
Medicare Hospice Manual

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal 59

Date: APRIL 2000

REFER TO CHANGE REQUEST 1111

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
303.1 (Cont.) - 303.7	3-13 - 3-16.3 (7 pp.)	3-13 - 3-16.3 (7 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: October 1, 2000

Section 303.1, Completion of the Uniform (Institutional Provider) Bill (HCFA-1450) for Hospice Bills, is amended to add a new occurrence code, 23, and a new occurrence span code, M2, to this section for use in hospice billing.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Use the following codes where appropriate:

<u>Code</u>	<u>Title</u>	<u>Definition</u>
24	Date Insurance Denied	Enter the date of receipt of a denial of coverage by a higher priority payer.
23	Cancellation of Hospice Election Period (INTERMEDIARY USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an intermediary as opposed to revocation by the beneficiary.
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 Discharge	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.)
C4-C9		Reserved for National Assignment.
D0-D9		Reserved for National Assignment.

FL 36. Occurrence Span Code and Dates

Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

<u>Code</u>	<u>Title</u>	<u>Definition</u>
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.

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

Required.--The only value codes that apply to hospice benefits are those that indicate Medicare payment is secondary to another payer. Enter the appropriate code(s) and related dollar amount(s) where the primary payer is other than Medicare, and where the primary payer has made payment at the time of billing Medicare. If the primary payer has denied payment, indicate this with zeros in the value amount. Enter the date of the denial and occurrence code 24 in the appropriate occurrence field. The value codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). If more than one value code is shown for a billing period, show codes in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used up before the second line is used). The amount of payment shown in the value field is deducted from the intermediary's payment to the hospice.

<u>Code</u>	<u>Title</u>	<u>Definition</u>
12	Working Aged Beneficiary/Spouse with an EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a

- conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 13 ESRD Beneficiary in a Medicare Coordination Period with an EGHP Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 14 No-Fault, Including Auto/Other Insurance Enter this code to indicate the amount shown is that portion of a higher priority no-fault insurance payment including auto/other insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 15 Workers' Compensation (WC) Enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 16 Public Health Service (PHS), Other Federal Agency Enter this code to indicate the amount shown is that portion of a higher priority PHS or other Federal agency's payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment.

61	Location Where Service is Delivered (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator, right justified to the left of the dollars/cents delimiter. Value code 61 is required to accompany only revenue codes 651 and 652.
----	---	---

FL 42. Revenue Code

Required.--Assign a revenue code for each payment rate. Enter the appropriate three-digit numeric revenue code on the adjacent line in FL 43 to explain each charge in FL 47.

NOTE: Use revenue code 657 to identify your charges for services furnished to patients by physicians employed by you, or receiving compensation from you. In conjunction with revenue code 657, enter a physician procedure code in the right hand margin of FL 43 (to the right of the dotted line adjacent to the revenue code in FL 42). Appropriate procedure codes are available to you from your intermediary. Procedure codes are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

Use these revenue codes to bill Medicare.

<u>Code</u>	<u>Description</u>	<u>Standard Abbreviation</u>
651*	Routine Home Care	RTN Home
652*	Continuous Home Care	CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour.)
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNL IP
657	Physician Services	PHY Ser (must be accompanied by a physician procedure code)

* Reporting of value code 61 is required with these revenue codes.

FL 43.--Revenue Description

Not Required.--Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under FL 42.

FL 46.--Units of Service

Required.--Enter the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

FL 47.--Total Charges

Required.--Enter the total charges for the billing period by revenue code (FL 42) on the adjacent line in FL 47. The last revenue code entered in FL 42 ("0001") represents the grand total of all charges billed. The total is in FL 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

FLs 50A, B, and C.--Payer Identification

Required.--If Medicare is the primary payer, enter "Medicare" on line A. If Medicare is not the primary payer, identify the primary payer on line A and enter Medicare on line B or C, if appropriate.

FL 51A, B, and C.--Provider Number

Required.--Enter your six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

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

Required.--Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C as applicable, and enter the insured's name on the applicable primary policy on line A.

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

Required.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67.--Principal Diagnosis Code

Required.--Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study that's chiefly responsible for the patient's admission.

FL 82.--Attending Physician I.D.

Required.--Enter the UPIN and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians that are assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Services' physicians, including the Indian Health Services;
- VAD000 for Department of Veterans' physicians;
- RET000 for retired physicians;
- SLF000 for providers to report that the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted unless the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 IDs may be audited.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

If more than one referring physician is indicated, enter the UPIN of the physician requesting the service with the highest charge.

FL 83. Other Physician I.D.

Required.--Enter the word "employee" or "nonemployee" to describe the relationship the patient's attending physician has with you.

FL 84. Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

FL 85-6. Provider Representative Signature and Date

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

303.2 Billing for Covered Medicare Services Unrelated to Hospice Care.--Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and are furnished during a hospice election period, are billed to the intermediary or carrier for non-hospice Medicare payment. These services are billed by the provider, in accordance with existing procedures, as a new admission with appropriate query and billing actions.

303.5 Frequency of Billing.--Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--Inpatient billing under PPS is normally done after discharge. However PPS hospitals not receiving periodic interim payments (PIP) may bill 60 days after an admission, and every 60 days thereafter.

Each PPS interim bill must include all diagnoses, procedures and services from admission to the through date. Repeat charges included on the prior bill on the subsequent interim adjustment bill.

Your initial PPS interim claims must have a patient status of 30 (still patient). Submit all interim PPS bills with the following designation:

-- 112 - for interim bill (first claim);

When you submit a bill subsequent to the first, submit it in the adjustment format as one of the following:

o A 117 bill with a patient status of 30 (still patient); or

o A 117 discharge bill with a patient status of:

- 01 - Discharged to home or self-care;
- 02 - Discharged/transferred to another short-term general hospital;
- 03 - Discharged/transferred to SNF;
- 04 - Discharged/transferred to ICF;
- 05 - Discharged/transferred to another type of institution (including distinct parts), or referred for outpatient services to another institution;
- 06 - Discharged/transferred to home under care of organized home health service organization;
- 08 - Discharged to home under care of a home IV therapy provider; or
- 20 - Expired (or did not recover - Christian Science Patient).

SNFs and non-PPS hospitals (i.e., excluded units or hospitals) bill upon discharge or after 30 days (and if necessary, every 30 days thereafter). You may bill more frequently if you bill electronically. Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed earlier. The from date must be the day after the through date on the earlier bill. If you receive PIP, you do not submit interim bills.

For hospice short-term inpatient care, submit the monthly bill designating the inpatient services with revenue code 655 or 656, as appropriate. Submit the bill in your normal manner if the inpatient hospice care is provided under your auspices. If the inpatient care is furnished by another entity, and they are billing Medicare directly, use occurrence span code 74 to show the period of inpatient care, as described under outpatient billing.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). These instructions also apply to Home Health Agency and hospice services under Part A. This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

<u>Service</u>	<u>Revenue Code</u>
- DME Rental	290-299
- Therapeutic Radiology	330-339
- Therapeutic Nuclear Medicine	342
- Respiratory Therapy	410-419
- Physical Therapy	420-429
- Occupational Therapy	430-439
- Speech Pathology	440-449
- Home Health Visits	550-599
- Hospice Services	650-659
- Kidney Dialysis Treatments	820-859
- Cardiac Rehabilitation Services	482, 943
- Psychological Services	910-919 (in a psychiatric facility)

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Bill other one-time Part B services upon completion of the service.

Bills for outpatient surgery must contain, on a single bill, all services provided on the day of surgery except for kidney dialysis services, which are billed on a 72X bill type. These services normally include:

- o Nursing services, services of technical personnel, and other related services;
- o The patient's use of the hospital's facilities;
- o Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- o Diagnostic or therapeutic items and services (except lab services);
- o Blood, blood plasma, platelets, etc.; and
- o Materials for anesthesia.

303.6 Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines.--

A. General.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B. Coverage Requirements.--Effective for services furnished on or after July 1, 1981, PPV and its administration is covered for patients if it is ordered by a physician who is a doctor of medicine or osteopathy.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

C. Billing Requirements.--Provide the influenza virus, pneumococcal pneumonia and hepatitis B vaccines to those beneficiaries who request them including those who elected the hospice benefit. These services are coverable when furnished by you. Bill services for the vaccines to your local carrier on the HCFA-1500. Payment is made using the same methodology as if you were a supplier. If you do not have a supplier number, contact your local carrier to obtain one. If you have any other specific billing questions, contact your carrier to obtain assistance.

D. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

- 90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
- 90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
- 90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
- 90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
- 90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
- 90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

These codes are for reporting of the vaccines only. The provider bills for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

NOTE: Hospices should contact their local carrier for instructions on simplified billing for influenza virus vaccine and pneumococcal pneumonia vaccine.

303.7 Clarification of Reimbursement for Transfers that Result in Same Day Hospice Discharge and Admission.--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 the day of discharge and admission.