CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2929	**Date: April 10, 2014**
	Change Request 8648

Transmittal 2910, dated March 14, 2014, is being rescinded and replaced by Transmittal 2929, dated April 10, 2014 to restore information in section 30.3, from CR 8569, Transmittal 2867, dated February 5, 2014, which was erroneously omitted. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Medicare Claims Processing Manual, Chapter 11. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications. Also, the title for section 110 was changed to delete the letter "N" after the X12. This is the only change to the title for section 110.

EFFECTIVE DATE: October 1, 2014
IMPLEMENTATION DATE: October 1, 2014

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/Table of Contents
R	11/20.1.2/Completing the Uniform (Institutional Provider) Bill (Form CMS 1450) for Hospice Election
R	11/30.3/Data Required on the Institutional Claim to Medicare Contractor
R	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 obliged 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2929	Date: April 10, 2014	Change Request: 8648

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SUBJECT: Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE: October 1, 2014
IMPLEMENTATION DATE: October 1, 2014

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Medicare Claims Processing Manual, Chapter 11.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8648.1	A/B MACs that process hospice claims shall be aware of the changes in Pub. 100-04, Medicare Claims Processing Manual, Chapter 11.			X						

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

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.

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev.2929, Issued: 04-10-14)

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

(Rev. 2929, Issued: 04-10-14, Effective: 10-01-14, Implementation: 10-01-14)

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election.

NOTE: Information regarding the form locator numbers that correspond to these data element names can be found in chapter 25.

Provider Name, Address, and Telephone Number

The minimum entry for this item is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Enter the 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

Patient's Name

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

Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

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

Patient's Sex

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

Admission Date

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, 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.

Provider Number

This is the 6-digit number assigned by Medicare (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI).

Insured's Name

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

Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's HICN. For example, if Medicare is the primary payer, enter this information. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

For notice of elections effective prior to January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

The reporting requirement optional for notice of elections effective on or after January 1, 2010, and required reporting on or after April 1, 2010, establishes that the hospice enters the NPI and name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.

Other Physician I.D.

For notice of elections effective prior to January 1, 2010, if the attending physician is a nurse practitioner, enter the NPI and name of the nurse practitioner.

For notice of elections 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.

Provider Representative Signature and Date

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

30.3 - Data Required on the Institutional Claim to Medicare Contractor

(Rev.2929, Issued: 04-10-14, Effective: 10-01-14, Implementation: 10-01-14)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 9, *§§*10 *&* 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the Medicare contractor. See section 20, of this chapter for information on NOE transaction types.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form*at* required for billing hospice services is the *ASC X12 837 institutional* claim transaction. Since the data structure of *this* transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the Form CMS-1450 hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

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

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

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

Code Structure

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

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

3rd Digit – Frequency	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The **"**Through" date of this bill is the discharge date, transfer date, or date of death.
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. Effective April 1, 2012, hospice late charge claims are no longer accepted by Medicare. Providers should use type of bill frequency 7. See below.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or **"**new" bill. 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.

Statement Covers Period (From-Through)

The hospice shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). The hospice does not show days before the patient's entitlement began. Since the 12-month hospice "cap period" (see §80.2) ends each year on October 31, hospices must submit separate bills for October and November.

Patient Name/Identifier

The hospice enters the beneficiary's name exactly as it appears on the Medicare card.

Patient Address

Patient Birth date

Patient Sex

The hospice enters the appropriate address, date of birth and gender information describing the beneficiary.

Admission/Start of Care Date

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

The admission date stays the same on all continuing claims for the same hospice election.

Patient Discharge Status

This code indicates the patient's status as of the **"**Through" date of the billing period. The hospice enters the most appropriate National Uniform Billing Committee (NUBC) approved code.

NOTE: that patient discharge status code 20 is not used on hospice claims. If the patient has died during the billing period, use codes 40, 41 or 42 as appropriate.

Medicare regulations at 42 CFR 418.26 define three reasons for discharge from hospice care:

1) The beneficiary moves out of the hospice's service area or transfers to another hospice,

2) The hospice determines that the beneficiary is no longer terminally ill or

3) The hospice determines the beneficiary meets their internal policy regarding discharge for cause.

Each of these discharge situations requires different coding on Medicare claims.

Reason 1: A beneficiary may move out of the hospice's service area either with, or without, a transfer to another hospice. In the case of a discharge when the beneficiary moves out of the hospice's service area without a transfer, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation and appends condition code 52. The hospice does not report occurrence code 42 on their claim. This discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit at any time as long they remain eligible for the benefit.

In the case of a discharge when the beneficiary moves out of the hospice's service area and transfers to another hospice, the hospice uses discharge status code 50 or 51, depending on whether the beneficiary is transferring to home hospice or hospice in a medical facility. The hospice does not report occurrence code 42 on their claim. This discharge claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary's hospice benefit is not affected.

Reason 2: In the case of a discharge when the hospice determines the beneficiary is no longer terminally ill, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The hospice does not report occurrence code 42 on their claim. This discharge claim will terminate the beneficiary's current hospice benefit period as of the Through" date on the claim.

Reason 3: In the case of a discharge for cause, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The hospice does not report occurrence code 42 on their claim. Instead, the hospice reports condition code H2 to indicate a discharge for cause. The effect of this discharge claim on the beneficiary's current hospice benefit period depends on the discharge status.

If the beneficiary is transferred to another hospice (discharge status codes 50 or 51) the claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary's hospice benefit is not affected. If any other appropriate discharge status code is used, this discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future and are willing to be compliant with care.

If the beneficiary has chosen to revoke their hospice election, the provider uses the NUBC approved discharge patient status code and the occurrence code 42 indicating the date the beneficiary revoked the benefit. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future.

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

<u>Untimely Face-to-Face Encounters and Discharge</u>

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, we would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

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

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

Condition Codes

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

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

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause. **NOTE**: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause.
52	Out of Hospice Service Area	Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.

Occurrence Codes and Dates

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

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

Code	Title	Definition
23	Cancellation of Hospice Election Period (Medicare contractor USE ONLY)	Code indicates date on which a hospice period of election is cancelled by a Medicare contractor as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. **NOTE:** regarding transfers from one hospice to another hospice: If a patient is in the first certification period when they transfer to another hospice, the receiving hospice would use the same certification date as the previous hospice until the 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$^{th)}$ and line item units reported as 3

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

Occurrence Span Codes:

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

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.

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	MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where

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

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

Revenue Codes

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

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

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

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	CTNS Home A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care do not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of

Code	Description	Standard Abbreviation
		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 Medicare contractor to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the Medicare contractor.

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

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

and necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care.

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

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

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

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

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

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

		description.
044x Speech Therapy – Language Pathology	G0153	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
055x Skilled Nursing	G0154	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
056x Medical Social Services	G0155	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
0569 Other Medical Social Services	G0155	Required detail: Each social service phone call is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the call defined in the HCPCS description.
057x Aide	G0156	Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description.

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

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

Charges associated with the reported visits are covered under the hospice bundled payment and reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines. The visit charges will be identified on the provider remittance advice notice with remittance code 97 "Payment adjusted because the benefit for this service is included in the payment / allowance for another service/procedure that has already been adjudicated."

Effective January 1, 2010, Medicare will require 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.

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

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

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

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

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

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

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

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

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

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

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

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

Q5003 is to be used for hospice patients in an unskilled nursing facility (NF) or hospice patients in the NF portion of a dually certified nursing facility, who are receiving unskilled care from the facility staff.

Q5004 is to be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff.

NOTE: Q5003 should be used for hospice patients located in a NF; many of these patients may also have Medicaid. Q5004 should be used when the hospice patient is in a SNF, and receiving skilled care from the facility staff, such as would occur in a GIP stay. For Q5004 to be used, the facility would have to be certified as a SNF. Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. When a patient is in the NF portion of a dually certified nursing facility, and receiving only unskilled care from the facility staff, Q5003 should be reported. Note that GIP care that is provided in a nursing facility can only be given in a SNF, because GIP requires a skilled level of care.

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.

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.

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.

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.

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.

Hospices may not report V-codes as the primary diagnosis on hospice claims.

Other Diagnosis Codes

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

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 I*nstitutional* claim f*ormat* 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.

110 - Medicare Summary Notice (MSN) Messages/ASC X12 Remittance Advice Adjustment Reason and Remark Codes

(Rev.2929, Issued: 04-10-14, Effective: 10-01-14, Implementation: 10-01-14)

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

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

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

MSN Code	**Message**	**ASC *X12 835 Adjustment* Codes**	**Message**
27.1	This service is not covered because you are enrolled in a hospice.	B9	Services are not covered because the patient is enrolled in a hospice.
27.2	Medicare will not pay for inpatient respite care when it exceeds 5 consecutive days at a time.	119	Benefit maximum for this time period has been reached.
27.3	The physician certification requesting hospice services was not received timely.	B17 with MA54	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Physician certification or election consent for hospice care not received timely.
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate. (This would be shown on the RA to the hospice by payment for that date as billed by the hospice.)	No separate message would be needed. The payment rate would be shown as the allowed amount.	
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home	57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this

MSN Code	Message	ASC *X12 835 Adjustment* Codes	Message
	care rate. (The level of care being paid would be indicated by the allowed amount.)		many services, this length of service, or this dosage.
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	106 with MA54	Patient payment option/election not in effect. Physician certification or election consent for hospice care not received timely.
27.8	The documentation submitted does not support that your illness is terminal.	57 with zero payment for hospice.	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.11	The provider has billed in error for the routine home care items or services received.	97	Payment is included in allowance for the basic service/procedure.
27.12	The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate.	NA	
27.13	According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.	NA	