

<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 1885</b>	<b>Date: December 23, 2009</b>
	<b>Change Request 6540</b>

*Transmittal 1885 dated December 23, 2009, rescinds and replaces Transmittal 1870 dated December 11, 2009, to allow the revised reporting instructions to be optional beginning January 1, 2010 and required for claims with dates of service on or after April 1, 2010. All other material remains the same.*

**Subject: Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness**

**I. SUMMARY OF CHANGES:** This instruction will ensure that the hospice reported data on the notice of election and claims for the attending physician /NP meet the definition of the attending physician/ NP in the code of Federal Regulations while also reporting the hospice physician responsible for certifying the terminal illness.

**Effective Date:** January 1, 2010 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices.

**Implementation Date:** January 4, 2010

*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. This revision changes the table of contents, but you will receive the new/revised information only, not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)  
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
R	11 Table of Contents
R	11/20.1.1 Notice of Election (NOE) – Form CMS-1450
R	11/20.1.2 Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election
R	11/20.1.3 Medicare Contractor Reply to Notice of Election
R	11/30.1 Levels of Care Data Required on the Institutional Claim to Medicare Contractor
R	11/30.3 Data Required on the Institutional Claim to Medicare Contractor
R	11/40.1.2 Hospice Attending Physician Services
R	11/40.1.3 Independent Attending Physician Services

**III. FUNDING:**

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**SECTION B: 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**

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

# Attachment – Business Requirements

<b>Pub. 100-04</b>	<b>Transmittal: 1885</b>	<b>Date: December 23, 2009</b>	<b>Change Request: 6540</b>
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*Transmittal 1885 dated December 23, 2009, rescinds and replaces Transmittal 1870 dated December 11, 2009, to allow the revised reporting instructions to be optional beginning January 1, 2010 and required for claims with dates of service on or after April 1, 2010. All other material remains the same.*

**SUBJECT: Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness**

**Effective Date:** January 1, 2010, for OPTIONAL reporting by hospices.  
April 1, 2010 for mandatory reporting by hospices.

**Implementation Date:** January 4, 2010

## I. GENERAL INFORMATION

**A. Background:** Previous instructions required that the hospice report the physician certifying the terminal illness in the attending physician field on the notice of election (NOE) and claim, regardless of whether that physician was the beneficiary’s selected attending physician. This instruction will ensure that the hospice reported data on the notice of election and claims for the attending physician /Nurse Practitioner (NP) meet the definition of the attending physician/ NP in the code of Federal Regulations while also reporting the hospice physician responsible for certifying the terminal illness.

**B. Policy:** Effective with this instruction for notice of elections and claims with effective dates or dates of service on or after January 1, 2010, the hospice may begin reporting the National Provider Identifier (NPI) of the attending physician/NP in the attending physician field on the NOE and claim. Hospices are required to report this data on the notice of elections and claims with effective dates or dates of service on or after April 1, 2010. The code of Federal Regulation, Title 42, section 418.3, defines the attending physician as:

- (1) a) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action;  
or  
b) Nurse practitioner who meets the training, education, and experience requirements as described in §410.75 (b).  
and
- (2) Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

For claims and elections with dates of service or effective dates on or after January 1, 2010, the hospice may begin reporting in the “Other Physician” field on the NOE and claim 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. Hospices are required to report this data on the notice of elections and claims with effective dates or dates of service on or after April 1, 2010.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility						
		A	D	F	C	R	Shared-System Maintainers	Other
		/	M	I	A	H		
		B	E		R	H		

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
6540.1	Medicare contractors shall be aware of the revision in the reporting requirements for the attending and certifying physician as provided in this instruction.	X				X					

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				Other
		M A C	M A C		R I E R		F I S S	M C S	V M S	C W F	
6540.2	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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.</p>	X				X					

### IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

### V. CONTACTS

**Pre-Implementation Contact(s):** Hospice Part A Claims [Wendy.Tucker@cms.hhs.gov](mailto:Wendy.Tucker@cms.hhs.gov), Hospice policy [Katherine.Lucas@cms.hhs.gov](mailto:Katherine.Lucas@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

### **Section B: 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

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

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

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

Hospices must send the Form CMS-1450 Election Notice to the **Medicare contractor** by mail, messenger, or direct data entry (DDE) depending upon the arrangements with the **Medicare contractor**. *The NOE should be filed as soon as possible after a patient elects the hospice benefit.*

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

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

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

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**

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

### **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.

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 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 even if the hospice physician certifying the terminal illness is the same as the attending physician.

### **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.

### **20.1.3 – Medicare Contractor Reply to Notice of Election**

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

The reply to the notice of election is furnished according to hospice arrangements with the *Medicare contractor*. Whether the reply is given by telephone, mail, or wire, it is based upon the *Medicare contractor's* query to CMS master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

### **30.1 - Levels of Care Data Required on the Institutional Claim to Medicare Contractor**

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

With the exception of payment for physician services, Medicare payment for hospice care is made at one of four predetermined rates for each day that a Medicare beneficiary is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the application of the statutory "caps" on overall payments and on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

The four levels of care into which each day of care is classified:

Routine Home Care	Revenue code 0651
Continuous Home Care	Revenue code 0652
Inpatient Respite Care	Revenue code 0655
General Inpatient Care	Revenue code 0656

For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For continuous home care the amount of payment is determined based on the number of hours, reported in increments of 15 minutes, of continuous care furnished to the beneficiary on that day. For the other categories a single rate is applicable for the category for each day.

For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

**A description of each level of care follows.**

**Routine Home Care** - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

**Continuous Home Care** - The hospice is paid the continuous home care rate when continuous home care is provided. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15 minute increments and these increments are used in calculating the payment rate. Only patient care **provided** during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g. meal beaks, report, education of staff). **Continuous home care is not intended to be used as respite care.**

The hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening, but care must reflect the needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.

Care by a home health aide and/or homemaker may not be discounted or provided “at no charge” in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.

For more detailed information on Continuous Home Care, see Pub. 100-02, Chapter 9, §40.2.1.

**Inpatient Respite Care** - The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than five days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.

**General Inpatient Care** - Payment at the inpatient rate is made when general inpatient care is provided.

### **30.3 - Data Required on *the Institutional Claim to Medicare Contractor*** *(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

See Pub. 100-02, Chapter 9, §§10 & 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. See section 20, of this chapter for information on Notice of Election (NOE) transaction types (81A,C,E and 82A,C,E).

Before billing, the hospice must submit an admission notice to the *Medicare contractor* (see section 20). 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 required for billing hospice services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 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 UB-04 (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 and a table to crosswalk UB-04 form locators to the 837 transaction 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 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 (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill. For additional information on late charge bills see Chapter 3.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or “new” bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously

3rd Digit – Frequency	Definition
	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.

The hospice enters the month, day, and year numerically as MM-DD-YY.

**Patient Discharge Status**

This code indicates the patient’s status as of the “Through” date (FL 6) of the billing period. The hospice enters the most appropriate NUBC approved code.

The codes most commonly used on hospice claims include:

- 01 Discharged to home or self care
- 30 Still patient
- 40 Expired at home

- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice
- 42 Expired - place unknown
- 50 Discharged/Transferred to Hospice - home
- 51 Discharged/Transferred to Hospice - medical facility

**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 Chapter 25.

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. Results only in a discharge from the provider’s care, not from the hospice benefit.

**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 FL 36 (occurrence span) 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 Chapter 25.

Code	Title	Definition
23	Cancellation of Hospice Election Period ( <i>Medicare</i> )	Code indicates date on which a hospice period of election is cancelled by a <i>Medicare contractor</i> as

Code	Title	Definition
	<i>contractor</i> USE ONLY)	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, has been decertified or discharged. <b>It cannot</b> be 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 Chapter 25.

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 –	Code indicates From/Through dates for a period of



<b>Code</b>	<b>Title</b>	<b>Definition</b>
	Utilization Charged	non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).

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.

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

If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, the hospice reports the CBSA that applies at the end of the billing period. This applies for either routine home care and continuous home care (e.g., the beneficiary's residence changes between locations in different CBSAs) or for general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs).

## 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.

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 does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (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)
<ul style="list-style-type: none"> <li>* Reporting of value code 61 is required with these revenue codes.</li> <li>**Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.</li> <li>***Reporting of value code G8 is required with these revenue codes.</li> </ul>		

**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
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	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 GIP care in 15 minute increments using the following revenue codes and associated HCPCS:

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.

**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)

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 skilled nursing facility residents in a non Medicare covered stay and nursing facility residents.

Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.

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).

### **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 FL 6 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.

### **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 Coding Guidelines. Hospices may not report V-codes as the primary diagnosis on hospice claims. The principal diagnosis code describes the terminal illness of the hospice patient and V-codes do not describe terminal conditions.

### **Other Diagnosis Codes**



The hospice enters diagnosis coding as required by ICD-9-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.

The reporting requirement optional for claims with dates of service 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 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.

The reporting requirement optional for claims with dates of service 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 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 even if the hospice physician certifying the terminal illness is the same as the attending physician.

### **40.1.2 - Hospice Attending Physician Services**

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

*Under the Medicare hospice benefit, an attending physician is defined as a doctor of medicine or osteopathy or a nurse practitioner (for professional services related to the terminal illness that are furnished on or after December 8, 2003) who is identified by the patient, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his or her medical care.* Payment for physicians or nurse practitioners serving as the attending physician, who provide direct patient care services and who are hospice employees or *working* under arrangement with the hospice, is made in the following manner:

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

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

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

#### **40.1.3 – *Independent* Attending Physician Services**

*(Rev. 1885; Issued: 12-23-09; Effective Date 01-01-10 for OPTIONAL reporting by hospices. April 1, 2010 for mandatory reporting by hospices; Implementation Date: 01-04-10)*

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an *independent* attending physician, who is not an employee of the designated hospice nor receives compensation from the hospice for those services. For purposes of administering the hospice benefit provisions, an “attending physician” means an individual who:

- Is a doctor of medicine or osteopathy or
- A nurse practitioner (for professional services related to the terminal illness that are furnished on or after December 8, 2003); and
- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

*Hospices should reiterate with patients that they must not see independent physicians for care related to their terminal illness other than their independent attending physician unless the hospice arranges it.*

Even though a beneficiary elects hospice coverage, he/she may designate and use an *independent* attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an *independent* attending physician, who may be a nurse practitioner as defined in Chapter 9, that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered *Medicare Part A* hospice services. Where the service is related to the hospice patient's terminal illness **but** was furnished by someone other than the designated "attending physician" [or a physician substituting for the attending physician] the physician or other provider must look to the hospice for payment. Professional services related to the hospice patient's terminal condition that were furnished by *an independent* attending physician, who may be a nurse practitioner, are billed to the *Medicare contractor through Medicare Part B*. When the *independent* attending physician furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the carrier and looks to the hospice for payment for the technical component. Likewise, the *independent* attending physician, who may be a nurse practitioner, would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests). The remainder of this section explains this in greater detail.

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, who may be a nurse practitioner, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered *Medicare Part A* "hospice services." These *independent* attending physician services are billed *through Medicare Part B* to the *Medicare contractor*, provided they were not furnished under a payment arrangement with the hospice. The *independent* attending physician codes services with the GV modifier "Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. The *Medicare contractor* makes payment to the *independent* attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

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

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

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

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

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician who may be a nurse practitioner (*i.e., by a non-independent physician/nurse practitioner*), the physician must look to the hospice for payment. In this situation the physicians' services are *Part A* hospice services and are billed by the hospice to its *Medicare contractor*.

*Medicare contractors* must process and pay for covered, medically necessary Part B services that physicians furnish to patients after their hospice benefits are revoked even if the patient remains under the care of the hospice. Such services are billed without the GV or GW modifiers. Make payment based on applicable Medicare payment and deductible rules for each covered service even if the beneficiary continues to be treated by the hospice after hospice benefits are revoked. The CWF response contains the periods of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. *Medicare contractor* use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.