Hospice Care

Introduction

Purpose

The purpose of this module is to provide an overview of the hospice care program for Medi-Cal recipients.

Objectives

Provide an overview of the Medi-Cal hospice care program coverage

Discuss hospice care program eligibility

Examine the policy and billing requirements

Introduce and review billing examples

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Program Coverage

Hospice care is a form of medical multidisciplinary care that addresses the unique requirements of terminally ill individuals.

Hospice is used to alleviate pain and suffering, and treat symptoms rather than to cure the illness. Medical and nursing services are designed to maximize the patient's comfort, alertness and independence so the patient can reside in the home as long as possible.

Providers must enroll as a Medi-Cal hospice provider. All claims are submitted using the *UB-04* claim form.

Hospice providers may include the following:

- Hospitals
- Skilled nursing facilities
- Intermediate care facilities
- Home health agencies
- Any licensed health provider who has been certified by Medicare to provide hospice care and is enrolled as a Medi-Cal hospice care provider.

NOTE
All services must be rendered in accordance with Medicare requirements.

Hospice is a covered optional benefit under Medi-Cal with two 90-day periods, beginning on the date of hospice election, followed by unlimited 60-day periods.

Hospice Care Eligibility

Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the patient (or representative) voluntarily files an election statement with the hospice provider. This statement acknowledges that the patient understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure the illness and that certain Medi-Cal benefits are waived by this election.

In accordance with Section 2302 of the Patient Protection and Affordable Care Act (ACA), any Medi-Cal eligible recipient younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice-related diagnosis.

Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments that are provided within their scope of practice and that are considered a benefit under the Medi-Cal program. All services are subject to current hospice frequency and utilization review guidelines.

Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.

Hospice Eligibility, Billing and Payment Requirements

Hospice Providers are reminded that once the election, revocation or re-election is made they are required to complete and submit the Hospice Notification and Election forms to the Department of Health Care Services, Medi-Cal Eligibility Division- Attn: Hospice Clerk. The hospice election form cannot be processed by DHCS unless it is signed by the patient or authorized representative. By choosing Hospice election, the recipient will receive specific services. Send all forms to the address below:

Attn: Hospice Clerk
Department of Health Care Services
Medi-Cal Eligibility Division, MS 4607
1501 Capitol Avenue, Room 4063
P.O. Box 997417-7417
Sacramento, CA 95899-7417

Hospice providers are also reminded of the binding federal regulations and the requirement to accept responsibility for the management, billing and payments associated with hospice services in a long term care (LTC) setting (room, board and hospice service). The federal regulations further describe the requirements for a hospice plan of care and criteria for participation in providing hospice services within an LTC setting, and are located in:

- Title 42, CFR sections 418.100, 418.108 and 418.112 of the Centers for Medicare & Medicaid Services (CMS)
- Medicare Benefits Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance, section 20.3, Election of Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries
- Social Security Act Section 1905 paragraph (o)(3)

Service Restrictions

The response from the eligibility verification system for recipients who elect to receive hospice care in lieu of curative treatment and services will state "Primary diagnosis/limited to hospice." The recipient is not eligible to receive services related to the terminal diagnosis from providers other than a hospice provider or the attending physician.

When the response is returned from the eligibility verification system, the other provider should identify the name of the recipient's hospice provider and inform the provider that the hospice patient is seeking other medical assistance related to the terminal diagnosis.

The special message "Primary diagnosis/limited to hospice" does not specify that Medi-Cal recipients are prohibited from receiving other services that are unrelated to the primary diagnosis, such as physician examinations, drugs or other medical care.

Patient Certification/Recertification Requirements

The attending physician and the medical director or physician member of the hospice interdisciplinary team must certify in writing at the beginning of the first 90-day period that the patient is terminally ill. For all subsequent recertification periods, only a hospice physician may certify that the patient is terminally ill. Only a physician (primary or hospice medical director) can certify that the patient is terminally ill with a life expectancy of six months or less.

At the start of the first 90-day period of care, the hospice provider must maintain an initial certification that the patient is terminally ill in the patient's medical records. At the start of each subsequent period of care, the hospice provider must maintain a recertification in the patient's medical records.

A hospice physician or NP is required to have a <u>face-to-face</u> <u>encounter</u> with every hospice patient to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

An encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period.

The hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.

A hospice physician or a hospice NP is a practitioner who can perform the encounter.

The hospice must retain the certification statements and have them available for audit purposes.

Timeframes for exceptional circumstances for new hospice admissions are in the third or later benefit period. In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

> **Example**: If the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period.

> In such documented cases, a face-to-face encounter that occurs within two days after admission is considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

> **Example**: When a Medi-Cal hospice patient transfers from one hospice to another, it is sometimes difficult to determine what benefit period a patient is currently in. In such cases, the receiving hospice may not know if a face-to-face recertification is necessary. The receiving hospice provider is required to document in the patient's medical records all efforts to obtain the previous hospice benefit period, either from the transferring hospice provider or from other sources.

> If the receiving hospice cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving hospice provider completed the intake process. This information must be maintained in the patient's medical records for auditing purposes.

Knowledge Review

1. A patient has an end-stage liver disease and her attending physician told her she has six months to live. The patient elects hospice in lieu of curative treatment. She completes the election package and her attending doctor and the hospice medical director or the physician member of the hospice interdisciplinary team certifies she is terminally ill. The woman elects hospice on September 1, 2017, and begins receiving hospice care.

   1. What is the date of the initial certification? _____

   2. What would be the date of the first recertification? _____

   3. What would be the date of the next recertification? _____

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Answer Key: 1) September 1, 2017; 2) November 30, 2017; 3) February 28, 2018

Hospice Revocation

A patient (or representative) may revoke the election or hospice care at any time in writing. However, a hospice cannot "revoke" a patient's election. To revoke the election of hospice care, the patient, as well as the hospice provider, must inform DHCS in writing and must include the following:

A signed statement that the individual revokes the election of hospice care for the remainder of that election period, and;

The effective date of that revocation. An individual may not designate an effective date earlier than the date the revocation is made.

NOTE
Verbal revocation of benefits is not acceptable. The individual forfeits hospice coverage for any remaining days in that election period.

Upon revoking of hospice care for a particular election period, the patient is no longer covered under the Medi-Cal hospice benefit and he or she resumes Medi-Cal coverage of the benefits waived when hospice care was elected.

An individual may, at any time, elect to receive hospice coverage for any other election periods that he or she is eligible to receive.

Subsequently, if the patient re-elects hospice care, the hospice provider must submit a new patient hospice election to DHCS. The hospice provider retains the initial certification of terminal illness from the hospice physician in the terminally ill patient's medical records.

The hospice care period starts again with the two 90-day periods followed by the unlimited 60-day periods.

Classification of Care

Each day of hospice care is classified into one of four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care (no respite)/hospice general care

Refer to the *Hospice Care* (hospic) section of the Part 2 provider manual under the Classification of Care heading.

Policies

HIPAA mandates the use of revenue codes and/or HCPCS Level II national codes as shown in the code conversion table below.

Revenue codes identify specific accommodations, ancillary services, unique billing calculations or arrangements. These codes permit facilities to bill for facility usage and services rendered. Many of these services do not have corresponding procedure codes. HIPAA requires that payers (including Medi-Cal) accept revenue codes and utilize them in claim adjudication. Hospice claims submitted without revenue codes will be denied. Frequency limitations also apply to hospice revenue codes.

Hospice Routine Home Care Updates

Federal Rule 42 CFR Part 418, CMS-1629-F RIN 0938-AS39 Medicare Program: *FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements* established an updated reimbursement rate of differential payments for routine home care services.

Reimbursement rates will be based on a recipient's length of stay. The first 60 days of routine home care in a recipient's certification period will utilize revenue code 0650 (routine home care high rate). Any subsequent days of care beyond the 60-day period, will utilize revenue code 0659 (routine home care low rate). In addition, revenue code 0552 (routine home care service intensity add-on [SIA] rate) payment for services provided by a registered nurse or social worker in the last seven days of a recipient's life for at least 15 minutes and up to four hours total per day has also been added.

Effective retroactively for dates of service on or after January 1, 2016, hospice providers are required to bill new revenue codes for routine home care services and SIA.

The existing local Medi-Cal revenue code 0651 (hospice service, routine home care) will be end-dated and replaced by the following three new applicable, HIPAA-compliant revenue codes:

0552 (routine home care [SIA rate]]

0650 (routine home care [high rate])

0659 (routine home care [low rate])

B   Hospice Care

Providers will be instructed to complete two new fields on the Outpatient *UB-04* claim form: *Admission Date* (Box 12) and *Status* (Box 17). The data captured in these fields will be used to assist Audits and Investigation (A&I) in verifying the validity of routine home care claims. Some applicable date values allowed for the *Status* field (Box 17) are as follows:

01 – Discharge to home or self-care

30 – Still a patient (for continuing hospice care for same recipient)

40 – Expired at home

41 – Expired in a medical facility

42 – Expired – place unknown

50 – Hospice – home

51 – Hospice – medical facility

NOTE

Providers are instructed to include any <u>transfer</u> information for the recipient from their previous hospice stay, including the National Provider Identifier (NPI) of the facility and admission and transfer dates in the *Remarks* field (Box 80) or on an attachment. A&I will address any text placed in the field.

NOTES

Service Description	Revenue Code	Description	When to Bill Medi-Cal Directly	Frequency Limitations
Hospice care services	0552	Routine home care (service intensity add-on [SIA] rate)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	15 minute increments, up to 4 hours per day, maximum of seven days
Hospice care services	0650	Routine home care (high rate) (per diem)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice care services	0659	Routine home care (low rate) (per diem)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice care services	0652	Continuous home care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Minimum of eight hours (units) Maximum of 24 hours (units) per claim line, per day
Hospice general care	0655	Inpatient respite care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day and limit of five days for each episode (stay) **NOTE** Services billed beyond five days for each episode will be paid at the routine home care rate (revenue code 0651) for additional days
Hospice general care	0656 **NOTE** Revenue code 0656 must be billed in conjunction with HCPCS code T2045. A TAR is required.	General inpatient care (no respite/hospice general care)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day

B   Hospice Care

Service Description	Revenue Code	Description	When to Bill Medi-Cal Directly	Frequency Limitations
Hospice general care	0657	Physician's services	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice room and board	0658 **NOTE** Hospice providers rendering services in an RCFE may not be reimbursed for room and board revenue code 0658.	Room and board codes	Always	

Medi-Cal hospice providers are required, upon request, to make available to DHCS complete and accurate medical and fiscal records, signed and dated by appropriate staff. This is to fully substantiate all claims for hospice services submitted to the California Medicaid Management Information System (California MMIS) Fiscal Intermediary and to permit access to all record and facilities for the purpose of claim auditing, program monitoring and utilization review.

NOTE
Records must be held three years from the last service date.

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Hospice Billing

Special Physician Services

- Address pain and symptom management
- Require revenue code 0657 when services are related to the terminal condition
- Are provided by a physician employed by or under arrangement made by the hospice
- May be billed only for physician services to manage symptoms that cannot be remedied by the recipient's attending physician because of one of the following:
    - Immediate need
    - Attending physician does not have the required special skills
- Bill revenue code 0657 on a separate line for each date of service
- If a recipient is receiving care for more than one day in a month, use the "from-through" billing method to bill per-diem service and room and board codes.
- If billing for a single day, bill that day on one line with a single date of service.
- Do not bill per-diem codes on a single line with a quantity greater than one (1), or the claim will be denied.

Medi-Cal requires that hospices document all coexisting or additional diagnoses related to the recipient's terminal illness on hospice claims. Hospice providers should not report coexisting or additional diagnoses unrelated to the terminal illness.

Same or Overlapping Dates of Service

Only one level of hospice care is allowed for any hospice recipient for the same date of service. Claims for more than one type of hospice service billed for the same recipient on the same or overlapping date(s) of service will be denied.

Exception: In cases where one hospice discharges a recipient and another hospice admits the same recipient on the same day, each hospice may bill for reimbursement and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

Room and Board Billing

When billing for room and board codes, the following information is required in the *Remarks* field (Box 80) or as an attachment to the *UB-04* claim:

The recipient resides in a certified NF or Intermediate Care Facility (ICF)

The name and address of the NF or ICF

A Minimum Data Set (MDS) on file at the NF verifies that the recipient meets the NF or ICF level of care

NOTE
A TAR is not required for hospice care room and board provided in a NF or ICF.

Share of Cost

Long Term Care Share of Cost (SOC) should be cleared by a hospice provider on the *UB-04* claim form by completing the *Value Codes* and *Amounts* fields (Boxes 39 and 41). The value code is "23" and the value amount is what has been paid or obligated by the patient for SOC.

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Hospice Billing Examples

The examples in this module are to assist providers in billing hospice care services on the *UB-04* claim form. The following examples are samples only. Please adapt to your billing situation.

"From-Through" Billing of General Inpatient Hospice Care

Scenario. The recipient has elected Medi-Cal hospice coverage and is admitted to the hospital on three separate occasions (three days each visit) for monitoring and adjustment of pain medications. Authorization is required for general inpatient care days.

Claim Line 1:

Enter the description of the service rendered (inpatient care) in the *Description* field (Box 43).

Enter the beginning service (June 1, 2018) in six-digit format as "060118" in the *Service Date* field (Box 45).

Claim Line 2:

Enter code "0656" to indicate that this is a general inpatient care (no respite)/hospice general care service in the *Revenue Code* field (Box 42).

Enter the specific days the services were rendered (6/1, 3, 4, 16, 17, 18, 25, 26 and 27) in the *Description* field (Box 43).

Enter the procedure code (HCPCS code T2045) in the *HCPCS/Rate* field (Box 44). (Enter the required TAR number).

Enter the "through" date of service (June 27, 2018) in six-digit format as "062718" in the *Service Date* field (Box 45).

Enter a "9" to indicate the number of days the recipient received inpatient care in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim Line 23:

Enter code 001 to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "81" (special facility – hospice [non-hospital based]) and one-character claim frequency code "1" as "811."
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.

NOTES

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 958235555	2		3a PAT. CNTL # b. MED. REC. # 5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	4 TYPE OF BILL 811

8 PATIENT NAME	a	9 PATIENT ADDRESS	a		c	d		e
b DOE, JOHN		b						

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
04251951	M						Y0							

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37	
a								a
b								b

38			39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
		a			
		b			
		c			
		d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	INPATIENT CARE		060118					1
2 0656	6/1 3 4 16 17 18 25 26 27	T2045	062718	9	45000			2
3								3
4								4
5								5
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21								21
22								22
23 001	PAGE ___ OF ___	CREATION DATE	TOTALS ➡		45000			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	63 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A O/P MEDI-CAL					45000	57
B						OTHER
C						PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		90000000A95001		A
B				B
C				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 01234567890		A
B		B
C		C

66 DX D1D1D1D	A B C D E F G H	68
0	I J K L M N O P Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI	QUAL
				LAST FIRST	
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI 2345678901	QUAL
				LAST FIRST	

80 REMARKS	81CC a	78 OTHER NPI	QUAL
	b	LAST FIRST	
	c	79 OTHER NPI	QUAL
	d	LAST FIRST	

UB-04 CMS-1450   OMB APPROVAL PENDING
© 2005 NUBC   NUBC™ National Uniform Billing Committee LIC9213257   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: "From-Through" Billing of General Inpatient Hospice Care

Room and Board

Scenario. A hospice provider is billing for room and board for a recipient who has no Medicare health coverage and has Alzheimer's disease. The recipient has elected Medi-Cal hospice coverage for monitoring and adjustment of pain medications.

Claim Line 1:

Enter the description of the service rendered (Room and Board) in the *Description* field (Box 43).

Enter the beginning service (June 1, 2018) in six-digit format as "060118" in the *Service Date* field (Box 45).

Claim Line 2:

Enter revenue code "0658" (room and board) in the *Revenue Code* field (Box 42).

Enter the specific days the services were rendered (6/1, 2, 3, 4 and 5) in the *Description* field (Box 43).

Enter the "through" date of service (June 5, 2018) in six-digit format as "060518" in the *Service Date* field (Box 45).

Enter a "5" to indicate the number of days the recipient received room and board services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim Line 23:

Enter code "001" to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges minus the SOC in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "26" (Nursing Facility Level B) and one-character claim frequency code "1" as "261."
39	Code Value Codes Amount	Enter aid code "23" in the *Code* column and "10000" for a $100 SOC in the *Value Codes Amount* column.
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.
80	Remarks	Enter any appropriate information or on attachment.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 958235555	2			3a PAT. CNTL #			4 TYPE OF BILL
				b. MED. REC. #			261
				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	

8 PATIENT NAME	a	9 PATIENT ADDRESS	a				
b DOE, JANE		b			c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
01231961	F				Y0				

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
	a	23 100 00		
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	ROOM AND BOARD		060118					1
2 0658	6/1 2 3 4 5		060518	5	145000			2
3								3
4								4
5								5
6								6
7								7
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21								21
22								22
23 001	PAGE ____ OF ____	CREATION DATE	TOTALS ➡		135000			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	63 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789	
A O/P MEDI-CAL					135000	57		A
B						OTHER		B
C						PRV ID		C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A		90000000A95001			A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX D1D1D1D	A B C D E F G H	68
0	I J K L M N O P Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI LAST FIRST	QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI 1234567890 LAST FIRST	QUAL
80 REMARKS	81CC a b c d			78 OTHER NPI LAST FIRST	QUAL
				79 OTHER NPI LAST FIRST	QUAL

UB-04 CMS-1450
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Sample: Room and Board

Routine Home Care High Rate, Low Rate and SIA Billing

Scenario. The recipient has elected Medi-Cal hospice coverage and is admitted to hospice routine care for 67 days in a row, up until the recipient's death on the 67th day.

Claim Line 1:

Enter revenue code "0650" (routine home care high rate) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (Routine Home Care High) in the *Description* field (Box 43).

Enter the beginning service (May 4, 2018) in six-digit format at "050418" in the *Service Date* field (Box 45).

Claim Line 2:

Enter the "through" date of service (July 2, 2018) in six-digit format as "070218" in the *Service Date* field (Box 45).

Enter a "60" to indicate the number of days the recipient received routine home care high rate services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each day/unit for this per-diem routine home care high rate service is $25 per day/unit.

Claim Line 4:

Enter revenue code "0659" (routine home care service low rate) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (routine home care low rate) in the *Description* field (Box 45).

Enter the beginning service (July 3, 2018) in six-digit format as "070318" in the *Service Date* field (Box 45).

Claim Line 5:

Enter the "through" date of service (July 9, 2018) in six-digit format as "070918" in the *Service Date* field (Box 45).

Enter a "7" to indicate the number of days the recipient received routine home care low rate services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each day/unit for this per-diem routine home care low rate service is $10 per day/unit.

Claim Line 7:

Enter revenue code "0552" (routine home care service intensity add-on) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (routine home care service intensity add-on) in the *Description* field (Box 43).

Enter the beginning service (July 3, 2018) in six-digit format as "070318" in the *Service Date* field (Box 45).

Claim Line 8:

Enter the specific days the services were rendered (07/3, 4, 5, 6, 7, 8, 9) in the *Description* field (Box 43).

Enter the "through" date of service (July 9, 2018) in six-digit format as "070918" in the *Service Date* field (Box 45).

Enter a "112" to indicate the number of units of routine home care SIA services the recipient received in the *Services Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each unit for the 15-minute increment routine home care SIA service is $50 per unit, up to 4 hours (16 units max) per day.

Claim Line 23:

Enter code "001" to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges minus the SOC in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "81" (Special Facility Inpatient) and one-character claim frequency code "1" as "811."
12	Admission Date	Start of recipient's hospice certification period
17	Patient Status	"41" – Expired in a medical facility, such as hospital, SNF, ICF or freestanding hospice
31	Occurrence Code/Date	"55" – Death of the recipient, happened on 7/9/2018
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 95823-1200	2		3a PAT. CNTL #		4 TYPE OF BILL
			b. MED. REC. #		811
			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a		9 PATIENT ADDRESS	a		c	d		e
b DOE, JANE			b						

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28							29 ACDT STATE	30
01231961	F	050418			41													

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE	OCCURRENCE SPAN FROM THROUGH	36 OCCURRENCE CODE	OCCURRENCE SPAN FROM THROUGH	37
a 55 070918								
b								

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		ROUTINE HOME CARE HIGH		050418					1
2	0650			070218	60	1500 00			2
3									3
4									4
5		ROUTINE HOME CARE LOW		070318					5
6	0659			070918	7	70 00			6
7									7
8									8
9		RHC SERVICE INTENSITY ADD-ON		070318					9
10	0552	07/3 4 5 6 7 8 9		070918	112	5600 00			10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	001	*PAGE ____ OF ____* CREATION DATE		TOTALS ➡		717000			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A O/P MEDI-CAL					717000	57 OTHER PRV ID	A
B							B
C							C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A		90000000A95001			A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A 01234567890			A
B			B
C			C

66 DX D1D1D1D 0	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI LAST FIRST	QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI 1234567890 LAST FIRST	QUAL
80 REMARKS	81CC a b c d			78 OTHER NPI LAST FIRST	QUAL
				79 OTHER NPI LAST FIRST	QUAL

UB-04 CMS-1450
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OMB APPROVAL PENDING

NUBC™ National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: **Routine Home Care High Rate, Low Rate and SIA Billing**

Knowledge Review

1. Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition.
   True ☐   False ☐

2. When billing for any subsequent days of care beyond the 60-day period, providers must utilize revenue code 0659 (routine home care low rate).
   True ☐   False ☐

3. Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.
   True ☐   False ☐

4. A recipient or representative may verbally revoke the election of hospice care at any time.
   True ☐   False ☐

5. Hospice care is intended to alleviate pain and suffering rather than to cure the illness.
   True ☐   False ☐

6. What are the two new fields required to be completed on the *UB-04* claim form?
   a.   _____
   b.   _____

7. Each day of hospice care is classified into one of four levels of care: routine home care, continuous home care, inpatient care and general inpatient care (no respite)/hospice general care.
   True ☐   False ☐

8. Hospice reimbursement rates will now be based on the recipient's length of stay.
   True ☐   False ☐

9. Hospice providers should not report coexisting or additional diagnose unrelated to the terminal illness on claims.
   True ☐   False ☐

10. Records must be kept for three years from the last service date.
    True ☐   False ☐

Answer Key: 1) True; 2) True; 3) True; 4) False; 5) True;
6) A. Admission Date, B. Status; 7) True; 8) True; 9) True; 10) True

Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)
OBRA and IRCA (obra)

Part 2

Form: Hospice General Inpatient Information Sheet (DHS 6194)
Hospice Care (hospic)
Hospice Care Billing Codes (hospic bil cd)
Hospice Care Billing Examples (hospic bil ex)
Hospice Care: General Billing Instructions (hospic ge)
Hospice Care: General Inpatient Information Sheet (hospic ge inf)
Revenue Codes for Inpatient Services (rev cd ip)
TAR and Non-Benefit: Introduction to List (tar and non)
TAR Completion (tar comp)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (ub comp op)