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Processing Hospice Claims – Principal Diagnosis Code Reporting Update: Medicare Claims Processing Manual, Chapter 11, Sections 30.3, 40.2 & 50

Related CR Release Date: March 13, 2025	**MLN Matters Number:** MM13882
Effective Date: April 1, 2025 – for claims received on or after April 1, 2025	**Related Change Request (CR) Number:** CR 13882
Implementation Date: April 7, 2025 – Non-System Requirements; July 7, 2025 – FISS Requirements	**Related CR Transmittal Number:** R13074CP
Related CR Title: Principal Diagnosis Code Reporting Update for Hospice and Manual Updates to Section 30.3, 40.2, and 50 of Chapter 11 of the Claims Processing Manual: Processing Hospice Claims	

Affected Providers

- Hospice providers
- Physicians
- Other providers billing Medicare Administrative Contractors (MACs) for hospice services they provide to Medicare patients

Action Needed

Make sure your billing staff knows about:

- Updated guidance regarding non-reportable principal diagnosis codes
- Clarification of liability for claim denials during a hospice election
- Updates to the Medicare Claims Processing Manual, Chapter 11, section 50 to include “related conditions” so the manual is consistent with the CFR and Federal Register

Background

As defined in the Uniform Hospital Discharge Data Set (UHDDS), a principal diagnosis is “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” This UHDDS definition also applies to all levels of hospice care.

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Hospices must report the principal diagnosis on claims as the diagnosis most related to the terminal prognosis. However, according to the FY 2025 ICD-10-CM Official Guidelines for Coding and Reporting, "codes for symptoms, signs, and ill-defined conditions from Chapter 18 aren't to be used as principal diagnosis when a related definitive diagnosis has been established."

Diagnosis codes considered as supplementary or additional codes for reporting are unacceptable as principal diagnosis codes.

The Medicare Code Editor (MCE) and Integrated Outpatient Code Editor (I/OCE) detect claim errors, including unacceptable principal diagnosis codes. The MCE defines the unacceptable principal diagnosis list.

If you report an unacceptable principal diagnosis as the principal diagnosis on a claim, we'll return the claim. We update the I/OCE files quarterly and you can use the "Data_DX10" table to reference diagnosis codes on the MCE unacceptable principal diagnosis list.

Other unacceptable principal diagnosis codes include those that describe "debility" and "failure to thrive." Neither accurately describes the hospice patients' terminal illness. Updated guidance in the Medicare Claims Processing Manual, Chapter 11, section 30.3 describes non-reportable principal diagnosis codes that will be returned for correction if you report them on a claim.

You must also follow ICD-10-CM coding conventions in the ICD-10-CM, Tabular List, Alphabetic Index, and official coding guidelines.

- ICD-10-CM has a coding convention requiring you to sequence the underlying condition first, if applicable, followed by the manifestation
- When this combination occurs, there's a "use additional code" note at the etiology code and a "code first" note at the manifestation code
- These notes indicate the proper sequencing order of the codes—etiology followed by manifestation

Example: Dementia with Parkinson's disease features this etiology/manifestation convention. The Alphabetic Index lists a code from category G20 first, followed by code F02.80 or F02.81- in brackets.

- The category G20- code represents the underlying etiology (Parkinson's disease), and you must sequence it first
- Codes F02.80 or F02.81- represent the manifestation of dementia in diseases classified elsewhere, with or without behavior disturbance
- Sequencing rules use "Code first" and "Use additional code" notes in classifying certain codes that aren't part of an etiology/manifestation combination
- If you use ICD-10-CM diagnosis codes that you can't use as the principal diagnosis according to ICD-10-CM Coding Guidelines, we'll return the claim to you for a more definitive hospice diagnosis
- Codes listed in Attachment A would cause us to return the claim

You should only use unspecified codes when the medical record, at the time of the encounter, is insufficient to assign a more specific code. We recognize the underlying condition causing the disease may be difficult to code because of insufficient documentation in the medical record. We encourage you to look at the coding conventions under the disease classification for coding conditions on hospice claims. If you report any of these diagnoses as a principal diagnosis, we'll return the claim to you for a more definitive hospice diagnosis.

The Medicare Claims Processing Manual, Chapter 11, section 40.2 clarifies liability for claim denials during a hospice election when the GV or GW modifier or condition code 07 is missing. When a patient elects the Medicare hospice benefit:

- You're required to provide all items and services needed for the palliative care and managing the terminal illness and related conditions
- Regulations at 42 CFR 418.202 describe covered services under the hospice benefit
- Regulations at 42 CFR 418.402 state that Medicare payment to a hospice discharges a person's liability for payment for all services, other than hospice coinsurance described in 42 CFR 418.400, that are considered covered hospice care

How to bill hospice services:

- You should bill services unrelated to the terminal illness using modifier GW (professional claims) or the condition code 07 (institutional claims)
- Attending physicians providing services related to the terminal illness should add modifier GV
- Services related to the terminal illness provided by someone other than the patient-designated attending physician aren't separately payable, nor is the patient liable for the charges
- We'll deny any claims missing the GW or GV modifier or condition code 07
- We'll assign provider liability to all claims denied for overlapping hospice during a hospice election period

Liability for Claim Denials During a Hospice Election

It's your responsibility to check each patient's Medicare status when providing and billing for services. We'll deny claims missing the GW or GV modifier or condition code 07 as provider liability.

More Information

We issued CR 13882 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
March 17, 2025	Initial article released.