

| | |
|--|---|
| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 2316 | Date: October 7, 2011 |
| | Change Request 7478 |

NOTE: Transmittal 2316 dated October 7, 2011 is being re-issued to change the implementation date to January 9, 2012. The transmittal number, date issued, and all other information remain the same.

SUBJECT: Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely

I. SUMMARY OF CHANGES: When a required face-to-face encounter does not occur timely, the beneficiary is not considered terminally ill for Medicare purposes due to lack of recertification, and therefore is not eligible for the hospice benefit. A hospice must discharge the patient but can re-admit once the encounter occurs. Use of occurrence span code 77 is not appropriate when a required face-to-face encounter does not occur timely.

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: January 9, 2012

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|--------------|---|
| R | 11/30/3/Data Required on the Institutional Claim to Medicare Contractor |

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

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

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

| | | | |
|-------------|-------------------|-----------------------|----------------------|
| Pub. 100-04 | Transmittal: 2316 | Date: October 7, 2011 | Change Request: 7478 |
|-------------|-------------------|-----------------------|----------------------|

NOTE: Transmittal 2316 dated October 7, 2011 is being re-issued to change the implementation date to January 9, 2012. The transmittal number, date issued, and all other information remain the same.

SUBJECT: Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely

Effective Date: January 1, 2011

Implementation Date: January 9, 2012

I. GENERAL INFORMATION

A. Background:

To be eligible for the Medicare hospice benefit, a beneficiary must have Medicare Part A, and must be certified as terminally ill by a physician (42 CFR 418.20). The Medicare hospice benefit requires that a written certification or recertification be on file prior to the submission of claim, in order to cover and pay for hospice services. A number of elements comprise a complete certification or recertification, including the physician's prognosis of the patient's life expectancy, a physician narrative, and clinical information or other documentation supporting the diagnosis. Section 3132(b) of the Affordable Care Act of 2010 (ACA) added a new element: as of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each patient prior to the start of the 180th-day recertification, and each subsequent recertification in order to determine continued eligibility for the hospice benefit. For more details on these elements and on the content of a certification, see the Medicare Benefit Policy Manual, Pub 100-02, Chapter 9, section 20.1.

This ACA requirement was based on a recommendation by the Medicare Payment Advisory Commission (MedPAC). In its March 2009 *Report to Congress*, MedPAC wrote that additional controls are needed to ensure adequate accountability for the hospice benefit. MedPAC reported that greater physician engagement is needed in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. The Commission reported that measures to ensure accountability would also help ensure that hospice is used to provide the most appropriate care for eligible patients.

In the November 17, 2010, Home Health PPS Final Rule, we interpreted the 180th-day recertification mentioned in Section 3132(b) of the ACA to occur at the third benefit period (see 75 FR 70436-70437). In that same Final Rule, we required that as of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the third benefit period, no more than 30 calendar days prior to the third benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care (75 FR 70438). When a required face-to-face encounter does not occur within these timeframes, it is not timely, and the beneficiary is not certified as terminally ill. Therefore, when a required face-to-face encounter does not occur timely, the beneficiary is not eligible for the Medicare hospice benefit.

| | | | | | | | | | | | |
|--------|--|-------------|-------------|---|------------------|---|------------------|-------------|-------------|-------------|--|
| | | M A C | M A C | | R I E R | I | F I S S | M C S | V M S | C W F | |
| 7478.1 | Medicare contractors shall be aware of and adhere to the guidelines in this instruction. | X | | X | | X | | | | | |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|--------|--|---|---------------------------|--------|--------------------------------|----------------------|---------------------------|-------------|-------------|-------------|-----------|
| | | A / B M A C | D M M A C | F I | C A R I E R | R H R I | Shared-System Maintainers | | | | OTH ER |
| | | | | | | | F I S S | M C S | V M S | C W F | |
| 7478.2 | <p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p> | X | | X | | X | | | | | |

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

| X-Ref Requirement Number | Recommendations or other supporting information: |
|--------------------------|--|
| | |

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Katie Lucas katherine.lucas@cms.hhs.gov; Wendy Tucker wendy.tucker@cms.hhs.gov.

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

VI. FUNDING

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

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

Section B: For *Medicare Administrative Contractors (MACs)*:

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

30.3 - Data Required on the Institutional Claim to Medicare Contractor *(Rev. 2316, Issued: 10-07-11, Effective: 01-01-11, Implementation: 01-09-12)*

See Pub. 100-02, Chapter 9, §§10 & 20.2 for coverage requirements for Hospice benefits. This section addresses only the submittal of claims. Before submitting claims, the hospice must submit a Notice of Election (NOE) to the Medicare contractor. See section 20, of this chapter for information on NOE transaction types.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing hospice services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

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

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular benefit period. It is referred to as a “frequency” code.

Code Structure

| |
|---|
| 1st Digit - Type of Facility |
| 8 - Special facility (Hospice) |
| 2nd Digit - Classification (Special Facility Only) |
| 1 - Hospice (Nonhospital based) |
| 2 - Hospice (Hospital based) |

| 3rd Digit – Frequency | Definition |
|-----------------------------------|--|
| 0 - Nonpayment/Zero Claims | Used when no payment from Medicare is anticipated. |
| 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. |
| 5 - Late Charges | <p>Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill.</p> <p>For additional information on late charge bills see Chapter 3.</p> |
| 7 - Replacement of Prior Claim | <p>This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or “new” bill.</p> <p>For additional information on replacement bills see Chapter 3.</p> |
| 8 - Void/Cancel of a Prior Claim | <p>This code is used to cancel a previously processed claim.</p> <p>For additional information on void/cancel bills see Chapter 3.</p> |

Statement Covers Period (From-Through)

The hospice shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). The hospice does not show days before the patient's entitlement began. Since the 12-month hospice "cap period" (see [§80.2](#)) ends each year on October 31, hospices must submit separate bills for October and November.

Patient Name/Identifier

The hospice enters the beneficiary's name exactly as it appears on the Medicare card.

Patient Address**Patient Birth date****Patient Sex**

The hospice enters the appropriate address, date of birth and gender information describing the beneficiary.

Admission/Start of Care Date

The hospice enters the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

The admission date stays the same on all continuing claims for the same hospice election.

Patient Discharge Status

This code indicates the patient's status as of the "Through" date of the billing period. The hospice enters the most appropriate National Uniform Billing Committee (NUBC) approved code.

Note that patient discharge status code 20 is not used on hospice claims. If the patient has died during the billing period, use codes 40, 41 or 42 as appropriate.

Medicare regulations at 42 CFR 418.26 define three reasons for discharge from hospice care:

- 1) The beneficiary moves out of the hospice's service area or transfers to another hospice,
- 2) The hospice determines that the beneficiary is no longer terminally ill or
- 3) The hospice determines the beneficiary meets their internal policy regarding discharge for cause.

Each of these discharge situations requires different coding on Medicare claims.

Reason 1: A beneficiary may move out of the hospice's service area either with, or without, a transfer to another hospice. In the case of a discharge when the beneficiary moves out of the hospice's service area without a transfer, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The hospice does not report occurrence code 42 on their claim. This discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit at any time as long they remain eligible for the benefit.

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

Reason 2: In the case of a discharge when the hospice determines the beneficiary is no longer terminally ill, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The hospice also reports occurrence code 42 on their claim and the date of their determination. This discharge claim will terminate the beneficiary's current hospice benefit period as of the occurrence code 42 date. This coding may also be used if the beneficiary has chosen to revoke their hospice election. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future.

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

If the beneficiary is transferred to another hospice (discharge status codes 50 or 51) the claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary's hospice benefit is not affected. If any other appropriate discharge status code is used, this discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future and are willing to be compliant with care.

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. 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 and occurrence code 42, as described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 11, Section 30.3. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of 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, we 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.

Occurrence span code 77 does not apply to the above described situations when the face-to-face encounter has not occurred timely.

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.

Condition Codes

The hospice enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

| | | |
|----|---|---|
| 07 | Treatment of Non-terminal Condition for Hospice | Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment. |
| 20 | Beneficiary Requested Billing | Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination. |
| 21 | Billing for Denial Notice | Code indicates the provider realizes services are |

| | | |
|----|---|---|
| | | at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers. |
| H2 | Discharge by a Hospice Provider for Cause | Discharge by a Hospice Provider for Cause. Note: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause. |

Occurrence Codes and Dates

The hospice enters any appropriate NUBC approved code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use the occurrence span code fields to record additional occurrences and dates.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

| Code | Title | Definition |
|------|--|---|
| 23 | Cancellation of Hospice Election Period (Medicare contractor USE ONLY) | Code indicates date on which a hospice period of election is cancelled by a Medicare contractor as opposed to revocation by the beneficiary. |
| 24 | Date Insurance Denied | Code indicates the date of receipt of a denial of coverage by a higher priority payer. |
| 27 | Date of Hospice Certification or Re-Certification | Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. Note regarding transfers from one hospice to another hospice: If a patient is in the first certification period when they transfer to another hospice, the receiving hospice would use the same certification date as the previous hospice until the next certification period. However, if they were in the next certification at the time of transfer, then they would enter that date in the Occurrence Code 27 and date. |
| 42 | Date of Termination of Hospice Benefit | Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice |

| Code | Title | Definition |
|-------------|--------------|---|
| | | benefits. This code can be used only when the beneficiary has revoked the benefit or has been decertified. It is not used in transfer situations. |

Occurrence code 27 is reported on the claim for the billing period in which the certification or re-certification was obtained. When the re-certification is late and not obtained during the month it was due, the occurrence span code 77 should be reported with the through date of the span code equal to the through date of the claim.

Occurrence Span Code and Dates

The hospice enters any appropriate NUBC approved code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alphanumeric digits and dates are shown numerically as MM-DD-YY.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

| Code | Title | Definition |
|-------------|--|---|
| M2 | Dates of Inpatient Respite Care | Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each. M2 is used when respite care is provided more than once during a benefit period. |
| 77 | Provider Liability – Utilization Charged | Code indicates From/Through dates for a period of non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care). |

Hospices must use occurrence span code 77 to identify days of care that are not covered by Medicare due to untimely physician recertification. This is particularly important when the non-covered days fall at the beginning of a billing period.

Value Codes and Amounts

The hospice enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

The most commonly used value codes on hospice claims are value codes 61 and G8, which are used to report the location of the site of hospice services. Otherwise, value codes are commonly used only to indicate Medicare is secondary to another payer. For detailed information on reporting Medicare secondary payer information, see the Medicare Secondary Payer Manual.

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

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

Revenue Codes

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

For claims with dates of service before July 1, 2008, hospices only reported the revenue codes in the table below. Effective on claims with dates of service on or after January 1, 2008, additional revenue codes will be reported describing the visits provided under each level of care. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in this table.

Hospice claims are required to report separate line items for the level of care each time the level of care changes. This includes revenue codes 0651, 0655 and 0656. For example, if a patient begins the month receiving routine home care followed by a period of general inpatient care and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care.

Each routine home care line reports a line item date of service to indicate the first date that level of care began for that consecutive period. This will ensure visits and calls reported on the claim will be associated with the level of care being billed.

| Code | Description | Standard Abbreviation |
|---|------------------------|--|
| 0651* | Routine Home Care | RTN Home |
| 0652* | Continuous Home Care | CTNS Home 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) |
| <ul style="list-style-type: none"> • * Reporting of value code 61 is required with these revenue codes. • **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner. • ***Reporting of value code G8 is required with these revenue codes. | | |

NOTE: Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner

require the addition of the modifier GV in conjunction with revenue code 0657. Procedure codes are required in order for the Medicare contractor to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the Medicare contractor.

Effective on claims with dates of service on or after July 1, 2008, hospices must report the number of visits that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes above. Charges for these codes will be reported on the appropriate level of care line. Total number of patient care visits is to be reported by the discipline (registered nurse, nurse practitioner, licensed nurse, home health aide (also known as a hospice aide), social worker, physician or nurse practitioner serving as the beneficiary's attending physician) for each week at each location of service. If visits are provided in multiple sites, a separate line for each site and for each discipline will be required. The total number of visits does not imply the total number of activities or interventions provided. If patient care visits in a particular discipline are not provided under a given level of care or service location, do not report a line for the corresponding revenue code.

To constitute a visit, the discipline, (as defined above) must have provided care to the beneficiary. Services provided by a social worker to the beneficiary's family also constitute a visit. For example, phone calls, documentation in the medical/clinical record, interdisciplinary group meetings, obtaining physician orders, rounds in a facility or any other activity that is not related to the provision of items or services to a beneficiary, do not count towards a visit to be placed on the claim. In addition, the visit must be reasonable and necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care.

Example 1: Week 1: A visit by the RN was made to the beneficiary's home on Monday and Wednesday where the nurse assessed the patient, verified effect of pain medications, provided patient teaching, obtained vital signs and documented in the medical record. A home health aide assisted the patient with a bath on Tuesday and Thursday. There were no social work or physician visits. Thus for that week there were 2 visits provided by the nurse and 2 by the home health aide. Since there were no visits by the social worker or by the physician, there would not be any line items for each of those disciplines.

Example 2: If a hospice patient is receiving routine home care while residing in a nursing home, the hospice would record visits for all of its physicians, nurses, social workers, and home health aides who visit the patient to provide care for the palliation and management of the terminal illness and related conditions, as described in the patient's plan of care. In this example the nursing home is acting as the patient's home. Only the patient care provided by the hospice staff constitutes a visit.

Hospices must enter the following visit revenue codes, when applicable as of July 1, 2008:

| | |
|----------------------|---|
| 055x Skilled Nursing | Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. |
|----------------------|---|

| | |
|------------------------------|---|
| 056x Medical Social Services | Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. |
| 057x Home Health Aide | Required detail: The earliest date of service this discipline was provided during the delivery of each level of care in each service location, service units which represent the number of visits provided in that location, and a charge amount. |

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than General Inpatient (GIP) care in 15 minute increments using the following revenue codes and associated HCPCS:

| Revenue Code | Required HCPCS | Required Detail |
|--|----------------|--|
| 042x Physical Therapy | G0151 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description. |
| 043x Occupational Therapy | G0152 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description. |
| 044x Speech Therapy – Language Pathology | G0153 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description. |
| 055x Skilled Nursing | G0154 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description. |

| | | |
|---|-------|---|
| 056x Medical Social Services | G0155 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description. |
| 0569 Other Medical Social Services | G0155 | Required detail: Each social service phone call is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the call defined in the HCPCS description. |
| 057x Aide | G0156 | Required detail: Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier the total time of the visit defined in the HCPCS description. |

Visits by registered nurses, licensed vocational nurses and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055x.

All visits to provide care related to the palliation and management of the terminal illness or related conditions, whether provided by hospice employees or provided under arrangement, must be reported. The two exceptions are related to General Inpatient Care and Respite care. CMS is not requiring hospices to report visit data at this time for visits made by non-hospice staff providing General Inpatient Care or respite care in contract facilities. However, General Inpatient Care or respite care visits related to the palliation and management of the terminal illness or related conditions provided by hospice staff in contract facilities must be reported, and all General Inpatient Care and respite care visits related to the palliation and management of the terminal illness or related conditions provided in hospice-owned facilities must be reported.

Charges associated with the reported visits are covered under the hospice bundled payment and reflected in the payment for the level of care billed on the claim. No additional payment is made on the visit revenue lines. The visit charges will be identified on the provider remittance advice notice with remittance code 97 "Payment adjusted because the benefit for this service is included in the payment / allowance for another service/procedure that has already been adjudicated."

Effective January 1, 2010, Medicare will require hospices to report additional detail for visits on their claims. For all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite care billing, Medicare hospice claims should report each visit performed by nurses, aides, and social workers who are employed by the hospice, and their associated time per visit in the number of 15 minute increments, on a separate line. The visits should be reported using revenue codes 055x

(nursing services), 057x (aide services), or 056x (medical social services), with the time reported using the associated HCPCS G-code in the range G0154 to G0156. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description.

Additionally, providers should begin reporting each RHC, CHC, and Respite visit performed by physical therapists, occupational therapists, and speech-language therapists and their associated time per visit in the number of 15 minute increments on a separate line. Providers should use existing revenue codes 042x for physical therapy, 043x for occupational therapy, and 044x for speech language therapy, in addition to the appropriate HCPCS G-code for recording of visit length in 15 minute increments. HCPCS G-codes G0151 to G0153 will be used to describe the therapy discipline and visit time reported on a particular line item. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. If a hospice patient is receiving Respite care in a contract facility, visit and time data by non-hospice staff should not be reported.

Social worker phone calls made to the patient or the patient’s family should be reported using revenue code 0569, and HCPCS G-code G0155 for the length of the call, with each call being a separate line item. Hospices should report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description. Only phone calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient’s plan of care (such as counseling, or speaking with a patient’s family or arranging for a placement) should be reported. Report only social worker phone calls related to providing and or coordinating care to the patient and family and documented as such in the clinical records.

When recording any visit or social worker phone call time, providers should sum the time for each visit or call, rounding to the nearest 15 minute increment. Providers should not include travel time or documentation time in the time recorded for any visit or call. Additionally, hospices may not include interdisciplinary group time in time and visit reporting.

HCPCS/Accommodation Rates/HIPPS Rate Codes

For services provided on or before December 31, 2006, HCPCS codes are required only to report procedures on service lines for attending physician services (revenue 657). Level of care revenue codes (651, 652, 655 or 656) do not require HCPCS coding.

For services provided on or after January 1, 2007, hospices must also report a HCPCS code along with each level of care revenue code (651, 652, 655 and 656) to identify the type of service location where that level of care was provided.

The following HCPCS codes will be used to report the type of service location for hospice services:

| HCPCS Code | Definition |
|------------|---|
| Q5001 | HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE |

| | |
|-------|---|
| Q5002 | HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY |
| Q5003 | HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF) |
| Q5004 | HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF) |
| Q5005 | HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL |
| Q5006 | HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY |
| Q5007 | HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTCH) |
| Q5008 | HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY |
| Q5009 | HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS) |
| Q5010 | Hospice home care provided in a hospice facility |

If care is rendered at multiple locations, each location is to be identified on the claim with a corresponding HCPCS code. For example, routine home care may be provided for a portion of the billing period in the patient's residence and another portion in an assisted living facility. In this case, report one revenue code 651 line with HCPCS code Q5001 and the number of days of routine home care provided in the residence and another revenue code 651 line with HCPCS code Q5002 and the number of days of routine home care provided in the assisted living facility.

Q5003 is to be used for hospice patients in an unskilled nursing facility (NF) or hospice patients in the NF portion of a dually certified nursing facility, who are receiving unskilled care from the facility staff.

Q5004 is to be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff.

NOTE: Q5003 should be used for hospice patients located in a NF; many of these patients may also have Medicaid. Q5004 should be used when the hospice patient is in a SNF, and receiving skilled care from the facility staff, such as would occur in a GIP stay. For Q5004 to be used, the facility would have to be certified as a SNF. Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. When a patient is in the NF portion of a dually certified nursing facility, and receiving only unskilled

care from the facility staff, Q5003 should be reported. Note that GIP care that is provided in a nursing facility can only be given in a SNF, because GIP requires a skilled level of care.

These service location HCPCS codes are not required on revenue code lines describing the visits provided under each level of care (e.g. 055X, 056X, 057X).

Service Date

The HIPAA standard 837 Institutional claim format requires line item dates of service for all outpatient claims. Medicare classifies hospice claims as outpatient claims (see Chapter 1, §60.4). For services provided on or before December 31, 2006, CMS allows hospices to satisfy the line item date of service requirement by placing any valid date within the Statement Covers Period dates on line items on hospice claims.

For services provided on or after January 1, 2007, service date reporting requirements will vary between continuous home care lines (revenue code 652) and other revenue code lines.

Revenue code 652 – report a separately dated line item for each day that continuous home care is provided, reporting the number of hours, or parts of hours rounded to 15-minute increments, of continuous home care that was provided on that date.

Other payment revenue codes – report a separate line for each level of care provided at each service location type, as described in the instructions for HCPCS coding reported above. Hospices report the earliest date that each level of care was provided at each service location. Attending physician services should be individually dated, reporting the date that each HCPCS code billed was delivered.

Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than GIP care as separate line items for each with the appropriate line item date of service. GIP visit reporting has not changed with the January 2010 update. GIP visits will continue to be reported as the number of visits per week.

For service visits that begin in one calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

Service Units

The hospice enters the number of units for each type of service. Units are measured in days for revenue codes 651, 655, and 656, in hours for revenue code 652, and in procedures for revenue code 657. For services provided on or after January 1, 2007, hours for revenue code 652 are reported in 15-minute increments. For services provided on or after January 1, 2008, units for visit discipline revenue codes are measured by the number of visits.

For services provided on or after January 1, 2010, hospices report social worker phone calls and visits performed by hospice staff for other than GIP care as a separate line item with the appropriate line item date of service and the units as an increment of 15 minutes. GIP visit reporting has not changed with the January 2010 update. The units for visits under GIP level of care continue to reflect the number of visits per week.

Report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description.

Total Charges

The hospice enters the total charge for the service described on each revenue code line. This information is being collected for purposes of research and will not affect the amount of reimbursement.

Payer Name

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

National Provider Identifier – Billing Provider

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

Principal Diagnosis Code

The hospice enters diagnosis coding as required by ICD-9-CM Coding Guidelines. Hospices may not report V-codes as the primary diagnosis on hospice claims. The principal diagnosis code describes the terminal illness of the hospice patient and V-codes do not describe terminal conditions.

Other Diagnosis Codes

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

Attending Provider Name and Identifiers

For claims with dates of service before January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

For claims with dates of service on or after January 1, 2010 the hospice shall enter the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Other Provider Name and Identifiers

For claims with dates of service before January 1, 2010, if the attending physician is a nurse practitioner, the hospice enters the NPI and name of the nurse practitioner.

For claims with dates of service on or after January 1, 2010, the hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note: Both the attending physician and other physician fields should be completed even if the hospice physician certifying the terminal illness is the same as the attending physician.