Hospice Value Code 61

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

An appropriate value code must be submitted with an appropriate revenue code. Hospices must report value code 61 when billing revenue codes 0651 and 0652. The edit will fire on a claim with Type of Bill 081X or 082X when a claim line is submitted with revenue code 0651or 0652 without value code 61. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

Reimbursement Guidelines

One of the most used value codes on hospice claims is value code 61, which is used to report the location of the site of hospice services. When Type of Bill 081X or 082X is submitted with a claim line with revenue code 0651or 0652 without value code 61, the claim will deny. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS).

The Medicare Claims Processing Manual, Chapter 11 Section 30.3 - Data Required on the Institutional Claim to Medicare Contractor states Hospices must report value code 61 when billing revenue code 0651 and 0652.

CMS MedLearn Matters MM5745 dated January 1, 2008, also defines value code 61 as the place of residence where service is furnished. Hospices report this value code when billing revenue code 0651 or 0652.

In summary, HRVCf will fire when revenue codes 0651 and 0652 are submitted without value code 61.

Value Code Description

Code	Code Description
61 Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	MSA or Core-Based Statistical Area (CBSA) number (or rural State code) of the location where the hospice service is delivered. A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care. Hospices must report value code 61 when billing revenue codes 0651 and 0652.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Revenue Code 0651	Routine Home Care – Standard Abbreviation RHC
Revenue Code 0652	Continuous Home Care – Standard Abbreviation CTNS A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8- hours of care do not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours (or less than 32 units) within a 24-hour period, then the care rendered would be covered as a routine home care day. Services provided by a nurse practitioner as the attending physician are not included in the CHC computation nor cares that is not directly related to the crisis included in the computation. CHC billing should reflect direct patient care during a period of crisis and should not reflect time related to staff working

	hours, time taken for meal breaks, time used for educating staff, time used to report etc.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	01/1/2023	New Policy
Revised Date	08/17/2023	Updated language, code descriptions, validated links
Revised Date	12/16/2024	Updated Template
Revised Date	08/4/2025	Updated Template

References

References This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS- Medicare Claims Processing Manual, Chapter 11, Section 30.3	Medicare Claims Processing Manual

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*