



# Provider Inquiry Assistance

## New Hospice Site of Service Code – JA6905

Related CR Release Date: April 28, 2010

Date Job Aid Revised: July 16, 2009

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

**Key Words** MM6905, CR6905, R1955CP, Hospice

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Regional Home Health Intermediaries (RHHIs)

**Provider Types Affected** Provider types affected are hospice providers submitting claims to Medicare A/B MACs, and/or RHHIs for services provided to Medicare beneficiaries.



Change Request (CR) 6905 announces that effective for claims with dates of service on or after October 1, 2010, hospices will report Healthcare Common Procedure Coding System (HCPCS) code Q5010 when Routine Home Care (RHC) or Continuous Home Care (CHC) is provided at a hospice residential facility or a hospice facility, which is also certified to provide inpatient care.

**Provider Needs to Know...**

- Effective for claims with dates of service on or after October 1, 2010, hospices will report HCPCS Q5010 when RHC or CHC is provided at a hospice residential facility or a hospice facility, which is also certified to provide inpatient care.
- Because Medicare regulations limit provision of general inpatient (GIP) or respite care to a Medicare or Medicaid certified facility, Medicare contractors will return to providers (RTP) any claims submitted for GIP or respite care, where the site of service is coded as Q5010.
- This is consistent with the instructions that were communicated in CR6778 (<http://www.cms.gov/Transmittals/downloads/R121BP.pdf>), that instructed contractors to RTP any claims submitted for GIP or respite where the site of service is a patient's home/residence, assisted living facility, or nursing long-term care facility or non-skilled nursing facility.

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- Technical edits to assist hospices in correct usage of existing HCPCS codes Q5003 and Q5004 are as follows:
    - The Centers for Medicare & Medicaid Services (CMS) is removing manual language which states, “Q5003 is to be used for skilled nursing facility (SNF) residents in a non Medicare covered stay and nursing facility residents.”
    - CMS is replacing it with **“Q5003 is to be used for hospice patients in an unskilled NF, or hospice patients in the NF portion of a dually certified NF, who are receiving unskilled care from the facility staff.”** Q5003 should be used for hospice patients located in a NF; many of these patients may also have Medicaid.
    - CMS is replacing manual language, which states, “Q5004 is to be used for SNF residents in a Medicare covered stay.”
    - CMS is replacing it with **“Q5004 is to be used for hospice patients in a SNF or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff.”** 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 NF and receiving only unskilled care from the facility staff, Q5003 should be reported. GIP care that is provided in a NF can only be given in a SNF because GIP requires a skilled level of care.
  - CMS is instructing contractors to RTP claims where the sum of the “Total Units” fields reported for the level of care revenue code lines does not equal the number of days in the billing period.
  - The following language is added to the hospice chapter of the *Medicare Claims Processing Manual* (Chapter 11, Section 90) to state longstanding policy, regarding hospice billing on the day a hospice patient is discharged from one facility and admitted to another (for example, in the case of a transfer):

*“In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill, and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.”*
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Background      N/A

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Operational Impact	N/A
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The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6905.pdf> on the CMS website.

The official instruction (CR6905) issued regarding this change may be found at <http://www.cms.gov/Transmittals/downloads/R1955CP.pdf> on the CMS website.

Reference  
Materials

For additional information, regarding the Hospice Payment System, providers should see [http://www.cms.gov/MLNProducts/downloads/hospice\\_pay\\_sys\\_fs.pdf](http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf) on the CMS website.

MM5245, *Instructions for Reporting Hospice Services in Greater Line Item Detail*, is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM5245.pdf> on the CMS website.

MM6778, *Medicare Systems Edit Refinements Related to Hospice Services*, is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM6778.pdf> on the CMS website.

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