CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3398	Date: November 6, 2015
	Change Request 9385

SUBJECT: Processing Hospice Denials When Face-to-Face Encounter is Not Received Timely

I. SUMMARY OF CHANGES: This Change Request creates a new payer-only occurrence code. The code will facilitate processing medical review determinations that some hospice services are denied due to an untimely face-to-face encounter.

EFFECTIVE DATE: April 1, 2016 - For claims medically reviewed on or after this date.
Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: April 4, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/190/Payer Only Codes Utilized by Medicare

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I.   GENERAL INFORMATION

A.   Background: Medicare coverage of hospice services requires a face-to-face encounter with a physician to be completed before the third hospice benefit period. If the face-to-face encounter does not occur in a timely fashion, Medicare coverage ends and the hospice must discharge the beneficiary. Once the encounter is complete, a new election of hospice services is required before the beneficiary can be readmitted by the hospice and continue covered services.

If a hospice claim for continuing care is selected for medical review and the reviewer finds that the face-to-face encounter was not timely, the dates of service following the date the encounter was required are denied. Currently, the partially-denied hospice claim does not cause Original Medicare systems to post a revocation date on the beneficiary's hospice benefit period. This interferes with the hospice's ability to submit a new election when coverage is restored. The situation must be resolved by manual workarounds that require the hospice to submit a paper adjustment claim or the reviewer to make manual changes to the claim data submitted by the hospice. The requirements below revise Medicare systems in order to prevent these inefficient workarounds.

Payer-only occurrence code 48 is not currently used by Medicare. As of the effective date, Medicare will use the code for internal processing with the definition "Date hospice face-to-face encounter was untimely." The medical reviewer will indicate the untimely date on the claim using this occurrence code and non-cover all subsequent line item dates of service, as currently happens in a partial denial situation.

When the partially-denied hospice claim is sent to the Common Working File (CWF), CWF will post the occurrence code 48 date as the revocation date on the current benefit. The hospice claim will be accepted by CWF with line item dates beyond the revocation date when occurrence code 48 is reported, as long as those line items are non-covered. This action will require the hospice to submit a new Notice of Election before any future dates of service can be submitted.

B.   Policy: This Change Request contains no new policy. It improves the implementation of existing policy.

II.   BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9385.1	The contractor shall accept payer-only occurrence					X				

Number	Requirement	A/B MAC			DME MAC	FISS	MCS	VMS	CWF	Other
		A	B	HHH						
	code (OC) 48 for internal processing on Types of Bill 081x and 082x as of the effective date, with the definition "Date hospice face-to-face encounter was untimely."									
9385.2	The contractor shall indicate the date hospice face to face encounter was untimely on the claim using occurrence code 48 and non-cover the occurrence code 48 date and all subsequent line item dates of service.			X						
9385.3	The contractor shall post the OC 48 date as the revocation date on the current benefit when the partially-denied hospice claim is sent to the Common Working File (CWF).								X	
9385.4	The contractor shall accept the hospice claim with line item dates beyond the revocation date when OC 48 is reported, as long as those line items are non-covered.								X	
9385.5	If a claim with OC 48 is adjusted, the contractor shall ensure the cancel portion of an adjustment removes the revocation date.								X	
9385.6	The contractor shall ensure that OC 48 is not sent on the COB outbound claim.					X				

III.   PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV.   SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9385.2	This situation may be identified when a documentation supporting a claim is medically reviewed.
9385.5	These adjustments will usually occur as a result of appeal determinations. Removing the revocation date is necessary to allow the lines which are now covered to be paid.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charles Nixon, charles.nixon@cms.hhs.gov , Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirement

190 – Payer Only Codes Utilized by Medicare
(Rev. 3398, Issued: 11-06-15, Effective: 04-01-16, Implementation: 04-04-16)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

> 12-14 - Not currently used by Medicare.
>
> 15 – Clean claim is delayed in CMS Processing System.
>
> 16 – SNF Transition exception.
>
> 60 – Operating Cost Day Outlier.
>
> 61 – Operating Cost Outlier.
>
> 62 – PIP Bill.
>
> 63 – Bypass CWF edits for incarcerated beneficiaries.   Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.
>
> 64 – Other Than Clean Claim.
>
> 65 – Non-PPS Bill.
>
> 98 – Data Associated With DRG 468 Has Been Validated.
>
> EY – Lung Reduction Study Demonstration Claims.
>
> M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
>
> M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
>
> M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.
>
> M3 – M9 Not used by Medicare.
>
> MA – GI Bleed.
>
> MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MZ – Not currently used by Medicare.

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48 - Date hospice face-to-face encounter was untimely

49 – Not currently used by Medicare.

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 –HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Accountable Care Organization reduction.

Q1 - Q9 – Not used by Medicare.