Billing Hospice Services

for VBID demonstration plans (2021-2022)

Tip Sheet

Making It Easier

for Physicians and Other Healthcare Providers

Humana.com/MakingItEasier

THIS INFORMATION APPLIES TO CLAIMS SUBMITTED FOR YOUR PATIENTS WITH HUMANA MEDICARE ADVANTAGE FOR SERVICES PROVIDED UNDER VALUE-BASED INSURANCE DESIGN (VBID) DEMONSTRATION PLANS IN CO, GA, KY, OH, VA AND WI.

This information applies only to patients making a hospice election on or after Jan. 1, 2021, in Year 1 markets and Jan. 1, 2022, in Year 2 markets.

Hospice providers should submit claims to both Humana and their Medicare Administrative Contractor.

Overview

- This information provides the requirements for submitting claims to Humana for hospice services.
- Humana uses the same methodology and formats currently used under Original Medicare.

Date of election: Admission date is a required field

- Admission date must be the same date as effective date of hospice election or change of election.
- Notice of election (NOE) claim must be submitted to Humana and to the Medicare Administrative Contractor (MAC). Use Revenue Code 0650 with HCPCS Q5009.

Medicare Advantage (MA) guidelines

- Bill hospice claims for MA patients monthly.
  - Monthly billing must conform to a calendar month, not a 30-day period.
    - Exception: Patient is discharged or revokes election and later re-elects hospice benefit during the same month.
- Do not submit more than one claim in a calendar month for the same patient.
  - Exception: Patient is discharged or revokes election and later re-elects hospice benefit during the same month.
- Submit hospice claims sequentially.
- Submit hospice claims on a CMS-1450 paper form (UB-04) or an ASC X12 837 institutional electronic claim transaction.

Bill types

- Type of bill is a required field.
  - Enter the three-digit number indicating the specific type of bill
    - Digit 1: Type of Facility = 8: Special Facility (Hospice)
    - Digit 2: Bill Classification = 1: Hospice (Non-hospital-based ownership) or 2: Hospice (Hospital-based ownership)
    - Digit 3: Number bill frequency type = Effect on election period

Bill coverage period: Dates

- Dates must be entered in six-digit format: MMDDYY.

Condition codes

- Hospice should report one condition code, only when applicable.

Occurrence codes

- Enter an occurrence code to define a specific event related to the billing period.
- Enter an occurrence span code, if applicable, with an associated beginning and ending date to define a specific event related to the billing period.
- Dates must be entered in the six-digit format: MMDDYY.

Value codes

- Enter a value code to identify the location of hospice services.

Revenue codes

- Assign a revenue code for each type of service provided.
- Report separate line items if different levels of care are provided.
- For each level of care, report the date of service on which that level began for the billing period and the unit(s) to represent the number of days for that level.

Service intensity add-on (SIA)

- Service-intensity add-on payment applies to social worker and registered nurse visits during the last seven days of life
- Humana will automatically reimburse for SIA if:
  - Revenue codes 0551 and/or 0561 are present, and
  - Occurrence code 55 is included, and
  - Charges are billed under revenue code 0651 and place of service code (Q5001-Q5010) for the last seven days of life.
- Exception: Humana cannot process SIA visits when the event spans two calendar months.
  - Hospices can notify Humana via HospiceVBID@Humana.com to request reprocessing of a claim for the SIA payment.

Place-of-service codes

- Required on all hospice claims to convey the volume and level of care provided by the setting

Patient status

- Enter the appropriate patient status code on each claim.

  Note: Patient discharge status code 20 is not used on hospice claims. If the patient died during the billing period, use codes 40, 41 or 42, as appropriate.

Patient discharge guidelines

- Reasons for discharge from hospice care
  - Patient moves out of the hospice's service area or transfers to another hospice.
  - Patient is no longer terminally ill.
  - Patient meets the hospice provider's internal policy regarding discharge for cause.

Consulting physicians

- Consulting physicians (not the patient's attending physician) provide professional services related to the treatment of terminal illness.
- Consulting physician services must be billed by the hospice.
- Consulting physicians must have a contract with the hospice for their services.
- Consulting physician services are reported on the hospice claim CMS-1450 (UB04) paper form or the electronic equivalent.

Additional resources

- CMS Medicare Claims Processing Manual, Chapter 11, Hospice Claims:
  CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
- Humana's claim payment policies:
  Humana.com/claimpaymentpolicies
- Humana's code editing:
  Humana.com/edits
  - **Claim processing edits**: Outlines changes to policies and claim payment systems
- Humana's code edit inquiry tools:
  Availity.com
  - **Research Procedure Code Edits**: Go to Payer Spaces → Humana → Applications → Research Procedure Code Edits
    - Enables submission of coding-related questions
  - **Code Edit Simulator:** Go to Payer Spaces → Humana → Applications → Code Edit Simulator
    - Enables entry of a claim scenario to identify potential coding errors instantly

  Note: Claims submitted with certain modifiers are subject to additional manual review using information on current and historical claims. Actual claim results may differ from simulator results.
- Instruction on claim disputes:
  Humana.com/publications
  - **Provider Manual**: Section titled "Provider Claims Dispute Process, Member Grievance/Appeal Process"

For additional topics in the **"Making It Easier for Physicians and Other Healthcare Providers"** series, please visit: **Humana.com/MakingItEasier**

Also accessible on Availity.com → Payer Spaces → Humana → Resources → Making It Easier

Appendix

Type of bill			
8xA	Notice of election (NOE)	8x2	First 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 through discharge		

Condition codes	
H2	Discharge for cause
52	Discharge for patient unavailability, inability to receive care or out of service area
85	Delayed recertification of hospice terminal illness

Occurrence codes	
27	Date of certification or recertification
42	Date of revocation (only)
55	Date of death (when patient status is 40, 41 or 42)

Occurrence span codes	
77	Noncovered days due to untimely recertification or untimely NOE
M2	Multiple respite stays, from/to dates each stay

Value codes		
61	Place of residence where service is furnished (routine home care and continuous home care)	Metropolitan statistical area (MSA) or core-based statistical area (CBSA) number (or rural state code) of the location where the hospice service is delivered. Hospices must report value code 61 when billing revenue codes 0651 and 0652.
G8	Facility where inpatient hospice service is delivered (general inpatient and inpatient respite care)	MSA or CBSA number (or rural state code) of the location where the hospice service is delivered. Hospice must report value code G8 when billing revenue codes 0655 and 0656.

Appendix

Revenue codes, HCPCS codes and modifiers		
Description	REV	HCPCS code(s) and modifier(s)
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 and board), report as noncovered charges
Discipline visit description	REV	HCPCS code(s) and modifier(s)
Physical therapy	0421	G0151, PM (post-mortem/attendance at death)
Occupational therapy	0431	G0152, PM
Speech language pathology	0441	G0153, PM
Skilled nursing	0551	G0154, PM G0299, PM G0300, 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 code(s)
Routine home care (1 unit = 1 day) (Q5001-Q5010)	0651	Q5001 (home) Q5002 (assisted-living facility) Q5003 (long-term care or nonskilled nursing facility) Q5004 (skilled nursing facility) 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 (1 unit = 1 hour) (Q5001-QQ5003, Q5009-Q5010)	0652	
Respite care (1 unit = 1 day) (Q5003-Q5009)	0655	
General inpatient care (1 unit = 1 day) (Q5004-Q5009)	0656	
Drugs/infusion pumps description	REV	HCPCS code(s) and modifier(s)
Noninjectable drugs	0250	None
Infusion pump (equipment)	029X	As appropriate
Infusion pump (drugs)	0294	As appropriate
Injectable drugs	0636	As appropriate

Appendix

Allowed place-of-service codes for levels-of-care codes	Routine 0651	CHC 0652	Respite 0655	GIP 0656
Q5001 (home)	Y	Y	N	N
Q5002 (assisted living facility)	Y	Y	N	N
Q5003 (long-term care or non-skilled NF)	Y	Y	Y	N
Q5004 (skilled NF)	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

Patient status	
01	Discharged to home
30	Still a patient
40	Expired at home
41	Expired at medical facility
42	Expired (place unknown)
50	Discharged/transferred to hospice (home)
51	Discharged/transferred to hospice (medical facility)

Discharge reason	Occurrence code	Condition code	Patient status code
Patient revokes	42	None	01
Patient transfers hospice	None	None	50 or 51
Patient no longer terminal	None	None	01
Patient discharged for cause	None	H2	01
Patient moves out of service area	None	52	01
Death	55	None	40, 41 or 42
Untimely face to face (stay not certified)	None	None	30