UnitedHealthcare Medicare Advantage CMS VBID hospice billing instructions

Starting Jan. 1, 2022, the **hospice benefit component** of the Centers for Medicare & Medicaid Services (CMS) Value-Based Insurance Design (VBID) model will change the UnitedHealthcare® Medicare Advantage member's benefits and how you bill for hospice services for certain members in participating health plans.

Under the VBID model, UnitedHealthcare will be responsible for coverage and payment of all hospice-related services for Medicare Advantage members within select participating plans that elect hospice on or after Jan. 1, 2022.

Purpose of this reference guide

To help ensure proper processing of hospice claims to reduce the possibility of payment delays.

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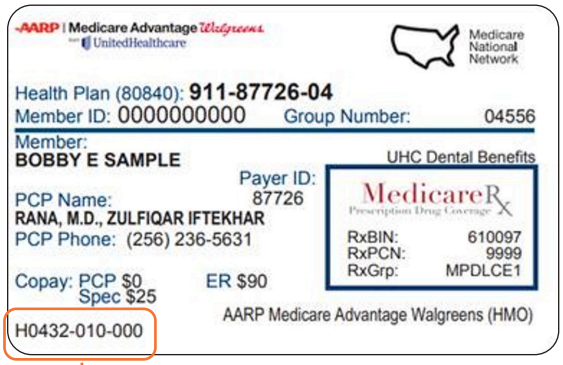
1 How to check if a member is eligible for the VBID model hospice benefit component

1. Confirm your patient's Medicare eligibility and check for Medicare Advantage enrollment. If your patient shows you a Medicare Advantage enrollment card, move to Step 2. If your patient shows you a Medicare card with a Medicare Beneficiary Identifier, use either your normal process or any of the following online tools or services to check for Medicare Advantage enrollment:
   - Medicare Administrative Contractor (MAC) Portal
   - MAC Interactive Voice Response (IVR) System
   - Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)
   - Billing agencies, clearinghouses or software vendors

2. If the patient is in a hospice VBID participating plan, and the hospice election date is on or after Jan. 1, 2022, identify the Medicare Advantage contract number and plan benefit package identification information on the Medicare Advantage enrollment card or by using one of the online tools or services in Step 1.



→ It will look like this: H#######. For example, H1234-001.

Reminder: Check the effective and termination dates to help ensure the patient's enrollment in the participating plan is for 2022.

3. Compare the patient's plan information to the list of plan benefit packages (PBPs) participating in the hospice benefit component of the VBID model. If their plan is part of the model, follow the directions below for submitting claims.

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2 Submission guidelines for hospice notices and claims

Submit all Notice of Elections (NOE) and claims electronically to the MAC and UnitedHealthcare. Please reference the Payer ID (87726) listed on the back of the member's card.

Electronic claims submission methods

- **Practice Management System (PMS) and Hospital Information System (HIS):** Software used by physicians or facilities for scheduling, registration, billing and account receivables management. Claim files can easily be created in batches or individually for electronic submission. Submit claims directly from your system or upload claim files to another source for transmission to payers.
- **Clearinghouse:** Accepts claims from a care provider's PMS or HIS and from online resources to forward to insurance payers. Clearinghouses function as the intermediary between the care provider and the payer, while providing key services to prevent time-consuming processing errors and delays. For example, claims received by clearinghouses are checked for errors, validating the information required by HIPAA and the payer.

Paper claims submission methods

We prefer to receive claims electronically but will accept claims submitted on paper for providers that are under an Administrative Simplification Compliance Act (ASCA) waiver. Please send completed claim form(s) to the claims address listed on the back of the member's ID card.

For more resources on claims submission, visit the following websites:

Claims and encounter data submissions – Ch.10, 2021 Administrative Guide | UHCprovider.com

Institutional paper claim form (CMS-1450) | CMS

Professional Paper Claim Form (CMS-1500) | CMS

3 Hospice claim billing instructions

Hospice providers are required to submit hospice care claims to both UnitedHealthcare and the MAC for any member in a participating VBID plan that has elected hospice on or after Jan. 1, 2022. Providers' claims are processed in alignment with Original Medicare hospice payment methodology.

Here is how to bill for a patient enrolled in a participating Medicare Advantage Organization (MAO) for hospice services:

- Confirm the patient's hospice election start date is on or after Jan. 1, 2022
- File the Notice of Election (NOE) with your MAC and UnitedHealthcare:

  NOTE: If you are a hospice provider, you need to file hospice NOE within 5 calendar days after the hospice admission date. If you do not file timely NOEs, then the MAO may not cover and pay for days of hospice care from the effective date of election to the date of filing of the NOE, as is current policy under Original Medicare.
- Submit claims to your MAC as you normally would. Medicare will treat these claims as informational for operational processing and monitoring and return a remittance advice with the following messages:
  - Claim Adjustment Reason Code (CARC) 96: Non-covered charge(s)
  - Remittance Advice Remark Code (RARC) MA73: Information remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care
  - Group Code Contractual Obligation (CO): MAOs participating in the VBID model's hospice benefit component will be responsible for coverage of the above services
- Submit the claim to the MAO: If you are a hospice provider that is not in the participating MAO's network, you can use the same forms you use to submit claims to your MAC
- Upon hospice discharge or benefit revocation, file the Notice of Termination or Revocation (NOTR) with your MAC and the MAO

If you are a hospice provider who is contracted with a participating MAO, follow the billing and claims processing guidelines within your contractual arrangements.

For help with any billing issues or questions, please contact your patient's MAO, your local MAC or CMS at **vbid@cms.hhs.gov.**

4 Hospice level of care

You must report services for all hospice levels of care (routine home care (RHC), continuous home care (CHC), general inpatient care (GIP) and inpatient respite care) with a HCPCS code that identifies the location where that level of care was provided. If the care was provided in different or multiple locations, you should identify each location with the corresponding HCPCS code as separate and distinct line items.

Allowed place of service (HCPCS) codes for levels of care (revenue) codes		RHC 0651	CHC 0652	Respite care 0655	GIP 0656
Q5001	Home	Y	Y	N	N
Q5002	Assisted living facility	Y	Y	N	N
Q5003	Long-term care (LTC) or non-skilled nursing facility (unskilled care)	Y	Y	Y	N
Q5004	SNF (skilled nursing facility)	Y	N	Y	Y
Q5005	Inpatient hospital	Y	N	Y	Y
Q5006	Inpatient hospice facility	Y	N	Y	Y
Q5007	LTC 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

5 Add-on service intensity payment

Effective for hospice services with dates of service on and after Jan. 1, 2016, we'll make a service intensity add-on (SIA) payment for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last 7 days of life. The SIA payment is in addition to the routine home care rate.

We provide the SIA payment for visits of a minimum of 15 minutes and a maximum of 4 hours per day (i.e., from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day). In addition, the time of a social worker's phone calls is not eligible for an SIA payment.

We calculate the SIA payment amount by multiplying the CHC rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and make adjustments for geographic differences in wages.

EXAMPLE CLAIM 1: End of Life (EOL) 7-day SIA:

Billing Period: Dec. 1, XX–Dec. 9, XX, Patient Status: 40

RHC in home, discharged deceased.

Revenue code	HCPCS	Line-item date of service	Units
0651	Q5001	12/01/XX	9
0551	G0154	12/01/XX	4
0571	G0146	12/02/XX	6
0561	G0155	12/05/XX	4
0571	G0156	12/05/XX	3
0551	G0154	12/06/XX	3
0571	G0156	12/06/XX	4
0551	G0154	12/09/XX	4
0561	G0155	12/09/XX	6
0571	G0156	12/09/XX	2

6 Type of bill and frequency

Type of bill (FL4) X=1 non-hospital-based | X=2 hospital-based			
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		
CMS Pub. 100-04, Chapter 11, Section 20.1.2 and 30.3			

Sequential billing

We're required to process claims for hospice services in sequence by date of service. This requirement, known as "sequential billing," is essential to the efficient processing of Medicare hospice claims. Medicare systems much match hospice claims to the appropriate 90- or 60-day hospice benefit period in order to receive payment.

Submit the first claim only after you have submitted the NOE. If you've qualified for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission, you must submit a hard copy NOE using the CMS-1450 Form.

Billing frequency

If you are a hospice provider, you must bill monthly (i.e., limit services to those in the same calendar month if services began mid-month) rather than over a 30-day period, which could span 2 calendar months. If you bill more frequently, it will cause the claims to return to you for correction.

7 Hospice benefit periods

Within the NOE, the hospice enters the admission date, which must be the start date of the benefit period. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the new admission date cannot be the same as the revocation or discharge date of the previous benefit period.

The date of admission may not precede the physician's certification by more than 2 calendar days and is the same as the certification date if the certification is not completed on time.

EXAMPLE: The hospice election date (admission) is Jan. 1, 2014. The physician's certification is dated Jan. 3, 2014. The hospice date for coverage and billing is Jan. 1, 2014. The first hospice benefit period ends 90 days from Jan. 1, 2014. Show the month, day and year numerically as MM-DD-YY.

8 Hospice-related prescription drugs

Effective for dates of service on and after Oct. 1, 2018, hospices are no longer required to report drugs using line-item detail. Hospices may report summary charges for drugs as shown in the following table. Hospices must enter the following visit revenue codes, when applicable:

Revenue code	Required HCPCS	Required detail
0250 Non-injectable prescription drugs	N/A	**Required detail:** Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled and should be reported as the unit measure. **For dates of service on and after Oct. 1, 2018:** Report a monthly charge total for all drugs (i.e., report a total charge amount for the period covered by the claim) using revenue code 0250.
029X Infusion pumps	Applicable HCPCS N/A	**Required detail:** Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS. **For dates of service on and after Oct. 1, 2018:** Report a monthly charge total for infusion DME (i.e., report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the infusion pumps and 0294 for DME infusion drugs.
0636 Injectable drugs	Applicable HCPCS	**Required detail:** Report on a line-item basis per fill with units representing the amount filled. (e.g., Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2). **For dates of service on and after Oct. 1, 2018:** Revenue code 0636 is not required.

9 Hospice Medicare billing codes

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	

Condition code (FL 18-28)	
H2	Discharge for cause (e.g., patient/staff safety)
52	Discharge for patient unavailability, inability to receive care or out-of-service area
85	Delayed recertification of hospice terminal illness (effective for claims received on or after Jan. 1, 2017)
CMS Pub. 100-04, Chapter 11, Section 30.3	

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	

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 and board) report as non-covered charges
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 (not valid for visits on/after Jan. 1, 2016) G0299, PM (valid for RN visits on/after Jan. 1, 2016) G0300, PM (valid for LPN visits on/after Jan. 1, 2016)
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) **Note:** Ensure Value Code (61) is present	**0651**	Q5001 – Home Q5002 – Assisted living facility Q5003 – LTC or non-SNF (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) **Note:** Ensure Value Code (61) is present	**0652**	
Respite care (Q5003-Q5009) **Note:** Ensure Value Code (G8) is present to show location	**0655**	
General inpatient care (Q5004-Q5009) **Note:** Ensure Value Code (G8) is present to show location	**0656**	
Drugs/infusion pumps description	**REV**	**HCPCS**
Non-injectable drugs	**0250**	None: NDC required for dates of service before Oct. 1, 2018 — see MM10573
Infusion pump — equipment	**029X**	As appropriate" to "As appropriate; not required for dates of service on/after Oct. 1, 2018 — see MM10573
Infusion pump — drugs	**0294**	As appropriate" to "As appropriate; not required for dates of service on/after Oct. 1, 2018 — see MM10573
Injectable drugs	**0636**	As appropriate" to "not required on claims with dates of service on/after Oct. 1, 2018

Additional notes

- The total number of units on the Hospice level of care lines (REV 651, 652, 655, 656) should equal the total number of days billed in the billing period
- Units associated with REV 651, 655 and 656 are measured in days
- Units associated with REV 652 are measured in hours (15-minute increments)

CMS Pub. 100-04, Chapter 11, Section 30.3

- View current HCPCS drug code list on **cms.gov**
- View MM10573 at **cms.gov**

10 Hospice transfer/hospice change

Transfers

Due to sequential billing requirements, hospices that are transferring a beneficiary to another hospice must submit their last claim, indicating the transfer, prior to the receiving hospice submitting their Notice of Transfer (TOB 8XC).

11 For more information

- For more information on hospice billing codes, visit **Hospice Billing Codes (palmettogba.com)**
- If you have questions about the hospice VBID model, or are interested in contracting with the UnitedHealthcare network, please send an email to **hospicevbid@uhc.com**
- For more billing instructions, visit the **CMS hospice VBID information site**
- For more information on the UnitedHealthcare claims submission process, visit **UHCprovider.com**

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