WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Hospice Billing Guidelines

Effective Date:
July 7, 2021

In an effort to ensure more timely and accurate processing of hospice claims, BCBSWY asks that providers follow the guidelines in this document. This policy applies to all BCBS lines of business except FEP and Medicare crossover claims.

Guidelines

Hospice services may include skilled nursing care, personal care aide, medical social services, and counseling/pastoral care. For inpatient hospice services that are performed in a hospital setting, the allowed amount includes home health care visits and skilled nursing services even if they are provided by a home health agency. All necessary medical equipment, supplies, drugs, and biologicals are also included in the maximum.

Charges related to physician services, outpatient radiation therapy and/or chemotherapy used to control distressing symptoms and illness are covered separately. Other services can be billed separately include enteral feedings, total parenteral nutrition (TPN), and medically necessary diagnostic services.

1. BCBSWY no longer applies the home hospice per diem to inpatient hospice services when a member's benefit plan excludes inpatient hospice services.
2. Bereavement counselling and hospice cannot be billed on the same date of services by the same provider.
3. Dates of service on a hospice claim cannot span multiple months.

Benefit Authorization

All inpatient hospice (Revenue Code 0655 or 0656) requires authorization through our Case Management Department. To obtain an authorization please call 1-307-829-3081. Be aware that not all BCBSWY contracts have an inpatient benefit.

To qualify for the inpatient hospice, benefit the member must meet the following:

1. Prognosis of six months of life or less with hospice certification.
2. Services must be palliative care that cannot be provided by home hospice. Curative care does not qualify.
3. Cannot be for patient convenience e.g. patient has no caregiver.

Coding

Hospice services should be billed on a UB04 with one of the following Types of Bill.

Type of Bill Selection

Type of Bill	Description
812	Admission Claim (Nonhospital-Based)
822	Admission Claim (Hospital-Based)
813	Continuing Claim (Nonhospital-Based)
823	Continuing Claim (Hospital-Based)
814	Discharge Claim (Nonhospital-Based)
824	Discharge Claim (Hospital-Based)

Revenue codes should be accompanied by an appropriate HCPCS code.

Please Note:
Home Hospice and Inpatient Hospice Revenue Codes cannot be billed on the same claim, nor on the same day.

The following table highlights the appropriate Procedure/Revenue code combinations.

Revenue Code Billing

Revenue Code	Medicare Description	Wyoming Description	HCPCS Code
0651	Routine Home Care	Home Hospice	Q5001
0652	Continuous Home Care	Home Hospice	BLANK
0655	Inpatient Respite Care	Inpatient Hospice	Q5006
0656	General Inpatient Hospice	Inpatient Hospice	Q5006

Coverage From and Through Dates

Claim Type	Coverage Date	Medicare Description	Wyoming Description
Initial Claim	From Date	Date of Hospice Election	Admission Date
Initial Claim	Thru Date	Not Required	End Date of Services Billed on Claim
Subsequent Claim	From Date	Date After Last Billed Service Date	Date After Last Billed Service Date
Subsequent Claim	Thru Date	Not Required	End Date of Services Billed on Claim

Condition Code

Condition Code	Description
BLANK	Use for initial claims submission
D0	Use for correction of from date referred to by Medicare as the election date ***This can only be billed with occurrence code 56**

Occurrence Codes and Dates

An occurrence code of 27 is required with the date of admission. The date of admission must match the from date on the claim.

An occurrence code of 56 may be used on claim where there is a correction of the from date referred to by Medicare as the election date. ***This can only be billed with condition code D0.**

Medicare Considerations

For claims where Medicare is secondary and inpatient hospice is not a benefit of BCBSWY the provider is required to bill using the following code combination: Revenue Code 0659, HCPCS A9270, and a GY modifier.

In order to be reimbursed for G0337 providers must bill on a HCFA 1500.