

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13860	Date: July 10, 2026
	Change Request 14495

SUBJECT: Reporting Face-to-Face Encounter Conducted by a Hospice Physician or Hospice Nurse Practitioner for Recertification via Telecommunications Technology on Hospice Claims, effective January 1, 2027

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the Hospice telehealth provision requiring the use of a modifier or G-code for reporting face-to-face encounters conducted by a hospice physician or hospice nurse practitioner for recertification via telecommunications technology on hospice claims.

EFFECTIVE DATE: January 1, 2027

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

IMPLEMENTATION DATE: January 4, 2027

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	11/30.3/Data Required on the Institutional Claim to A/B MAC (HHH)

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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**

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)), requires the use of 1 or more modifiers or codes on a hospice claim to indicate that a face-to-face encounter was furnished through a telehealth virtual platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and claims for telehealth services that are furnished incident to a physician's or practitioner's professional service.

B. Policy: Effective January 1, 2027, Hospices shall report face-to-face encounters conducted by a hospice physician or hospice nurse practitioner for recertification via telecommunications technology on hospice claims. Hospices shall submit the use of telecommunications technology when conducting face-to-face encounters for recertification, on the hospice claim via G0679.

G0679: Hospice face-to-face encounter conducted by a hospice physician or hospice nurse practitioner for recertification via telecommunications technology (this telehealth encounter is considered an administrative expense).

Hospices shall report the encounter via telecommunications technology in line item detail and each service must be reported as a separately dated line under the appropriate revenue code for each discipline furnishing the service.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14495.1	The contractor shall allow Healthcare Common Procedure Coding System (HCPCS) codes G0679 on claims with dates of			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	service on or after January 1, 2027.									
14495.2	The contractor shall return to the provider claims containing HCPCS code G0679 if the Type of Bill (TOB) is other than 81x or 82x.	X		X		X				
14495.3	The contractor shall return to the provider claims containing HCPCS code G0679 if reported with revenues codes other than 0657.			X		X				
14495.4	The contractor shall return to the provider claims billed with only HCPCS code G0679 with revenue code 0657; no other services are present on the claim.			X		X				

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part HHH

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

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10 – Overview

(Rev. 4280, Issued: 04-19-19, Effective: 07-21-19, Implementation: 07-21-19)

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period. Election/termination dates are retained on CWF.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for 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 attending physician, which may include a nurse practitioner or physician assistant. If the attending physician, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). Nurse practitioners or physician assistants serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact.

See the Medicare Benefit Policy Manual, Chapter 9, for additional general information about the Hospice benefit.

See Chapter 29 of this manual for information on the appeals process that should be followed when an entity is dissatisfied with the determination made on a claim.

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

10.1 - Hospice Pre-Election Evaluation and Counseling Services

(Rev. 3577, Issued: 08-05-16; Effective: 01-01-17; Implementation: 01-03-17)

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 A/B MAC (HHH) 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, A/B MACs (HHH) 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 A/B MAC (HHH) 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.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO
CARC: 97
RARC: M86
MSN: 16.45

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.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N/A
MSN: 17.9

20 - Hospice Notice of Election

(Rev. 1, 10-01-03)

HSP-201

20.1 - Procedures for Hospice Election and Related Transactions **(Rev. 3866, Issued: 09-26-17, Effective: 01-01-18, Implementation: 01-02-18)**

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

20.1.1 - Notice of Election (NOE) **(Rev. 12847; Issued: 09-13-24; Effective: 06-03-24; Implementation: 10-07-24)**

When a Medicare beneficiary elects hospice services, hospices must complete the data elements identified below for the Uniform (Institutional Provider) Bill (Form CMS-1450) or its electronic equivalent, which is a Notice of Election (NOE).

Timely-filed hospice NOEs shall be filed within 5 calendar days after the hospice admission date. A timely-filed NOE is a NOE that is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) within 5 calendar days after the hospice admission date. While a timely-filed NOE is one that is submitted to and accepted by the Medicare contractor A/B MAC (HHH) within 5 calendar days after the hospice election, posting to the CWF may not occur within that same time frame. The date of posting to the CWF is not a reflection of whether the NOE is considered timely filed. In instances where a NOE is not timely-filed, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the A/B MAC (HHH). These days shall be a provider liability, and the provider shall not bill the beneficiary for them. The hospice shall report these non-covered days on the claim with an occurrence span code 77, and charges for all claim lines reporting these days shall be reported as non-covered, or the claim will be returned to the provider.

If a hospice fails to file a timely-filed NOE, it may request an exception which, if approved, waives the consequences of filing a NOE late. The four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the hospice admission date are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
2. an event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the hospice;
3. a newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or,
4. other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the hospice.

If one of the four circumstances described above prevents a hospice from filing a timely-filed NOE, the hospice may request an exception which, if approved, would waive the consequences of filing the NOE late.

When an NOE is submitted within the five-day timely filing period, but the NOE contains inadvertent errors (such as a beneficiary identifier that has recently changed), the error does not trigger the NOE to be immediately returned to the hospice for correction. In these instances, the hospice must wait until the incorrect information is fully processed by Medicare systems before the NOE is returned to the hospice for correction.

There are other NOE errors, such as an incorrect admission date, that will not be returned for correction and instead must be finalized and posted by the Medicare systems before the hospice can correct the NOE. Only the hospice is aware of the error. Such delays in Medicare systems could cause the NOE to be late.

Delays due to Medicare system constraints are outside the control of the hospice and may qualify for an exception to the timely filing requirement.

Hospices can reduce the number of errors and exception requests related changes to the beneficiary identifier by performing an eligibility check immediately before admission. This can confirm that the Medicare Beneficiary Identifier (MBI) is active and accurate since the eligibility inquiry system contains an MBI End Date field. If there is a date in that field, the MBI is not valid after that date. The hospice can contact the beneficiary or use the MBI Lookup tool to determine the current MBI to use on the NOE.

Since correct beneficiary identifier information is available to the hospice, only changes that occur shortly before the admission are beyond the hospice control. A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the hospice more than two weeks prior to the admission date.

Medicare contractors shall grant an exception for the late NOE if the hospice is able to provide documentation showing:

- When the original NOE was submitted;
- When the NOE was returned to the hospice for correction or was accepted and available for correction and;
- Evidence the hospice resubmitted the returned NOE within two business days of when it was available for correction or cancelled an accepted NOE within two business days and submitted the new NOE within two business days after the date that the cancellation NOE finalized.

The hospice shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the case. If the remarks are not sufficient, Medicare contractors shall request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above.

Medicare contractors shall not grant exceptions if:

- The hospice can correct the NOE without waiting for Medicare systems actions,
- The hospice submits a partial NOE to fulfill the timely-filing requirement, or,
- Hospices with multiple provider identifiers submit the identifier of a location that did not actually provide the service.

In the great majority of cases, the five-day timely filing period allows enough time to submit NOEs on a day when Medicare systems are available (i.e. the period allows for ("dark days"). Additionally, the receipt date is typically applied to the NOE immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, if the hospice can provide documentation showing an NOE is submitted on the day before a dark day period and the NOE does not receive a receipt date until the

day following the dark days, the contractor shall grant an exception to the timely filing requirement. CMS expects these cases to be very rare.

Hospices must send the NOE to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE) depending upon the arrangements with the A/B MAC (HHH). EDI submissions require additional data not required by the NOE itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html. Hospices may voluntarily agree to adopt the companion guide and use it to submit EDI NOEs at any time.

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

Hospices complete the following data elements when submitting an NOE.

Provider Name, Address, and Telephone Number

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

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81A - Hospice (Non-hospital Based) Initial Election Notice

82A - Hospice (Hospital Based) Initial Election Notice

Statement Covers Period (From-Through)

The hospice enters the From date of this hospice election. A Through date is not required on NOEs.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

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

Admission Date

The hospice enters the admission date, which must be the start date of the benefit period. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the new admission date cannot be the same as the revocation or discharge date of the previous benefit period.

The date of admission may not precede the physician’s certification by more than 2 calendar days and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is 01/01/XX. The physician’s certification is dated 01/03/XX. The hospice date for coverage and billing is 01/01/XX. The first hospice benefit period ends 90 days from 01/01/XX.

Show the month, day, and year numerically as MM-DD-YY.

Condition Codes

Condition codes are not required on an original NOE. If the hospice is correcting an election date using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the NOE will be returned to the hospice.

Occurrence Codes and Dates

The hospice reports occurrence code 27 and the date of certification. This date must match the From Date and Admission Date.

Hospices may submit an NOE that corrects an election date previously submitted in error. In this case, the hospice reports the correct election date in the From Date, Admission Date and occurrence code 27 fields and reports the original, incorrect election date using occurrence code 56. Medicare systems use the original, incorrect date to find the election record to be corrected, then replaces that election date with the corrected information.

Release of Information

Valid values are:

I-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Insured's Unique Identifier

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's unique identifier by the health plan for the insured. For example, if Medicare is the primary payer, enter the MBI. To ensure accuracy and prevent a delay in the timely receipt or posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Physician I.D.

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Provider Representative Signature and Date

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

20.1.2 - Notice of Termination/Revocation (NOTR)

(Rev. 12847; Issued: 09-13-24; Effective: 06-03-24; Implementation: 10-07-24)

NOTR is used when the hospice beneficiary is discharged alive from the hospice or revokes the election of hospice services. An NOTR should not be used when a patient is transferred. If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice shall file a timely-filed Notice of Election Termination / Revocation (NOTR), unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) within 5 calendar days after the effective date of discharge or revocation. While a timely-filed NOTR is one that is submitted to and accepted by the A/B MAC (HHH) within 5 calendar days after the hospice election, posting to the CWF may not occur within that same timeframe. The date of posting to the CWF is not a reflection of whether the NOTR is considered timely-filed. In order for the NOTR to be accepted into the system, an election period must be established. If the notice of election, which creates the hospice election period is not submitted and posted before the NOTR, the NOTR will be rejected.

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81B - Hospice (Non-hospital Based) NOTR

82B – Hospice (Hospital Based) NOTR

Statement Covers Period (From-Through)

The hospice submits the From date on an NOTR differently in the following scenarios: When there is no change in the provider number during the election, the hospice must submit the start date of the election period as the From date on the NOTR.

If the revocation follows a transfer, the From date on the NOTR must match the START DATE2 on the benefit period that initiated the transfer.

If the revocation follows a change of ownership, the From date on the NOTR must match the OWNER CHANGE start date on the benefit periods. This process is to ensure that only the provider currently providing services to the beneficiary can submit the NOTR. In all cases, the Admission Date on the NOTR must match the From date.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

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

Admission Date

The hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs.

On a NOTR, the hospice enters the start date of the hospice benefit period in which the discharge or revocation is effective, not the initial hospice admission date.

Show the month, day, and year numerically as MM-DD-YY.

Facility Zip Code

Enter the hospice's ZIP code (9-digit). The ZIP code entered must match the ZIP code in the Master Address field of the provider's address file.

Condition Codes

Condition codes are not required on an original NOTR. If the hospice is correcting a revocation date using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the NOTR will be returned to the hospice.

Occurrence Codes and Dates

Hospices may submit an NOTR that corrects a revocation date previously submitted in error. In this case, the hospice reports the correct revocation date in the Through Date field and reports the original, incorrect revocation date using occurrence code 56. Medicare systems use the original, incorrect date to find the election record to be corrected, then replaces that revocation date with the corrected information.

If a revocation date was submitted entirely in error (for instance, the beneficiary actually transferred to another hospice, rather than revoking their hospice benefit), the hospice can remove the revocation date via Direct Data Entry by submitting TOB 8xB with zeroes in the Through date. The hospice reports the original, incorrect revocation date on the NOTR using occurrence code 56 and indicate the NOTR is a correction by adding condition code D0.

Release of Information

Valid values are:

I-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI. Medicare systems ensure that the provider number submitted on the NOTR is the currently active billing provider (e.g. the provider number matches that on the hospice election period or the most recent transfer date or change of ownership date on any benefit period). If any other provider number is submitted, the NOTR is returned.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Insured's Unique Identifier

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's unique identifier by the health plan for the insured. For example, if Medicare is the primary payer, enter the MBI. To ensure accuracy and prevent a delay in the timely receipt or posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Physician I.D.

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Provider Representative Signature and Date

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

20.1.3 - Change of Provider/Transfer Notice

(Rev. 12847; Issued: 09-13-24; Effective: 06-03-24; Implementation: 10-07-24)

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 after the transfer has occurred and the beneficiary's hospice benefit is not affected. The 8XC does not get submitted until after the other provider has finalized their billing.

NOTE: Transfers are not allowed from the same provider. Hospices must not submit an 8XC if the CMS Certification Number (CCN) is the same. In this scenario the beneficiary is not transferred to another hospice, they are transferred to another location of the same hospice.

A beneficiary can change hospices only once per benefit period (90-day or 60-day). When the beneficiary transfers to a different hospice, he/she continues in the same benefit period. To transfer hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

1. The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.
2. The date the change is to be effective.

Given that hospices bill for the date of discharge or transfer, for claims purposes, the "From" date for the receiving hospice must be the same as the "Through" date for the transferring hospice, otherwise this would constitute a gap in care and a gap in billing and would not be considered a transfer. For example, if a beneficiary designates that a transfer is to be effective on January 10th, the transferring hospice "Through" date must be January 10th and the receiving hospice "From" date must be January 10th in order to be a continuous hospice election without a gap in care or billing. That is, the transferring hospice is responsible for the beneficiary up until and including the transfer date.

If the beneficiary is transferring from outside the service area and the transferring hospice cannot arrange care until the beneficiary reaches the new hospice, the hospice may discharge the beneficiary. This way, if the beneficiary requires medical treatment while in the process of transferring, he/she can access it under his/her traditional Medicare coverage. This would terminate the beneficiary's current benefit period and require the beneficiary to re-elect hospice coverage at the new hospice and begin a new benefit period.

The hospice transfer will be rejected if the transfer does not occur immediately. If the receiving hospice's claim "from date" is not the same as the "through date" with "patient status" indicating a transfer (codes 50 or 51), the

transfer will be rejected. The edit will not apply to a subsequent claim, if a transfer is posted and the hospice's claim "from date" is the same as the "transfer date".

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81C - Hospice (Non-hospital Based) Change of provider

82C - Hospice (Hospital Based) Change of provider

Statement Covers Period (From-Through)

The "From" date would be the date the change is effective. No through date is required.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

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

Admission Date

The hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the receiving hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the new admission date cannot be the same as the revocation or discharge date of the previous benefit period.

Show the month, day, and year numerically as MM-DD-YY.

Condition Codes

Condition codes are not required on an original transfer notice. If the hospice is correcting a date of transfer using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the transfer notice will be returned to the hospice.

Occurrence Codes and Dates

An occurrence code 27 is not required on a transfer notice, unless the date of transfer is also the first day of the next benefit period.

Hospices may submit a transfer notice that corrects a date of transfer previously submitted in error. In this case, the hospice reports the correct effective date of the transfer in the From Date field and reports the original, incorrect effective date using occurrence code 56. Medicare systems use the original, incorrect date to find the benefit period to be corrected, then replaces that date of transfer with the corrected information.

Release of Information

Valid values are:

I- Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Insured's Unique Identifier

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's unique identifier by the health plan for the insured. For example, if Medicare is the primary payer, enter the MBI. To ensure accuracy and prevent a delay in the timely receipt or posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Physician I.D.

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Provider Representative Signature and Date

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

20.1.4 – Cancellation of an Election

(Rev. 12847; Issued: 09-13-24; Effective: 06-03-24; Implementation: 10-07-24)

A cancellation notice is used when the beneficiary will not be receiving services from the hospice, but the admission date has already been entered. The entered dates will be voided since the beneficiary never participated with the hospice.

A cancellation notice removes the hospice election period that was created by an NOE. Cancellation notices are not needed to remove hospice benefit periods, which are automatically removed when all claims in the benefit period are cancelled. See section 20.1.6.

Cancellation notices can also be used to remove a transfer or a change of ownership that was submitted in error.

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81D - Hospice (Non-hospital Based) Void/Cancel hospice election

82D - Hospice (Hospital Based) Void/Cancel hospice election

Statement Covers Period (From-Through)

When there is no change in the provider number during the election, the hospice enters the election date of the election period that is being canceled. No through date is required. Any claims processed during the election must be cancelled before an election period can be removed.

When there has been a transfer or change of ownership, the From date on the 8xD must match the corresponding transfer or change date to ensure those dates are removed correctly.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

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

Admission Date

Show the month, day, and year numerically as MM-DD-YY.

When there has been a transfer or change of ownership, the admit date on the 8xD must match the corresponding transfer or change date to ensure those dates are removed correctly.

Release of Information

Valid values are:

I-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Insured's Unique Identifier

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's unique identifier by the health plan for the insured. For example, if Medicare is the primary payer, enter the MBI. To ensure accuracy and prevent a delay in the timely receipt or posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Physician I.D.

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Provider Representative Signature and Date

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

has occurred and the beneficiary's hospice benefit is not affected. The 8XC does not get submitted until after the other provider has finalized their billing.

20.1.5 – Change of Ownership Notice

(Rev. 12847; Issued: 09-13-24; Effective: 06-03-24; Implementation: 10-07-24)

A change of ownership notice is used when the beneficiary will remain with the same hospice, but the person or group running the hospice is changing. A change of ownership typically occurs when a Medicare provider has been purchased (or leased) by another organization.

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81E - Hospice (Non-hospital Based) Change of Ownership

82E - Hospice (Hospital Based) Change of Ownership

Statement Covers Period (From-Through)

The "From" date would be the date the change is effective. No through date is required.

Patient's Name

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

Patient's Address

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

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

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

Admission Date

The hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs.

The date of admission may not precede the physician's certification by more than 2 calendar days and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is 01/01/XX. The physician's certification is dated 01/03/XX. The hospice date for coverage and billing is 01/01/XX. The first hospice benefit period ends 90 days from 01/01/XX. Show the month, day, and year numerically as MM-DD-YY.

Condition Codes

Condition codes are not required on an original change of ownership notice. If the hospice is correcting the effective date of a change using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the transfer notice will be returned to the hospice.

Occurrence Codes and Dates

Hospices may submit a change of ownership notice that corrects the effective date of a change previously submitted in error. In this case, the hospice reports the correct effective date of the change of ownership in the From Date field and reports the original, incorrect effective date using occurrence code 56. Medicare systems use the original, incorrect date to find the benefit period to be corrected, then replaces the effective date of the change of ownership with the corrected information.

Release of Information

Valid values are:

I-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes,

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI. When a hospice agency changes ownership and a new Medicare provider number issued, the A/B Medicare Administrative Contractor (MAC) must be notified to update the provider number in the hospice period. This will avoid mistaking the change as a beneficiary-elected transfer.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Insured's Unique Identifier

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's unique identifier by the health plan for the insured. For example, if Medicare is the primary payer, enter the MBI. To ensure accuracy and prevent a delay in the timely receipt or posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

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

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

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

Attending Physician I.D.

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Physician I.D.

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Provider Representative Signature and Date

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

20.1.6 Hospice Election Periods and Benefit Periods in Medicare Systems

(Rev. 4280, Issued: 04-19-19, Effective: 07-21-19, Implementation: 07-21-19)

Election Periods

An election period as described in CFR § 418.21 is the initial 90-day period, subsequent 90-day period; or an unlimited number of subsequent 60-day periods. In the Medicare systems the term 'election period' is used to describe the overall period between an election and revocation, which may include multiple 90-day or 60-day periods. Medicare systems refer to the 90-day or 60-day periods as 'benefit periods.' Therefore, hospices should be aware that when they see references to 'election periods' in regulation or in the Medicare Benefit Policy Manual, they are referring to what is called a 'benefit period' for purposes of claims processing.

Hospice election and revocation date information are stored in a separate election period in Medicare systems from benefit period information, so the two types of information can be changed independently. Both election periods and benefit periods are stored in Medicare's Common Working File (CWF) and can be viewed via inquiry screens. When a hospice submits an NOE (TOB 8xA), Medicare systems create an election period. The election period file for each beneficiary contains the following data elements for each of their election periods:

- Period Number – a sequential number assigned to each election period
- Elect Date – the date of election reported in the From date of the NOE
- Receipt Date – the receipt date of the NOE that created the election period
- Revoc Date – the revocation date reported in the Through date of the NOTR or of a discharge claim
- Revoc Ind – a revocation indicator assigned when the revocation date is recorded
- Provider – the CMS Certification Number (CCN) of the hospice that submitted the NOE
- NPI – the National Provider Identifier of the hospice that submitted the NOE.

When an 8xA is processed, the election date and receipt date will be updated on the election period CWF inquiry screen. The revocation date remains blank, and the revocation indicator is 0.

The NOE receipt date will be retained on the election period permanently. If benefit periods are cancelled, this will not remove the NOE receipt date from Medicare systems. If the election date is changed using the occurrence code 56/condition code D0 process described above, the NOE receipt date will not change. When a hospice submits an NOTR (TOB 8xB), Medicare systems will post a revocation date on the election period and change the revocation indicator to 1. Similarly, if a revocation date is corrected using the 56/D0 process, the correct date will be displayed on the election period.

If the hospice files the discharge claim in lieu of the NOTR, the claim will also post the revocation date and revocation indicator on the election period, in addition to updating the Term Date1 of the benefit period to match the revocation date.

A later NOE for the same beneficiary when there is no revocation date on the election period will be rejected. Consistent submission of revocations, via NOTRs or claims, within 5 days of the revocation date as required by regulation, is very important to prevent this.

When a hospice submits a Change of Provider/Transfer Notice (TOB 8xC) or a Change of Ownership Notice (TOB 8xE), this will make no changes to the election period.

Benefit Periods

The hospice benefit period file pre-existed the episode period file and retained all the same fields it had historically, but election-related fields on those screens will no longer be used. The hospice benefit period file for each beneficiary contains the following data elements for each of the benefit periods they use while receiving hospice care:

- Start Date1 – the start date of the benefit period

- Term Date1 -- the end date of the benefit period
- Prov1 -- the CCN of the hospice whose claim created the benefit period
- Inter1—a number identifying the Medicare Administrative Contractor serving Prov1
- DOEBA Date – date of earliest billing activity, the first date billed in the period
- DOLBA Date – date of latest billing activity, the Through date of the last claim processed in the period
- Days Used – the number of days in the period used to date
- Start Date2 – the effective dates of a transfer during the period
- Prov2 -- the CCN of the hospice from the 8xC transfer notice
- Inter2 -- a number identifying the Medicare Administrative Contractor serving Prov1
- Revocation Ind – no longer used.

Benefit periods contain two columns of information. One captures information on the original billing hospice and any hospice receiving a transfer. A second column labelled “Owner Change” captures information about a change of ownership to either of these hospices.

Benefit periods are created by submitting claims. Benefit period information supports claims processing functions only, while the election period carries only the beneficiary’s election status.

If a hospice needs to cancel all the claims in a benefit period, Medicare systems will remove the hospice benefit period.

The first claim submitted by the hospice after an election must ensure the From and Admission dates match the election period start date. This will ensure the first benefit period in the election is created correctly and subsequent claims will process.

When a hospice submits a Change of Provider/Transfer Notice (TOB 8xC) or a Change of Ownership Notice (TOB 8xE), this will post the Start Date2 and Prov2 information on the hospice benefit period.

When a hospice submits a Change of Ownership Notice (TOB 8xE), this will post an Owner Change start date on the benefit period.

Summary Chart

The following chart provides a reference to help hospices understand which of their submissions will impact an election period or a benefit period.

		Effects of Election Periods			Effects of Benefits Periods	
Transaction Type	Type of Bill	Creates Election Period	Changes Existing Election Period	Removes Election Period	Creates Benefit Period	Changes Existing Benefit Period
Notice of Election Period	8xA	Always	OC 56 only	Never	Never	Never
Notice of Termination/Revocation	8xB	Never	Always	Never	Never	Makes Term Date match revocation date
Transfer Notice	8xC	Never	Never	Never	Only when no claims have created periods for previous hospice	Always
Void/Cancel of Election	8xD	Never	Never	Always	Never	Never
Change of Ownership Notice	8xE	Never	Never	Never	Only when no claims have created	Always
		Effects of Election Periods			Effects of Benefits Periods	
Transaction Type	Type of Bill	Creates Election Period	Changes Existing Election Period	Removes Election Period	Creates Benefit Period	Changes Existing Benefit Period
					periods for previous hospice	
Admit thru Discharge Claim	8x1	Never	Adds revocation date and rev ind., if not a transfer	Never	Always	Always
Admission Claim	8x2	Never	Never	Never	Always	Always
Continuing Claim	8x3	Never	Never	Never	If OC 27 is present and "Through" date spans end of current period	Always

Discharge Claim	8x4	Never	Adds revocation date and rev ind., If not a transfer	Never	If OC 27 is present and “Through” date spans end of current period	Always
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30 - Billing and Payment for General Hospice Services

(Rev. 1, 10-01-03)

30.1 - Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH)

(Rev. 3326, Issued: 08-14-15, Effective: 01- 01-16, Implementation: 01-04-16)

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

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

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

For claims with date of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. See section 30.2 of this chapter for additional instructions on the high and low RHC rates.

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

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

A description of each level of care follows.

Routine Home Care - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the

volume or intensity of routine home care services provided on any given day and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

Continuous Home Care - The hospice is paid the continuous home care rate when continuous home care is provided in the patient's home. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours to arrive at an hourly rate. A minimum of 8 hours must be provided. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15-minute increments and these increments are used in calculating the payment rate. Only patient care provided during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g., meal breaks, report, education of staff). Continuous home care is not intended to be used as respite care.

The hospice provides a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours in the evening, but care must reflect the needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.

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

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

Inpatient Respite Care - The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than 5 days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF.

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided at a Medicare certified hospice facility, hospital, or skilled nursing facility.

30.2 - Payment Rates

(Rev. 3378, Issued: 10-16-15, Effective: 01-01-16, Implementation: 01-01-16)

The CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. These rates must then be adjusted by the A/B MAC (A) based on the beneficiary's locality.

National rates are issued as described below. These rates are updated annually and published in the “Recurring Update Notification.” This example is the national rates for October 1, 2004, through September 30, 2005.

Description	Revenue Code	Daily Rate	Wage Amount	Non-weighted Component
Routine Home Care	0651	\$121.98	\$83.81	\$38.17
Continuous Home Care Full Rate = 24 hours of care; \$29.66 hourly rate	0652	\$711.92	\$489.16	\$222.76
Inpatient Respite Care	0655	\$126.18	\$68.30	\$57.88
General Inpatient Care	0656	\$542.61	\$347.32	\$195.29

For claims with dates of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. Medicare systems count 60 days from the date of admission regardless of whether some days are covered or non-covered.

For a hospice patient that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the patient. If the hospice patient is discharged from hospice care for more than 60 days a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC high rate upon the new admission.

Example:

- Patient elected hospice for the first time on 01/10/XX
- The patient revoked hospice on 01/30/XX
- The patient re-elected hospice on 02/16/XX
- The patient discharged deceased from hospice care on 03/28/XX

Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.

RHC provided during first election from 01/10 to 01/30 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27.

Multiple RHC days are reported on a single line-item on the claim. The line-item date of service represents the first date at the level of care, and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line-item.

Extending the example above, if the March claim for this patient consisted entirely of RHC days at home, the payment line-item would look like this:

Revenue Code	HCPCS	Line-Item Date of Service	Units
651	Q5001	03/01/XX	31

Medicare systems would:

- calculate the dates from 3/01 to 3/26 at the high RHC rate,
- calculate the dates from 3/27 to 3/31 at the low RHC rate and sum these two amounts in the payment applied to this line-item.

30.2.1 - Payments to Hospice Agencies That Do Not Submit Required Quality Data (Rev. 2696, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.

Penalties for Failure to Report

For fiscal year 2014 through FY 2023, failure to submit required quality data shall result in a 2-percentage point reduction to the market basket percentage increase for that fiscal year.

Beginning with the FY 2024 and for each subsequent year, failure to submit required quality data shall result in a 4-percentage point reduction to the market basket percentage for any hospice that does not comply with the quality data submission requirements for that FY.

Medicare will provide A/B MACs (HHH) with a Technical Direction Letter (TDL) prior to each fiscal year, identifying hospice agencies not meeting the quality data reporting requirements. A/B MACs (HHH) must update the quality indicator in the Provider Outpatient Specific File for each identified, hospice agency subject to the payment reduction.

30.2.2 – Service Intensity Add-on (SIA) Payments (Rev. 3502, Issued: 04-28-16, Effective: 01-01-16, Implementation: 10-03-16)

Effective for hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15-minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment.

The SIA payment amount is calculated by multiplying the continuous home care (CHC) rate (per 15-minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

EXAMPLE CLAIM: End of Life (EOL) 7 day SIA: Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40 RHC in home, discharged deceased.

Revenue Code	HCPCS	Line-Item	Date of Service	Units
0651	Q5001		12/01/XX	9
0551	G0299		12/01/XX	4
0571	G0156		12/02/XX	6
0561	G0155		12/05/XX	4
0571	G0156		12/05/XX	3
0551	G0299		12/06/XX	3
0571	G0156		12/06XX	4
0551	G0299		12/09/XX	4
0561	G0155		12/09/XX	6
0571	G0156		12/09/XX	2

*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.

Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.

Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.

Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4.

Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/06/XX UNITS 3.

Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.

Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.

Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/09/XX UNITS 4.

30.3 – Data Required on the Institutional Claim to A/B MAC (HHH)

(Rev. 13860; Issued: 07-10-2026; Effective: 08-10-2026; Implementation: 08-10-2026)

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, for coverage requirements for Hospice benefits. This section addresses only claims submission. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the A/B MAC (HHH).

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 format required for billing hospice services is the ASC X12 837 institutional claim transaction.

Since the data structure of this transaction is difficult to express in narrative form and to help small providers exempted from the electronic claim requirement, the instructions below are given relative to the data element names on the Form CMS-1450 hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

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

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

The hospice enters on of the following Type of Bill codes:

081x – Hospice (non-hospital based)

082x – Hospice (hospital based)

4th 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 is the discharge date, transfer date, or date of death.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or “new” bill.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim.

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. Statement periods should follow the frequency of billing instructions in section 90.

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. Valid values most commonly used on hospice claims include:

Code	Description
01	Discharged to home or self-care
30	Still patient
40	Expired at home
41	Expired in a medical facility
42	Expired- place unknown
50	Discharged/transferred to hospice- home
51	Discharged/transferred to hospice- medical facility

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:

- The beneficiary moves out of the hospice's service area or transfers to another hospice.
- The hospice determines that the beneficiary is no longer terminally ill.

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

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

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

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

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

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

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 reelect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future and are willing to be compliant with care.

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

If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice shall file a timely-filed Notice of Election Termination / Revocation (NOTR) using type of bill 8xB, unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) within 5 calendar days after the effective date of discharge or revocation. While a timely-filed NOTR is one that is submitted to and accepted by the A/B MAC (HHH) within 5 calendar days after the hospice election, posting to the CWF may not occur within that same timeframe. The date of posting to the CWF is not a reflection of whether the NOTR is considered timely filed. A NOTR (type of bill 8xB) is entered via Direct Data Entry in the same way as an NOE (type of bill 8xA). Hospices continue to have 12 months from the date of service in which to file their claims timely.

A patient can also be admitted and discharged on the same day. They would submit an 8x1 Type of Bill (“Admission through Discharge Claim”), matching “From” and “Through” dates, and whatever the appropriate level of care the revenue code was, with 1 unit. A patient cannot be discharged and readmitted to the same hospice on the same day.

Untimely Face-to-Face Encounters and Discharge

When a required face-to-face encounter occurs prior to, but no more than 30 calendar days prior to, the third benefit period recertification and every benefit period recertification thereafter, it is considered timely. A timely face-to-face encounter would be evident when examining the face-to-face attestation, which is part of the recertification, as that attestation includes the date of the encounter. While the face-to-face encounter itself must occur no more than 30 calendar days prior to the start of the third benefit period recertification and each subsequent recertification, its accompanying attestation must be completed before the claim is submitted.

If the required face-to-face encounter is not timely, the hospice would be unable to recertify the patient as being terminally ill, and the patient would cease to be eligible for the Medicare hospice benefit. In such instances, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes.

When a discharge from the Medicare hospice benefit occurs due to failure to perform a required face-to-face encounter timely, the claim should include the most appropriate patient discharge status code. Occurrence span code 77 does not apply when the face-to-face encounter has not occurred timely.

The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice’s failure to meet the face-to-face requirement, CMS would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

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 Nonterminal Condition for Hospice	Code indicates the patient has elected hospice care, but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause. NOTE: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause.
52	Out of Hospice Service Area	Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.
85	Delayed recertification of hospice terminal illness	Code indicates the hospice received the recertification of terminal illness later than 2 days after the first day of a new benefit period. This code is reported with occurrence span code 77, which reports the provider liable days associated with the untimely recertification.

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 (A/B MAC (HHH) USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an A/B MAC (HHH) 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 Recertification	<p>Code indicates the date of certification or recertification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.</p> <p>The OC 27 code/date is only required on claims where initial certification or recertification occurs. CMS will not be conducting certifying/recertifying physician enrollment checks on physicians reported on claims that do not have occurrence code 27 and date reported.</p> <p>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.</p>
42	Date of Termination of Hospice Benefit	<p>Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit. It is not used in transfer situations.</p> <p>NOTE: Occurrence code 42 is not required on the NOTR, since the through date represents the revocation date. Occurrence codes are only necessary on NOTRs when carrying the original revocation date on a correction.</p>
55	Beneficiary is Deceased	Report the appropriate NUBC discharge status code that best describes the place in which the beneficiary died (40, 41, or 42). Discharge status code 20 is not used on hospice claims.

Occurrence code 27 is required on the claim for the billing period in which the certification or recertification was obtained. It may be optionally reported on other claims.

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-DDYY.

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 billing period.
77	Provider Liability – Utilization Charged	Code indicates From/Through dates for a period of non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).

Respite care is payable only for periods of respite up to 5 consecutive days. Claims reporting respite periods greater than 5 consecutive days will be returned to the provider. Days of respite care beyond 5 days must be billed at the appropriate home care rate for payment consideration.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line-item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed 5 days, including consecutive respite periods.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6 and later returns to respite care from July 15 to July 18, and completes the month on routine home care, the provider must report two separate line-items for the respite periods and two occurrence span code M2, as follows:

Revenue Line-items:

- Revenue code 0655 with line-item date of service 07/01/XX (for respite period July 1 through July 5) and line-item units reported as 5.
- Revenue code 0651 with line-item date of service 07/06/XX (for routine home care July 6 through July 14) and line-item units reported as 9.

- Revenue code 0655 with line-item date of service 07/15/XX (for respite period July 15 through 17th) and line-item units reported as 3.
- Revenue code 0651 with line-item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line-item units reported as 14.

Occurrence Span Codes:

- M2 0701XX – 07/05/XX
- M2 0715XX – 07/17/XX

Provider Liability Periods Using Occurrence Span Code 77: 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 noncovered days fall at the beginning of a billing period other than the initial certification period.

Example:

A new benefit period begins on 6/14/20XX. The hospice is required to obtain the recertification (verbal or written) by 6/16/20XX. The hospice obtains the recertification 6/19/20XX.

The hospice reports 6/14 – 6/18 as non-covered days using occurrence span code 77.

The hospice reports the date the certification was obtained, 6/19/20XX, in occurrence code 27.

Condition code 85 is only reported in this case because the certification was untimely.

- Late-filing of a Notice of Election (NOE). A timely-filed NOE is a NOE that is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) within 5 calendar days after the hospice admission date. When the hospice files a NOE late, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to and accepted by the A/B MAC (HHH). The date the NOE is submitted to and accepted by the A/B MAC (HHH) is an allowable day for payment.

Example:

Admission date is 10/10/20XX (Fri). Day 1 = Sat.

10/11/20XX

Day 2 = Sun. 10/12/20XX Day 3 = Mon.

10/13/20XX Day 4 = Tues. 10/14/20XX

Day 5 = Weds. 10/15/20XX 10/15/20XX is the NOE Due Date.

IF NOE Receipt date is 10/16/20XX, the hospice reports 10/10- 10/15 as noncovered days using occurrence span code 77 or Medicare systems return the claim to the provider for correction.

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. Provider-submitted codes:

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)	<p>MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered.</p> <p>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.</p> <p>Hospices must report value code 61 when billing revenue codes 0651 and 0652.</p>
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care).	<p>MSA or Core Based Statistical Area (CBSA) number (or rural State code) of the facility where inpatient hospice services are delivered.</p> <p>Hospices must report value code G8 when billing revenue codes 0655 and 0656.</p>

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the hospice.

Code	Title	Definition
62	Number of High Routine Home Care Days	Days that fall within the first 60 days of a routine home care hospice claim. The Medicare system puts the high days returned by Pricer on the claim as a value code 62 amount.
63	Number of Low Routine Home Care Days	Days that come after the first 60 days of a routine home care hospice claim. The Medicare system puts the low days returned by Pricer on the claim as a value code 63 amount.

If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, the hospice reports the CBSA that applies at the end of the billing period. For routine home care and continuous

home care (e.g., the beneficiary's residence changes between locations in different CBSAs), report the CBSA of the beneficiary's residence at the end of the billing period. For general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs), report the CBSA of the latest facility that served the beneficiary. If the beneficiary receives both home and inpatient care during the billing period, the latest home CBSA is reported with value code 61 and the latest facility CBSA is reported with value code G8.

Revenue Codes

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

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.

Code	Description	Standard Abbreviation
0651	Routine Home Care	RTN Home
0652	Continuous Home Care	CTNS Home A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care do not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (or less than 32 units) within a 24-hour period, then the care rendered would be covered as a routine home care day. Services provided by a nurse practitioner as the attending physician are not included in the CHC computation nor is care that is not directly related to the crisis included in the computation. CHC billing should reflect direct patient care during a period of crisis and should not reflect time related to staff working hours, time taken for meal breaks, time used for educating staff, time used to report etc.
0655**	Inpatient Respite Care	IP Respite
0656**	General Inpatient Care	GNL IP
0657	Physician Services	PHY SER (must be accompanied by a physician procedure code)

The date of discharge from general inpatient or inpatient respite care is paid at the appropriate home care rate and must be billed with the appropriate home care revenue code unless the patient is deceased at the time of discharge in which case, the appropriate inpatient respite or general inpatient care revenue code should be used.

NOTE: Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physicians, nurse practitioners, or physician assistants employed by the hospice; or physicians, nurse practitioners or physician assistants 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 for the A/B MAC (HHH) to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the A/B MAC (HHH). The Medicare contractor will pay the lesser of the actual charge or 85% of the fee schedule amount when revenue code 657 is billed with modifier GV. Additional revenue codes are reported describing the visits provided under each level of care.

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, 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. During an initial or comprehensive assessment, it would not be best practice to wait until later (after the clinician has left the home) to document the findings of an assessment or the interventions provided during a patient visit. It is recommended that this information be documented as close to the time of the assessment or intervention as possible. 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.

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.

When making the determination as to whether a particular visit should be reported, a hospice should consider whether the visit would have been reported, and how it would have been reported, if the patient were receiving RHC in his or her private home. If a group of tasks would normally be performed in a single visit to a patient living in his or her private home, then the hospice should count the tasks as a single visit for the patient residing in a facility. Hospices should not record a visit every time a staff member enters the patient's room. Hospices should use clinical judgment in counting visits and summing time.

Hospices report social worker phone calls and all visits performed by hospice staff in 15- minute increments using the following revenue codes and associated HCPCS. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists.

All visits to provide care related to the palliation and management of the terminal illness or related conditions in the home, whether provided by hospice employees or provided under arrangement, must be reported in line-item detail. All services provided by hospice employees in all other sites of service, including contract facilities, must also be reported in line-item detail with the exception of hospice inpatient facilities.

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. However, these services may be reported as a number of visits in each discipline per week, using HCPCS code Q5006. Hospices do not

report visit data at this time for visits made by non-hospice staff providing General Inpatient Care or respite care in contract facilities.

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. 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.

For dates of service before October 1, 2018, Hospice agencies shall report injectable and noninjectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injectable prescription drugs shall be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy.

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

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

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

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

Effective for dates of service on and after 10/1/2018, hospices are no longer required to report drugs using line-item detail. Hospices may report summary charges for drugs as shown in the table below. Hospices must enter the following visit revenue codes, when applicable:

Revenue Code	Required HCPCS	Required Detail
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0250 Non-injectable Prescription Drugs	N/A	<p>Required detail: Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled and should be reported as the unit measure.</p> <p>For dates of service on and after 10/1/2018: Report a monthly charge total for all drugs (i.e., report a total charge amount for the period covered by the claim) using revenue code 0250.</p>
029X Infusion pumps	<p>Applicable HCPCS</p> <p>N/A</p>	<p>Required detail: Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.</p> <p>For dates of service on and after 10/1/18: Report a monthly charge total for infusion DME (i.e., report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the infusion pumps and 0294 for DME infusion drugs.</p>
042x Physical Therapy	G0151 or G0157	<p>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.</p>
043x Occupational Therapy	G0152 or G0158	<p>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.</p>
044x Speech Therapy – Language Pathology	G0153	<p>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.</p>
055x Skilled Nursing	G0299 or G0300	<p>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.</p>

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.
0636 Injectable Drugs	Applicable HCPCS	Required detail: Report on a line-item basis per fill with units representing the amount filled. (i.e., Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2). For dates of service on and after 10/1/2018: Revenue code 0636 is not required.

* If revenue code 656 with HCPCS Q5006 is reported on a claim, then claim lines with a visit revenue code 055x, or 057x do not need a corresponding visit HCPCS code(s) if those lines fall under the general inpatient revenue code line (656/Q5006) dates.

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.

Hospices shall use G0299 for "direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting" and G0300 "direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting."

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 contractor shall use the following remittance advice messages and associated codes when bundling line-items under this policy. This CARC/RARC combination is compliant with CAQH

CORE Business Scenario Four. Group Code: CO

CARC: 97 RARC: N/A

MSN: N/A

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.

For information regarding the billing requirements for Coverage of Kidney Disease Patient Education Services under hospice see Chapter 32, §20.1).

HCPCS/Accommodation Rates/HIPPS Rate Codes

Hospices must 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 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 a 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.

Q5004 shall be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility. There are 4 situations where this would occur:

1. If the beneficiary is receiving hospice care in a solely certified SNF.
2. If the beneficiary is receiving general inpatient care in the SNF.

3. If the beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition unrelated to the terminal illness and related conditions and is receiving hospice routine home care; this is uncommon.
4. If the beneficiary is receiving inpatient respite care in a SNF.

If a beneficiary is in a nursing facility but doesn't meet the criteria above for Q5004, the site shall be coded as Q5003, for a long-term care nursing facility.

General inpatient care provided by hospice staff requires line-item visit reporting in units of 15-minute increments when provided in the following sites of service: Skilled Nursing Facility (Q5004), Inpatient Hospital (Q5005), Long Term Care Hospital (Q5007), Inpatient Psychiatric Facility (Q5008).

The total number of visits is to be reported for each discipline per week at each location of service for General inpatient care provided in an inpatient hospice facility (Q5006). Each visit will represent one unit.

These service location HCPCS codes are not required on revenue code lines describing the visits provided under each level of care. These lines report the HCPCS codes shown in the table under Revenue Codes.

Telehealth Service Reporting

Effective January 1, 2027, Hospices shall report face-to-face encounters conducted by a hospice physician or hospice nurse practitioner for recertification via telecommunications technology on hospice claims. Hospices shall submit the use of telecommunications technology when conducting face-to-face encounters for recertification, on the hospice claim via G-0679.

G0679: Hospice face-to-face encounter conducted by a hospice physician or hospice nurse practitioner for recertification via telecommunications technology (this telehealth encounter is considered an administrative expense).

Hospices shall report the encounter via telecommunications technology in line-item detail, and each service must be reported as a separately dated line under the appropriate revenue code for each discipline furnishing the service.

Modifiers

The following modifier is required reporting for claims:

PM – post-mortem visits. Hospices shall report visits and length of visits (rounded to the nearest 15-minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Post-mortem visits occurring on a date after the date of death are not to be reported. The reporting of post-mortem visits, on the date of death, should occur regardless of the patient's level of care or site of service. Date of death is defined as the date of death reported on the death certificate. Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.

For example, assume that a nurse arrives at the home at 9 pm to provide routine home care (RHC) to a dying patient, and that the patient passes away at 11 pm. The nurse stays with the family until 1:30 am. The hospice should report a nursing visit with eight 15-minute time units for the visit from 9 pm to 11 pm. On a separate

line, the hospice should report a nursing visit with a PM modifier with four 15-minute time units for the portion of the visit from 11 pm to midnight to account for the 1-hour post-mortem visit.

If the patient passes away suddenly, and the hospice nurse does not arrive until after his death at 11:00 pm, and remains with the family until 1:30 am, then the hospice should report a line-item nursing visit with a PM modifier and four 15-minute increments of time as the units to account for the 1-hour post mortem visit from 11:00 pm to midnight.

The following modifier may be used to identify requests for an exception to the consequences of not filing the NOE timely:

KX - Even if a hospice believes that exceptional circumstances beyond its control are the cause of its late-filed NOE, the hospice shall file the associated claim with occurrence span code 77 used to identify the non-covered, provider liable days. The hospice shall also report a KX modifier with the Q HCPCS code reported on the earliest dated level of care line on the claim. The KX modifier shall prompt the A/B MAC (HHH) to request the documentation supporting the request for an exception. Based on that documentation, the A/B MAC (HHH) shall determine if a circumstance encountered by a hospice qualifies for an exception.

If the request for an exception is approved by the A/B MAC (HHH), the A/B MAC (HHH) shall process the claim with the CWF override code and remove the submitted provider liable days, which will allow payment for the days associated with the late-filed NOE. If the A/B MAC (HHH) finds that the documentation does not support allowing an exceptional circumstance, the A/B MAC (HHH) shall process the claim as submitted.

The contractor shall use the following remittance advice messages and associated codes under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three Group

Code: CO CARC: 96

RARC: MA54 MSN: N/A

Hospices may appeal the contractor's determination that an exceptional circumstance did not apply. Modifier GV may be used to identify attending physician services performed by a Doctor of Medicine, Doctor of Osteopathy, Nurse Practitioner or Physician Assistant.

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).

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 level of care 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.

Service reporting revenue codes – report dates as described in the table above under Revenue Codes.

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. Units for revenue code 652 are reported in 15-minute increments.

When days are non-covered due to not filing a timely NOE, the hospice reports two lines for the affected level of care. For example, if a billing period contains 31 days of routine home care and the first 5 days are non-covered due to not filing a timely NOE:

The hospice reports one revenue code 0651 line containing the earliest noncovered date of service, 5 units and all non-covered charges.

- The hospice reports a second revenue code 0651 line containing the first covered date of service, 26 units and all covered charges.
- Report units for service reporting lines as a multiplier of the visit time defined in the HCPCS description.

When the revenue code or HCPCS code requires 15-minute increment reporting, visits of any length are to be reported, rounding the time to the nearest 15-minute increment.

Units for summary drug charges lines may be reported using '1' to satisfy the required field or using a number of drugs provided during the billing period, at the option of the hospice. Service unit data will not be used by Medicare for payment or data analysis.

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.

Non-Covered Charges

The hospice enters a charge amount equal to the Total Charges for any revenue code line with a Service Date within a non-covered period (e.g., an occurrence span code 77 period).

Payer Name

The hospice identifies the appropriate payer(s) for the claim.

National Provider Identifier – Billing Provider

The hospice enters its own National Provider Identifier (NPI).

Principal Diagnosis Code

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

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

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

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

The principal diagnosis listed is the diagnosis most contributory to the terminal prognosis.

Non-reportable Principal Diagnosis Codes to be returned to the provider for correction:

- Hospices may not report ICD-10-CM codes as the principal diagnosis on hospice claims if the ICD-10-CM code is listed on the unacceptable principal diagnosis list.
- Hospices may not report ICD-10-CM z-codes as the principal diagnosis on hospice claims.
- Hospices may not report ICD-10-CM z-codes describing debility or failure to thrive as principal hospice diagnoses on the hospice claim.
- Hospices may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines or require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing guidelines.

Other Diagnosis Codes

The hospice enters diagnosis coding as required by ICD-10-CM Coding Guidelines. Hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual. This will also include the reporting of any mental health disorders and conditions that would affect the plan of care.

Attending Provider Name and Identifiers

The hospice enters the name and provider identifier of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care. The patient's designated attending physician could be an independent physician, hospice physician, a nurse practitioner, or physician assistant. If there is no attending physician listed, then the hospice shall report the hospice certifying/recertifying physician.

Other Provider Name and Identifiers

The hospice enters the name and provider identifier of the hospice physician responsible for certifying/recertifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name.

NOTE: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying/recertifying the terminal illness. When the attending physician is also the physician certifying/recertifying the terminal illness, only the attending physician field is required to be populated, the other physician field would not need to be populated.

Hospices shall report the NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice. The billing hospice shall obtain the NPI for the facility where the patient is receiving care and report the facility's name, address, and NPI on the 837 Institutional claim format in Loop 2310E- Service Facility Location. When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

Failure to report this information for claims reporting place of service HCPCS Q5003 (long term care nursing facility), Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5007 (long term care hospital) and Q5008 (inpatient psychiatric facility) will result in the claim being returned to the provider.

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 A/B MACs (HHH) maintain payment responsibility for managed care enrollees who elect hospice. These regulations are found at 42 CFR Part 417, Subpart P: go to <http://www.gpo.gov/fdsys/browse/collectionCfr.action>; select the applicable year, and scroll down to Part 417, and go to 42 CFR 417.585 Special Rules: Hospice Care (b); and also at 42 CFR 417.531 Hospice Care Services (b) which can be located in the same manner. Medicare Fee for Service retains payment responsibility for all hospice and nonhospice 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 A/B MAC (A), (B), or (HHH) 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 A/B MAC (HHH) 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 bills 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 A/B MAC (HHH) 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. A/B MACs (HHH) process these claims in accordance with regular claims processing rules. When these modifiers are used, A/B MAC (HHH) 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 A/B MACs (HHH) 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 A/B MACs (HHH) 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.

30.5 – Hospice Claims for Vaccine Services

(Rev. 3621, Issued: 10-07-16, Effective: 10-01-16, Implementation: 10-03-16)

For dates of service on or after October 1, 2016, services for the vaccines provided by a hospice may be billed on an institutional claim to the hospice's Medicare contractor. Since these services are not part of the Medicare hospice benefit, they must be billed on a separate claim that includes only the vaccines and their administration. For information on coding and payment of vaccine services, see chapter 18, section 10 of this manual.

40 - Billing and Payment for Hospice Services Provided by a Physician

(Rev. 1, 10-01-03)

HSP-406, B3-4175, B3-2020, B3-15513

40.1 - Types of Physician Services

(Rev. 1, 10-01-03)

HSP-406

Payment for physician services provided in conjunction with the hospice benefit is made based on the type of service performed.

40.1.1 - Administrative Activities

(Rev.4280, Issued: 04-19-2019, Effective: 07-21-19, Implementation: 07-21-19)

Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group (IDG). Nurse practitioners or physician assistants may not serve as or replace the medical director or physician member of the IDG.

40.1.2 - Hospice Attending Physician Services (Rev. 4280, Issued: 04-19-19, Effective: 07-21-19, Implementation: 07-21-19)

Under the Medicare hospice benefit, an attending physician is defined as a Doctor of Medicine or Osteopathy or a Nurse Practitioner or Physician Assistant (for professional services related to the terminal illness that are furnished on or after December 8, 2003 and January 1, 2019, respectively) who is identified by the patient, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his or her medical care. Payment for physicians, nurse practitioners, or physician assistants serving as the attending physician, who provide direct patient care services and who are hospice employees or working under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill the A/B MAC (HHH) for these services under Medicare Part A.
- The A/B MAC (HHH) pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services or 85 percent of the fee schedule amount for nurse practitioner or physician assistant services. This payment is in addition to the daily hospice rates.
- Payment for attending physician services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.
- No payment is made for attending physician services furnished voluntarily. However, some attending physicians may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the attending physician for the services. An attending physician must treat Medicare patients on the same basis as other patients in the hospice and may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.
- EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the A/B MAC (HHH) and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.
- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role.

40.1.3 - Independent Attending Physician Services (Rev. 4280, Issued: 04-19-19, Effective: 07-21-19, Implementation: 07-21-19)

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 and related conditions that are furnished on or after December 8, 2003), or
- A physician assistant (for professional services related to the terminal illness and related conditions that are furnished on or after and January 1, 2019; 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 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 are billed to the A/B MAC (B) through Medicare Part B. When the independent attending physician furnishes a service related to the patient's terminal illness and related conditions that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the A/B MAC (B) on a professional claim and looks to the hospice for payment for the technical component. Likewise, the independent attending physician would look to the hospice for payment for 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, 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 and related conditions are not considered Medicare Part A "hospice services." These independent attending physician services are billed through Medicare Part B to the A/B MAC (B), 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 A/B MAC (B) makes payment to the independent attending physician 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 must be coordinated with any direct care services provided by hospice physicians.

Only the direct professional services of an independent attending physician, 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 substitute physician are billed by the designated attending physician under either the reciprocal billing or fee-for-time compensation arrangement (formerly referred to as Locum Tenens Arrangements) 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, the attending 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 A/B MAC (HHH).

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. A/B MACs (B) use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

40.1.3.1 - Care Plan Oversight

(Rev. 4280, Issued: 04-19-2019, Effective: 07-21-19, Implementation: 07-21-19)

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

For a physician or NP employed by or under arrangement with a hospice agency, CPO functions are incorporated and are part of the hospice per diem payment and as such may not be separately billed.

For information on separately billable CPO services by the attending physician, nurse practitioner, or physician assistant, see Chapter 12, §180 of this manual.

40.2 - Processing Professional Claims for Hospice Beneficiaries

(Rev.13074, Issued: 03-13-25, Effective: 04-01-25, Implementation: 04-07-25)

Professional services of attending physicians, who may be nurse practitioners or physician assistants, 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.

A/B MACs (B) 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, or the GW modifier is billed for services unrelated to the patient's terminal condition) or the trailer information on the CWF reply shows a hospice election. The A/B MAC (B) shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information.

For beneficiaries enrolled in hospice, A/B MACs (B) shall deny any services on professional claim that are submitted without either the GV or GW modifier. A/B MACs (A) and (B) or DME MACs, shall deny claims for all other services related to the patient's terminal condition furnished by individuals or entities other than the designated attending physician. All claims denied for overlapping hospice election are assigned provider

liability. 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.

DME MACs shall make determinations of relatedness in the same way the A/B MACs Part B do today – based entirely on the presence of the GW modifier and not based on diagnosis coding. In the event that the claim exceeds the number of allowable modifiers, the DME MAC shall instruct the supplier to use modifier 99 on the line to indicate additional modifiers are reported in the remarks field. The supplier must include the GW modifier in the claim remarks. Claims that do not contain the GW modifier shall be denied.

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, A/B MACs (B) 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. 13074, Issued: 03-13-25, Effective: 04-01-25, Implementation: 04-07-25)

Any covered Medicare services not related to the treatment of the terminal condition or related conditions 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.” Any claims missing the GW modifier or condition code 07 would be denied and all denied claims for overlapping hospice election would be denied as provider liability. A/B MACs (A) and (B) 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, A/B MACs (A) and (B) may conduct pre-payment development or post-payment review to validate that services billed with the GW modifier or condition code 07 are not related to the patient’s terminal condition.

60 - Billing and Payment for Services Provided by Hospices Under Contractual Arrangements with Other Institutions

(Rev. 1, 10-01-03) A-02-102

There may be circumstances in which another health care entity may wish to “purchase” some of the highly specialized staff time or services of a hospice to better meet the needs of their specific patient population. In these cases, the services are not “hospice” services in terms of Medicare payment but become part of the service package of the provider under whose care the patient is. Examples of such circumstances are provided below.

EXAMPLE 1

A dually eligible Medicare/Medicaid beneficiary enrolled in the Program of All-Inclusive Care for the Elderly (PACE) program for approximately two years has been diagnosed with a life limiting terminal illness with a prognosis of six months or less. In the course of routine assessments, the PACE provider recognizes that the beneficiary would benefit from the specialized services of a pain management specialist or a grief counselor.

The PACE provider would then enter into a contractual arrangement with a Medicare certified hospice to purchase these specialized services. The hospice provider would bill the PACE provider for the services, and the PACE provider would in turn pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which in this example are PACE services and included in the PACE provider's capitated rate). In this example, the PACE provider would maintain a medical record on the patient and the hospice provider would submit any documentation related to the care of the PACE patient to the PACE provider.

EXAMPLE 2

A Medicare beneficiary is receiving skilled services from a Medicare certified home health agency (HHA). The beneficiary has been diagnosed with a life limiting terminal illness, but chooses to continue curative treatments, thereby rendering him ineligible for the Medicare hospice benefit. The beneficiary is experiencing a period of intractable pain, and the HHA wishes to purchase specialized pain control services from the hospice provider. The HHA would then enter into a contractual arrangement with a Medicare certified hospice to purchase specialized nursing services. The hospice would bill the HHA and the HHA would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which, in this example, are home health services and therefore included in the HHA's episode payment). In this example, the HHA would maintain a medical record on the patient, and the hospice submits any documentation related to the pain management to the HHA.

EXAMPLE 3

A Medicare beneficiary (non-dual eligible) resides in a skilled nursing facility (SNF) and has a diagnosis of Alzheimer's disease. The beneficiary's disease process has progressed to a stage in which he/she can no longer ingest food or fluids. The beneficiary's family has been approached by the SNF regarding the placement of a feeding tube and has been told, "their loved one may not live much longer." The family is struggling with this concept and has requested assistance from the SNF regarding hospice care and grief counseling. The SNF has provided information about the Medicare hospice benefit to the family, but the patient's legal representative has made a decision not to elect hospice care at this time. The SNF does not have a trained grief counselor or full-time social worker on staff but has a business relationship with a local hospice and has requested the services of a pastoral or grief counselor. The SNF and hospice enter into a contractual arrangement for the provision of grief counseling to this beneficiary's family by a pastoral care counselor. The hospice provider would bill the SNF, and the SNF would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare Part A or B separately for the pastoral care services (which in this example are included in the Medicare's Resource Utilization Group or RUG payments to the SNF).

The SNF maintains the medical record on this patient and the hospice provider would submit any documentation related to the pastoral care services provided to the SNF.

60.1 - Instructions for the Contractual Arrangement (Rev. 1, 10-01-03) A-02-102

A contractual agreement between both parties must be on file and available for review by the state survey agency responsible for conducting surveys on behalf of CMS to assess compliance with the relevant conditions of participation for the provider contracting for the hospice services. Where a PACE organization contracts with a hospice organization, the contract, which is reviewed by CMS, must meet the requirements specified in 42 CFR 460.70. Go to <http://www.gpo.gov/fdsys/browse/collectionCfr.action>; select the applicable year, choose title42, and select Chapter IV - Centers for Medicare & Medicaid Services and then locate 460.70. The

agreement must specify each of the services to be provided, the credentials required for any of the professionals providing the services, the billing method and payment amounts, and any required documentation.

60.2 - Clarification of the Payment for Contracted Services

(Rev. 1, 10-01-03) A-02-102

In all of the examples provided above, the billing and payment for the services are between each of the providers. It is our expectation that Medicare will not be billed separately for any of the contracted services referred to in the examples provided above.

70 - Deductible and Coinsurance for Hospice Benefit

(Rev. 1, 10-01-03)

HSP 410

70.1 - General

(Rev. 1, 10-01-03)

A3-3142

There is no deductible.

The payment rates have been reduced by a coinsurance amount on outpatient drugs and biologicals, and inpatient respite care as required by law. No other coinsurance or deductibles may be imposed for services furnished to beneficiaries during the period of an election, regardless of the setting of the services. Hospices may charge beneficiaries for the applicable coinsurance amounts only for drugs and biologicals and for inpatient respite care.

The hospice is responsible for billing and collecting any coinsurance amounts from the beneficiary.

70.2 - Coinsurance on Outpatient Drugs and Biologicals

(Rev. 1, 10-01-03)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than \$5, for each prescription furnished on an outpatient basis.

The hospice is not required to make this charge but may do so in accordance with the following:

- The hospice must establish a “drug copayment schedule” that specifies each drug and the copayment to be charged. The copayment charges included on the schedule must approximate 5 percent of the cost of the drugs or biologicals to the hospice, up to a \$5 maximum. Additionally, the cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The hospice must submit this schedule to the A/B MAC (HHH) in advance for approval.

70.3 - Coinsurance on Inpatient Respite Care

(Rev. 4280, Issued: 04-19-19, Effective: 07-21-19, Implementation: 07-21-19)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the national Medicare respite care rate, after adjusting the national rate for local wage differences. This coinsurance is not counted toward the hospital deductible, but it is limited to the same amount.

EXAMPLE

Assume a wage adjusted inpatient respite care rate for the year (as provided by the A/B MAC (HHH)) of \$100. The maximum coinsurance rate would be \$5. The hospice may charge any amount up to and including \$5 for inpatient respite care only.

The total amount of coinsurance for inpatient respite care for any beneficiary during a hospice coinsurance period may not exceed the amount of the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. A hospice coinsurance period begins with the first day for which an election for hospice services is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on which no such election is in effect for the beneficiary.

EXAMPLE

Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care under an additional election period. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, the maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

No other coinsurance may be charged by the hospice.

80 - Caps and Limitations on Hospice Payments

(Rev. 2482, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)

For information regarding caps and limitations on hospice payments, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 90.

90 - Frequency of Billing and Same Day Billing

(Rev. 3502, Issued: 04-28-16, Effective: 01-01-16, Implementation: 10-03-16)

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing must 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. Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned beginning on dates of service July 1, 2013. The only exception to this requirement is in the case of the beneficiary being discharged or revoking the benefit and then later re-electing the benefit during the same month. The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8 to August 31 and a separate claim is submitted with dates of service September 1 to September 1. Hospice claims should not span multiple months. Any hospice claim spanning multiple months will be returned to the provider for correction.

In cases where one hospice transfers a beneficiary to another hospice that admits the 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.

100 - Billing for Hospice Denials

(Rev. 2748, Issued: 07-26-13, Effective: 01-01-14, Implementation: 01-06-14)

100.1 - Billing for Denial of Hospice Room and Board Charges

(Rev. 2410, Issued: 02-03-12, Effective: 07-01-12, Implementation: 07-02-12)

Hospice providers wishing to receive a line-item denial for room and board charges may submit the charges as non-covered using revenue code 0659 with HCPCS A9270 and modifier GY on an otherwise covered hospice claim.

100.2 - Demand Billing for Hospice General Inpatient Care

(Rev. 2748, Issued: 07-26-13, Effective: 01-01-14, Implementation: 01-06-14)

The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by the hospice to Medicare beneficiaries in situations where Medicare payment is expected to be denied. ABN issuance is mandatory when the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C). When a Medicare hospice beneficiary has been receiving covered general inpatient care (GIP) and the hospice determines that continued hospice GIP care is not reasonable and medically necessary, the provider must issue an ABN. Billing instructions for demand bills associated with ABN issuance are provided in this manual in Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32).

Hospices should be aware Medicare may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN. A/B MACs (HHH) reviewing GIP reported on a hospice claim with an ABN provided may conclude the care is not reasonable and medically necessary. When the A/B MAC (HHH) makes the non-coverage determination, they must non-cover the GIP line-item(s) on the claim. Hospices may be paid the routine home care (RHC) rate in lieu of the denied GIP service. The A/B MAC (HHH) adds a line-item for RHC (revenue code 0651) for each denied GIP line. The charges associated with the added RHC line should be the RHC charges the hospice reports on their claim or in the absence of a hospice submitted RHC line-item, the A/B MAC (HHH) shall enter the applicable RHC base rate.

These instructions are not applicable when the beneficiary is not questioning the Medicare coverage but needs a Medicare denial for a secondary payer. In those cases, the provider should submit a non-covered claim with the condition code 21.

110 - Payment Procedures for Terminated Hospices

(Rev. 13190; Issued: 04-24-25; Effective: 10-01-25; Implementation:10-06-25)

Medicare regulations allow that payment may be made for hospice services for up to thirty days after a hospice terminates their Medicare provider agreement. This payment may be made if the hospice services are furnished under a plan of care established before the effective date of the termination. Medicare continues to make payments for claims which extend beyond a provider's termination date if the hospice services are provided under a plan of care established prior to that date and if the hospice period of care ends within the 30-day period.

120 - A/B MACs (B) Responsibilities for Publishing Hospice Information

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

A/B MACs (B) 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. A/B MACs (B) shall include information on the use of special modifiers that are in effect at that time. A/B MACs (B) may also publish related material on Web pages.

130 - HOSPICE Pricer Program

(Rev. 3930; Issued: 12-01-17, Effective: 03-01-18, Implementation: 03-01-18)

Hospice services billed on TOB 081x and 082x are reimbursed based on calculations made by the Hospice Pricer. The Hospice Pricer is a module within Medicare claims processing systems. The Hospice Pricer makes all payment calculations applicable under Hospice claims, including all levels of care (Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care).

Medicare claims processing systems must send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the shared systems. The following section describes the elements of Hospice claims that are used in the Hospice Pricer and the logic that is used to make payment determinations. The following is presented for A/B MACs (HHH) in order to help understand their Hospice payments and how they are determined.

130. - Input/Output Record Layout

(Rev. 4393, Issued: 09- 13-19; Effective: 11-25-19, Implementation: 11-25-19)

The required data and format for the Hospice Pricer input/output record are shown below:

Field Name	Field Layout	Position	Description
NPI	X(10)	1-10	Input item: The billing provider's National Provider Identifier, copied from the claim.
PROV-NO	X(6)	11-16	Input item: The billing provider's CMS Certification Number (CCN), copied from the claim. (FISS crosswalks the CCN based on the NPI submitted by the provider).
FROM-DATE	9(8)	17-24	Input item: The statement covers period "From" date, copied from the claim. Date format must be CCYYMMDD.
ADMISSION- DATE	9(8)	25-32	Input item: The admission date, copied from the claim. Date format must be CCYYMMDD.
Filler	x(10)	33-42	
PROV- CBSA	X(5)	43-47	Input item: The CBSA code used to wage-adjust inpatient levels of care. Copied from the value code G8 amount on the claim.
BENE-CBSA	X(5)	48-52	Input item: The CBSA code used to wage-adjust home levels of care. Copied from the value code 61 amount on the claim.

PROV-WAGE-IND	99V9(4)	53-58	Output item: The wage index value that corresponds to the PROV-CBSA.
BENE-WAGE-IND	99V9(4)	59-64	Output item: The wage index value that corresponds to the BENE-CBSA.
NA Day1 Add-on Units	x(2)	65-66	Input item: The number of days from a prior hospice benefit period if identified by CWF as part of the first 60 days of RHC.
NA Day 2 Add-on Units	x(2)	67-68	Input item: Not used.
EOL Day 1 Add-on Units	x(2)	69-70	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 2 Add-on Units	x(2)	71-72	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 1 day. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 3 Add-on Units	x(2)	73-74	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 2 days. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 4 Add-on Units	x(2)	75-76	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 3 days. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 5 Add-on Units	x(2)	77-78	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 4 days. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 6 Add-on Units	x(2)	79-80	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 5 days. No units input if the lines are not associated with routine home care (revenue code 0651).
EOL Day 7 Add-on Units	x(2)	81-82	Input item: The sum of the units associated with revenue codes 055x (if G0299 present) and 056x (other than 0569) on the date of death minus 6 days. No units input if the lines are not associated with routine home care (revenue code 0651).
Filler	x(10)	83-92	

QIP- REDUCTI ON- IND	x	93	Input item: An indicator of whether the hospice's payments are subject to the 4% reduction for not reporting quality data. Valid values: blank = no reduction, 1 = 4% reduction applies.
REV1	X(4)	94-97	Input item: Revenue code 0651 (if present) copied from the claim.
HCPC1	X(5)	98-102	Input item: HCPCS G code associated with revenue code 0651, copied from the claim.
Line Item DOS1	9(8)	103-110	Input item: The line-item date of service associated with revenue code 651, copied from the claim.
UNITS1	9(7)	111-117	Input item: The number of units associated with revenue code 0651, copied from the claim. This represents the number of days of routine home care to be paid.
THEIR- PAY- CHG1	9(6)V99	118-125	Output item: The total payment to be made on the revenue code 0651 line.
REV2	X(4)	126-129	Input item: Revenue code 0652 (if present) copied from the claim.
HCPC2	x(5)	130-134	Input item: HCPCS G code associated with revenue code 0652, copied from the claim.
Line Item DOS2	9(8)	135-142	Input item: The line-item date of service associated with revenue code 652, copied from the claim.
UNITS2	9(7)	143-149	Input item: The number of units associated with revenue code 0652, copied from the claim. This represents the number of 15-minute increments of continuous home care to be paid.
THEIR- PAY- CHG2	9(6)V99	150-157	Output item: The total payment to be made on the revenue code 0652 line.
REV3	X(4)	158-161	Input item: Revenue code 0655 (if present) copied from the claim.
HCPC3	x(5)	162-166	Input item: HCPCS G code associated with revenue code 0655, copied from the claim.
Line Item DOS3	9(8)	167-174	Input item: The line-item date of service associated with revenue code 655, copied from the claim.
UNITS3	9(7)	175-181	Input item: The number of units associated with revenue code 0655, copied from the claim. This represents the number of days of inpatient respite care to be paid.
THEIR- PAY- CHG3	9(6)V99	182-189	Output item: The total payment to be made on the revenue code 0655 line.
REV4	X(4)	190-193	Input item: Revenue code 0656 (if present) copied from the claim.
HCPC4	x(5)	194-198	Input item: HCPCS G code associated with revenue code 0656, copied from the claim.

Line Item DOS4	9(8)	199-206	Input item: The line-item date of service associated with revenue code 656, copied from the claim.	
UNITS4	9(7)	207-213	Input item: The number of units associated with revenue code 0656, copied from the claim. This represents the number of days of general inpatient care to be paid.	
THEIR-PAY-CHG4	9(6)V99	214-221	Output item: The total payment to be made on the revenue code 0656 line.	
NA Day 1 Add-on Pay	9(6)V99	222-229	Output item: Not used.	
NA Day 2 Add-on Pay	9(6)V99	230-237	Output item: Not used.	
EOL Day 1 Add-on Pay	9(6)V99	238-245	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 2 Add-on Pay	9(6)V99	246-253	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 3 Add-on Pay	9(6)V99	254-261	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 4 Add-on Pay	9(6)V99	262-269	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 5 Add-on Pay	9(6)V99	270-277	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 6 Add-on Pay	9(6)V99	278-285	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
EOL Day 7 Add-on Pay	9(6)V99	286-293	Output item: Payment associated with the corresponding ADD-ON-UNITS field (units multiplied by the CHC rate, up to a limit of 16 units).	
PAY-AMT	9(6)99	294-301	Output item: The sum of all payment amounts returned on this record.	
RTC	XX	302-303	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			00	Home rate returned.
			73	Low RHC rate applies to all RHC.
			74	Low RHC rate with EOL SIA.
			75	High RHC rate applies to some or all RHC.
			77	High RHC with EOL SIA.

			No rate return error codes:
			10 Bad units.
			20 Bad units2<8.
			30 Bad CBSA code.
			40 Bad hospice wage index from CBSA file.
			50 Bad bene wage index from CBSA file.
			51 Bad provider number.
High RHC Days	99	304-305	Output item: The number of high RHC days applied to the claim. This number is placed on the claim as a value code 62 amount.
Low RHC Days	99	306-307	Output item: The number of low RHC days applied to the claim. This number is placed on the claim as a value code 63 amount.
FILLE R	x(8)	308-315	

130.2 - Decision Logic Used by the Pricer on Claims

(Rev. 4393, Issued: 09- 13-19; Effective: 11-25-19, Implementation: 11-25-19)

The following components are used by the Hospice Pricer to determine the Hospice payment rate:

- Wage Index
- Labor and Non-Labor Amounts for each level of care rate
 - Routine Home Care (RHC) rates days 1 thru 60
 - Routine Home Care (RHC) rates days 60+
 - Continuous Home Care (CHC) rates
 - Inpatient Respite Care (IRC) rates
 - General Inpatient Care (GIP) rates
- Service Intensity Add-on (SIA) rates

These components are updated in the Hospice Pricer annually. Whenever the Hospice Pricer is updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes.

On each input record, Pricer performs the following calculations:

1. Determine the payment rate for the RHC level of care REV1 by multiplying the labor portion of the RHC payment rate by the associated BENE CBSA wage index and sum with the non-labor portion. The

labor portion plus the non-labor portion, multiplied by the number of RHC days determines the payment amount.

There are high/low RHC labor and non-labor share rates. The RHC low rate is applied to all RHC days for service beyond the 60th day (calculated by looking at the span between the ADMISSION DATE field and the LINE-ITEM DOS1 date field plus NA DAY 1 ADD-ON UNITS). The RHC high rates are applied to service on the 60th day or earlier.

If EOL Day 1 Add-on Units are present, then SIA payment will be made. The payment will be equal to the CHC hourly rate, multiplied by the hours of nursing or social worker services provided (up to four hours total) that occurred on the day of service or a total of 16 units per day for the final seven days of life.

2. Determine the payment rate for the CHC level of care REV2 by multiplying the labor portion of the CHC payment rate by the associated BENE CBSA wage index and sum with the non-labor portion. The labor portion plus the non-labor portion, multiplied by the number of CHC hours (UNITS2 divided by 4) determines the payment amount.
3. Determine the payment rate for the IRC level of care REV3 by multiplying the labor portion of the IRC payment rate by the associated PROV CBSA wage index and sum with the non-labor portion. The labor portion plus the non-labor portion, multiplied by the number of IRC days determines the payment amount.
4. Determine the payment rate for the GIP level of care REV4 by multiplying the labor portion of the GIP payment rate by the associated PROV CBSA wage index and sum with the non-labor portion. The labor portion plus the non-labor portion, multiplied by the number of GIP days determines the payment amount.
5. Calculate the total claim payment by adding all the THEIR-PAY-CHRG fields plus the SIA payment amount total. This is informational only. The claims processing systems uses the THEIR-PAY- CHRG fields to make payment.

NOTE: Pricer reduce payment by 4% if the hospice does not submit quality data. A value of 1 in the QIP REDUCTION IND field indicates that the hospice is subject to the 4% payment reduction due to not reporting required quality data.