

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1738	Date: MAY 15, 2009
	Change Request 6440

Transmittal 1738, dated May 15, 2009 rescinds and replaces Transmittal 1713 issued April 24, 2009, to change “rounding up to the nearest 15 minute increment” to “rounding to the nearest 15 minute increment.” This was done in both the Business Requirements attachment and in the Internet-Only Manual update. All other material remains the same.

Subject: Additional Data Collection on Hospice Claims

I. SUMMARY OF CHANGES: Requires hospices to report additional data on their claims for Medicare payment that describe the services provided in the course of delivering routine home care, continuous home care, and respite care. Also requires line-item billing on claims.

NEW / REVISED MATERIAL

EFFECTIVE DATE: October 1, 2009 for systems changes and for OPTIONAL reporting by hospices. January 1, 2010 for mandatory reporting by hospices.

IMPLEMENTATION DATE: October 5, 2009

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.

II. CHANGES IN MANUAL INSTRUCTIONS: R=REVISED, N=NEW, D=DELETED-

R/N/D	Chapter/Section.Subsection/Title
R	11/30.3/Data Required on Claim to FI

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

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SUBJECT: Additional Data Collection on Hospice Claims

Effective Date: October 1, 2009 for systems changes and for OPTIONAL reporting by hospices.
January 1, 2010 for mandatory reporting by hospices.

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: Over the past several years the Medicare Payment Advisory Commission (MedPAC), the General Accounting Office, and the Office of the Inspector General have all recommended that CMS collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, which required reporting of a HCPCS code on the claim to describe the location where services were provided. This CR also required reporting of continuous home care time in 15 minute increments. In April 2008 CMS issued CR 5567, requiring Medicare hospices to provide detail on claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. The start date of this mandatory CR 5567 reporting requirement was July, 2008.

On several occasions, MedPAC and industry representatives have communicated to CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care. Of particular concern was the fact that CMS was not requiring reporting of the visit intensity. Reporting visit intensity would improve Medicare’s ability to carefully analyze the services provided in this growing benefit.

B. Policy: 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.

Billing of physician visits to hospice patients is not changing, and is unaffected by this CR.

At this time, we are not collecting data on claims for chaplains/spiritual counselors or volunteers. We will collect information from these valued providers of hospice services in a future phase of the data collection.

For General Inpatient (GIP) care, we are not requiring reporting of visit intensity data at this time. Providers should continue to report the number of GIP visits in accordance with CR 5567. We are continuing to exempt visit reporting by non-hospice staff when hospice patients in a contract facility are receiving GIP.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement

Number	Requirement	Responsibility								
		A / B M A C	D M E M A C	F I M I E R	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6440.1	Medicare systems shall allow revenue codes 042x, 043x, 044x and 0569 on types of bill 81x and 82x effective 10/1/09.						X			
6440.1.1	Medicare systems shall process revenue codes 042x, 043x, 044x and 0569 as covered services with no additional reimbursement						X			
6440.1.2	Medicare systems shall reflect these bundled services on the remittance advice with reason code 97 and CO (contractual obligation).						X			
6440.1.3	Medicare systems shall ensure that these charges are crossed over to trading partners with the liability assigned to the provider.						X			
6440.1.4	Medicare contractors shall reflect MSN message 16.34 on hospice claims reporting visits bundled in the hospice	X				X	X			

Number	Requirement	Responsibility									
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H H I S	Shared-System Maintainers				Other
							F I S	M C S	V M S	C W F	
	per diem.										
6440.1.5	Medicare contractors shall ensure that these visit charges are not reflected in the "You May Be Billed" column of the MSN.	X				X	X				
6440.2	For claims with dates of service on or after 1/1/2010, Medicare systems shall return to the provider hospice claims NOT containing revenue codes 0655 and 0656, that DO contain one or more of the visit revenue codes without the appropriate HCPCS: <ul style="list-style-type: none"> o Revenue code 042x with HCPCS G0151 o Revenue code 043x with HCPCS G0152 o Revenue code 044x with HCPCS G0153 o Revenue code 055x with HCPCS G0154 o Revenue code 056x with HCPCS G0155 o Revenue code 057x with HCPCS G0156 						X				
6440.3	For claims with dates of service on or after 1/1/2010, Medicare systems shall return to the provider hospice claims containing revenue code 0569 when billed without HCPCS G0155.						X				
6440.4	Medicare systems shall allow multiple identical lines reported for the same line item date of service without rolling up the lines.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A / B M A C	D M E M A C	F I M A C	C A R I E R	R H H I S S	Shared-System Maintainers				Other
						F I S S	M C S	V M S	C W F		
6440.5	<p>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.</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: For any recommendations and supporting information associated with listed requirements, use the box below:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6440.1.2	Remittance Reason Code 97 is defined "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."
6440.1.4	MSN Message 16.34 is defined as "You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.

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

V. CONTACTS

Pre-Implementation Contact(s):

Policy: Katie Lucas 410-786-7723, katherine.lucas@cms.hhs.gov; or Randy Thronset 410-786-0131, randy.thronset@cms.hhs.gov;

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Claims Processing: Wendy Tucker 410-786-3004, wendy.tucker@cms.hhs.gov

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.

30.3 - Data Required on Claim to FI

(Rev. 1738; Issued: 05-15-09; Effective Date 10-01-09 for systems changes and for OPTIONAL reporting by hospices. 01-01-10 for mandatory reporting by hospices; Implementation Date: 10-05-09)

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 FI (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

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

Code	Description	Standard Abbreviation
		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"> • * 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 FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

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

<i>Revenue Code</i>	<i>Required HCPCS</i>	<i>Required Detail</i>
042x	G0151	<i>Required detail: Each visit is identified on a separate line item with the appropriate line item</i>

<i>Physical Therapy</i>		<i>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.</i>
<i>043x Occupational Therapy</i>	<i>G0152</i>	<i>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.</i>
<i>044x Speech Therapy – Language Pathology</i>	<i>G0153</i>	<i>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.</i>
<i>055x Skilled Nursing</i>	<i>G0154</i>	<i>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.</i>
<i>056x Medical Social Services</i>	<i>G0155</i>	<i>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.</i>
<i>0569 Other Medical Social Services</i>	<i>G0155</i>	<i>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.</i>
<i>057x Aide</i>	<i>G0156</i>	<i>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.</i>

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

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.

Other Provider Name and Identifiers

If the attending physician is a nurse practitioner, the hospice enters the NPI and name of the nurse practitioner.