



Attention Providers!

Effective October 1, 2006, Medicare will only generate the Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at

<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0656.pdf> on the CMS website.

MLN Matters Number: MM5245 **Revised**

Related Change Request (CR) #: 5245

Related CR Release Date: July 28, 2006

Effective Date: January 1, 2007

Related CR Transmittal #: R1011CP

Implementation Date: January 2, 2007

Instructions for Reporting Hospice Services in Greater Line Item Detail

Note: This article was updated on November 6, 2012, to reflect current Web addresses. This article was previously revised on October 29, 2010, to add a reference to related MM6905 (New Hospice Site of Service Code) in the Additional Information section below. All other information remains the same.

Provider Types Affected

Hospices submitting claims to Medicare regional home health intermediaries (RHHIs) for hospice services provided to Medicare beneficiaries

Impact on Providers

This article is based on Change Request (CR) 5245, which provides billing instructions for hospices, as well as requirements for RHHIs concerning billing for continuous home care services on separately dated line items in 15-minute time increments. It also includes information on reporting Healthcare Common Procedure Coding System (HCPCS) codes to identify the service location of all hospice levels of care.

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Background

Historically, billings by institutional providers to the Centers for Medicare & Medicaid Services (CMS) fiscal intermediaries (FIs) contained limited service line information. Claim lines on a typical institutional claim in the 1980s or early 1990s may have reported only the following:

- Revenue Code;
- Number of units; and
- Total charge amount.

Over the last ten years, legislated payment requirements have changed, and CMS has implemented increasingly complex payment methods. These changes have required more line item detail on claims for most institutional provider types, such as:

- Line item dated services;
- Reporting HCPCS codes and modifiers; and
- Submission of non-covered charges.

This detail has supported the payment requirements of legislated payment systems and also improved the quality and richness of CMS analytic data files. However, hospice claims have been an exception to this process.

Since the inception of the hospice program in 1983, hospices have been required to submit on CMS claims only a small number of service lines to report the number of days at each of the four Hospice levels of care, and HCPCS coding was required only to report procedures performed by the beneficiary's attending physician (if that physician was employed by the hospice). This limited claims data has restricted CMS's ability to ensure optimal payment accuracy in the hospice benefit, and to carefully analyze the services provided in this growing benefit. Therefore, effective January 1, 2007, CMS will require hospices to report additional detail on their claims.

A hospice is paid a continuous home care (CHC) rate when CHC is provided. This rate is paid:

- Only during a period of crisis and
- Only as necessary to maintain the terminally ill individual at home.

The CHC rate is divided by 24 hours in order to arrive at an hourly rate, and a **minimum of eight hours must be provided**. The CHC need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening, but **the care must reflect the needs of an individual in crisis**.

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The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, **at least half of the hours of care are provided by the RN or LPN**. Homemaker or home health aide services may be provided to supplement the nursing care.

Note: Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for CHC.

The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into CHC.

Services at the CHC level of care must be billed using separately dated line items, which report the number of hours of care provided in 15-minute increments, and these increments are used in calculating the payment rate. Payment for CHC is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable.

Note: Only direct patient care during the period of crisis may be billed, and documentation of the crisis and care rendered should be noted in the Hospice medical record.

Since CHC requires a minimum of 8 hours in a 24-hour period (starting at midnight and ending at 11:59 PM of the same day) claims with less than 32 units (15-minute increments) for the day (i.e. 8 hours) will be paid at the routine care payment rate.

Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g., meal breaks, report, education of staff). **CHC is not intended to be used as respite care.**

Services for all hospice levels of care must be reported with a HCPCS code that identifies the location where that level of care was provided including:

- Routine home care;
- CHC;
- General inpatient care (GIP); and
- Inpatient respite care.

If there are different or multiple locations where care has been provided, each location is to be identified with the corresponding HCPCS code as separate and distinct line items.

For services provided on or after January 1, 2007, hospices must report a HCPCS code (in FL 44) along with each level of care Revenue Code to identify the type of

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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	Descriptor
Q5001	HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE
Q5002	HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE HOSPITAL (LTCH)
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY
Q5009	HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)

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

In submitting claims, remember that the HIPAA standard 837 Institutional claim format requires line item dates of service for all outpatient claims and Medicare classifies hospice claims as outpatient claims. For claims for services provided on or before December 31, 2006, CMS allows hospices to satisfy this requirement by placing any valid date in the Statement Covers Period dates (FL 6 on the claim). For services provided on or after January 1, 2007, service date reporting will vary between continuous home care lines as follows:

- For 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; and

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- For other 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 (FL 44) as mentioned above. (Hospices may continue to report any valid date in FL 6 Statement Covers Period on these line items.)

CR5245 instructs your RHHI to ensure that:

- Service lines on Hospice claims with Revenue Codes 651 (Routine Home Care), 652 (CHC), 655 (Inpatient Respite Care) or 656 (General Inpatient Care) **should also contain** HCPCS codes in the range Q5001 – Q5009. Failure to include the HCPCS code will cause the RHHI to return the claim to you.
- The number of service units reported on a Hospice claim with Revenue Code 652 (CHC) **does not exceed 96**. Claims with service units above 96 will be returned.
- Payment on Hospice claims will be calculated by interpreting the number of units reported with Revenue Code 652 (CHC) as 15-minute increments and multiplying the hourly CHC rate using the number of increments.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1011CP.pdf> on the CMS website.

Providers may also want to read the following related CRs and their related MLN Matters® articles:

- CR5567 (Reporting of Additional Data to Describe Services on Hospice Claims) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1494CP.pdf> and related MM5567 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5567.pdf> and
- CR5745 (Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1352CP.pdf> and related MM5745 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5745.pdf> on the CMS website.
- CR6905 (New Hospice Site of Service Code) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1955CP.pdf> *and related*

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article, MM6905 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6905.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. **Protect Yourself. Protect Your Patients. Get Your Flu Shot.**

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