CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4035	**Date: April 27, 2018**
	Change Request 10573

SUBJECT: Enhancements to Processing of Hospice Routine Home Care Payments

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create new fields on the hospice pricer output to display the number of days paid at the high and the number of days paid at the low routine home care rates. This CR also instructs the Fiscal Intermediary Shared System (FISS) to create an output record to match the updates to the hospice pricer output and for the Common Working File (CWF) to store with FISS the number of prior days retained for the life of the claim.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 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	1/190/Payer Only Codes Utilized by Medicare
R	11/30.3/Data Required on the Institutional Claim to A/B MAC (HHH)
R	11/130.1/Input/Output Record Layout

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: 4035	Date: April 27, 2018	Change Request: 10573

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I. GENERAL INFORMATION

A. Background: Medicare pays a higher rate for hospice services at the Routine Home Care (RHC) level of care for the first 60 days of service. These 60 days are counted on a beneficiary level across any hospice benefit periods that are not separated by a 60-day gap. The number of prior service days cannot be identified in all cases by the Fiscal Intermediary Shared System (FISS) from the face of the claim. The Common Working File (CWF) must read data from services provided at other hospices and return additional days that apply to the payment calculation to FISS.

CMS has received comments from hospice providers on the difficulties of determining which RHC days were paid at the high or low rate. CMS is looking for ways to make high vs low RHC payments more transparent. Through discussions with the Medicare Administrative Contractors (MACs), CMS believes that one way of accomplishing this transparency is to add value codes to the claim to display the number of days paid at the high and low RHC payment rates.

An additional step is to add a separate field on the claim record that will store any days from a prior period that were used in determining the count of days. This data is currently used in processing but is not stored for future reference.

Section 3132(a) of the Affordable Care Act of 2010 (ACA) authorized the collection of data as needed to revise payments for hospice care. Change Request 8358 implemented line-item reporting for hospice drugs, which became effective January 1, 2014 for voluntary reporting and April 1, 2014 for mandatory reporting. In the FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20789), CMS invited public comments regarding possible improvements for the health care delivery system that may lead to the reduction of unnecessary burdens for clinicians, other providers, and patients and their families. Commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices. CMS has determined that there is no longer a need to collect this data for the purposes of hospice payment reform; therefore, CMS believes removal of this data collection requirement is appropriate. Instead, hospices shall report total durable medical equipment (DME) and medication charges on the claim.

B. Policy: Hospices shall report a monthly charge total for all drugs (i.e., report a total charge amount for the period covered by the claim) using revenue code 0250. Hospices shall report a monthly charge total for DME (i.e., report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the item of DME and 0294 for DME infusion drugs. CMS no longer requires hospices to report a charge total and amount dispensed per drug, CMS no longer requires hospices to report injectable drugs using revenue code 0636, and CMS no longer requires hospices to report HCPCS codes for DME infusion pumps or DME drugs.

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	
10573.1	The contractor shall modify the input/output record to the Hospice Pricer to reflect the revised layout in the Medicare Claims Processing Manual, chapter 11.					X				Hospice Pricer
10573.2	The contractor shall create fields that display the number of days paid at the high RHC rate, and the number of days paid at the low RHC rate.									Hospice Pricer
10573.3	The contractor shall put the high days returned by Pricer on the claim as a value code 62 amount.					X				
10573.4	The contractor shall put the low days returned by Pricer on the claim as a value code 63 amount.					X				
10573.5	The contractor shall ensure value codes 62 and 63 are not sent on an 837I COB transaction.					X				
10573.6	The contractor shall create a new field to store the prior period days that are returned by CWF.					X				
10573.6.1	The contractor shall send the stored prior period days to the integrated data repository.					X				IDR
10573.6.2	The contractor shall ensure the prior period days are updated in the field if the prior period days are changed on an adjustment claim.					X				
10573.7	The contractor shall remove the 5196 override code from all hospice adjustments before returning the adjustment to CWF					X				
10573.8	The contractor shall allow revenue code lines with 0250 and 029X without HCPS codes and NDC on hospice claims.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10573.9	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10573.6	The prior period days refer to the PRIOR BP DAYS returned in Trailer 02 when CWF sets edit 5196.

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: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

190 – Payer Only Codes Utilized by Medicare

(Rev.4035; Issued: 04-27-18; Effective: 10-01-18; Implementation: 10-01-18)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – M9 Not used by Medicare.

MA – GI Bleed.

MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MT – Not currently used by Medicare.

MZ – IOCE error code bypass

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48 - Date hospice face-to-face encounter was untimely

49 – Original Notice of Election (NOE) receipt date

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – *On Type of Bill 032x:* HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
On Type of Bills 081x 0r 082x: Number of High Routine Home Care Days - Days that fall within the first 60 days of a routine home care hospice claim.

63 – *On Type of Bill 032x:* HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

On Type of Bills 081x 0r 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Accountable Care Organization reduction.

Q1 – Pioneer payment reduction

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – Reserved for future use

Q5 – EHR

Q6 – PQRS

Q7 – Q9 – Not used by Medicare.

QD – Device Credit

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU –Device credit with device offset

QV – Value-based purchasing adjustment amount

QW – Placeholder reserved for future use

Medicare Claims Processing Manual
Chapter 11 – Processing Hospice Claims

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

(Rev.4035; Issued: 04-27-18; Effective: 10-01-18; Implementation: 10-01-18)

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.

4th Digit – Frequency	Definition
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.

Code	Title	Definition
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 17th) and line item units reported as 3
- Revenue code 0651 with line item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line item units reported as 14.

Occurrence Span Codes:

- M2 0701XX – 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 10/10/20XX
  (Fri). Day 1 = Sat. 10/11/20XX
  Day 2 = Sun. 10/12/20XX
  Day 3 = Mon.
  10/13/20XX Day 4 =
  Tues. 10/14/20XX
  Day 5 = Weds. 10/15/20XX 10/15/20XX is the NOE Due Date.

  IF NOE Receipt date is 10/16/20XX, 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.

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

Code	Title	Definition
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered. A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care. Hospices must report value code 61 when billing revenue codes 0651 and 0652.

G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care).	MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility where inpatient hospice services are delivered. Hospices must report value code G8 when billing revenue codes 0655 and 0656.

If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, the hospice reports the CBSA that applies at the end of the billing period. 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.

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the hospice.

Code	***Title***	***Definition***
62	*Number of High Routine Home Care Days*	*Days that fall within the first 60 days of a routine home care hospice claim. The Medicare system puts the high days returned by Pricer on the claim as a value code 62 amount.*
63	*Number of Low Routine Home Care Days*	*Days that come after the first 60 days of a routine home care hospice claim. The Medicare system puts the low days returned by Pricer on the claim as a value code 63 amount.*

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)

- ** 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.

For dates of service before October 1, 2018, 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.

Effective for dates of service on and after 10/1/2018, hospices are no longer required to report drugs using line item detail. Hospices may report summary charges for drugs as shown in the table below.

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. *For dates of service on and after 10/1/2018: Report a monthly charge total for all drugs (i.e., report a total charge amount for the period covered by the claim) using revenue code 0250.*

029X Infusion pumps	Applicable HCPCS *N/A*	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. *For dates of service on and after 10/1/18: Report a monthly charge total for DME (i.e., report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the item of DME and 0294 for DME infusion drugs.*
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). *For dates of service on and after 10/1/2018: Revenue code 0636 is not required.*

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 charge
- 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.

For dates of service on and after 10/1/2018, units for summary drug charges lines may be reported using '1' to satisfy the required field or using a number of drugs provided during the billing period, at the option of the hospice. Service unit data will not be used by Medicare for payment or data analysis.

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.
pices 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 Q50 8 (inpatient psychiatric facility) will result in the claim being returned to the provider

130.1 Input/Output Record Layout

(Rev.4035; Issued: 04-27-18; Effective: 10-01-18; Implementation: 10-01-18)

The required data and format for the Hospice Pricer input/output record are shown below:

FIELD NAME	FIELD LAYOUT	POSITION	DESCRIPTION
NPI	X(10)	1-10	Input item: The billing provider's National Provider Identifier, copied from the claim.
PROV-NO	X(6)	11-16	Input item: The billing provider's CMS Certification Number (CCN), copied from the claim. (FISS crosswalks the CCN based on the NPI submitted by the provider.)
FROM-DATE	9(8)	17-24	Input item: The statement covers period "From" date, copied from the claim. Date format must be CCYYMMDD.
ADMISSION-DATE	9(8)	25-32	Input item: The admission date, copied from the claim. Date format must be CCYYMMDD.
Filler	x(10)	33-42	
PROV-CBSA	X(5)	43-47	Input item: The CBSA code used to wage-adjust inpatient levels of care. Copied from the value code G8 amount on the claim
BENE-CBSA	X(5)	48-52	Input item: The CBSA code used to wage-adjust home levels of care. Copied from the value code 61 amount on the claim
PROV-WAGE-IND	99V9(4)	53-58	Output item: The wage index value that corresponds to the PROV-CBSA
BENE-WAGE-IND	99V9(4)	59-64	Output item: The wage index value that corresponds to the BENE-CBSA

NA Day 1 Add-on Units	x(2)	65-66	Input item: The number of days from a prior hospice benefit period if identified by CWF as part of the first 60 days of RHC.
NA Day 2 Add-on Units	x(2)	67-68	Input item: Not used
EOL Day 1 Add-on Units	x(2)	69-70	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 2 Add-on Units	x(2)	71-72	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 1 day. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 3 Add-on Units	x(2)	73-74	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 2 days. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 4 Add-on Units	x(2)	75-76	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 3 days. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 5 Add-on Units	x(2)	77-78	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 4 days. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 6 Add-on Units	x(2)	79-80	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 5 days. No units input if the lines are not associated with routine home care (revenue code 0651)
EOL Day 7 Add-on Units	x(2)	81-82	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 6 days. No units input if the lines are not associated with routine home care (revenue code 0651)
Filler	x(10)	83-92	
QIP-REDUCTION-IND	x	93	Input item: An indicator of whether the hospice's payments are subject to the 2% reduction for not reporting quality data. Copied from field 74 on the Outpatient Provider Specific File. Valid values: blank = no reduction, 1 = 2% reduction applies. See CR 8241 for details.
REV1	X(4)	94-97	Input item: Revenue code 0651 (if present) copied from the claim.

HCPC1	X(5)	98-102	Input item: HCPCS G code associated with revenue code 0651, copied from the claim.
Line Item DOS1	9(8)	103-110	Input item: The line item date of service associated with revenue code 651, copied from the claim.
UNITS1	9(7)	111-117	Input item: The number of units associated with revenue code 0651, copied from the claim. This represents the number of days of routine home care to be paid.
THEIR-PAY-CHG1	9(6)V99	118-125	Output item: The total payment to be made on the revenue code 0651 line.
REV2	X(4)	126-129	Input item: Revenue code 0652 (if present) copied from the claim.
HCPC2	x(5)	130-134	Input item: HCPCS G code associated with revenue code 0652, copied from the claim.
Line Item DOS2	9(8)	135-142	Input item: The line item date of service associated with revenue code 652, copied from the claim.
UNITS2	9(7)	143-149	Input item: The number of units associated with revenue code 0652, copied from the claim. This represents the number of 15 minute increments of continuous home care to be paid.
THEIR-PAY-CHG2	9(6)V99	150-157	Output item: The total payment to be made on the revenue code 0652 line.
REV3	X(4)	158-161	Input item: Revenue code 0655 (if present) copied from the claim.
HCPC3	x(5)	162-166	Input item: HCPCS G code associated with revenue code 0655, copied from the claim.
Line Item DOS3	9(8)	167-174	Input item: The line item date of service associated with revenue code 655, copied from the claim.
UNITS3	9(7)	175-181	Input item: The number of units associated with revenue code 0655, copied from the claim. This represents the number of days of inpatient respite care to be paid.
THEIR-PAY-CHG3	9(6)V99	182-189	Output item: The total payment to be made on the revenue code 0655 line.
REV4	X(4)	190-193	Input item: Revenue code 0656 (if present) copied from the claim.
HCPC4	x(5)	194-198	Input item: HCPCS G code associated with revenue code 0656, copied from the claim.
Line Item DOS4	9(8)	199-206	Input item: The line item date of service associated with revenue code 656, copied from the claim.
UNITS4	9(7)	207-213	Input item: The number of units associated with revenue code 0656, copied from the claim. This represents the number of days of general inpatient care to be paid.
THEIR-PAY-CHG4	9(6)V99	214-221	Output item: The total payment to be made on the revenue code 0656 line.
NA Day 1 Add-on Pay	9(6)V99	222-229	Output item: Not used
NA Day 2 Add-on Pay	9(6)V99	230-237	Output item: Not used

EOL Day 1 Add-on Pay	9(6)V99	238-245	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 2 Add-on Pay	9(6)V99	246-253	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 3 Add-on Pay	9(6)V99	254-261	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 4 Add-on Pay	9(6)V99	262-269	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 5 Add-on Pay	9(6)V99	270-277	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 6 Add-on Pay	9(6)V99	278-285	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
EOL Day 7 Add-on Pay	9(6)V99	286-293	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units)
PAY-AMT	9(6)99	294-301	Output item: The sum of all payment amounts returned on this record.
RTC	XX	302-303	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.
High RHC Days	*99*	*304-305*	*Output item: The number of high RHC days applied to the claim.*
Low RHC Days	*99*	*306-307*	*Output item: The number of low RHC days applied to the claim.*
FILLER	*x(8)*	*308-315*	