CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1955	**Date: April 28, 2010**
	Change Request 6905

Change Request 6905, Transmittal 1955, sent on April 28, 2010, is no longer sensitive. The transmittal number, date issued and all other information remain the same.

SUBJECT: New Hospice Site of Service Code

I. SUMMARY OF CHANGES: CMS is implementing a new HCPCS code for Hospice Residential Facility for use on hospice facility claims including standard system editing to ensure proper payment for this site of service. In addition, the Internet Only Manual is being updated to include long standing policy regarding hospice billing on the day a hospice patient transfers from one facility to another.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/Table of Contents
R	11/30.3 - Data Required on the Institutional Claim to Medicare Contractor
R	11/90 - Frequency of Billing and Same Day Billing

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: 1955	Date: April 28. 2010	Change Request: 6905

Change Request 6905, Transmittal 1955, sent on April 28, 2010, is no longer sensitive. The transmittal number, date issued and all other information remain the same.

SUBJECT: New Hospice Site of Service Code

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: CR 5245, Transmittal 1011, dated July 28, 2006, entitled "Instructions for Reporting Hospice Services in Greater Line Item Detail" began requiring hospices to report the site of service for claims on or after January 1, 2007. Now a growing trend in the industry, hospices are opening residential facilities, which are places for patients to live while receiving routine home care or continuous home care. These hospice residential facilities are not certified by Medicare or Medicaid for provision of general inpatient (GIP) or respite care, and our regulations at 42 CFR 418.202(e) do not allow provision of GIP or respite care at hospice residential facilities. Additionally, hospices are also providing home level of care in facilities which are certified to also provide inpatient levels of care. We have received questions from providers asking which site of service code to use when a patient receives a home level of care in a hospice inpatient unit. Since the implementation of CR 5245, CMS recognizes that another code is needed to identify when a hospice facility is a site of service for those receiving a home level of care.

B. Policy: To clarify for hospices how to code the site of service when a patient resides in a hospice residential facility or hospice inpatient facility, and receives a home level of care, CMS is adding a HCPCS code for Hospice Home Care Provided in a Hospice Facility as the site of service. Effective for claims with dates of service on or after October 1, 2010, hospices will report HCPCS Q5010 when Routine Home Care (RHC) or Continuous Home Care (CHC) is provided at a hospice residential facility or a hospice facility which is also certified to provide inpatient care. Additionally, because the regulations limit provision of GIP or respite care to a Medicare or Medicaid certified facility, we are also instructing our contractors to return to providers (RTP) any claims submitted for GIP or respite care, where the site of service is coded as Q5010. This is consistent with the instructions that were communicated in CR 6778, Transmittals 121 and 1907, (Pubs 100-02 and 100-04 respectively) dated February 5, 2010, entitled Medicare Systems Edit Refinements Related to Hospice Services, in which we instructed our contractors to RTP any claims submitted for GIP or respite where the site of service is a patient's home/residence, assisted living facility, or nursing long term care facility or non-skilled nursing facility.

To improve the accuracy of Medicare claims processing, CMS is also implementing several technical edits. In response to industry concerns, CMS is clarifying the difference between a skilled and unskilled nursing facility in our claims processing manual, to assist hospices in correct usage of existing HCPCS codes Q5003 and Q5004. CMS is removing manual language which says, "Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay and nursing facility residents." and replacing it with "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." CMS is replacing manual language which says, "Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay." and replacing it with "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."

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.

Additionally, CMS is instructing contractors to RTP claims where the sum of the "Total Units" fields reported for the level of care revenue code lines does not equal the number of days in the billing period.

Finally, we are adding the following language to the hospice claims processing manual (IOM 104, chapter 11), section 90, to state longstanding policy regarding hospice billing on the day a hospice patient is discharged from one facility and is admitted to another (for example, in the case of a transfer): *"In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill, and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission."*

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6905.1	Medicare contractors shall accept the HCPCS Q5010 on hospice bill types 81x and 82x.	X				X	X				
6905.2	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x billing for GIP revenue code 0656 when reported with the HCPCS Q5010	X				X	X				
6905.3	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x billing for respite revenue code 0655 with the HCPCS Q5010.	X				X	X				
6905.4	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x when the sum of the total units reported on the level of care revenue code lines does not equal the number of days in the billing period.	X				X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6905.5	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. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
6905.4	Level of care revenue codes 0651, 0652, 0655 and 0656. Note that the units for 0652 are reported in 15 minute increments, therefore 96 units equals 1 day.

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

V. CONTACTS

Pre-Implementation Contact(s): Hospice and Institutional claims Wendy.Tucker@cms.hhs.gov, Hospice policy Randy.Throndset@cms.hhs.gov or Katherine.Lucas@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

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

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

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

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

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev. 1955)

30.3 - Data Required on the Institutional Claim to Medicare Contractor

(Rev.1955, Effective: 10-01-10, Implementation: 10-04-10)

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

Before billing, the hospice must submit an admission notice to the Medicare contractor (see section 20). The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing hospice services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

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

Provider Name, Address, and Telephone Number

The hospice enters this information for their agency.

Type of Bill

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

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**

3rd Digit – Frequency	Definition
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The **"**Through" date of this bill (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill. For additional information on late charge bills see Chapter 3.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or **"**new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

Statement Covers Period (From-Through)

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

Patient Name/Identifier

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

Patient Address

Patient Birth date

Patient Sex

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

Admission/Start of Care Date

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

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

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

Patient Discharge Status

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

The codes most commonly used on hospice claims include:

01 Discharged to home or self care
30 Still patient
40 Expired at home
41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice
42 Expired - place unknown
50 Discharged/Transferred to Hospice - home
51 Discharged/Transferred to Hospice - medical facility

Condition Codes

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

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal

		condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause. Note: Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause. Results only in a discharge from the provider's care, not from the hospice benefit.

Occurrence Codes and Dates

The hospice enters any appropriate NUBC approved code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) to record additional occurrences and dates.

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

Code	Title	Definition
23	Cancellation of Hospice Election Period (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

Code	Title	Definition
		they would enter that date in the Occurrence Code 27 and date.
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit, has been decertified or discharged. **It cannot** be used in transfer situations.

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

Occurrence Span Code and Dates

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

Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see Chapter 25.

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

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

Value Codes and Amounts

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

The most commonly used value codes on hospice claims are value codes 61 and G8, which are used to report the location of the site of hospice services. Otherwise, value codes are commonly

used only to indicate Medicare is secondary to another payer. For detailed information on reporting Medicare secondary payer information, see the Medicare Secondary Payer Manual.

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

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

Revenue Codes

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

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

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

- * 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 FL 6 Statement Covers Period dates on line items on hospice claims.

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

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

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

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

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

Service Units

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

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

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

Total Charges

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

Payer Name

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

National Provider Identifier – Billing Provider

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

Principal Diagnosis Code

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

Other Diagnosis Codes

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

Attending Provider Name and Identifiers

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

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.

90 - Frequency of Billing *and Same Day Billing*

(Rev. 1955, Effective: 10-01-10, Implementation: 10-04-10)

The hospice will bill monthly. If the care is interrupted, e.g., an inpatient hospital admission for an unrelated condition, occurrence span code 74 is used to show the period not applicable to hospice care.

In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.