Hospice Medicare Billing Codes Sheet

Type of Bill (FL4) X=1 non hospital based • X=2 hospital based			
8XA	Notice of Election (NOE)	**8X2**	1st claim in series
8XB	Notice of Termination/Revocation (NOTR)	**8X3**	Continuing claim
8XC	Change of hospice	**8X4**	Discharge claim
8XD	Cancel NOE/benefit period	**8X7**	Adjustment claim
8X0	Nonpayment claim	**8X8**	Cancel claim
8X1	Admit thru discharge		
CMS Pub. 100-04, Chapter 11, Section 20.1.2 & 30.3			

Type of Admission (FL14)					
1	Emergency	**3**	Elective	**9**	Information not available
2	Urgent	**5**	Trauma		
CMS Pub. 100-04, Chapter 25, Section 75.1					

Point of Origin (Source of Admission) (FL15)			
1	Non-health care facility	**6**	Transfer from Another Health Care Facility
2	Clinic or physician's office		
4	Transfer from hospital	**8**	Court/Law Enforcement
5	Transfer from SNF or ICF	**9**	Information not available
CMS Pub. 100-04, Chapter 25, Section 75.1			

Patient Status (FL17) as of "To" date on claim	
01	Discharged to home, revoked, or decertified
30	Still a patient ("To" date must be last day of month)
40	Expired at home (see occurrence code 55)
41	Expired at medical facility (see occurrence code 55)
42	Expired – place unknown (see occurrence code 55)
50	Discharged/transferred to hospice – home (routine or CHC)
51	Discharged/transferred to hospice – medical facility (respite or GIP)
CMS Pub. 100-04, Chapter 11, Section 30.3	

Website Reference - CMS Pub. 100: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

Condition Code (FL 18-28)	
H2	Discharge for cause (i.e. patient/staff safety)
52	Discharge for patient unavailability, inability to receive care, or out of service area
CMS Pub. 100-04, Chapter 11, Section 30.3	

Claim Change Reason Code (CCRC) (FL 18-28) & Adjustment Reason Code (ARC) (FISS only)			
Description	**CCRC**	**ARC**	**TOB**
Change in dates of service	D0	RF	8X7
Change in charges	D1	RG	8X7
Change in revenue/HCPCS code	D2	RH	8X7
Cancel to correct provider #/HIC	D5	RI	8X8
Cancel duplicate or OIG payment	D6	RJ	8X8
Any other/multiple change(s)	D9	RM	8X7
Change in patient status	E0	RN	8X7
CMS Pub. 100-04, Chapter 1, Section 130.1.2.1			

Occurrence Codes (FL 31-34)	
27	Date of certification or recertification
42	Date of revocation (ONLY)
55	Date of death (when patient status = 40, 41 or 42)
CMS Pub. 100-04, Chapter 11, Section 30.3	

Occurrence Span Codes (FL 35-36)	
77	Noncovered days due to untimely recertification OR Untimely NOE
M2	Multiple respite stays, From/To dates of each stay
CMS Pub. 100-04, Chapter 11, Section 30.3	

NOTE: The codes listed on this billing codes sheet represent those most frequently submitted on hospice NOEs/claims. A complete listing of all codes is accessible from the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual: http://www.nubc.org.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospice Medicare Billing Codes Sheet

MSP Value Codes (FL 39-41)	
Description	**VC**
Working aged	12
ESRD	13
No Fault (no attorney involved)	14
Workers' Compensation	15
Public Health Svc/Other Federal	16
Disabled	43
Black Lung	41
Liability (attorney involved)	47
CMS Pub. 100-05, Chapter 3, Section 5	

Allowed Place of Service (HCPCS) Codes for Levels of Care (Revenue) Codes	Routine 0651	CHC 0652	Respite 0655	GIP 0656
Q5001 – Home	Y	Y	N	N
Q5002 – Assisted living facility	Y	Y	N	N
Q5003 – LTC or non-skilled NF (unskilled care)	Y	Y	Y	N
Q5004 – Skilled nursing facility (skilled care)	Y	N	Y	Y
Q5005 – Inpatient hospital	Y	N	Y	Y
Q5006 – Inpatient hospice facility	Y	N	Y	Y
Q5007 – Long term care hospital	Y	N	Y	Y
Q5008 – Inpatient psychiatric facility	Y	N	Y	Y
Q5009 – Place not otherwise specified	Y	Y	Y	Y
Q5010 – Hospice residential facility	Y	Y	N	N

Revenue Codes (FL 42), HCPCS Codes and Modifiers (FL 44)			
Description	**REV**	**HCPCS, Modifiers**	
Total units/charges	**0001**	None	
Physician services	**0657**	As appropriate, 26 (technical component) As appropriate, GV (nurse practitioner is attending)	
Other	**0659**	A9270, GY (room & board)	
Discipline Visit Description	**REV**	**HCPCS, Modifiers** (PM if post-mortem)	
Physical therapy	**0421**	G0151, PM	
Occupational therapy	**0431**	G0152, PM	
Speech language pathology	**0441**	G0153, PM	
Skilled nursing	**0551**	G0154, PM	
Medical social service (visit)	**0561**	G0155, PM	
Medical social service (phone call)	**0569**	G0155, PM	
Home health aide	**0571**	G0156, PM	
Levels of Care Description	**REV**	**HCPCS (Place of Service)**	
Routine home care (Q5001-Q5010)	**0651**	Q5001 – Home Q5002 – Assisted living facility Q5003 – LTC or non-skilled NF (receiving unskilled care) Q5004 – Skilled nursing facility (receiving skilled care) Q5005 – Inpatient hospital Q5006 – Inpatient hospice facility Q5007 – Long term care hospital Q5008 – Inpatient psychiatric facility Q5009 – Place not otherwise specified Q5010 – Hospice residential facility	
Continuous home care (Q5001-Q5003, Q5009-Q5010)	**0652**		
Respite care (Q5003-Q5009)	**0655**		
General inpatient care (Q5004-Q5009)	**0656**		
Drugs/Infusion Pumps Description	**REV**	**HCPCS**	
Non-injectable drugs	**0250**	None, however, NDC is required	
Infusion pump – equipment	**029X**	As appropriate	
Infusion pump – drugs	**0294**	As appropriate	See: http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Downloads/2015-Table-of-Drugs-.pdf
Injectable drugs	**0636**	As appropriate	
CMS Pub. 100-04, Chapter 11, Section 30.3			

Hospice Medicare Billing Codes Sheet

Reporting of Hospice Visits

Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 11, §30.3
(http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf).

Reporting of hospice visits is based on the level of care the visit was provided under, and who provided the visit. To determine how to report a visit, find the appropriate column for the level of care provided. For Respite and GIP, find the column for who provided the visit.

Discipline	Level of Care Visit Provided Under					
	Visit under Routine Home Care	Visit under Continuous Home Care	Visit under Respite		Visit under General Inpatient Care (GIP)	
			Hospice employed staff	Non-hospice staff	Hospice employed staff	Non-hospice staff
Skilled nurse **Aide** **Social worker** **Social worker (phone call)** **Physical therapy** **Speech-language pathology** **Occupational therapy**	Each visit line item billed, 15-minute increments	Each visit line item billed, 15-minute increments	Each visit line item billed, 15-minute increments	Visits not reported	**For all locations (except Q5006):** Each visit line item billed in 15-min increments **For Q5006:** Visits reported weekly (Sunday-Saturday) except: • PT, SLP and OT visits are not reported • Social worker phone calls are not reported • Post-mortem visits are not reported	Visits not reported

Reporting of Hospice Discharges

Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 11, §30.3
(http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf).
To determine the data required on a hospice claim, use the table below.

Discharge Reason	Occurrence Code	Condition Code	Patient Status Code
Patient revokes	42	None	Appropriate code
Patient transfers hospices	None	None	50 or 51
Patient no longer terminal	None	None	Appropriate code
Patient discharged for cause	None	H2	Appropriate code
Patient moves out of service area	None	52	Appropriate code
Death	55	None	40, 41, or 42
Untimely FTF	None	None	Appropriate code

Hospice Medicare Billing Codes Sheet

FISS Fields and UB-04 Field Locators (FL) for Hospice Billing

R = required C = conditional N = not required O = optional

FISS Pg	FISS Field Name	UB FL	Data Entered	NOE	Claim
1	HIC	60	Medicare (HIC) number	R	R
1	TOB	4	Type of Bill	R	R
1	NPI	56	NPI number	R	R
1	Pat.Cntl#:	3a	Patient Control Number	O	O
1	Stmt Date From	6	From date of service	R	R
1	To	6	To date of service	N	R
1	Last	8	Patient's last name	R	R
1	First	8	Patient's first name	R	R
1	DOB	10	Patient's date of birth	R	R
1	Addr 1	9	Patient's address	R	R
1	Addr 2	9	City State	R	R
1	Zip	9	Zip	R	R
1	Sex	11	Sex code (M or F)	R	R
1	Admit Date	12	Date of admission	R	R
1	Hr	13	Admission hour	N	R[1]
1	Type	14	Type of Admission	N	R
1	Src	15	Source of admission	N	R
1	Stat	17	Patient status	N	R
1	Cond Codes	18-28	Condition codes	N	C
1	Occ Cds/Date	31-34	Occurrence code(s)/date(s)	R	C[2]
1	Span Codes/Dates	35-36	Occurrence span code(s)/date(s)	N	C[3]
1	Fac.zip	1	Facility zip code	R	R
1	DCN	64	Document control number	N	C[4]
1	Value Codes	39-41	Value codes	N	R[5]
2	Rev	42	Revenue codes	N	R
2	HCPC	44	HCPCS	N	R
2	Modifs	44	Modifier	N	C
2	Tot Unit	46	Total units	N	R
2	Cov Unit	46	Covered units	N	R
2	Tot Charge	47	Total charges	N	R
2	Ncov Charge	48	Noncovered charges	N	C
2	Serv Date	45	Service date	N	R
3	CD	50	Payer code	R	R
3	Payer	50	Payer name	R	R
3	RI	52	Release of information	R	R
3	SERV FAC NPI	N/A	NPI of Facility	N	C[7]
3	Medical Record Nbr	3b	Medical Record Number	O	O
3	Diag Codes	67	Diagnosis codes	R	R
3	Att Phys NPI	76	Attending physician's NPI	R	R
3	L	76	Attending physician's last name	R	R
3	F	76	Attending physician's first name	R	R
3	M	76	Attending physician's middle initial	O	O
3	Opr Phys NPI	77	Operating physician's NPI	N	N
3	L	77	Operating physician's last name	N	N
3	F	77	Operating physician's first name	N	N
3	M	77	Operating physician's middle initial	N	N
3	Ref Phys NPI	78	Certifying physician's NPI	C[6]	C[6]
3	L	78	Certifying physician's last name	C[6]	C[6]
3	F	78	Certifying physician's first name	C[6]	C[6]
3	M	78	Certifying physician's middle initial	O	O
4	Remarks	80	Remarks	C	C

Note: For information on billing Medicare Secondary Payer (MSP) claims, refer to the MSP Billing and Adjustments quick resource tool (http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf)

1 Required for DDE

2 OC 27 is required when certification/recertification overlaps the claim's date of service.
OC 42 is required only when the patient revokes hospice.
OC 55 is required to report the patient's date of death.

3 OSC 77 is required when the NOE or recertification was untimely.
OSC M2 is required when multiple respite stays in billing period.

4 Adjustments and cancels only.

5 Value code 61 and CBSA code required for rev. code 0651 or 0652. Value code G8 and CBSA code required for rev. code 0655 or 0656.

6 The certifying physician's information is only completed if different than the attending physician.

7 Required when patient in nursing facility, hospital, hospice inpatient facility.

Common Hospice Billing Errors by Reason Code (RC)

RC	Problem	Resolution
34952	SERV FAC NPI missing	A service facility NPI must be reported when billing Q5003, Q5004, Q5005, Q5007 or Q5008
37402	Sequential billing	Ensure prior claim has paid (P), denied (D), or rejected (R). Ensure no skip in days between prior and subsequent claim.
38200	Duplicate claim	Delete previously submitted batches. Check remittance advice or use FISS Option 12 to check for paid claims.
U5106	NOE w/in open episode	Check the patient's eligibility for open hospice election. Contact other hospice if needed.
U5194	Untimely NOE and no OSC 77	If NOE is untimely, report OSC 77 and noncovered dates