National Government Services

A CMS Contracted Agent

Medicare

Hospice Claim Submission

Background

Individuals who are entitled to hospital insurance (Part A) and have a terminal illness (with a life expectancy of six months or less) have the option of electing hospice benefits for treatment and management of their terminal condition. An eligible individual (or his authorized representative) must elect hospice care to receive it by filing a signed election statement with a particular hospice. Once an eligible individual elects hospice, the hospice submits a notice of election (NOE) to the Medicare contractor, which transmits the information to the Common Working File (CWF). Once the initial election is processed, the CWF maintains the beneficiary in hospice status until death or until an election termination is received.

The NOE should be filed as soon as possible after a patient elects the hospice benefit. By submitting the NOE timely, other providers will see that the patient is in the Medicare hospice benefit. This helps to avoid inappropriate billing to Medicare contractors by nonhospice providers and can help to avoid inappropriate billing by other hospices.

The NOE must be submitted and processed prior to submitting the first hospice claim to Medicare. Once the NOE is processed, the hospice can begin submitting claim(s) to National Government Services for payment.

Hospice Claims

Hospice claims must be submitted and processed sequentially (date of service order). This requirement is essential to the correct processing of Medicare hospice claims. Hospice claims must be matched by Medicare systems to the appropriate 90-or 60-day hospice benefit period in order to be paid. Edits are in place to prevent acceptance of an out-of-sequence claim. If there is no prior claim in the system, the claim will be returned to the provider (RTP'd). If there is a prior claim that has been received but has not been finalized (location B9997), the system will hold the out-of-sequence claim until the prior claim is finalized.

Sequential billing also ensures that there is no gap in days between the prior claim's "To" date and the subsequent claim's "From" date. Any gap in service dates will cause the claim to move to the RTP file (status/location T B9997).

Medicare regulations also state that hospices must submit claims on a monthly basis for patients that remain on service through the last day of the month. Monthly billing must conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month). Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned.

The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8–August 31and a separate claim is submitted with dates of service September 1–September 1.

Note: Valid values that are specific to hospice billing are provided below; however, the National Uniform Billing Committee (NUBC) maintains the UB-04 data element specifications and revenue code tables. They may be contacted for subscription to the UB-04.

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

Submitting Claims Via Fiscal Intermediary Standard System/Direct Data Entry

Steps

1	From the **Fiscal Intermediary Standard System (FISS) Main Menu,** Key **02** in the *ENTER MENU SELECTION* field
2	< **Enter** > The **Claims and Attachments Entry Menu** will be displayed

Screen

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MAP1703              NATIONAL GOVERNMENT SERVICES, INC.
                     CLAIM AND ATTACHMENTS ENTRY MENU
                              CLAIMS ENTRY
                       INPATIENT                20
                       OUTPATIENT               22
                       SNF                      24
                       HOME HEALTH              26
                       HOSPICE                  28
                       NOE/NOA                  49
                       ROSTER BILL ENTRY        87
                              ATTACHMENT ENTRY

                       HOME HEALTH              41
                       DME HISTORY              54
                       ESRD  CMS-382 FORM       57

    ENTER MENU SELECTION:28
      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
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Steps

1	Key **28** in the *ENTER MENU SELECTION* field
2	< **Enter** > The **INST Claim Entry Menu** will be displayed
3	Key in applicable claims data as shown below.

Claim Page One

Field	Description/Valid Values
MBI (Required)	Enter the Medicare Beneficiary Identifier (MBI)
TOB (Required)	Valid Values: **First and Second Positions** ▪ 81X (Freestanding hospice) ▪ 82X (Hospital-based hospice) **Third Position** ▪ XX1 (Admit Through Discharge Claim) ▪ XX2 (Interim-First Claim) ▪ XX3 (Interim-Continuing Claim) ▪ XX4 (Interim-Last Claim) ▪ XX7 (Replacement of Prior Claim) ▪ XX8 (Void/Cancel of a Prior Claim)
NPI (Required)	Enter the National Provider Identifier (NPI) associated with the OSCAR number.
STMT DATES: FROM (Required)	Enter the beginning date of service of the period included on this claim in the MMDDYY format.
STMT DATES: TO (Required)	Enter the ending date of service of the period included on this claim in the MMDDYY format.
PATIENT DATA (Required)	Enter the beneficiary's last name, first name, date of birth (MMDDCCYY), full mailing address, zip code, and gender.
ADMIT DATE (Required)	Enter the date of the hospice election/admission in the MMDDYY format. (The admission date stays the same on all continuing claims for the same hospice election.)
HR	Enter the hour during which the patient was admitted for outpatient care. Enter the hour in military time format or enter '99' if the hour is unknown.
TYPE (Required)	Enter the appropriate NUBC approved Priority (Type) of Admission or Visit code. Providers that are unsure which code to use are to use code 9 (Information not Available).
STAT (Required)	Enter beneficiary's patient status as of the "TO" date on this claim. Use the appropriate NUBC approved code. Valid values most commonly used on hospice claims include: ▪ 01 (Discharged to home or self-care) ▪ 30 (Still patient) ▪ 40 (Expired at home) ▪ 41 (Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF) or freestanding hospice) ▪ 42 (Expired-place unknown) ▪ 50 (Discharged/Transferred to Hospice-home) ▪ 51 (Discharged/Transferred to Hospice-medical facility)
COND CODES (Situational)	If applicable, enter the appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing. Valid values most commonly used on hospice claims include: ▪ 20 (Beneficiary Requested Billing): Used when 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): Used when 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. ▪ H2 (Discharge by a Hospice Provider for Cause): Used by the provider to indicate the patient meets the hospice's documented policy addressing

Field	Description/Valid Values
	discharges for cause. Results only in a discharge from the provider's care, not from the hospice benefit. ▪ 52 (Discharge out of service area): Used by the provider to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient.
OCC CDS/DATE (Situational)	If applicable, enter the appropriate NUBC approved code(s) and associated date(s) defining a specific event relating to this billing period. ▪ 55: Used on claims when the patient discharge status code indicates death (40-expired at home, 41-expired at medical facility, or 42-expired place unknown). This code and date of death is required when the above discharge status codes are reported. **On claims for the billing period in which the certification or recertification was obtained:** ▪ Enter the occurrence code 27 along with the date of certification in the MMDDYY format (Do not report an occurrence code 27 on the claim if the certification/recertification was done prior to the service dates on the claim.) **On final claims due to revocation:** ▪ Enter the occurrence code 42 along with the date of termination of the hospice benefit when the reason for the final claim is patient revocation.
SPAN CODES/DATES (Situational)	If applicable, enter the appropriate NUBC approved code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period. Valid values most commonly used on hospice claims: ▪ 77 (Provider Liability –Utilization Charged). This 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). This code is used ONLY for late recertifications and late-filed NOEs only. Do not use this code for late face-to-face encounters. (All revenue code lines associated with the OSC 77 dates are reported as noncovered.) ▪ M2 (Multiple respite stays on one claim). Providers must include this code for all periods of respite. The span dates will represent the date of admission through the fifth consecutive day of respite or the last day the patient was in the inpatient respite level of care through midnight, whichever is sooner.
FAC. ZIP (Required)	Enter the facility Zip Code of the provider.
VALUE CODES (Required)	Enter the appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing. Valid values most commonly used on hospice claims: ▪ If revenue codes 0651 or 0652 are present, value code 61 has to be reported with the appropriate Core-Based Statistical Area (CBSA) code for the beneficiary's location. ▪ If revenue codes 0655 or 0656 are present, value code G8 has to be reported with the appropriate CBSA code for the facility's location. CBSA codes can be found within the appropriate Hospice Rates section of our website at *HHH > Review Process > Audit and Reimbursement > Hospice Rates*.

Claim Page Two

Field	Description/Valid Values
REV (Required)	Enter the appropriate NUBC approved level of care revenue code(s), discipline revenue codes, and the total charges revenue code (0001).

Field	Description/Valid Values
	Valid level of care values: ▪ 0651 (Routine home care) ▪ 0652 (Continuous home care) ▪ 0655 (Inpatient respite care) ▪ 0656 (General inpatient care [GIP]) Valid discipline values: ▪ 042X (Physical therapy) ▪ 043X (Occupational therapy) ▪ 044X (Speech therapy – language pathology) ▪ 055X (Skilled nursing) ▪ 056X (Medical social services) ▪ 057X (Hospice aide) ▪ 0657 (Physician services) Valid drug/infusion pump values*: ▪ 0250 (Noninjectable prescription drugs; reported with applicable national drug code) ▪ 029X (Infusion pumps/equipment; reported with applicable Healthcare Common Procedure Coding System [HCPCS] code) ▪ 0294 (Infusion pumps-drugs; reported with applicable HCPCS code) ▪ 0636 (Injectable Drugs; reported with applicable HCPCS code) *See Change Request (CR) 8358 for more information on drugs/infusion pumps reporting requirements.

Field	Description/Valid Values
HCPC (Required)	Enter the appropriate HCPCS/current procedural terminology (CPT) code associated with the revenue code reported. For level of care revenue codes, enter the site of service location HCPCS code to identify the type of service location where that level of care was provided. Valid Values: ▪ 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 nonskilled 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]) ▪ Q5010 (Hospice home care provided in a hospice facility) For discipline revenue codes (other than physician services), enter the HCPCS code that corresponds with the discipline being reported. **Note** with the implementation of CR8358, the only time that these HCPCS codes are not reported is when the discipline services are being provided in the general inpatient setting in a hospice inpatient unit (site of service code Q5006). Valid Values: ▪ G0151 (Services of a physical therapist in home health or hospice settings, each 15 minutes) ▪ G0152 (Services of an occupational therapist in home health or hospice settings, each 15 minutes) ▪ G0153 (Services of a speech and language pathologist in home health or hospice settings, each 15 minutes) ▪ G0154 (Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes) ▪ G0155 (Services of clinical social worker in home health or hospice settings, each 15 minutes) ▪ G0156 (Services of home health/hospice aide in home health or hospice settings, each 15 minutes) For physician services revenue codes, enter the procedure code to identify the services that were provided by the physician.
MODIFS (Situational)	If applicable, enter an appropriate modifier along with the HCPCS/CPT code to improve the accuracy of coding. Valid values most commonly used on hospice claims: ▪ GV (Required with revenue code 0657 when billing physician services performed by a nurse practitioner) ▪ KX (Required on the first level of care line item when requesting an exception for a late-filed NOE) ▪ PM (Required when reporting visits that occur after the patient's death, on the date of death. Voluntary reporting of this modifier begins with claims that have through dates on or after 1/1/2014. Mandatory reporting begins with claims that have through dates on or after 4/1/2014.)
TOT UNIT (Required)	Enter the number of units for each revenue code line billed as appropriate.

Field	Description/Valid Values
COV UNIT (Required)	Enter the number of covered units for each revenue code line billed as appropriate.
TOT CHARGE (Required)	Enter the total charge for the service described on each revenue code line.
NCOV CHARGE (Situational)	If applicable, enter the amount of noncovered charges for the services described on each revenue code line.
SERV DT (Required)	Enter the line item date of service for each claim line. Level of Care lines: ▪ For 0651, 0655 and 0656, enter the earliest date that each level of care was provided at each service location. ▪ For 0652, enter a separately dated line item for each day that continuous home care is provided. Discipline lines: ▪ For social worker phone calls and visits performed by hospice staff, enter a separately dated line item for each call/visit. – For social worker phone calls and visits performed by hospice staff for GIP care provided in an inpatient hospice unit, enter the earliest date of service the discipline was provided during the delivery of each level of care in each service location for each week. ▪ Physician services should be individually dated, reporting the date that each procedure code billed was delivered.

Claim Page Three

Field	Description/Valid Values
CD (Required)	Payer Code "Z" is system-generated for Medicare primary claims. Medicare Secondary Payer (MSP) claims cannot be submitted in FISS/DDE. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
PAYER (Required)	Payer "Medicare" is system-generated for Medicare primary claims. MSP claims cannot be submitted in FISS/DDE. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
RI (Required)	Enter the release of information indicator. Valid values are: ▪ "Y" to indicate you have a signed statement on file permitting you to release data to other organizations to adjudicate claims. ▪ "R" to indicate the release is limited or restricted. ▪ "N" to indicate there is no release is on file.
SERV FAC NPI (Situational)	Report the NPI of any SNF, NF, hospital, or hospice inpatient facility where the patient is receiving services when the service is not performed at the same location as the billing hospice's location (i.e., your own hospice-inpatient facility). This is required for any hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 (when not the same as the billing hospice), Q5007 and Q5008. Note this is not reported on paper claims. See CR8358 for more information on this reporting requirement.
DIAGNOSIS CODES (Required)	Enter the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code(s) as required by ICD-9-CM Coding Guidelines. The principal diagnosis code describes the terminal illness of the hospice patient (1st position).

Field	Description/Valid Values
ADJUSTMENT REASON CODE (Situational)	Not required for new claim entry. Adjustment reason codes are applicable only on adjustments (type of bill (TOB) XX7 and XX8). A listing of adjustment reason codes are available in the **Adjustment Reason Codes** file (option 16) in the **Inquiries** menu (key '01' from the **FISS Main Menu**).
ATTENDING PHYS NPI/LN/FN (Required)	Enter the NPI and the name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.*
OTHER PHYS NPI/LN/FN (Situational)	Enter the NPI and name of the hospice physician responsible for certifying/recertifying that the patient is terminally ill if the certifying physician differs from the attending physician. **Note:** For electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

*If there is no attending physician, enter the certifying physician in this field.

Claim Page Four

Field	Description/Valid Values
REMARKS (Situational)	Enter any remarks needed to provide information that is not reported elsewhere on the claim and/or may be necessary to ensure proper Medicare payment.

Claim Page Five

Field	Description/Valid Values
INSURED NAME (Required)	On the same line (A, B, C) that corresponds to the Payer line A, B, C on claim page 3, enter the patient's name as reported on his/her Medicare health insurance card. If billing supplemental insurance, enter the name of the individual insured under Medicare on line A and enter the name of the individual insured under a supplemental policy on line B. **Note:** MSP claims cannot be submitted in FISS/DDE. More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.

Field	Description/Valid Values
REL (Required)	▪ On the same line (A, B, C) that corresponds to the Payer line A, B, C on claim page 3, enter the code indicating the relationship of the patient to the identified insured. ▪ Valid values: ▪ 01 (Spouse) ▪ 04 (Grandfather or Grandmother) ▪ 05 (Grandson or Granddaughter) ▪ 07 (Nephew or Niece) ▪ 10 (Foster Child) ▪ 15 (Ward) ▪ 17 (Stepson or Stepdaughter) ▪ 18 (Self) ▪ 19 (Child) ▪ 20 (Employee) ▪ 21 (Unknown) ▪ 22 (Handicapped Dependent) ▪ 23 (Sponsored Dependent) ▪ 24 (Dependent of a Minor Dependent) ▪ 29 (Significant Other) ▪ 32 (Mother) ▪ 33 (Father) ▪ 36 (Emancipated Minor) ▪ 39 (Organ Donor) ▪ 40 (Cadaver Donor) ▪ 41 (Injured Plaintiff) ▪ 43 (Child Where Insured Has No Financial Responsibility) ▪ 53 (Life Partner) ▪ G8 (Other relationship)
CERT-SSN-MBI (Required)	Enter the patient's MBI if Medicare is the primary payer.
SEX (Required)	▪ Enter the sex of the patient. ▪ Valid Values: – F (Female) – M (Male) – U (Unknown)
GROUP NAME (Situational)	▪ Enter the name of the group or plan of provided insurance, if applicable. MSP claims cannot be submitted in FISS/DDE. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
DOB (Required)	Enter the insured's date of birth in the MMDDCCYY format.
INS GROUP NUMBER (Situational)	Enter the Insurance Group identification number, control number, or code assigned by that health insurance company to identify the group under which the insured individual is covered, if applicable. MSP claims cannot be submitted in FISS/DDE. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.

Submitting Claims Hardcopy

The following data elements must be completed by the hospice on the Form CMS-1450 when submitting a hardcopy claim. All fields listed below are required unless otherwise specified.

UB04 (CMS-1450)

Form Locator (FL)	Description/Valid Values
FL 01	Enter the provider's name, city, state and ZIP Code
FL 03a PAT. CNTL #	Enter the patient's unique alpha-numeric control number assigned by the provider.
FL 04 TYPE OF BILL	Valid Values: **First and Second Positions** ▪ 81X (Freestanding hospice) ▪ 82X (Hospital-based hospice) **Third Position** ▪ XX1 (Admit Through Discharge Claim) ▪ XX2 (Interim-First Claim) ▪ XX3 (Interim-Continuing Claim) ▪ XX4 (Interim-Last Claim) ▪ XX7 (Replacement of Prior Claim) ▪ XX8 (Void/Cancel of a Prior Claim)
▪ **FL 05** ▪ FED. TAX NO.	Enter the provider's Federal Tax Number in the NN-NNNNNNN format.
▪ **FL 06** STATEMENT COVERS PERIOD: FROM/THROUGH	In the FROM field, enter the beginning date of service of the period included on this claim in the MMDDYY format. In the THROUGH field, enter the ending date of service of the period included on this claim in the MMDDYY format.
FL 08 PATIENT NAME	Enter the beneficiary's last name and first name in Line A.
FL 09 PATIENT ADDRESS	Enter the beneficiary's full mailing address, including street number and name, city, State, and ZIP Code.
FL 10 BIRTHDATE	Enter the beneficiary's date of birth in the MMDDYY format.
FL 11 SEX	Enter the beneficiary's gender. Valid values are: ▪ "M" (male) ▪ "F" (female)
FL 12 ADMISSION: DATE	Enter the date of the hospice election/admission in the MMDDYY format. (The admission date stays the same on all continuing claims for the same hospice election.)
FL 13 ADMISSION: HR	Enter the hour during which the patient was admitted for outpatient care. Enter the hour in military time format or enter '99' if the hour is unknown.
FL 14 ADMISSION: TYPE	Enter the appropriate NUBC approved Priority (Type) of Admission or Visit code. Providers that are unsure which code to use are to use code 9 (Information not Available).

Form Locator (FL)	Description/Valid Values
FL 17 STAT	Enter beneficiary's patient status as of the "TO" date on this claim. Use the appropriate NUBC approved code. Valid values most commonly used on hospice claims include: ▪ 01 (Discharged to home or self-care) ▪ 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 (Discharged/Transferred to Hospice-home) ▪ 51 (Discharged/Transferred to Hospice-medical facility)
FL 18-28 CONDITION CODES (Situational)	If applicable, enter the appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing. Valid values most commonly used on hospice claims include: ▪ 20 (Beneficiary Requested Billing): Used when 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): Used when 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. ▪ H2 (Discharge by a Hospice Provider for Cause): Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause. Results only in a discharge from the provider's care, not from the hospice benefit. ▪ 52 (Discharge out of service area): Used by the provider to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient.
FL 31-34 OCCURRENCE: CODE/DATE (Situational)	If applicable, enter the appropriate NUBC approved code(s) and associated date(s) defining a specific event relating to this billing period. ▪ 55: Used on claims when the patient discharge status code indicates death (40-expired at home, 41-expired at medical facility, or 42-expired place unknown). This code and date of death is required when the above discharge status codes are reported. **On claims for the billing period in which the certification or recertification was obtained:** ▪ Enter the occurrence code 27 along with the date of certification in the MMDDYY format (Do not report an occurrence code 27 on the claim if the certification/recertification was done prior to the service dates on the claim.) **On final claims due to revocation:** ▪ Enter the occurrence code 42 along with the date of termination of the hospice benefit when the reason for the final claim is patient revocation.

Form Locator (FL)	Description/Valid Values
FL 35-36 OCCURRENCE SPAN: CODE/FROM/THROUGH (Situational)	If applicable, enter the appropriate NUBC approved code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period. Valid values most commonly used on hospice claims: ▪ 77 (Provider Liability – Utilization Charged). This 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). This code is used **only** for late recertifications and late-filed NOEs only. Do not use this code for late face-to-face encounters. (All revenue code lines associated with the OSC 77 dates are reported as noncovered.) ▪ M2 (Multiple respite stays on one claim). Providers must include this code for all periods of respite. The span dates will represent the date of admission through the fifth consecutive day of respite or the last day the patient was in the inpatient respite level of care through midnight, whichever is sooner.
FL 39-41 VALUE CODES: CODE/AMOUNT	Enter the appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing. Valid values most commonly used on hospice claims: ▪ If revenue codes 0651 or 0652 are present, value code 61 has to be reported with the appropriate Core-Based Statistical Area (CBSA) code for the beneficiary's location. ▪ If revenue codes 0655 or 0656 are present, value code G8 has to be reported with the appropriate CBSA code for the facility's location. CBSA codes can be found within the appropriate Hospice Rates section of our website at *HHH > Review Process > Audit and Reimbursement > Hospice Rates*.
FL 42 REV. CD.	Enter the appropriate NUBC approved level of care revenue code(s) and discipline revenue codes. Valid level of care values: ▪ 0651 (Routine home care) ▪ 0652 (Continuous home care) ▪ 0655 (Inpatient respite care) ▪ 0656 (General inpatient care) Valid discipline values: ▪ 042X (Physical therapy) ▪ 043X (Occupational therapy) ▪ 044X (Speech therapy – language pathology) ▪ 055X (Skilled nursing) ▪ 056X (Medical social services) ▪ 057X (Hospice aide) ▪ 0657 (Physician services) Valid drug/infusion pump values*: ▪ 0250 (Noninjectable prescription drugs; reported with applicable national drug code) ▪ 029X (Infusion pumps-equipment; reported with applicable HCPCS code) ▪ 0294 (Infusion pumps-drugs; reported with applicable HCPCS code) ▪ 0636 (Injectable Drugs; reported with applicable HCPCS code) ▪ *See CR8358 for more information on drugs/infusion pumps reporting requirements.
FL 44	Enter the appropriate HCPCS/CPT code associated with the revenue code reported.

Form Locator (FL)	Description/Valid Values
HCPCS/RATE/HIPPS CODE	For level of care revenue codes, enter the site of service location HCPCS code to identify the type of service location where that level of care was provided. Valid Values: ▪ 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 nonskilled 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]) ▪ Q5010 (Hospice home care provided in a hospice facility) For discipline revenue codes (other than physician services), enter the HCPCS code that corresponds with the discipline being reported. **Note** with the implementation of CR8358, the only time that these HCPCS codes are not reported is when the discipline services are being provided in the general inpatient setting in a hospice inpatient unit (site of service code Q5006). Valid Values: ▪ G0151 (Services of a physical therapist in home health or hospice settings, each 15 minutes) ▪ G0152 (Services of an occupational therapist in home health or hospice settings, each 15 minutes) ▪ G0153 (Services of a speech and language pathologist in home health or hospice settings, each 15 minutes) ▪ G0154 (Services of skilled nurse in home health, or nurse in hospice settings, each 15 minutes) ▪ G0155 (Services of clinical social worker in home health or hospice settings, each 15 minutes) ▪ G0156 (Services of home health/hospice aide in home health or hospice settings, each 15 minutes) For physician services revenue codes, enter the procedure code to identify the services that were provided by the physician. If applicable, enter an appropriate modifier along with the HCPCS/CPT code to improve the accuracy of coding. Valid values most commonly used on hospice claims: ▪ GV (Required with revenue code 0657 when billing physician services performed by a nurse practitioner) ▪ KX (Required on the first level of care line item when requesting an exception for a late-filed NOE) ▪ PM (Required when reporting visits that occur after the patient's death, on the date of death. Voluntary reporting of this modifier begins with claims that have through dates on or after 1/1/2014. Mandatory reporting begins with claims that have through dates on or after 4/1/2014.)

Form Locator (FL)	Description/Valid Values
FL 45 SERV.DT	Enter the line item date of service for each claim line. Level of Care lines: ▪ For 0651, 0655 and 0656, enter the earliest date that each level of care was provided at each service location. ▪ For 0652, enter a separately dated line item for each day that continuous home care is provided. Discipline lines: ▪ For social worker phone calls and visits performed by hospice staff, enter a separately dated line item for each call/visit. – For social worker phone calls and visits performed by hospice staff for GIP care provided in an inpatient hospice unit, enter the earliest date of service the discipline was provided during the delivery of each level of care in each service location for each week. ▪ Physician services should be individually dated, reporting the date that each procedure code billed was delivered.
FL 46 SERV.UNITS	Enter the number of units for each revenue code line billed as appropriate.
FL 47 TOTAL CHARGES	Enter the total charge for the service described on each revenue code line.
FL 48 NON-COVERED CHARGES (Situational)	If applicable, enter the amount of noncovered charges for the services described on each revenue code line.
PAGE_OF_	Enter the page number of page number (e.g., PAGE 1 of 1) on all pages of the UB-04.
CREATION DATE	Enter the date that the UB-04 is created on all pages of the UB-04 in MMDDYY format.
TOTALS	Enter the claim total for both covered and non-covered charges in the Totals box on the final claim page.
FL 50 PAYER NAME	If Medicare is the primary payer, enter “Medicare” on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 51 HEALTH PLAN ID	If Medicare is the primary payer, enter the NPI. All entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 52 REL INFO	Enter the release of information indicator. Valid values are: ▪ “Y” to indicate you have a signed statement on file permitting you to release data to other organizations to adjudicate claims. ▪ “R” to indicate the release is limited or restricted. ▪ “N” to indicate there is no release is on file.

Form Locator (FL)	Description/Valid Values
FL 54 PRIOR PAYMENTS (Situational)	If Medicare is not the primary payer, enter the amount that the indicated primary payer (identified in FL 50) has paid to the provider towards this bill.
FL 56 NPI	Enter the NPI
FL 58 INSURED'S NAME	If Medicare is the primary payer, enter the beneficiary's name as shown on the Health Insurance card. All entries across line A supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 59 P.REL	▪ On the same line (A, B, C) that corresponds to the Payer line A, B, C on claim FL 50, enter the code indicating the relationship of the patient to the identified insured. ▪ Valid values: – 01 (Spouse) – 04 (Grandfather or Grandmother) – 05 (Grandson or Granddaughter) – 07 (Nephew or Niece) – 10 (Foster Child) – 15 (Ward) – 17 (Stepson or Stepdaughter) – 18 (Self) – 19 (Child) – 20 (Employee) – 21 (Unknown) – 22 (Handicapped Dependent) – 23 (Sponsored Dependent) – 24 (Dependent of a Minor Dependent) – 29 (Significant Other) – 32 (Mother) – 33 (Father) – 36 (Emancipated Minor) – 39 (Organ Donor) – 40 (Cadaver Donor) – 41 (Injured Plaintiff) – 43 (Child Where Insured Has No Financial Responsibility) – 53 (Life Partner) – G8 (Other relationship)
FL 60 INSURED'S UNIQUE ID	If Medicare is primary, enter the beneficiary's MBI. All entries across line A supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider enters the unique number assigned by the health plan to the insured on line A and enters Medicare information on line B or C as appropriate. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.

Form Locator (FL)	Description/Valid Values
FL 61 GROUP NAME (Situational)	If Medicare is primary, leave blank. All entries across line A supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer and a Worker's Compensation (WC) or an Employer Group Health Plan (EGHP) is involved, the provider enters the name of the group or plan through which that insurance is provided on line A. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 62 INSURED GROUP NO. (Situational)	If Medicare is primary, leave blank. All entries across line A supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer and a WC or an EGHP is involved, the provider enters the Insurance Group identification number, control number, or code assigned by that health insurance company to identify the group under which the insured individual is covered. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 65 EMPLOYER NAME (Situational)	If Medicare is primary, leave blank. All entries across line A supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer and a WC or an EGHP is involved, the provider enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58. (More information on billing MSP claims can be found in the Medicare Secondary Payer section of our website at *Home Health and Hospice > Claims > Medicare Secondary Payer*.
FL 66 DX	Enter the ICD-9-CM diagnosis code(s) as required by ICD-9-CM Coding Guidelines. The principal diagnosis code describes the terminal illness of the hospice patient (1st position).
FL 76 ATTENDING: NPI/LAST/FIRST	Enter the NPI and the name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.*
FL 78 OTHER: NPI/LAST/FIRST (Situational)	Enter the NPI and name of the hospice physician responsible for certifying/recertifying that the patient is terminally ill if the certifying physician differs from the attending physician.
FL 80 REMARKS (Situational)	Enter any remarks needed to provide information that is not reported elsewhere on the claim and/or may be necessary to ensure proper Medicare payment.

*If there is no attending physician, enter the certifying physician in this field.

Related Content

- CMS Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25
- CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 26

Last Updated 5/2018