| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2258** | **Date: July 29, 2011** |
| | **Change Request 7473** |

**SUBJECT: Correction to Processing of Hospice Discharge Claims**

**I. SUMMARY OF CHANGES:** This Change Request revises Medicare systems to ensure hospice discharge claims update the hospice benefit period correctly.

**EFFECTIVE DATE: January 1, 2012**
**IMPLEMENTATION DATE: January 3, 2012**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 11/Table of Contents |
| R | 11/10.1/Hospice Pre-Election Evaluation and Counseling Services |
| R | 11/30.3/Data Required on the Institutional Claim to Medicare Contractor |
| N | 11/30.4/Claims From Medicare Advantage Organizations |
| R | 11/40.1.3/Independent Attending Physician Services |
| R | 11/40.2/Processing Professional Claims for Hospice Beneficiaries |
| R | 11/40.2.1/Claims After the End of Hospice Election Period |
| D | 11/40.2.2/Claims From Medicare Advantage Organizations |
| R | 11/50/Billing and Payment for Services Unrelated to Terminal Illness |
| R | 11/90/Frequency of Billing and Same Day Billing |
| R | 11/120/Contractor Responsibilities for Publishing Hospice Information |

**III. FUNDING:**
**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**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

| Pub. 100-04 | Transmittal: 2258 | Date: July 29, 2011 | Change Request: 7473 |
|---|---|---|---|

**SUBJECT: Correction to Processing of Hospice Discharge Claims**

**Effective Date**: January 1, 2012

**Implementation Date:** January 3, 2012

## I. GENERAL INFORMATION

**A. Background:** 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
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. This Change Request (CR) revises chapter 11 of the Medicare Claims Processing Manual to provide more detailed instructions to hospices regarding this coding.

Section 418.26 also specifies that any discharge from hospice care other than an immediate transfer to another hospice has the following effects:

1) The beneficiary is no longer covered under Medicare for hospice care;
(2) The beneficiary resumes Medicare coverage of the benefits waived by their hospice election; and
(3) The beneficiary may at any time elect to receive hospice care if he or she is again eligible.

It has come to CMS' attention that certain hospice discharge claims are not having these effects in Medicare systems. The requirements below are intended to ensure all hospice discharge claims have the required effects on the coverage status of Medicare beneficiaries.

Finally, this CR makes various revisions to chapter 11 to remove outdated language and clarify existing instructions.

**B. Policy:** This CR contains no new policy. The requirements improve the implementation of longstanding policy under Medicare regulations at 42 CFR 418.26.

## II. BUSINESS REQUIREMENTS TABLE

| Number | Requirement | Responsibility | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 7473.1 | Medicare contractors shall set the revocation indicator on a beneficiary's hospice benefit period when a hospice claim | | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | is received with any discharge status code other than 30, 40, 41, 42, 50 or 51, and occurrence code 42 is not present. | | | | | | | | | | |
| 7473.2 | Medicare contractors shall set the end date of the beneficiary's hospice benefit period to match the claim "Through" date when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51, and occurrence code 42 is not present. | | | | | | | | | X | |
| 7473.3 | Medicare contractors shall set the end date of the beneficiary's hospice benefit period to match the occurrence code 42 date when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51, and occurrence code 42 is present. | | | | | | | | | X | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 7473.4 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>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. | X | | | | X | | | | | HH & H MACs |

## 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):** Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov , Wendy Tucker, 410-786-3004, wendy.tucker@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

## VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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),* include the following statement:**

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.2258, Issued: 07- 29-11)***

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

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)***

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

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

HCPCS code G0337 "Hospice Pre-Election Evaluation and Counseling Services" *is* used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies bill their *Medicare contractor with home health and hospice jurisdiction* directly using HCPCS G0337 with Revenue Code 0657. No other revenue codes may appear on the claim.

Claims for "Hospice Pre-Election and Counseling Services", HCPCS code G0337, *are* not subject to the editing *usually required on hospice claims* to match the claim to an established hospice period. Further, contractors *do* not apply payments for hospice pre-election evaluation and counseling consultation services to the overall hospice cap amount.

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

MSN messages: 16.8: *"Payment is included in another service received on the same day"* and 16.45: *"You cannot be billed separately for this item or service. You do not have to pay this amount."*

*Claim adjustment reason code (CARC)* 97: *"The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."*

*Remittance advice* remark code (RARC) M86:

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

HCPCS code G0337 is only payable when billed on *a hospice claim*. *Contractors* shall not make payment for HCPCS code G0337 *on professional claims*. *Contractors* shall deny line items *on professional claims* for HCPCS code G0337 and use the following messages:

MSN message 17.9: *"Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor."*

*CARC* 109: "*Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor ."*

## 30.3 - Data Required on the Institutional Claim to Medicare Contractor

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12)***

See Pub. 100-02, 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 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

| **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.<br>For additional information on late charge bills see Chapter 3. |

| 3rd Digit – Frequency | Definition |
|---|---|
| 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.<br><br>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.<br><br>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. 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 also reports occurrence code 42 on their claim and the date of their determination. This discharge claim will terminate the beneficiary's current hospice benefit period as of the occurrence code 42 date. This coding may also used if the beneficiary has chosen to revoke their hospice election. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future.*

*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.*

**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.<br><br>Note: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause. |

**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.<br>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 *or* has been decertified. *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). |

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 Continuous Home Care) | MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered.<br><br>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 | MSA or Core Based Statistical Area (CBSA) |

| | | |
|---|---|---|
| | Service is Delivered (General Inpatient and Inpatient Respite Care). | number (or rural State code) of the facility where inpatient hospice services are delivered.<br><br>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.

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<br><br>A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care do not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (or less |

| Code | Description | Standard Abbreviation |
|---|---|---|
| | | 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.

**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:

| 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) |
| 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).

**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 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.

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

## *30.4 - Claims From Medicare Advantage Organizations*

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12 ;)***

*Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice. These regulations are found at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b). Medicare Fee for Service retains payment responsibility for all hospice and non-hospice related claims beginning on the date of the hospice election.*

### *A - Covered Services*

*While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, or a provider treating an illness not related to the terminal condition, to a fee-for-service contractor of CMS. These claims are subject to the usual Medicare rules of payment, but only for the following services:*

1. *Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;*

2. *Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;*

3. *Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or*

4. *Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.*

***B - Billing of Covered Services***

*Medicare hospices bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage just as they do for beneficiaries with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X or 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment is not disrupted.*

*Medicare physicians may also bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.*

*As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. MA plan enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.*

## 40.1.3 - Independent Attending Physician Services

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12 )***

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 Medicare contractor on a professional claim* 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.

## 40.2 - Processing *Professional* Claims for Hospice Beneficiaries

**(*Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12*)**

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

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

For beneficiaries enrolled in hospice, *contractors* shall deny any services *on professional claim* that are submitted without either the GV or GW modifier. *Contractors shall deny* claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician, who may be a nurse practitioner. Such claims include bills for any DME, supplies or independently practicing speech-language pathologists or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the *institutional claim*.

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

## 40.2.1 - Claims After the End of Hospice Election Period

**(*Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12*)**

Upon revocation of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. After revocation, Medicare contractors process and pay *professional claims* for covered Part B services that hospice employed physicians may furnish.

## 50 - Billing and Payment for Services Unrelated to Terminal Illness

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12*)**

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider *using professional or institutional claims* for non-hospice Medicare payment. *On professional claims, these* services are coded with the GW modifier "service not related to the hospice patient's terminal condition." *On institutional claims, these services are coded* with condition code 07 "Treatment of Non-terminal Condition for Hospice." Contractors process services coded with the GW modifier *or* condition code *07* in the normal manner for coverage and payment determinations. *See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for physician services) for billing instructions.* If warranted, contractors may conduct prepayment development or postpayment review to validate that services billed with the GW modifier or condition code *07* are not related to the patient's terminal condition.

## 90 - Frequency of Billing and Same Day Billing

**(*Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12*)**

*Hospices must bill for their Medicare beneficiaries on a monthly basis*. *Monthly billing should conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months.*

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.

## 120 - Contractor Responsibilities for Publishing Hospice Information

***(Rev. 2258, Issued: 07- 29-11, Effective: 01-01-12, Implementation: 01-03-12*)**

*Medicare contractors processing professional claims shall*, at least annually, include in newsletters and bulletins to physicians and suppliers an explanation of the hospice program and the requirements for billing for physicians who *serve as the attending physician to* a hospice

patient. *These contractors shall include* information on the use of special modifiers that are in effect at that time. *These contractors* may also publish related material on Web pages.