CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1011	**Date: JULY 28, 2006**
	Change Request 5245

SUBJECT: Instructions for Reporting Hospice Services in Greater Line Item Detail

I. SUMMARY OF CHANGES: This transmittal provides billing instructions for hospices and requirements for Regional Home Health Intermediaries regarding billing continuous home care services on separately dated line items in 15 minute time increments and reporting HCPCS codes to identify the service location of all hospice levels of care.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2007
IMPLEMENTATION DATE: January 2, 2007

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	11/30.1/Levels of Care
R	11/30.3/Data Required on Claim to FI

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1011	Date: July 28, 2006	Change Request 5245

SUBJECT: Instructions for Reporting Hospice Services in Greater Line Item Detail

I. GENERAL INFORMATION

A. Background: Historically, billings by institutional providers to Medicare fiscal intermediaries contained limited service line information. Claim lines on a typical institutional claim in the 1980s or early 90s may have reported only a revenue code, a number of units, and a total charge amount. Over the last decade, legislated payment requirements have changed and Medicare 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 Medicare analytic data files.

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 Medicare claims only a small number of service lines to report the number of days at each of the four hospice levels of care. 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 Medicare's ability to ensure optimal payment accuracy in the hospice benefit, and to carefully analyze the services provided in this growing benefit.

B. Policy: Effective January 1, 2007, Medicare will require hospices to report additional detail on their claims. Services at the continuous home care level of care must be billed using separately dated line items which report the number of hours of care provided in 15-minute increments. Payment for continuous home care (CHC) will be paid based upon the total number of 15-minute increments and will no longer allow for rounding to the next higher hour. Only direct patient care during the period of crisis may be billed. Documentation of the crisis and care rendered is to be noted in the hospice medical record. Since CHC requires a minimum of 8 hours in a 24-hour period beginning at midnight until 11:59 PM of the same day, claims with less than 32 units for the day will be paid at the routine care payment rate.

Services for all hospice levels of care (routine home care, CHC, general inpatient care (GIP) and inpatient respite care) must be reported with a HCPCS code that identifies the location where that level of care was provided. 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.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5245.1	Medicare systems shall ensure that service lines on hospice claims with revenue codes 651, 652, 655 or 656 also contain HCPCS codes in the range Q5001 – Q5009.					X				
5245.1.1	Medicare systems shall return to the provider hospice claims with service lines with revenue codes 651, 652, 655 or 656 that do not contain HCPCS codes in the range Q5001 – Q5009.		X			X				
5245.2	Medicare systems shall ensure that the number of service units reported on a hospice claim with revenue code 652 (continuous home care) does not exceed 96.					X				
5245.2.1	Medicare systems shall return to the provider hospice claims if the number of service units reported with revenue code 652 exceeds 96.		X			X				
5245.3	Medicare systems shall calculate payment on hospice claims interpreting the number of units reported with revenue code 652 as 15-minute increments and multiplying the hourly CHC rate using the number of increments.					X				Hospice Pricer
5245.4	Medicare systems shall calculate payment on hospice claims which report units less than 32 on revenue code 652 lines using the routine home care rate.					X				Hospice Pricer

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5245.5	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5245.1 – 5245.4	Hospice claims are claims with types of bill 81x or 82x.
5245.3	The hospice Pricer will now multiply the hourly continuous home care rate by numbers of hours that include fractions (e.g. 38 units = 9.5 hours).
5245.4	The hospice Pricer shall no longer set error return code 20 when less than 8 hours of continuous home care (CHC) are reported.

B. Design Considerations: N/A

C. Interfaces: No changes to input/output record of the hospice Pricer are required by this instruction. All units and payment information will be carried in existing fields.

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Wil Gehne (claims), 410-786-6148 or Terri Deutsch (policy) 410-786-9462 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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

30.1 - Levels of Care

(Rev.1011, Issued: 07-28-06, Effective: 01-01-07, Implementation: 01-02-07)

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

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

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

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

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

A description of each level of care follows.

Routine Home Care - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

Continuous Home Care - The hospice is paid the continuous home care rate when continuous home care is provided. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse or licensed practical nurse. *Parts of an hour are identified through the reporting of time for continuous home care days in 15*

minute increments and these increments are used in calculating the payment rate. Only direct patient care ***provided*** *during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g. meal beaks, report, education of staff).* ***Continuous home care is not intended to be used as respite care.***

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

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

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

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

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided.

30.3 - Data Required on Claim to FI

(Rev.1011, Issued: 07-28-06, Effective: 01-01-07, Implementation: 01-02-07)

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 FI (see section 20).

Hospices use the Uniform (Institutional Provider) Bill (Form CMS-1450) or electronic equivalent to bill the FI for all covered hospice services.

This form, also known as the Uniform Bill 92 (UB-92), is suitable for billing most third party payers (both Government and private). Because it serves 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. For a complete list of instructions for all Medicare claims see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp. Items not listed need not be completed although hospices may complete them when billing multiple payers.

FL 1 (Field Locator 1) - (Untitled) - Provider Name, Address, and Telephone Number

FL 4 - 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.
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

3rd Digit Frequency	Definition
	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.

FL 6 - Statement Covers Period (From-Through)

Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do 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, submit separate bills for October and November.

FL 12 - Patient's Name

Enter the beneficiary's name exactly as it appears on the Medicare card.

FL 13 - Patient's Address

FL 14 - Patient's Birth date

FL 15 - Patient's Sex

FL 17 - Admission Date

Enter 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.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

The admission date stays the same on all continuing claims for the same benefit period.

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

FL 22 - Patient Status

This code indicates the patient's status as of the **"**Through" date (FL 6) of the billing period

Code Structure

01 Discharged to home or self care (revocation, de-certification**,** or transfer from the agency)

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 Hospice - home

51 Hospice - medical facility

FL 23 - Medical Record Number (Optional)

FLs 24, 25, 26, 27, 28, 29, and 30 - Condition Codes

Code(s) identifying conditions related to this bill that may affect processing.

Codes listed are only those specific to Hospice; see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp for a complete list of codes.

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.

FLs 32, 33, 34, and 35 - Occurrence Codes and Dates

Enter 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) or FL 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

Code	**Title**	**Definition**
23	Cancellation of Hospice Election Period (FI USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an FI 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.
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

Code	Title	Definition
		transfer situations.

FL 36 - Occurrence Span Code and Dates

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. Use the following code(s) where appropriate:

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.

FLs 39, 40, and 41 - Value Codes and Amounts

The most commonly used value code on hospice claims is value code 61, which is 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	Location Where Service is Furnished	*CBSA* number (or rural State code) of the location where the hospice service is delivered. Reporting of value code 61 is required when billing revenue codes 0651 and 0652. The hospice enters the *five* digit *CBSA*, with two trailing zeroes, in the "amount" field (i.e., if the *CBSA* is *10180*, enter *1018000.*

FL 42 - Revenue Code

Assign a revenue code for each type of service provided. Enter the appropriate four-digit numeric revenue code on line FL42 to explain each charge in FL47.

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, the procedure HCPCS code is entered in FL44. Procedure codes are required in order for the FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

Hospices use these revenue codes to bill Medicare.

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)

Code	Description	Standard Abbreviation
• * 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.		

FL 43 - Revenue Description (Not Required)

FL 44 - HCPCS/Rates

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 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)*

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.

***FL 45** – 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 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 in FL 44 above. Hospices may continue to report any valid date within the FL 6 Statement Covers Period dates on these line items.

FL 46 - Units of Service

Enter 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.*

FL 47 - Total Charges

FLs 50A, B, and C - Payer Identification

FL 51A, B, and C - Provider Number

FLs 58A, B, and C - Insured's Name

FLs 60A, B, and C - Certificate/Social Security Number and Health Insurance Claim/Identification Number

FL 67 - Principal Diagnosis Code

FL 82 - Attending Physician I.D.

Enter the UPIN 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 Enter the UPIN in the first six positions followed by the physician's last name, first name, and middle initial (optional).

FL 83 - Other Physician I.D.

If the attending physician is a nurse practitioner, enter the UPIN and name of the nurse practitioner*. The UPIN is shown in the first six positions followed by two spaces, the nurse practitioner's last name, one space, first name, one space, and middle initial.*

FL 84 - Remarks (Not Required)

FL 85-6 - Provider Representative Signature and Date

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