

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 3577</b>	<b>Date: August 5, 2016</b>
	<b>Change Request 9590</b>

**SUBJECT: New Condition Code To Use When Hospice Recertification Is Untimely and Corrections to Hospice Processing Problems**

**I. SUMMARY OF CHANGES:** This Change Request creates a new condition code for hospices to use to identify when an occurrence span code 77 period is caused by a late recertification of the terminal illness. It also corrects a number of problems in hospice claims processing.

**EFFECTIVE DATE: January 1, 2017 - for claims received on or after this date**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: January 3, 2017**

*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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	11/10.1/Hospice Pre-Election Evaluation and Counseling Services
R	11/30.3/Data Required on the Institutional Claim to A/B MAC (HHH)
D	11/110/Medicare Summary Notice (MSN) Messages/ASC X12 Remittance Advice Adjustment Reason and Remark Codes

**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: 3577	Date: August 5, 2016	Change Request: 9590
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## **I. GENERAL INFORMATION**

**A. Background:** Original Medicare regulations require that following the initial benefit period, for subsequent periods of hospice care, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim. Hospices use occurrence span code (OSC) 77 to report provider liable non-covered days when the recertification was not received timely. Medicare systems ensure that occurrence code 27 (the hospice certification date) may not be reported within the OSC 77 dates.

Since October 2014, Medicare regulations also require that hospice Notices of Election (NOEs) shall be filed within 5 calendar days after the hospice admission date. In instances where a NOE is not timely-filed, Medicare does not cover the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days are a provider liability, and the provider may not bill the beneficiary for them. Hospices also use OSC 77 to report provider liable non-covered days when the NOE was not submitted within 5 days. Medicare systems compare incoming hospice claims to the NOE receipt date and enforce the presence of OSC 77 for the appropriate dates. An occurrence code 27 date within the OSC span dates in the case of an untimely NOE is perfectly appropriate.

Medicare systems cannot differentiate the two uses of OSC 77 during processing. Currently, claims are rejected in error when the occurrence code 27 falls within the OSC 77 dates and the OSC 77 was used to report an untimely NOE. To correct this, Medicare requested the National Uniform Billing Committee to create a new code to serve as indicator of which circumstance is leading the hospice to use OSC 77. The new condition code 85 is effective on January 1, 2017 and is defined "Delayed recertification of hospice terminal illness." When hospices report this code, Medicare systems will ensure the occurrence code 27 date does not fall within the OSC 77 dates. Business requirements 9590.1 through 9590.3.1 describe the necessary changes.

Additionally, CMS has discovered errors in the implementation of previous hospice payment policies. Change Request (CR) 9289 created a process in which Medicare systems checked whether prior benefit period days should be applied to the count of 60 days of service used to determine high routine home care (RHC) payments. This process only checked a single prior benefit period, when the policy requires that all benefit periods not separated by 60 days with no hospice services should apply. Business requirement 9590.4 and its sub-requirements correct this.

CR 9289 also established automatic adjustments to the prior month's claim when a patient dies within the first seven days of a billing period. Service intensity adjustment (SIA) payments may be due during the prior month. In situations where the patient dies within the first seven days of a month but no SIA payment applied on that claim since no routine home care (RHC) was provided on that claim, SIA payments may still be due on RHC days in the prior month. Automatic adjustments are not occurring in these cases. There are also situations in which an automatic adjustment to a claim applies SIA payments, but those payments are





Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9590.8	MLN Article: A provider education article related to this instruction will be available at <a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/</a> 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:
9590.7	This requirement revises current CWF edit 5194.
9590.6	This requirement excludes adjustments from the criteria applied in BR 9289.8 and establishes separate criteria for them. Original claims will apply the criteria in BR 9289.8. Adjustments created by FISS in response to IURs will apply the criteria in BR 9289.13.2. All other adjustments will apply the criteria in the new requirement.
9590.1	In this requirement 'hospice claims' excludes notice transactions, TOBs 8xA - 8xE.
9590.4	This requirement revises current CWF edit 5196.

<b>X-Ref Requirement Number</b>	<b>Recommendations or other supporting information:</b>
9540.5	This requirement revises the criteria established by BR 9289.13.

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

## **V. CONTACTS**

**Pre-Implementation Contact(s):** Wil Gehne, wilfried.gehne@cms.hhs.gov , Charles Nixon, charles.nixon@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 11 - Processing Hospice Claims

### 10.1 – Hospice Pre-Election Evaluation and Counseling Services

*(Rev.3577, Issued: 08-05-16; Effective: 01-01-17; Implementation: 01-03-17)*

Effective January 1, 2005, Medicare allows payment to a hospice for specified hospice pre-election evaluation and counseling services when furnished by a physician who is either the medical director of or employee of the hospice.

Medicare covers a one-time only payment on behalf of a beneficiary who is terminally ill, (defined as having a prognosis of 6 months or less if the disease follows its normal course), has no previous hospice elections, and has not previously received hospice pre-election evaluation and counseling services.

HCPCS code G0337 “Hospice Pre-Election Evaluation and Counseling Services” is used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies bill their A/B MAC (HHH) with home health and hospice jurisdiction directly using HCPCS G0337 with Revenue Code 0657. No other revenue codes may appear on the claim.

Claims for “Hospice Pre-Election and Counseling Services”, HCPCS code G0337, are not subject to the editing usually required on hospice claims to match the claim to an established hospice period. Further, A/B MACs (HHH) do not apply payments for hospice pre-election evaluation and counseling consultation services to the overall hospice cap amount.

Medicare must ensure that this counseling service occurs only one time per beneficiary by imposing safeguards to detect and prevent duplicate billing for similar services. If “new patient” physician services (HCPCS codes 99201-99205) are submitted by a A/B MAC (HHH) to CWF for payment authorization but HCPCS code G0337 (Hospice Pre-Election Evaluation and Counseling Services) has already been approved for a hospice claim for the same beneficiary, for the same date of service, by the same physician, the physician service will be rejected by CWF and the service shall be denied as a duplicate.

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

*Group Code: CO*

*CARC: 97*

*RARC: M86*

*MSN: 16.45*

Likewise, if a “new patient” claim for HCPCS codes 99201-99205 has been approved and subsequently, a hospice claim is submitted to CWF for payment authorization for HCPCS code G0337, (for same beneficiary, same date of service, same physician), CWF shall reject the claim and the contractor shall deny the bill and use the messages above.

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

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

Group Code: CO  
CARC: 109  
RARC: N/A  
MSN: 17.9

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

*(Rev.3577, Issued: 08-05-16; Effective: 01-01-17; Implementation: 01-03-17)*

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, §§10 & 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the 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

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



3rd Digit – Frequency	Definition
	expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The “Through” date of this bill is the discharge date, transfer date, or date of death.
5 - Late Charges	<p>Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill.</p> <p>Effective April 1, 2012, hospice late charge claims are no longer accepted by Medicare. Providers should use type of bill frequency 7. See below.</p>
7 - Replacement of Prior Claim	<p>This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or “new” bill.</p> <p>For additional information on replacement bills see Chapter 3.</p>
8 - Void/Cancel of a Prior Claim	<p>This code is used to cancel a previously processed claim.</p> <p>For additional information on void/cancel bills see Chapter 3.</p>

### Statement Covers Period (From-Through)

The hospice shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). The hospice does not show days before the patient’s entitlement began.

*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.

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

If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice shall file a timely-filed Notice of Election Termination / Revocation (NOTR) using type of bill 8xB, unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to the 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.

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

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

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

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

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

### Condition Codes

The hospice enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause.  <b>NOTE:</b> 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	<i>Delayed recertification of hospice terminal illness</i>	<i>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.</i>

### Occurrence Codes and Dates

The hospice enters any appropriate NUBC approved code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use the occurrence span code fields to record additional occurrences and dates.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

Code	Title	Definition
23	Cancellation of Hospice	Code indicates date on which a hospice period of

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

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

### Occurrence Span Code and Dates

The hospice enters any appropriate NUBC approved code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alphanumeric digits and dates are shown numerically as MM-DD-YY.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

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

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

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

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

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

Revenue Line items:

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

Occurrence Span Codes:

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

Provider Liability Periods Using Occurrence Span Code 77: Hospices must use occurrence span code 77 to identify days of care that are not covered by Medicare due to:

- Untimely physician recertification. This is particularly important when the non-covered days fall at the beginning of a billing period other than the initial certification period.
- Late-filing of a Notice of Election (NOE). A timely-filed NOE is a NOE that is submitted to the 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 10/10/2014 (Fri).

Day 1 = Sat. 10/11/2014

Day 2 = Sun. 10/12/2014

Day 3 = Mon. 10/13/2014

Day 4 = Tues. 10/14/2014

Day 5 = Weds. 10/15/2014 10/15/2014 is the NOE Due Date.

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

## Value Codes and Amounts

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

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

Code	Title	Definition
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	<p>MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered.</p> <p>A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care.</p> <p>Hospices must report value code 61 when billing revenue codes 0651 and 0652.</p>
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care).	<p>MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility where inpatient hospice services are delivered.</p> <p>Hospices must report value code G8 when billing revenue codes 0655 and 0656.</p>

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

## Revenue Codes

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

For claims with dates of service before July 1, 2008, hospices only reported the revenue codes in the table below. Effective on claims with dates of service on or after January 1, 2008, additional revenue codes will be reported describing the visits provided under each level of care. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in this table.

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

<b>Code</b>	<b>Description</b>	<b>Standard Abbreviation</b>
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	CTNS Home  A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care do not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (or less than 32 units) within a 24 hour period, then the 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)

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

**NOTE:** Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657. Procedure codes are required in order for the A/B MAC (HHH) to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the A/B MAC (HHH).



Effective on claims with dates of service on or after July 1, 2008, hospices must report the number of visits that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes above. Charges for these codes will be reported on the appropriate level of care line. Total number of patient care visits is to be reported by the discipline (registered nurse, nurse practitioner, licensed nurse, home health aide (also known as a hospice aide), social worker, physician or nurse practitioner serving as the beneficiary's attending physician) for each week at each location of service. If visits are provided in multiple sites, a separate line for each site and for each discipline will be required. The total number of visits does not imply the total number of activities or interventions provided. If patient care visits in a particular discipline are not provided under a given level of care or service location, do not report a line for the corresponding revenue code.

To constitute a visit, the discipline, (as defined above) must have provided care to the beneficiary. Services provided by a social worker to the beneficiary's family also constitute a visit. For example, phone calls, documentation in the medical/clinical record, interdisciplinary group meetings, obtaining physician orders, rounds in a facility or any other activity that is not related to the provision of items or services to a beneficiary, do not count towards a visit to be placed on the claim. In addition, the visit must be reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care.

Example 1: Week 1: A visit by the RN was made to the beneficiary's home on Monday and Wednesday where the nurse assessed the patient, verified effect of pain medications, provided patient teaching, obtained vital signs and documented in the medical record. A home health aide assisted the patient with a bath on Tuesday and Thursday. There were no social work or physician visits. Thus for that week there were 2 visits provided by the nurse and 2 by the home health aide. Since there were no visits by the social worker or by the physician, there would not be any line items for each of those disciplines.

Example 2: If a hospice patient is receiving routine home care while residing in a nursing home, the hospice would record visits for all of its physicians, nurses, social workers, and home health aides who visit the patient to provide care for the palliation and management of the terminal illness and related conditions, as described in the patient's plan of care. In this example the nursing home is acting as the patient's home. Only the patient care provided by the hospice staff constitutes a visit.

Hospices must enter the following visit revenue codes, when applicable as of July 1, 2008:

055x Skilled Nursing	Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.
056x Medical Social Services	Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.
057x Home Health Aide	Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than General Inpatient (GIP) care in 15 minute increments using the following revenue codes and associated HCPCS. Hospices shall report line-item visit data for hospice staff providing general inpatient care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length

reported as is done for routine home care and continuous home care. This also includes certain calls by hospice social workers (as described further below).

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

Visits by registered nurses, licensed vocational nurses and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055x.

All visits to provide care related to the palliation and management of the terminal illness or related conditions, whether provided by hospice employees or provided under arrangement, must be reported. The two exceptions are related to General Inpatient Care and Respite care. CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care or respite

care in contract facilities. However, General Inpatient Care or respite care visits related to the palliation and management of the terminal illness or related conditions provided by hospice staff in contract facilities must be reported, and all General Inpatient Care and respite care visits related to the palliation and management of the terminal illness or related conditions provided in hospice-owned facilities must be reported.

Charges associated with the reported visits are covered under the hospice bundled payment and reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines.

*The 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*

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

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

Additionally, providers should begin reporting each RHC, CHC, and Respite visit performed by physical therapists, occupational therapists, and speech-language therapists and their associated time per visit in the number of 15 minute increments on a separate line. Providers should use existing revenue codes 042x for physical therapy, 043x for occupational therapy, and 044x for speech language therapy, in addition to the appropriate HCPCS G-code for recording of visit length in 15 minute increments. HCPCS G-codes G0151 to G0153 will be used to describe the therapy discipline and visit time reported on a particular line item. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. If a hospice patient is receiving Respite care in a contract facility, visit and time data by non-hospice staff should not be reported.

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

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

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

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

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

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

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

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

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

### HCPCS/Accommodation Rates/HIPPS Rate Codes

For services provided on or before December 31, 2006, HCPCS codes are required only to report procedures on service lines for attending physician services (revenue 657). Level of care revenue codes (651, 652, 655 or 656) do not require HCPCS coding.

For services provided on or after January 1, 2007, hospices must also report a HCPCS code along with each level of care revenue code (651, 652, 655 and 656) to identify the type of service location where that level of care was provided.

The following HCPCS codes will be used to report the type of service location for hospice services:

<b>HCPCS Code</b>	<b>Definition</b>
Q5001	HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE
Q5002	HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTCH)
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY
Q5009	HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)
Q5010	Hospice home care provided in a hospice facility

If care is rendered at multiple locations, each location is to be identified on the claim with a corresponding HCPCS code. For example, routine home care may be provided for a portion of the billing period in the patient's residence and another portion in an assisted living facility. In this case, report one revenue code 651 line with HCPCS code Q5001 and the number of days of routine home care provided in the residence and another revenue code 651 line with HCPCS code Q5002 and the number of days of routine home care provided in the assisted living facility.

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

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

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

These service location HCPCS codes are not required on revenue code lines describing the visits provided under each level of care (e.g. 055X, 056X, 057X).

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

## **Modifiers**

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

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

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

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

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

### **Service Date**

The HIPAA standard 837 Institutional claim format requires line item dates of service for all outpatient claims. Medicare classifies hospice claims as outpatient claims (see Chapter 1, §60.4). For services provided on or before December 31, 2006, CMS allows hospices to satisfy the line item date of service requirement by placing any valid date within the Statement Covers Period dates on line items on hospice claims.

For services provided on or after January 1, 2007, service date reporting requirements will vary between continuous home care lines (revenue code 652) and other revenue code lines.

Revenue code 652 – report a separately dated line item for each day that continuous home care is provided, reporting the number of hours, or parts of hours rounded to 15-minute increments, of continuous home care that was provided on that date.

Other payment revenue codes – report a separate line for each level of care provided at each service location type, as described in the instructions for HCPCS coding reported above. Hospices report the earliest date that each level of care was provided at each service location. Attending physician services should be individually dated, reporting the date that each HCPCS code billed was delivered.

Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

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

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

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

### **Service Units**

The hospice enters the number of units for each type of service. Units are measured in days for revenue codes 651, 655, and 656, in hours for revenue code 652, and in procedures for revenue code 657. For services provided on or after January 1, 2007, hours for revenue code 652 are reported in 15-minute increments. For services provided on or after January 1, 2008, units for visit discipline revenue codes are measured by the number of visits.

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

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

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

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

### **Total Charges**

The hospice enters the total charge for the service described on each revenue code line. This information is being collected for purposes of research and will not affect the amount of reimbursement.

### **Non-Covered Charges**

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

### **Payer Name**

The hospice identifies the appropriate payer(s) for the claim.

### **National Provider Identifier – Billing Provider**

The hospice enters its own National Provider Identifier (NPI).

### **Principal Diagnosis Code**

The hospice enters diagnosis coding as required by ICD-9-CM / ICD-10-CM Coding Guidelines.

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

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

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

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

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

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

### **Other Diagnosis Codes**

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

### **Attending Provider Name and Identifiers**

For claims with dates of service before January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

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

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

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

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

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

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



psychiatric facility) with dates of service on or after April 1, 2014, will result in the claim being returned to the provider.