYY.

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 receiving 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 new admission date cannot be the same as the revocation or discharge date of the previous benefit period.

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

Occurrence Code/Date

An occurrence code 27 is not required on a transfer NOE, unless the date of transfer is also the first day of the next benefit period.

Release of Information

Valid values are:

I-*Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes*

Y*-Yes, provider has a signed statement permitting release of information.*

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

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.

20.1.4 – Cancellation of an Election

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

A notice of cancellation is used when the beneficiary will not be receiving services from the hospice, but the admission date has already been entered. The entered dates will be voided since the beneficiary never participated with the hospice.

Type of Bill

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

81D - Hospice (Nonhospital-Based) Void/Cancel hospice election
82D - Hospice (Hospital-Based) Void/Cancel hospice election

***Statement Covers Period** (From-Through)*

When cancelling an NOE, the hospice enters the statement covers period "from" date of the NOE that is being canceled.
Through Date-Not required

When cancelling a benefit period, the hospice enters the "start" date of the benefit period that is being canceled.
Through Date-A 'TO' date is required if a revocation indicator has been posted to the benefit period being canceled. The 'TO' date must reflect the termination date of the revoked benefit period.

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

Show the month, day, and year of birth numerically as MM-DD-YYYY.

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

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

Release of Information

Valid values are:

***I**-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,*

***Y**-Yes, provider has a signed statement permitting release of information.*

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

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.

20.1.5 – Change of Ownership Notice

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

A change of ownership notice is used when the beneficiary will remain with the same hospice, but the person or group running the hospice is changing. A Change of Ownership typically occurs when a Medicare provider has been purchased (or leased) by another organization.

Type of Bill

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

81E - Hospice (Nonhospital-Based) Change of Ownership
82E - Hospice (Hospital-Based) Change of Ownership

***Statement Covers Period** (From-Through)*

The "From" date would be the date the change is effective. No through date is required.

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

Show the month, day, and year of birth numerically as MM-DD-YYYY.

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.

The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is January 1, 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.

Release of Information

Valid values are:

***I**-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,*

***Y**-Yes, provider has a signed statement permitting release of information.*

Provider Number

The hospice enters their NPI. When a hospice agency changes ownership and a new Medicare provider number issued, the A/B Medicare Administrative Contractor (MAC) must be notified to update the provider number in the hospice period. This will avoid mistaking the change as a beneficiary-elected transfer.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

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.

30.3 - Data Required on the Institutional Claim to A/B MAC (HHH)

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, for coverage requirements for Hospice benefits. This section addresses only *claims submission*. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the A/B MAC (HHH). 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

The hospice enters on of the following Type of Bill codes:

081x – Hospice (non-hospital based)
082x – Hospice (hospital based)

4th **Digit – Frequency**	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The **"**Through" date of this bill is the discharge date, transfer date, or date of death.
7 - Replacement of Prior Claim	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.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim.

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.
Statement periods should follow the frequency of billing instructions in section 90.

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 Moves Out of Service Area	*Condition Code 52*
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 Revokes	*Occurrence code 42*

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 A/B MAC (HHH) and accepted by the A/B MAC (HHH) 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 A/B MAC (HHH) 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.

A patient can also be admitted and discharged on the same day. They would submit an 8x1 Type of Bill ("Admission through Discharge Claim"), matching "From" and "Through" dates, and whatever the appropriate level of care the revenue code was, with 1 unit. A patient cannot be discharged and re-admitted to the same hospice on the same day.

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. *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.

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

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.

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.
85	Delayed recertification of hospice terminal illness	Code indicates the hospice received the recertification of terminal illness later than 2 days after the first day of a new benefit period. This code is reported with occurrence span code 77,

		which reports the provider liable days associated with the untimely recertification.

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 (A/B MAC (HHH) USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an A/B MAC (HHH) as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. **NOTE:** regarding transfers from one hospice to another hospice: If a patient is in the first certification period when they transfer to another hospice, the receiving hospice would use the same certification date as the previous hospice until the next certification period. However, if they were in the next certification at the time of transfer, then they would enter that date in the Occurrence Code 27 and date.
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit. It is not used in transfer situations.
55	*Beneficiary is Deceased*	*Report the appropriate NUBC discharge status code that best describes the place in which the beneficiary died (40, 41, or 42). Discharge status code 20 is not used on hospice claims.*

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 17$^{th)}$ 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 – 07/05/XX

- M2 0715XX – 07/17/XX

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 A/B MAC (HHH) and accepted by the A/B MAC (HHH) 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 A/B MAC (HHH). The date the NOE is submitted to and accepted by the A/B MAC (HHH) is an allowable day for payment.

  Example:
  Admission date is 10/10/20*XX* (Fri).
  Day 1 = Sat. 10/11/20*XX*
  Day 2 = Sun. 10/12/20*XX*
  Day 3 = Mon. 10/13/20*XX*
  Day 4 = Tues. 10/14/20*XX*
  Day 5 = Weds. 10/15/20*XX* 10/15/20*XX* is the NOE Due Date.

  IF NOE Receipt date is 10/16/20*XX*, the hospice reports 10/10- 10/15 as non-covered days using occurrence span code 77 *or Medicare systems* return 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)	MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered. A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care. Hospices must report value code 61 when billing revenue codes 0651 and 0652.
G8	Facility where Inpatient Hospice Service is Delivered (General	MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility where

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

If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, the hospice reports the CBSA that applies at the end of the billing period. For routine home care and continuous home care (e.g., the beneficiary's residence changes between locations in different CBSAs), report the CBSA of the beneficiary's residence at the end of the billing period. For general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs), report the CBSA of the latest facility that served the beneficiary. If the beneficiary receives both home and inpatient care during the billing period, the latest home CBSA is reported with value code 61 and the latest facility CBSA is reported with value code G8.

Revenue Codes

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

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.

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 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)

Code	Description	Standard Abbreviation

- ** The date of discharge from general *inpatient* or inpatient *respite* 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 *inpatient* 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. Procedure codes are required in order for the A/B MAC (HHH) to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the A/B MAC (HHH).

Additional revenue codes are reported describing the visits provided under each level of care.

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, 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. *During an initial or comprehensive assessment, it would not be best practice to wait until later (after the clinician has left the home) to document the findings of an assessment or the interventions provided during a patient visit. It is recommended that this information be documented as close to the time of the assessment or intervention as possible.* 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.

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.

When making the determination as to whether or not a particular visit should be reported, a hospice should consider whether the visit would have been reported, and how it would have been reported, if the patient were receiving RHC in his or her private home. If a group of tasks would normally be performed in a single visit to a patient living in his or her private home, then the hospice should count the tasks as a single visit for the patient residing in a facility. Hospices should not record a visit every time a staff member enters the patient's room. Hospices should use clinical judgment in counting visits and summing time.

Hospices report social worker phone calls and *all* visits performed by hospice staff in 15 minute increments using the following revenue codes and associated HCPCS. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists

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.
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. 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.

Hospices must enter the following visit revenue codes, when applicable:

Revenue Code	Required HCPCS	Required Detail
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.*
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 (before 01/01/2016)) G0299 or G0300 (on or after 01/01/2016)	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.
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).*

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.

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 contractor shall use the following remittance advice messages and associated codes when bundling line items under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO

CARC: 97
RARC: N/A
MSN: N/A

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

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.

HCPCS/Accommodation Rates/HIPPS Rate Codes
Hospices must 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.

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).

These service location HCPCS codes are not required on revenue code lines describing the visits provided under each level of care. *These lines report the HCPCS codes shown in the table under Revenue Codes.*

Modifiers

The following modifier is required reporting for claims:

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:

KX - *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 A/B MAC (HHH) to request the documentation supporting the request for an exception. Based on that documentation, the A/B MAC (HHH) shall determine if a circumstance encountered by a hospice qualifies for an exception.*

If the request for an exception is approved by the A/B MAC (HHH), the A/B MAC (HHH) 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 A/B MAC (HHH) finds that the documentation does not support allowing an exceptional circumstance, the A/B MAC (HHH) shall process the claim as submitted.

The contractor shall use the following remittance advice messages and associated codes under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three

Group Code: CO
CARC: 96
RARC: MA54
MSN: N/A

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

Modifier GV may be used to identify attending physician services performed by a nurse practitioner.

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).

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 *level of care* 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.

Service *reporting* revenue codes – report dates as described in the table above under Revenue Codes.

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

Service Units

The hospice enters the number of units for each type of service. Units are measured in days for revenue codes 651, 655, and 656. , *Units* for revenue code 652 are reported in 15-minute increments.

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.

Report units *for service reporting lines* 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

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 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

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

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, 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) will result in the claim being returned to the provider.

40.1.3 - Independent Attending Physician Services

(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)

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 of the Benefit Policy Manual, 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 A/B MAC (B) 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 A/B MAC (B) 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 A/B MAC (B), 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 A/B MAC (B) 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 *substitute* physician are billed by the designated attending physician *under either the reciprocal billing or fee-for-time compensation arrangement (formerly referred to as Locum Tenens Arrangements) 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 A/B MAC (HHH).

A/B MACs (B) 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. A/B MACs (B) use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

Attachment 1: Proposed NOE Companion Guide

The guide below will be posted on the CMS website shortly after the publication of CR 10064.

CMS

Companion Guide Transaction Information

Instructions related to the Non-Standard Use of the 837 Health Care Claim: Institutional Transaction as a Hospice Notice of Election based on ASC X12 Technical Report Type 3 (TR3), version 005010A2

Companion Guide Version Number: 1.0

Month xx, 2017

Preface

Companion Guides (CGs) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is in conformance with ASC X12's Fair Use and Copyright statements.

Table of Contents

Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.1.4 Use for a Non-HIPAA Transaction

This Transaction Instruction uses a standard transaction format for the submission of hospice Notices of Election (NOEs). The NOE is not a HIPAA-covered

transaction. It does not meet the definition of a claim or encounter at 45 CFR § 162.1101 because it does not request payment or report health care services.

While the contents of this Transaction Instruction meet the compliance requirements described in sections 1.1.2 and 1.1.3, this is a non-standard use of 837I Implementation Guide. Medicare-participating hospices may adopt the use of this Transaction Instruction for NOEs on a strictly voluntary basis and as an optional extension of their existing trading partner agreement with the Medicare program and their Medicare Administrative Contractor.

Medicare encourages hospice to submit groups of NOEs in separate batch transmissions from groups of claims. This practice may reduce the risk that translator-level rejections related to NOEs, if they occur, could impact payments to the hospice.

NOEs will receive 277CA acknowledgements.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X223A2	Health Care Claim: Institutional (837)

3. Instruction Table

This table contains rows for where supplemental instruction information is located. The order of table content follows the order of the implementation transaction set as presented in the corresponding implementation guide.

Category 1. Situational Rules that explicitly depend upon and reference knowledge of the transaction receiver's policies or processes.

Category 2. Technical characteristics or attributes of data elements that have been assigned by the payer or other receiving entity, including size, and character sets applicable, that a sender must be aware of for preparing a transmission.

Category 3. Situational segments and elements that are allowed by the implementation guide but do not impact the receiver's processing. (applies to inbound transactions)

Category 4. Optional business functions supported by an implementation guide that an entity doesn't support.

Category 5. To indicate if there needs to be an agreement between PAYER and the transaction sender to send a specific type of transaction (claim/encounter or specific kind of benefit data) where a specific mandate doesn't already exist.

Category 6. To indicate a specific value needed for processing, such that processing may fail without that value, where there are options in the TR3.

Category 7. TR3 specification constraints that apply differently between batch and real- time implementations, and are not explicitly set in the guide.

Category 8. To identify data values sent by a sender to the receiver.

Category 9. To identify processing schedules or constraints that are important to trading partner expectations.

Category 10. To identify situational data values or elements that are never sent.

005010X223A2 Health Care Claim: Institutional Submitted as a Hospice Notice of Election (NOE)

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Errors identified for business level edits performed prior to the SUBSCRIBER LOOP (2000B) will result in immediate file failure at that point. When this occurs, no further editing will be performed beyond the point of failure.	9
				The billing provider must be associated with an approved electronic submitter. NOEs submitted for billing providers that are not associated to an approved electronic submitter will be rejected.	9
				Contractor will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be	2

Loop ID	Reference	Name	Codes	Notes/Comments	Category
				Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.	9
				Medicare requires the National Provider Identifier (NPI) be submitted as the identifier for all NOEs. NOEs submitted with legacy identifiers will be rejected.	6
				National Provider Identifiers will be validated against the NPI algorithm. NOEs which fail validation will be rejected.	2
				All dates that are submitted on an incoming 837 transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the NOE or the applicable interchange (transmission).	2
	ISA05	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA05	6
	ISA06	Interchange Sender ID		Contractor will reject an interchange (transmission) that does not contain a valid ID in ISA06.	6
	ISA07	Interchange ID Qualifier	28, ZZ	Contractor will reject an interchange (transmission) that does not contain 28 or ZZ in ISA07.	6
	ISA12	Interchange Control Version Number		Contractor will reject an interchange (transmission) that does not contain 00501 in ISA12.	6
				Contractor will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).	4
				Contractor will only process one transaction type per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	4
	GS03	Application Receiver's Code		Contractor will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the contractor definition.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
	GS04	Functional Group Creation Date		Contractor will reject an interchange (transmission) that is submitted with a future date.	6
				Contractor will only accept claims and NOEs for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.	4
	ST01	Transaction Set Identifier Code	837	Trading partners acknowledge that although '837' is the submitted in this data element, an NOE is not a health care claim under the HIPAA definition.	5
	ST02	Transaction Control Set		Contractor will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	6
	BHT02	Transaction Set Purpose Code	00	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	6
	BHT06	Claim/Encounter Identifier	CH	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE). This is because the NOE is simulating a claim, not because any charges being made.	6
1000A	NM109	Submitter ID		Contractor will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	5
1000B	NM103	Receiver Name		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC name (NM1).	5
1000B	NM109	Receiver Primary Identifier		Contractor will reject an interchange (transmission) that is not submitted with a valid Part A MAC code (NM1). Each individual Contractor determines this	5
2000B	HL04	Hierarchical Child Code	0	The value accepted is "0". Submission of "1" will cause your file to reject.	6
2000B	SBR01	Payer Responsibility Sequence Number Code	P	Submit all NOEs as "P" for primary, since payer sequence is not relevant to identifying an election.	6
2000B	SBR02, SBR09	Subscriber Information		For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.	6
2010AC	Loop Rule	PAY TO PLAN LOOP		Must not be present. Submission of this loop will cause your NOE to reject.	4

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2010BA	NM102	Subscriber Entity Type Qualifier	1	The value accepted is 1. Submission of value 2 will cause your NOE to reject.	6
2010BA	NM108	Subscriber Identification Code Qualifier	MI	The value accepted is "MI". Submission of value "II" will cause your NOE to reject.	6
2010BA	NM109	Subscriber Identification Code		Must be in the format of AAANNNNNNNNN or ANNNNNN or AANNNNNN or AANNNNNNNNN or AAANNNNNN or NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN ("A" - alpha character, "N" - numeric digit). Submission of other formats will cause your NOE to reject.	6
2010BA	DMG02	Subscriber Birth Date		Must not be a future date. Must be present.	6
2010BA	REF – Segment Rule	SUBSCRIBER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2010BB	NM108	Payer Identification Code Qualifier	PI	The value accepted is "PI". Submission of value "XV" will cause your NOE to reject.	6
2010BB	REF – Segment Rule	PAYER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2010BB	REF – Segment Rule	BILLING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2000C	HL – Segment Rule	PATIENT HIERARCHICAL LEVEL		Must not be present. Submission of this segment will cause your NOE to reject.	4
2000C	PAT – Segment Rule	PATIENT INFORMATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2010CA	Loop Rule	PATIENT NAME LOOP		Must not be present. Submission of this loop will cause your NOE to reject.	4
2300	CLM02	Total Submitted Charges		NOEs are submitted with a zero charge amount.	8
2300	CLM05 - 1	Facility Type Code	81, 82	Must identify the facility type as a hospice	6
2300	CLM05-3	Claim Frequency Type Code	A, B, C, D, E	Must report a valid NUBC code representing an NOE or NOE-related transaction.	6
2300	DTP03	Admission Date		Must not be a future date.	6

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2300	CL102	Admission Source Code	1	Not normally required by an NOE, but required by the 837I format. Submit a default value of '1.'	6
2300	CL103	Patient Status Code	30	Not normally required by an NOE, but required by the 837I format. Submit a default value of '30.'	6
2300	CN1 – Segment Rule	CONTRACT INFORMATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2300	REF – Segment Rule	PAYER CLAIM CONTROL NUMBER		Must not be present. Submission of this segment will cause your NOE to reject.	4
2310A	REF – Segment Rule	ATTENDING PROVIDER SECONDARY IDENTIFICATION		Must not be present. Submission of this segment will cause your NOE to reject.	4
2400	SV2 segment	INSTITUTIONAL SERVICE LINE		Not normally required by an NOE, but required by the 837I format. Submit a single SV2 segment with the default values listed below.	6
2400	SV201	Product/Service ID	0650	Submit revenue code 0650 (Hospice Services – General Classification)	6
2400	SV202-1	Product or Service ID Qualifier	HC	Submit qualifier HC.	6
2400	SV202-2	Product/Service ID	Q5009	Not normally required by an NOE, but required by the 837I format. Submit HCPCS Q5009 since the hospice site of service may not be determined at the time of submission.	6
2400	SV203	Monetary Amount		Submit a zero charge amount.	6
2400	SV205	Quantity	1	Submit 1 unit.	6
2400	DTP03	DATE - SERVICE DATE		Must not be a future date.	6

The instructions in the table above supplement existing Medicare guidance on submission of NOEs in Pub. 100-04, chapter 11, section 20, which satisfy many other required fields on the 837I. Additional fields may be required by the 837I claim which can be completed based entirely on instructions in the TR3 itself.

4. TI Additional Information

4.1 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources during the transition year.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/
Central Version 005010 and D.0 Webpage on CMS website	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/40_Educational_Resources.html
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	http://www.cms.gov/MFFS5010D0/
Frequently Asked Questions	https://questions.cms.gov/
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/

Attachment 2: Transaction Completeness Edits

The NOE Companion Guide describes how to complete various fields with compliant data when a variety of options exist for required fields. To successfully process, the NOE must also pass basic claim completion edits that are not specified in the Companion Guide because the required information is specified in the 837 Institutional TR3. The table below provides a list of these edits.

Segment or Element	Description	Loop	Values	Edits
NM1	**SUBMITTER NAME**	**1000A**		**1000A.NM1 must be present.**
NM101	Entity Identifier Code		41	1000A.NM101 must be present.
NM102	Entity Type Qualifier		1, 2	1000A.NM102 must be present.
NM103	Submitter Last or Organization Name			1000A.NM103 must be present.
NM104	Submitter First Name			If 1000A.NM102 is "2", 1000A.NM104 must not be present.
NM108	Identification Code Qualifier		46	1000A.NM108 must be present.
NM109	Submitter Identifier			1000A.NM109 must be present.
PER	**SUBMITTER EDI CONTACT INFORMATION**	**1000A**		**1000A.PER must be present.**
PER01	Contact Function Code		IC	1000A.PER01 must be present.
PER03	Communication Number Qualifier		EM, FX. TE	1000A.PER03 must be present.
PER04	Communication Number			1000A.PER04 must be present.
NM1	**RECEIVER NAME**	**1000B**		**1000B.NM1 must be present.**
NM101	Entity Identifier Code		40	1000B.NM101 must be present.
NM102	Entity Type Qualifier		2	1000B.NM102 must be present.
NM103	Receiver Name			1000B.NM103 must be present.

NM108	Identification Code Qualifier		46	1000B.NM108 must be present.
NM109	Receiver Primary Identifier			1000B.NM109 must be present. (contractor number)
NM1	**Billing Provider Name**	**2010AA**		**2010AA.NM1 must be present.**
NM101	Entity Identifier Code		85	2010AA.NM101 must be present.
NM102	Entity Type Qualifier		2	2010AA.NM102 must be present.
NM103	Billing Provider Last or Organizational Name			2010AA.NM103 must be present.
NM108	Identification Code Qualifier		XX	2010AA.NM108 must be present.
NM109	Billing Provider Identifier			2010AA.NM109 must be valid according to the NPI algorithm.
N3	**BILLING PROVIDER ADDRESS**	**2010AA**		**2010AA.N3 must be present.**
N301	Billing Provider Address Line			2010AA.N301 must be present.
N4	**BILLING PROVIDER CITY/STATE/ZIP CODE**	**2010AA**		**2010AA.N4 must be present.**
N401	Billing Provider City Name			2010AA.N401 must be present.
N402	Billing Provider State or Province Code			2010AA.N402 must be a valid state code.
N403	Billing Provider Postal Zone or ZIP Code			2010AA.N403 must be a valid 9 digit zip code.
REF	**BILLING PROVIDER TAX**	**2010AA**		**2010AA.REF must be present.**

	IDENTIFICATION			
REF01	Reference Identification Qualifier		EI	2010AA.REF01 must be present.
REF02	Billing Provider Additional Identifier			2010AA.REF02 must be present.
SBR	**SUBSCRIBER INFORMATION**	**2000B**		**2000B.SBR must be present.**
SBR01	Payer Responsibility Sequence Number Code		A, B, C, D, E, F, G, H, P, S, T, U	2000B.SBR01 must be "S" or "P" or "T".
SBR02	Individual Relationship Code		18	2000B.SBR02 must be "18".
SBR09	Claim Filing Indicator Code		11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	2000B.SBR09 must be "MA".
NM1	**SUBSCRIBER NAME**	**2010BA**		**2010BA.NM1 must be present.**
NM101	Entity Identifier Code		IL	2010BA.NM101 must be present.
NM102	Entity Type Qualifier		1, 2	2010BA.NM102 must be "1".
NM103	Subscriber Last Name			2010BA.NM103 must be present.
NM104	Subscriber First Name			2010BA.NM104 must be present.
NM108	Identification Code Qualifier		II, MI	2010BA.NM108 must be "MI".
NM109	Subscriber Primary Identifier			2010BA.NM109 must be present. HIC or MBI

N3	**SUBSCRIBER ADDRESS**	**2010BA**		**2010BA.N3 must be present when 2000B.SBR02 is "18".**
N301	Subscriber Address Line			2010BA.N301 must be present.
N4	**SUBSCRIBER CITY/STATE/ZIP CODE**	**2010BA**		**2010BA.N4 must be present when 2000B.SBR02 is "18".**
N401	Subscriber City Name			2010BA.N401 must be present.
N402	Subscriber State Code			If 2010BA.N404 is not present, 2010BA.N402 must be present.
N403	Subscriber Postal Zone or ZIP Code			2010BA.N403 must be a valid postal/zip Code
DMG	**SUBSCRIBER DEMOGRAPHIC INFORMATION**	**2010BA**		**2010BA.DMG must be present.**
DMG01	Date Time Period Format Qualifier		D8	2010BA.DMG01 must be present.
DMG02	Subscriber Birth Date		CCYYMMDD	2010BA.DMG02 must be present.
DMG03	Subscriber Gender Code		F, M, U	2010BA.DMG03 must be present.
NM1	**PAYER NAME**	**2010BB**		**2010BB.NM1 must be present.**
NM101	Entity Identifier Code		PR	2010BB.NM101 must be present.
NM102	Entity Type Qualifier		2	2010BB,NM102 must be present.
NM103	Payer Name			2010BB.NM103 must be present.
NM108	Identification Code Qualifier		PI, XV	2010BB.NM108 must be "PI".
NM109	Payer Identifier			2010BB.NM109 must be present.

CLM	**CLAIM INFORMATION**	**2300**		**2300.CLM must be present.**
CLM01	Patient Control Number			2300.CLM01 must be present.
CLM02	Total Claim Charge Amount			2300.CLM02 must be present.
CLM05-1	Facility Type Code			2300.CLM05-1 must be present.
CLM05-2	Facility Code Qualifier		A	2300.CLM05-2 must be present.
CLM05-3	Claim Frequency Code			2300.CLM05-3 must be the 3rd position of a valid Uniform Bill Type Code.
CLM07	Medicare Assignment Code		A, B, C	2300.CLM07 must be present.
CLM08	Benefits Assignment Certification Indicator		N, W, Y	2300.CLM08 must be present.
CLM09	Release of Information Code		I, Y	2300.CLM09 must be present.
DTP	**DATE - STATEMENT DATES**	**2300**		**2300.DTP must be present.**
DTP01	Date Time Qualifier		434	2300.DTP01 must be present.
DTP02	Date Time Period Format Qualifier		RD8	2300.DTP02 must be present.
DTP03	Statement From or To Date		CCYYMMDD-CCYYMMDD	2300.DTP03 must be present.
DTP	**DATE - ADMISSION DATE/HOUR**	**2300**		**Only one iteration of 2300.DTP with DTP01 = "435" is allowed.**
DTP01	Date Time Qualifier		435	2300.DTP01 must be present.

DTP02	Date Time Period Format Qualifier		D8, DT	2300.DTP02 must be present.
DTP03	Admission Date and Hour		CCYYMMDD, CCYYMMDDHHMM	2300.DTP03 must be present.
CL1	**INSTITUTIONAL CLAIM CODE**	**2300**		**2300.CL1 must be present.**
CL101	Priority (Type) of Admission or Visit Code			2300.CL101 must be a valid Priority (Type) of Admission or Visit code.
CL102	Point of Origin for Admission or Visit Code			2300.CL102 must be present when 2300.CLM05-1 is not "14".
CL103	Patient Status Code			2300.CL103 must be a valid Patient Status Code. When 2300.CL103 value “20”, “40”, “41”, or “42” is present, at least one occurrence of 2300.HI01-2 thru HI12-2 must = “55” where HI01-1 is “BH”.
HI	**PRINCIPAL DIAGNOSIS**	**2300**		**2300.HI with HI01-1 = "BK" or "ABK" must be present.**
HI01-1	Code List Qualifier Code		ABK, BK	2300.HI01-1 must be present.
HI01-2	Industry Code			2300.HI01-2 must be present.
HI01-2				must be a valid ICD-9 or 10 Diagnosis code.
HI	**OCCURRENCE INFORMATION**	**2300**		
HI01-1	Code List Qualifier Code		BH	2300.HI01-1 must be "BH".
HI01-2	Occurrence Code			
HI01-4	Date Time Period		CCYYMMDD	

NM1	**ATTENDING PROVIDER NAME**	**2310A**		**If present, only one iteration of 2310A.NM1 is allowed.**
NM101	Entity Identifier Code		71	2310A.NM101 must be present.
NM102	Entity Type Qualifier		1	2310A.NM102 must be present.
NM103	Name Last			2310A.NM103 must be present.
NM108	Identification Code Qualifier		XX	2310A.NM108 must be "XX".
NM109	Identifier			2310A.NM109 must be valid according to the NPI algorithm.
NM1	**SERVICE FACILITY LOCATION NAME**	**2310E**		**Only one iteration of 2310E.NM1 is allowed.**
NM101	Entity Identifier Code		77	2310E.NM101 must be present.
NM102	Entity Type Qualifier		2	2310E.NM102 must be present.
NM103	Laboratory or Facility Name			2310E.NM103 must be present.
NM108	Identification Code Qualifier		XX	2310E.NM108 must be "XX".
NM109	Laboratory or Facility Primary Identifier			2310E.NM109 must be present if 2310E.NM108 is present.
N3	**SERVICE FACILITY LOCATION ADDRESS**	**2310E**		**If 2310E.NM1 is present, 2310.N3 must be present.**
N301	Laboratory or Facility Address Line			2310E.N301 must be present.
N302	Laboratory or Facility Address Line			If present, 2310E.N302 must contain at least one non-space character.

N4	**SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE**	**2310E**		**If 2310E.N3 is present, 2301E.N4 must be present.**
N401	Laboratory or Facility City Name			2310E.N401 must be present.
N402	Laboratory or Facility State or Province Code			2310E.N402 must be a valid state code.
N403	Laboratory or Facility Postal Zone or ZIP Code			2310E.N403 must be a valid 9 digit zip code.
NM1	**REFERRING PROVIDER NAME**	**2310F**		**Only one iteration of 2310F.NM1 with NM101 = "DN" is allowed.**
NM101	Entity Identifier Code		DN	2310F.NM101 must be present.
NM102	Entity Type Qualifier		1	2310F.NM102 must be present.
NM103	Referring Provider Last Name			2310F.NM103 must be present.
NM108	Identification Code Qualifier		XX	2310F.NM108 must be "XX".
NM109	Referring Provider Identifier			2310F.NM109 must be valid according to the NPI algorithm.
LX	**SERVICE LINE NUMBER**	**2400**		**2400.LX must be present.**
LX01	Assigned Number			2400.LX01 must be present.
SV2	**INSTITUTIONAL SERVICE LINE**	**2400**		**2400.SV2 must be present.**
SV201	Revenue Code			2400.SV201 must be a valid revenue code.

SV202-1	Product or Service ID Qualifier		ER, HC, HP, IV, WK	2400.SV202-1 must be "HP" or "HC".
SV202-2	Procedure Code			When 2400.SV202-1 = "HC", 2400.SV202-2 must be a valid HCPCS Code. When 2400.SV202-1 = "HP", 2400.SV202-2 must be a valid HIPPS Code.
SV203	Line Item Charge Amount			2400.SV203 must be present.
SV204	Unit or Basis for Measurement Code		DA, UN	2400.SV204 must be present.
SV205	Service Unit Count			2400.SV205 must be present.