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# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

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Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 205

Date: JUNE 15, 2004

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CHANGE REQUEST 3226

**NOTE: This transmittal replaces Pub. 100-04, Transmittal 193, which was issued on May 28, 2004. The transmittal page has been modified. All other information remains the same.**

**I. SUMMARY OF CHANGES:** The Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims, has been edited to reflect the requirements to implement section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003. This section allows nurse practitioners in hospice to serve as the attending physician.

**NEW/REVISED MATERIAL - EFFECTIVE DATE:** December 8, 2003

**IMPLEMENTATION DATE:** For providers billing Local Part B carriers, and Local Part B carriers, for all applicable requirements, June 28, 2004.

**For providers billing intermediaries,** Use of the GV modifier is to be implemented June 28, 2004, as presented in the revised section 30.2 listed below.

**For intermediary billing and systems,** for all other applicable requirements, October 4, 2004

*Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.)**

**(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)**

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10 / Overview
R	20.1.1/ Notice of Election
R	20.1.2/Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election
R	30.2/Payment Rates
R	30.3/Data Required on Claim to FI
R	40.1/Types of Physician Services

<b>R</b>	40.1.1/Administrative Activities
<b>R</b>	40.1.2/Patient Care Services
<b>R</b>	40.1.3/Attending Physician Services
<b>R</b>	40.1.3.1/Care Plan Oversight
<b>R</b>	40.2/Carrier Processing of Claims for Hospice Beneficiaries

**\*III. FUNDING:**

**These instructions shall be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>x</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Notification</b>
	<b>Recurring Update Notification</b>

## 10 - Overview

*(Rev. 205, 06-15-04)*

### **B3-4175, A3-3140, A3-3143, AB-02-009, AB-03-008**

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period. Election/termination dates are retained on CWF.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, *which may include a nurse practitioner*. If the attending physician, *who may be a nurse practitioner*, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). *Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness*. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. *It should be noted that predicting life expectancy is not always exact*.

See the Medicare Benefit Policy Manual, Chapter 9, for additional general information about the Hospice benefit.

See Chapter 29 of this manual for information on the appeals process that should be followed when an entity is dissatisfied with the determination made on a claim.

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

## **20.1.1 - Notice of Election (NOE) - Form CMS-1450**

*(Rev. 205, 06-15-04)*

### **HSP-302**

When a Medicare beneficiary elects hospice services, hospices must complete FLs 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, 67, 82, 83, and 85 of the Uniform (Institutional Provider) Bill (Form CMS-1450), which is an election notice. In addition, the hospice must complete the Form CMS-1450 when the election is for a patient who has changed an election from one hospice to another.

Hospices must send the Form CMS-1450 Election Notice to the FI by mail, messenger, or *direct data entry (DDE)* depending upon the arrangements with the FI.

If a patient enters hospice care before the month he/she becomes entitled to Medicare benefits, e.g., before age 65, the hospice should not send the election notice before the first day of the month in which he/she becomes 65.

## **20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election**

*(Rev. 205, 06-15-04)*

### **HSP-302.1, HO-460**

The following fields must be completed by the hospice on the Form CMS-1450 for the Notice of Election:

#### **Form Locator (FL) 1. (Untitled) - 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.

#### **FL 4. Type of Bill**

Enter the 3-digit numeric type of bill code: 81A, B, C, D, *E* or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

## **Code Structure**

### **1st Digit - Type of Facility**

8 - Special (Hospice)

### **2nd Digit - Classification (Special Facility)**

1 - Hospice (Nonhospital-Based)

2 - Hospice (Hospital-Based)

### **3rd Digit - Frequency**

A - Hospice benefit period initial election notice

B - Termination/revocation notice for previously posted hospice election

C - Change of provider

D - Void/cancel hospice election

*E - Hospice Change of Ownership*

## **FL 12. Patient's Name**

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

## **FL 13. 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.

## **FL 14. Patient's Birth Date**

(If available.) Show the month, day, and year of birth numerically as MM-DD-YYYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

## **FL 15. Patient's Sex**

Show an "M" for male or an "F" for female. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

## **FL 17. Admission Date**

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than two calendar days, and is the same as the certification date if the certification is not completed on time.

## **EXAMPLE**

The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

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

### **FLs 51A, B, and C. Provider Number**

This is the 6-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

### **FLs 58A, B, C. Insured's Name**

Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name exactly as it appears on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

### **FLs 60A, B, C. 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 in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. 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.

### **FL 67. Principal Diagnosis Code**

The full ICD-9-CM diagnosis code is required. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. The CMS accepts only ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

### **FL 82. Attending Physician I.D.**

Enter the UPIN and name of the physician currently responsible for certifying *the terminal illness*. The UPIN is shown in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Claims Where Physician Not Assigned a UPIN - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. In addition, numbers are not assigned to physicians who limit their practice to

the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians; and
- OTH000 for all other unspecified entities not included above. The OTH000 ID may be audited.

**FL 83. Other Physician I.D.**

*If the attending physician is a nurse practitioner, enter the UPIN and name of the nurse practitioner. The UPIN is shown in the first six positions followed by two spaces, the nurse practitioner's last name, one space, first name, one space, and middle initial.*

The word "employee" or "nonemployee" must be entered here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under the hospice jurisdiction.

**FL 85-6. 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.

## 30.2 - Payment Rates

*(Rev. 205, 06-15-04)*

### HSP-403, HSP-404, 9/5/01 ARA update memo, A-02-059

The CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. These rates must then be adjusted by the FI based on the beneficiary's locality.

National rates are issued as described below. These rates are updated annually and published in the "Federal Register." This example is the national rates for October 1, 2002, through September 30, 2003.

Description	Revenue Code	Daily Rate	Wage Amount	Unweighted Component
Routine Home Care	0651	\$118.080	\$ 81.1378.47	\$ 36.95
Continuous Home Care	0652	\$689.18	\$476.5457.97	\$215.64
Inpatient Respite Care	0655	\$122.15	\$ 66.12	\$56.03
General Inpatient Care	0656	\$525.28	\$336.23	\$189.05

These national rates are adjusted by FI as follows:

#### 1 - Rate Components

The rate is considered to have two components

- A wage amount component
- An unweighted component

#### 2 - Adjustment to Wage Component

The wage amount component is adjusted (multiplied) by the wage index for the location of the beneficiary's home to provide for regional differences in wages.

The hospice wage index is published in the "Federal Register" each year, and is effective October 1 of that year through September 30 of the following year. To select the proper



index for the hospice area, first determine if the beneficiary is located in one of the Urban Areas listed in Table A of the “Federal Register” notice. If so, use the index shown for the area. If the beneficiary is not located in one of the Urban Areas, use the index number of the rural area for the State, listed in Table B of the “Federal Register” notice.

### 3 - Adjusted Payment Rate

The adjusted wage component is then added to the unweighted component. This is the payment rate for the year

**EXAMPLE I:** If the wage index for the beneficiary’s area is .87, a \$78.47 national wage amount for routine home care would be multiplied by .87 to determine the wage amount, and this amount (\$68.27) would be added to the unweighted component of \$35.73 to provide a local rate for *code* 0651 of \$100.68104.00.

**EXAMPLE II:** If the wage index for the beneficiary’s area is .87, a \$457.97 national wage amount for continuous home care would be multiplied by .87 to determine the wage amount, and this amount (\$398.43) would be added to the unweighted component of \$208.55 to provide a local daily rate for revenue code 0652 of \$606.98. Divide by 24 to get the local hourly rate of \$25.29.

Similar calculations are done for the rates for the other revenue codes.

## 30.3 - Data Required on Claim to FI

*(Rev. 205, 06-15-04)*

### A3-3648, HSP-302, HSP-303-303.1

See the Medicare Benefit Policy Manual, Chapter 9 for coverage requirements for Hospice benefits.

This section addresses only the submittal of claims. See *section 20*, of this chapter for information on Notice of Election (NOE) transaction types (81A,C,E and 82A,C,E).

Before billing, the hospice must submit an admission notice to the FI (*see Section 20*).

Hospices use the Uniform (Institutional Provider) Bill (Form CMS-1450) or electronic equivalent to bill the FI for all covered hospice services.

This form, also known as the Uniform Bill 92 (UB-92), is suitable for billing most third party payers (both Government and private). Because it serves 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. For a complete list of instructions for all Medicare claims see the general instructions for completing the UB-92 at <http://www.cms.hhs.gov/providers/edi/edi5.asp>. Items not listed need not be completed although hospices may complete them when billing multiple payers.

**FL 1 (Field Locator 1) - (Untitled) - Provider Name, Address, and Telephone Number**

**FL 4 - Type of Bill**

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

Code Structure

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

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

<b>3rd Digit Frequency</b>	<b>Definition</b>
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
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.

<b>3rd Digit Frequency</b>	<b>Definition</b>
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 (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill.  For additional information on late charge bills see Chapter 3.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or “new” bill.  For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim.  For additional information on void/cancel bills see Chapter 3.

**FL 6 - Statement Covers Period (From-Through)**

Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient’s entitlement began. Since the 12-month hospice “cap period” (see [§80.2](#)) ends each year on October 31, submit separate bills for October and November.

**FL 12 - Patient’s Name**

Enter the beneficiary’s name exactly as it appears on the Medicare card.

**FL 13 - Patient’s Address**

**FL 14 - Patient’s *Birth date***

**FL 15 - Patient’s Sex**

**FL 17 - Admission Date**

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

**EXAMPLE:** The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

The admission date stays the same on all continuing claims for the same benefit period.

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

**FL 22 - Patient Status**

This code indicates the patient's status as of the "Through" date (FL 6) of the billing period

Code Structure

- 01 Discharged to home or self care (revocation, de-certification, or transfer from the agency)
- 30 Still patient
- 40 Expired at home
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice
- 42 Expired - place unknown
- 50 Hospice - home
- 51 Hospice - medical facility

**FL 23 - Medical Record Number (Optional)**

**FLs 24, 25, 26, 27, 28, 29, and 30 - Condition Codes**

Code(s) identifying conditions related to this bill that may affect processing.

Codes listed are only those specific to Hospice; see the general instructions for completing the UB-92 at <http://www.cms.hhs.gov/providers/edi/edi5.asp> for a complete list of codes.

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.

**FLs 32, 33, 34, and 35 - Occurrence Codes and Dates**

Enter 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 FL 36 (occurrence span) or FL 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

<b>Code</b>	<b>Title</b>	<b>Definition</b>
23	Cancellation of Hospice Election Period (FI USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an FI as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit, has been decertified or discharged. <b>It cannot</b> be used in transfer situations.

### FL 36 - Occurrence Span Code and Dates

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. Use the following code(s) where appropriate:

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.

### FLs 39, 40, and 41 - Value Codes and Amounts

The most commonly used value code on hospice claims is value code 61, which is 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	Location Where Service is Furnished	MSA number (or rural state code) of the location where the hospice service is delivered. Reporting of value code 61 is required when billing revenue codes 0651 and 0652 or when another insurance carrier is primary to Medicare. The hospice enters the four digit MSA, with two trailing zeroes, in the "amount" field (i.e., if the MSA is 1900, enter 190000)

### FL 42 - Revenue Code

Assign a revenue code for each type of service provided. Enter the appropriate four-digit numeric revenue code on line FL42 to explain each charge in FL47.

**NOTE:** Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician *or nurse practitioner* employees, or physicians *or nurse practitioners* receiving compensation from the hospice. *Physician services performed by a nurse practitioner require the addition of the modifier GV* in conjunction

with revenue code 0657, the procedure HCPCS code is entered in FL44. Procedure codes are required in order for the FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

Hospices use these revenue codes to bill Medicare.

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours within a 24 hour period, then the care rendered would be covered as a routine home care day. <i>Services provided by a nurse practitioner as the attending physician are not included in the CHC computation.</i>
0655	Inpatient Respite Care	IP Respite
0656	General Inpatient Care	GNL IP
0657**	Physician Services	PHY SER (must be accompanied by a physician procedure code)
<ul style="list-style-type: none"> <li>• Reporting of value code 61 is required with these revenue codes.</li> <li>• <i>**Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.</i></li> </ul>		

**FL 43** - Revenue Description (Not Required)

**FL 44** - HCPCS/Rates

**FL 46** - Units of Service

Enter the number of units for each type of service. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

**FL 47 - Total Charges**

**FLs 50A, B, and C - Payer Identification**

**FL 51A, B, and C - Provider Number**

**FLs 58A, B, and C - Insured's Name**

**FLs 60A, B, and C - Certificate/Social Security Number and Health Insurance Claim/Identification Number**

**FL 67 - Principal Diagnosis Code**

**FL 82 - Attending Physician I.D.**

Enter the UPIN 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. Enter the UPIN in the first six positions followed by the physician's last name, first name, and middle initial (optional).

See the general instructions for completing the UB-92 at <http://www.cms.hhs.gov/providers/edi/edi5.asp> for information about Physicians that have not been assigned a UPIN.

**FL 83 - Other Physician I.D.**

Enter the word "employee" or "nonemployee." (See [§§40](#) for definition.)

**FL 84 - Remarks (Not Required)**

**FL 85-6 - Provider Representative Signature and Date**

A hospice representative makes sure that the required physician's certification, and a signed hospice election statement are in the records before signing Form CMS-1450. A stamped signature is acceptable.



## **40 - Billing and Payment for Hospice Services Provided by a Physician**

(Rev. 1, 10-01-03)

HSP-406, B3-4175, B3-2020, B3-15513

### **40.1 - Types of Physician Services**

(Rev. 1, 10-01-03)

HSP-406

Payment for physician services provided in conjunction with the hospice benefit is made based on the type of service performed.

#### **40.1.1 - Administrative Activities**

*(Rev. 205, 06-15-04)*

HSP-406

Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group (*IDG*). *Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.*

#### **40.1.2 - Patient Care Services**

*(Rev. 205, 06-15-04)*

HSP-406

Payment for physicians or *nurse practitioner serving as the attending physician, who provide direct* patient care services *and who are* hospice employees or under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill the FI for these services.
- The FI pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for *physician services or 85% of the fee schedule amount for nurse practitioner services*. This payment is in addition to the daily hospice rates.

- Payment for physician and *nurse practitioner* services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.
- No payment is made for physician *or nurse practitioner* services furnished voluntarily. However, some physicians *and nurse practitioners* may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the physician *or nurse practitioner* for the services. A physician *or nurse practitioner* must treat Medicare patients on the same basis as other patients in the hospice; a physician *or nurse practitioner* may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.
- *No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.*

**EXAMPLE:** Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the FI and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.

### **40.1.3 - Attending Physician Services**

*(Rev. 205, 06-15-04)*

#### **B3-4175, B3-4175.1, B3-4175.4**

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 “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.

Even though a beneficiary elects hospice coverage, he/she may designate and use an 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 attending physician, *who may be a nurse practitioner as defined in Chapter 9*, that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services.

Where the service is considered a hospice service (i.e., a service related to the hospice patient's terminal illness that 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 the "attending physician", *who may be a nurse practitioner*, are billed to carriers. When the 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 carrier and looks to the hospice for payment for the technical component. Likewise, the 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.

The hospice must notify the Medicare carrier of the hospice election and the name of the physician *or nurse practitioner* who has been designated as the attending physician whenever the attending physician is not a hospice employee.

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 "hospice services." These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice. The 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. Carriers make payment to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

*Payments for the services of* attending physician *are not* counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Services provided by an independent attending physician *who may be a nurse practitioner* must be coordinated with any direct care services provided by hospice physicians.

Only the direct professional services of an independent attending physician, *who may be a nurse practitioner*, to a patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.

If another physician covers for a *hospice patient's* designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician *who may be a nurse practitioner*, the physician must look to the hospice for payment. In this situation the physicians' services are hospice services and are billed by the hospice to its FI.

Carriers 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 period of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. Carriers use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

### **40.1.3.1 - Care Plan Oversight**

*(Rev. 205, 06-15-04)*

#### **B3-2020G, B3-15513**

The attending physician may bill for care plan oversight services for a hospice enrollee. The physician must bill for these services using Form CMS-1500; these services are not to be included on the hospice bill

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of

CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

Claims for CPO must be submitted with no other services billed on that claim and may be billed only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months. One unit of service is shown for the month.

Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family or friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and/or physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

For CPO claims submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider number of the hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the hospice Medicare provider numbers.

For additional information on CPO, see the Medicare Benefit Policy Manual, Chapter 15.

## **40.2 - Carrier Processing of Claims for Hospice Beneficiaries**

*(Rev. 205, 06-15-04)*

### **B3-4175.2, B3-4175.4**

*Professional services* of attending physicians, *who may be nurse practitioners*, furnished to hospice beneficiaries are *coded* with modifier GV. Attending physician not employed or paid under arrangement by the patient's hospice provider. This modifier must be retained and reported to CWF.

*Local Part B carriers shall presume that hospice benefits are not involved unless the biller codes services on the claim to indicate that the patient is a hospice enrollee (e.g. the GV modifier is billed by the attending physician, who may be a nurse practitioner, or the GW modifier is billed for services unrelated to the terminal illness) or the trailer information on the CWF reply shows a hospice election. The carrier shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information. .*

For beneficiaries enrolled in hospice, carriers *shall* deny any services furnished on or after January 1, 2002, that are submitted without either the GV or GW modifier. For services furnished to a hospice patient prior to January 1, 2002, the attending physician is to include an attestation statement that is the written equivalent of the GV modifier and carriers are responsible for determining whether or not a service is related to the patient's terminal condition.

*Deny* claims for all other services *related to the terminal illness* furnished by *individuals or entities* other than the designated attending physician, *who may be a nurse practitioner*. *Such claims* include bills for any DME, supplies or independently practicing speech or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the FI.

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