CMS Manual System Pub. 100-04 Medicare Claims Processing	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal 458	Date: JAUNUARY 28, 2005

CHANGE REQUEST 3686

SUBJECT: Hospice Physician Recertification Requirements

I. SUMMARY OF CHANGES: This instruction designates the use of occurrence span code 77 to indicate non-covered days during a Hospice billing period due to untimely physician recertification.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	11/30.3 Data Required on Claim to FI

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 458	Date: January 28, 2005	Change Request 3686

SUBJECT: Hospice Physician Recertification Requirements

I. GENERAL INFORMATION

A. Background:

The Medicare hospice benefit requires that a written certification be on file at the hospice prior to the submission of a claim. Frequently, written physician recertification for continued periods of hospice care is not received within the designated time limits. Consequently, care provided during the timeframe prior to receipt of the recertification may not be reimbursed for that billing period. FIs need an indicator to underscore the non covered days that appear on the claim.

B. Policy:

Following the initial benefit period, for subsequent periods of hospice care, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim to the fiscal intermediary.

C. Provider Education:

A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3686.1	Medicare systems shall allow the presence of occurrence span code 77 on hospice claims (TOBs 81x, 82x) to indicate non covered days during the From/Through dates of the billing period.		X			X				
3686.2	Medicare systems shall require that the covered days billed on claim line items and the span of non covered days reported in occurrence span code 77 on hospice claims do not exceed the statement dates in the billing period.					X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3686.1	Condition codes 20 and 21 do not apply to non covered days due to untimely recertification and should not be used in this circumstance as they generate unnecessary medical review.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Kelly Buchanan (KBuchanan@cms.hhs.gov) **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

30.3 - Data Required on Claim to FI

(Rev. 458, Issued: 01-28-05, Effective: 07-01-05; Implementation: 07-05-05)

See the Medicare Benefit Policy Manual, Chapter 9 for coverage requirements for Hospice benefits.

This section addresses only the submittal of claims. See section 20, of this chapter for information on Notice of Election (NOE) transaction types (81A,C,E and 82A,C,E).

Before billing, the hospice must submit an admission notice to the FI (see section 20).

Hospices use the Uniform (Institutional Provider) Bill (Form CMS-1450) or electronic equivalent to bill the FI for all covered hospice services.

This form, also known as the Uniform Bill 92 (UB-92), is suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. For a complete list of instructions for all Medicare claims see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp. Items not listed need not be completed although hospices may complete them when billing multiple payers.

FL 1 (Field Locator 1) - (Untitled) - Provider Name, Address, and Telephone Number

FL 4 - Type of Bill

This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular benefit period. It is referred to as a "frequency" code.

Code Structure

1st Digit - Type of Facility
8 - Special facility (Hospice)

2nd Digit - Classification (Special Facility Only)
1 - Hospice (Nonhospital based)
2 - Hospice (Hospital based)

3rd Digit Frequency	Definition
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The "Through" date of this bill (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill. For additional information on late charge bills see Chapter 3.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

FL 6 - Statement Covers Period (From-Through)

Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient's entitlement began. Since the 12-month hospice "cap period" (see §80.2) ends each year on October 31, submit separate bills for October and November.

FL 12 - Patient's Name

Enter the beneficiary's name exactly as it appears on the Medicare card.

FL 13 - Patient's Address

FL 14 - Patient's Birth date

FL 15 - Patient's Sex

FL 17 - Admission Date

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

The admission date stays the same on all continuing claims for the same benefit period.

Show the month, day, and year numerically as MM-DD-YY.

FL 22 - Patient Status

This code indicates the patient's status as of the "Through" date (FL 6) of the billing period

Code Structure

01 Discharged to home or self care (revocation, de-certification, or transfer from the agency)

30 Still patient

40 Expired at home

41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice

42 Expired - place unknown

50 Hospice - home

51 Hospice - medical facility

FL 23 - Medical Record Number (Optional)

FLs 24, 25, 26, 27, 28, 29, and 30 - Condition Codes

Code(s) identifying conditions related to this bill that may affect processing.

Codes listed are only those specific to Hospice; see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp for a complete list of codes.

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.

FLs 32, 33, 34, and 35 - Occurrence Codes and Dates

Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) or FL 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

Code	Title	Definition
23	Cancellation of Hospice Election Period (FI USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an FI as opposed to revocation by the beneficiary.

Code	Title	Definition
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit, has been decertified or discharged. **It cannot** be used in transfer situations.

FL 36 - Occurrence Span Code and Dates

Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alphanumeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each. M2 is used when respite care is provided more than once during a benefit period.
77	*Provider Liability – Utilization Charged*	*Code indicates From/Through dates for a period of non covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).*

Hospices must use occurrence span code 77 to identify days of care that are not covered by Medicare due to untimely physician recertification.

FLs 39, 40, and 41 - Value Codes and Amounts

The most commonly used value code on hospice claims is value code 61, which is used to report the location of the site of hospice services. Otherwise, value codes are commonly used only to indicate Medicare is secondary to another payer. For detailed information on reporting Medicare secondary payer information see the Medicare Secondary Payer Manual.

Code	Title	Definition
61	Location Where Service is Furnished	MSA number (or rural state code) of the location where the hospice service is delivered. Reporting of value code 61 is required when billing revenue codes 0651 and 0652 or when another insurance carrier is primary to Medicare. The hospice enters the four digit MSA, with two trailing zeroes, in the “amount” field (i.e., if the MSA is 1900, enter 190000

FL 42 - Revenue Code

Assign a revenue code for each type of service provided. Enter the appropriate four-digit numeric revenue code on line FL42 to explain each charge in FL47.

NOTE: Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657, the procedure HCPCS code is entered in FL44. Procedure codes are required in order for the FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

Hospices use these revenue codes to bill Medicare.

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care does 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 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.
0655	Inpatient Respite Care	IP Respite

Code	Description	Standard Abbreviation
0656	General Inpatient Care	GNL IP
0657**	Physician Services	PHY SER (must be accompanied by a physician procedure code)
• Reporting of value code 61 is required with these revenue codes. • **Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.		

FL 43 - Revenue Description (Not Required)

FL 44 - HCPCS/Rates

FL 46 - Units of Service

Enter the number of units for each type of service. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

FL 47 - Total Charges

FLs 50A, B, and C - Payer Identification

FL 51A, B, and C - Provider Number

FLs 58A, B, and C - Insured's Name

FLs 60A, B, and C - Certificate/Social Security Number and Health Insurance Claim/Identification Number

FL 67 - Principal Diagnosis Code

FL 82 - Attending Physician I.D.

Enter the UPIN and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment Enter the UPIN in the first six positions followed by the physician's last name, first name, and middle initial (optional).

See the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp for information about Physicians that have not been assigned a UPIN.

FL 83 - Other Physician I.D.

Enter the word "employee" or "nonemployee." (See §§40 for definition.)

FL 84 - Remarks (Not Required)

FL 85-6 - Provider Representative Signature and Date

A hospice representative makes sure that the required physician's certification, and a signed hospice election statement are in the records before signing Form CMS-1450. A stamped signature is acceptable.