Hospice Coalition Q & A

To: Hospice Coalition Members
From: Palmetto GBA Provider Outreach and Education
Date: March 12, 2012
Location: Palmetto GBA GPC Building – Palmetto Room III
Time: 12:30 p.m. ET
Number: (877) 239-1087
Pass code: 3269486217

Attachment A:	**Snapshot of Palmetto GBA Performance Measures**
Attachment B:	**Hospice Discharge Charts**
Attachment C:	**EDI 5010 Updates**
Attachment D:	**Billing Dispute Resolution Request Form**
Attachment E:	**CAP Updates**
Attachment F:	**NCLOS – Regional Rates**
Attachment G:	**NCLOS – State Chart**
Attachment H:	**NCLOS Rates by LCD Policy – 2011 First Half**
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1. Face-to-Face Visit: Would the following documentation be in compliance with Palmetto's medical record review of a F2F visit if it included within a SOAP format the following: Patient name, date of visit, location of visit, short statement of condition/symptoms, and a physical examination that is only pertinent to the terminal diagnosis?

   The visit documentation would also need to indicate why the medical condition of this particular beneficiary is such that it is reasonable to expect a medical prognosis of six months or less. The documentation must identify the person who performed the face-to-face visit. If that visit was performed by a nurse practitioner there should be documentation within the medical record to indicate the hospice physician was given the results of the face-to-face encounter which was used in his/her decision to recertify.

If the Medical Director performs the F2F within 15 days prior to the new certification period (3rd benefit and beyond), can their F2F assessment documentation and recertification narrative be documented as one?

Regulatory language in 42CFR Part 418 – Hospice Care, updated March 20, 2012, does not preclude the use of one form for both the recertification narrative and the face-to-face encounter assessment documentation. However, the attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Reference: Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1 (b).

Note: All the required elements for both the narrative and the face-to-face must be present.

2. At the time of admission, the hospice nurse put in the computer system the "prospective" terminal diagnosis. The Medical Director certifies and documents that the patient has a different terminal diagnosis. The "prospective" diagnosis did not get changed in the computer system and therefore, is billed. This actually continues for over 3 certification periods. When an internal chart/billing audit is completed, the error is found. The decision is made to correct the billing errors to reflect the correct terminal diagnosis.

   The bills cancel out until it hits a certification period. There have been numerous phone calls to seek guidance and the provider has been told by Customer Representatives that the issue or hold up is getting the common working file to back out the certification periods. The provider has been told that these common working file delays would not cause the claims to reject due to timely filing. We have pages of documentation of working with Customer Representatives to resolve these issues and to rebill Many of the claims due to the certification periods in the Common Working File could not be canceled. Now we have tens of thousands of dollars lost due to our inability to re-file because these claims are now considered untimely. If the Common Working File is what created the extensive delays why would the provider be held to the untimely filing policy?

   Palmetto GBA stands ready to assist in the resolution of this matter. Please provide specific case details so that we can expedite this resolution. The claim and documentation given for consideration for the extension to timely filing would need to be reviewed in order to explain the reason for denial. There are numerous variables that would need to both be documented and considered.

A hospital provider has a hospice Medical Director providing in-hospital palliative care consultation. The Medical Director is discharging terminal patients to his hospice inpatient unit for a few days prior to being sent home/NF. They are using the inpatient unit as a step-down from the hospital stating that they can admit to the hospice under the General Inpatient level of care to assess the patient, make medication changes and assist the patient's transition to home or the NF. Is this really how the hospice general inpatient level of care should be utilized?

Appropriate use of the General Inpatient level of care is outlined in CMS IOM Publication 100-02, Chapter 9, Section 40.1.5.

General Inpatient care MAY be required for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. A brief period of General Inpatient care MAY be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, General Inpatient care MAY be appropriate. Appropriate General Inpatient care may also include a patient in need of medication adjustment, observation, or other stabilizing treatment. Documentation in the medical record must support the fact it is reasonable and necessary that the patient be at the General Inpatient level of care.

Concerned hospice providers may contact appropriate state agencies.

3. Please talk about the approach to the recent NCLOS probe edit.
   a. Why were the ADRs processed before providers were notified of the edit?

      Generally, providers are notified in advance of receiving ADRs. Medical Review made some changes that resulted in letters being sent later than normal. In the future we plan to continue the normal process of sending letters in advance.

   b. It would be helpful if you provided education to providers on responding to ADRs. Are there any plans for this in 2012?

      ADR education is provided at workshops, in the Additional Documentation Request (ADR) letters, and in articles on our Web site. Providers have 30 days to respond to ADRs. A hard copy of the medical records may be mailed, submitted via fax, esMD or via CD/DVD in TIFF format.

c. Can you please verify the most expeditious method to submit medical records? Providers received conflicting information. The provider letter said that use of fax would expedite the process. Submission of TIFF files on a CD/DVD has been published as an option. However, a provider called Medical Review and was told that mailing the records was the most expeditious – faxes over 50 pages don't always process, TIFF files are delayed while waiting on someone to print them, but paper can be reviewed right away

   All formats are accepted. Fax is probably the easiest if you are not using two-sided forms. If two-sided forms are being used, you have to remember to make a copy of the second page and place it in the appropriate order. esMD and fax enter the system the same so there should not be a difference in the mode of delivery.

d. Repeatedly our redeterminations are being misplaced, lost or unaccounted for at Palmetto GBA Appeals. We have Fed Ex tracking with staff Palmetto GBA staff signatures on delivery and yet weeks to months after delivery the PCC claims that they have no evidence of our appeals. What avenue can we take to ensure that we do not have our appeals dismissed for non-receipt or deadlines for appeal missed?

   Palmetto GBA will be glad to research this issue. Please provide examples, such as shipping and tracking information, so that we can expedite a resolution to this matter.

4. Is it acceptable for Hospice Medicare forms such as the Hospice Medicare Election Statement and the Hospice Medicare Revocation Statement to be in solely electronic format? Specifically, can they be customized E-forms that are electronically signed by the patient/representative on a laptop and then maintained as part of the patient electronic medical record?

   Palmetto GBA is researching this issue.

5. Please discuss the changes in the use of Occurrence Code 42 and the addition of Condition Code 52. Can you provide a grid that shows when these codes are used?

   Effective for dates of service on or after July 1, 2012, Change Request (CR) 7677 requires hospices to discontinue use of occurrence code 42 for situations when a provider initiates the termination of hospice care. Providers are instructed to use occurrence code 42 only to indicate a discharge due to a patient revocation, in accordance with the existing National Uniform Billing Committee (NUBC) instructions.

   Additionally, providers must begin to use the new NUBC condition code 52 to indicate a discharge due to the patient's unavailability or inability to receive hospice services from the hospice that has been responsible for the patient.

Examples of when to use the condition code 52 include, but are not limited to:

a. When a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation.

b. When a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient.

c. Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility before making a determination that discharging the patient from the hospice is appropriate. See Attachment B.

6. How is implementation of 5010 going?
   a. Are most hospice claims being submitted in the 5010 format?
   b. What common problems can we alert providers about that are occurring during the transition?
   c. What is Palmetto's current state of readiness for 5010?

See Attachment C.

9. What process should a hospice follow when they submitted a claim for a patient they handled as a transfer and then find out the receiving hospice did not do a timely admission? It seems fraudulent for the transferring hospice to have to change their final claim when they acted properly. But if they don't then receiving hospice can't bill. If the transferring hospice refuses to make the change to a discharge, would Palmetto intervene and make the change in the system?

In the above scenario, it appears that the second hospice did not follow through with the admission of the patient within the time that was needed for the appropriate transfer notification to be submitted to Medicare. Based on the rules governing the hospice program, Medicare systems will not process a transfer notification if there is a break of more than one day (discharge today from hospice 1 and admit tomorrow to hospice 2) between the "discharge" date from one agency and the admission to another agency. Therefore, it would be best for the two hospices to communicate with each other to determine the best resolution to the situation.

In the case of a dispute, both agencies are required under Medicare regulations to make an attempt to resolve the issue between them. If the agencies are unable to resolve the dispute, Palmetto GBA may be contacted for assistance. Palmetto GBA will work with both agencies to settle the dispute. Providers seeking assistance from Palmetto GBA to resolve a billing dispute may complete the Billing Resolution Dispute Form (Attachment D) or access the Billing Dispute Resolution Request Form on the Palmetto GBA Web site. All information on the form is required to assist the provider.

Upon receipt of the completed form or a written request that includes all the required information, Palmetto GBA will take the necessary steps to assist the provider with resolving the situation.

10. A hospice patient is receiving respite care in a hospice freestanding inpatient facility for 5 days. The hospice physician is asked to see the patient because of the development of a new symptom. What CPT code should be used when billing the physician visit for this patient, domiciliary/rest home, home care, or inpatient?

    Hospice facilities should look to the physician for the accurate CPT code to bill on the 1450 claim form for the physician visit to the hospice patient. For your information, CMS's guidance to physicians billing on the 1500 form is to use place of service 34 (Free-Standing Hospice) and CPT code range 99307-99310 (nursing facility codes). Inpatient and home care CPT codes are not advised for use.

    Reference: CMS Change Request 4246

11. Please provide clarification regarding the use of modifiers when an ABN is issued to a Hospice Patient, specifically what modifiers if any, need to be on the claim?

    Palmetto GBA is researching this issue.

12. How is an agency notified of its revalidation status once the re-enrollment has been submitted?

    Providers should allow up to three weeks after they submit their re-enrollment applications to check the status of their applications. Providers can verify receipt and status of applications using the Enrollment Application Status Lookup tool on Palmetto GBA's Web site at www.PalmettoGBA.com/hhh. Select "Enrollment Application Status Lookup" under the "Self-Service Tools" heading. Enter your Provider Transaction Access Number (PTAN), which is the six-digit Medicare provider number issued by CMS.

13. Sometimes the attending physician fails to date the initial certification of terminal illness (CTI) for new hospice admissions. It has been a practice for some providers to time/date stamp the signature on the CTI when received. This provides proof that it was indeed received prior to the submission of billing. However, we now see entities denying payment stating that this is insufficient evidence that the attending physician's signature was received prior to billing submission. Notarized attestations from the attending physician, indicating that he/she did indeed sign prior to the date of billing submission are also not being accepted. Please provide guidance of how to properly correct issues when the physician fails to date the CTI.

CMS clarified that the physician must date his/her signature therefore, received date stamps are not acceptable. The written certification must be signed and dated prior to billing Medicare for the services. It would be a good practice for providers to have a system in place to check to ensure all documents received from certifying physicians are signed and dated prior to submitting any billing on that beneficiary.

14. If the benefit period dates were incorrectly calculated, and several months down the road you find the patient was re-certified on incorrect dates, how do you correct this?

    a. If a face to face should have been done and it does not occur due to the incorrectly calculated dates as above, what recourse does a hospice have to correct this and bill for services provided?

    Medicare cannot make appropriate payment without correct dates. The claim(s) would need to be cancelled and re-billed correctly and the documentation should note the discrepancy clearly.

    The Medicare regulations state the face-to-face must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter. The recertification may be completed up to 15 days prior to the start of the third benefit period before the services can be billed to Medicare. A written certification must be on file in the hospice patient's record prior to submission of a claim to the Medicare contractor.

    Reference: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.

    b. A patient has received prior hospice services and the prior hospice does not bill their final bill to match the documentation they have sent us. For example, the document they sent us states they are transferring the patient, but then they bill as if it was a revocation—thereby throwing off our benefit periods and F2F. After contacting the other hospice multiple times and giving them the opportunity to fix the error, after several months, the error is still not fixed.

    c. What are the steps to take to get this corrected in the system?

    d. Is there a standard period of time the receiving hospice should give the prior hospice to respond?

    e. In what manner does the receiving hospice document contact with the prior hospice to demonstrate efforts to resolve this issue?

    In cases of a dispute, both agencies are required under Medicare regulations to make an attempt to resolve the issue between them. If the agencies are unable to resolve the dispute, Palmetto GBA may be contacted for assistance. Providers seeking assistance from Palmetto GBA to resolve a billing dispute may complete the Billing Resolution Dispute Form (Attachment D) or access the form Billing Dispute Resolution Request Form on the Palmetto GBA Web site. All information on the form is required to assist the provider.

Upon receipt of the completed form or a written request that includes all the required information, Palmetto GBA will take the necessary steps to assist the provider with resolving the situation.

16. Does a patient have to be at routine home level of care before they qualify for respite? If the patient is in a nursing facility and the family needs time to get things together before caring for the patient at home, can the patient be admitted directly into the respite benefit? Or do they have to have been at routine home care level first?

    There is no Medicare regulation that requires the patient be admitted at the routine level of care first. The patient can be admitted directly into one of the other levels of care as long as all the general hospice regulations are in place and the patient meets the requirements for that level of care.

17. Who do we call to get guidance regarding Physicians' claims that are being denied by Medicare when Hospice patients are seeing physicians for unrelated conditions? Many of the Physician's billers are not familiar with the use of the modifier codes or the process to file this type of claims. It would be very helpful if there is someone we can talk to from Medicare or a site to review the billing of this type of claims.

    For billing questions regarding care that is not related to the terminal illness, independent physicians in the states of North Carolina, South Carolina, Virginia, and West Virginia, should call Palmetto GBA's Part B Provider Contact Center (PCC) at (866) 830-3043. Physicians in all other states should call their designated Medicare Part B contractor.

    Per the CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 11, Sections 40.2 and 50 defines physician's billing for services unrelated to the terminal diagnosis. The primary attending physician and/or consulting physician bill Medicare Part B with the applicable CPT code for the service and include the GW modifier indicating the service is not related to the terminal diagnosis.

18. If a patient is admitted into the 3rd or subsequent benefit period, all consents are signed, and then 2 weeks later it is found that the F2F was not done, the agency will need to complete the F2F, write off those days as nonbillable, and readmit once the F2F is done. Question: what admission paperwork needs to be completed since the patient was on the program already? Is completing the Medicare election form enough, or must we also do informed consents, new initial plan of care, comprehensive assessment, etc.

    Since the beneficiary is being discharged and re-admitted all admission paperwork would need to be completed.

Will Palmetto be doing any training for hospice on the ICD-10 coding that starts this year?

Palmetto GBA J11 Hospice Local Coverage Determinations (LCDs) are being mapped at this time. CMS announced they plan a delay in implementation of ICD-10. Any training with regard to hospice services related to coverage under the LCDs will not be scheduled until further instruction has been received by CMS regarding the ICD-10 implementation schedule.

19. If a patient transfers to another hospice ON THE DATE of his re-certification, which hospice is responsible for obtaining the re-cert? Does the transferring hospice or the receiving hospice submit the claim with the code on it for the re-cert?

The CMS IOM Publication 100-04, Medicare Claims Processing Manual, Section 30.3 states: "The receiving agency in a transfer situation enters Occurrence Code 27 with the start date of the benefit period in which the beneficiary is transferred."

The CMS IOM Publication 100-04, Medicare Claims Processing Manual, Section 30.3 states: "The receiving agency in a transfer situation enters Occurrence Code 27 with the start date of the benefit period in which the beneficiary is transferred."

In the case where the patient was transferred on the date that the next benefit period begins, then the admit date and OC 27 date of the receiving agency would be the same. The admit date on the receiving agency's claim is the date the patient was actually admitted to their agency. In situations such as this, communication between both providers is very important. Additionally, both hospice agencies should have supporting documentation in their files to support the re certification requirements. Agencies are also encouraged to review the hospice transfer guidelines outlined in CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.2.

For more information about this issue, please review the job aid for Billing Occurrence Code 27 and Occurrence Span Code 77 located under Top Links at www.PalmettoGBA.com/hhh.

As a reminder, in cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill, and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission. This language has been added to CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 11 Section 90 and Publication 100-02, Chapter 9, Section 20.2.

20. The hospice MD had a stroke and residual problems where he is shaky and cannot write. He must have someone either write type or translate dictation for his contributions to the chart. How does the hospice verify or certify his signature or notation to be in compliance?

    A physician may dictate information. The dictated information can then be transcribed into the medical record. The documentation should reflect this was dictated by the physician. The physician would then sign and date the document. If the physician signature is illegible the provider should follow the CMS signature guidelines.

    For more information about signature requirements, please review the "Signature Guidelines for Medical Review Purposes" (MLN Matters article MM6698) which is available on the Palmetto GBA Web site at www.PalmettoGBA.com/hhh.

21. Since Dec 28th we have received 35 ADRs in Home Health and 14 in Hospice. According to the letter, a provider has 30 days to respond and Palmetto then has 60 days to review. What is the normal time for payment of claims after a favorable ADR review?

    Once medical review has completed their review, the claim normally would process for payment within a few days of the review decision. Please note, however, the claim may encounter other edits prior to final processing which means the claim may move to another location prior to final adjudication. Other status locations may include: Return to provider (RTP); Suspended (S) due to edits related to the processing of the claim through common working file (CWF); sequential billing or other edits.

22. This question relates to the use of the LCD for Adult Failure to Thrive. When determining eligibility for FTT, if a provider is using arm circumference, how much does the arm circumference have to decrease and over what period of time to support FTT?

    The use of anthropometry was incorporated into the Adult Failure to Thrive (AFTT) Local Coverage Determination (LCD) for situations when the beneficiary COLULD NOT BE WEIGHED.

    According to the US Centers for Disease Control and Prevention (CDC):
    "The field of anthropometry encompasses a variety of human body measurements, such as weight, height, and size, including circumferences; lengths, breadths, and skin fold thicknesses. Anthropometry is a key component of nutrition status assessment in children and adults."

While a BMI (and therefore a weight) is required at the time of initial hospice election/certification for the FTT Syndrome, there may be circumstances (e.g., pain and decreased mobility) where obtaining a weight is not feasible for subsequent certifications. Following discussions among the Hospice IAC members and Palmetto GBA the use of standard measurements, like mid-arm circumference (MAC) in centimeters, was included in the FTT LCD.

The value of using a standard measurement, like MAC in centimeters, is that age and gender-specific population-based normative tables exist and the individual measures taken by the hospice can be used compared to the range of normative values. If an individual had the Adult Failure to Thrive Syndrome (AFTT) one would expect that their MAC would be on the low end of the spectrum for their age and gender. While no specific percentage change in MAC can determine eligibility - over time, one would anticipate that the MAC for a given beneficiary would change (i.e., increase or decrease - depending on whether the FTT Syndrome was caused by a reversible condition or not). Both the initial value and trend over time should therefore be factored into care planning and decision-making.

The CDC publication at the URL below contains gender and age-specific normative values for women and men (see tables 21 and 34, respectively).

www.cdc.gov/nchs/data/ad/ad361.pdf

23. Patient of hospice #1 transfers to inpatient hospice facility (hospice #2) during an acute phase. Their condition improves and patient is sent back to hospice #1 as a transfer. The above occurs during the same benefit period. We understand that only 1 transfer per benefit period is allowed. What are the implications for the receiving hospice if they accept the patient back incorrectly as a transfer?

    Hospice benefits are not payable when a beneficiary transfers more than once in a benefit period. If this occurs, the second provider who accepts the beneficiary as a transfer for the second time in the same benefit period will not receive payment from Medicare. The Medicare regulations state that one transfer can occur per benefit period and that the beneficiary would remain in their current benefit period. Providers could consider a contract between the hospice and the inpatient hospice facility; however providers should not advise patients to revoke hospice in this situation.

    Reference: CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 11, Section 30.

24. Occasionally there will be a consent obtained for hospice to begin once a patient finishes antibiotics, rehab or radiation before electing the hospice benefit. Is there an appropriate time frame that a consent should be acted upon?

    There is no specific Medicare regulation addressing such a consent form. Instead, Medicare addresses the Notice of Election form. At the time of admission, each hospice designs and prints its election statement. The election statement must ensure acknowledgment that the individual has been given full understanding of hospice care particularly the palliative rather than curative nature of treatment and acknowledgment that the individual understands that certain Medicare services are waived by the election.

    Reference: CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 20.2.

25. Will you share you scheduling of state/regional educational programs and topics for 2012?

    Palmetto GBA's topics for this year's hospice workshops include the following:

    Hospice billing topics will include:

    - **Medicare updates**
    - **HIPAA 5010 and Electronic Data Interchange (EDI)**
    - **Billing changes as a result of 5010**
    - **Hospice discharge codes**
    - **Hospice ABN**
    - **Data analysis**
    - **Top Web site searches**
    - **Top billing issues**
    - **Top provider telephone and written inquiries**
    - **Top Comprehensive Error Rate Testing (CERT) billing errors**
    - **J11 Hospice Provider Enrollment Revalidation Initiative**
    - **The Internet-based Provider Enrollment Chain and Ownership System (PECOS)**
    - **Questions and answers**

Hospice Clinical topics will include:

- **Admission and election**
- **NCLOS rates**
- **General assessment scales**
- **Liver LCD**
- **Cancer presentations**
- **Fraud and abuse**
- **Questions and answers**

Palmetto GBA has scheduled a number of workshops with multiple state associations beginning March 15, 2012.

Palmetto GBA will also sponsor additional workshops this year, in addition to Medicare Secondary Payer (MSP) workshops, in the following locations:

- **Atlanta, Georgia - April 5, 2012**
- **Dallas or Houston, Texas - May 23, 2012**
- **Columbia, South Carolina - June 6, 2012**
- **Oklahoma City or Tulsa, Oklahoma - August 8, 2012**

The schedule of our workshops are available on Palmetto GBA's Web site at www.PalmettoGBA.com/HHH. Select Learning & Education and then the Event Portal Registration link.

****Note, the exact locations for Texas and Oklahoma has not yet been confirmed. Once the final arrangements have been made, we will post them to the Web site.**

26. Any MAC updates, for example how hospice chain providers will be affected? As some chain providers are opening new programs they are finding that they will be administered through the locally assigned MAC not Palmetto GBA their current MCA.

    New hospice providers are assigned to the MAC for their geographic region. Existing hospice providers not currently assigned geographically will remain with their current MAC, i.e. Palmetto GBA at this time.

For HHH Region C, Palmetto GBA currently has 104 hospice "Out of Jurisdiction Providers" (OJPs) hospice providers for whom we handle all functions—claims, cost reports, hospice cap calculations, etc. These OJPs were previously assigned to Palmetto GBA through individual provider nominations, or through chains being granted single Fiscal Intermediary status. Conversely, there are some hospices located in the 16-state HHH Region C now being served by other MAC contractors.

CMS plans to redistribute Out of Jurisdiction Providers to their 'correct/geographic' MAC once all the MACs are fully implemented.

Per Change Request 5979, all home health and hospice (HHH) providers will be assigned to the MAC contracted by CMS to administer HHH claims for the geographic locale in which the provider is physically located. The following link to the CMS Web site also provides more information of the HHH MAC Specialty Jurisdictions.

www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp#TopOfPage

Although not directly asked as part of this question, please note a change in responsibilities for the hospice cap calculations for hospital based hospices. The HHH MACs are now responsible for completing these annual calculations for all the hospices in their jurisdiction (for whom they are paying claims). Before the change, the MAC handling the cost report, rather than the one paying the claims, would have been responsible for the hospice cap calculation.

27. Give us a CAP update on the two cap determination methodologies and the election process.

    CMS has not revised the manual to incorporate the two cap determination methodologies nor issued any formal directive on the election process. However, letters were mailed to providers on November 1, 2011, requesting the number of beneficiaries electing hospice care for period September 28, 2010, through September 27, 2011. Included in the letter was information on the Streamlined Methodology and Patient by Patient Proportional Methodology.

    See Attachment E - 2 reports.

28. Please provide an update on the status of the current NCLOS medical review, the number of hospices currently under review and the stages of those reviews.

    There are 382 hospices currently on review. No probe edit effectiveness decisions have been completed at this time.

29. Please provide an update to the NCLOS rates for the Palmetto GBA region and by state for the last 6 months of 2011 and trends you are seeing.

    a. See Attachments F-I.

    b. NCLOS Rates by LCD Policy for 2011, 1st half compared to 2nd half, is almost identical. The only trend seen is one of consistency.

30. Please provide updates on which edits / probes are planned by Palmetto for 2012
    This is pending the results of the current probe reviews.

31. What provider deficiencies are Palmetto finding in their probes—either technical or clinical?

    Palmetto GBA is finding that the hospice certification and face to face documentation does not provide enough information to reach the same determination as the agency. Foe example, Palmetto GBA has received some certifications with the following statement: "Hospice appropriate, beneficiary is dying soon." This is not sufficient documentation.

32. Please provide:
    a. Update on the Intermediary Advisory Committee (IAC) activity.
    At present there has not been change in policy to indicate need for an IAC.

    b. Update on additional LCD activity
    The Local Coverage Determinations (LCDs) remain consistent except for coding updates. It is anticipated the LCDs will remain unchanged until ICD-10 coding has been completed.

ATTACHMENT A

Snapshot of Palmetto GBA Performance Measures:

November 2011 – January 2012
Jurisdiction 11 Home Health and Hospice Medicare Administrative Contractor
(J11 HHH MAC)

Claims Processing (Includes SC Part A and HHH)

- All Claims Processed in 30 days
  - Metric Goal: 95 percent
  - Palmetto GBA performance: 99.6 percent
  - **Metric Exceeded**

Claims processed: 3,397,148 (Includes SC Part A and HHH)

Dollars paid: $5,062,373,907 (Includes SC Part A and HHH)

Appeals (includes SC Part A & HHH)

- Redeterminations Completed in 60 days
  - Metric Goal: 100 percent
  - Palmetto GBA performance: 31 percent
  - **Metric Not Met**

  ***Note: The appeals inventory was reduced by over two-thirds and Palmetto GBA anticipates that all appeals will be current within the next month.**

Provider Contact Center (PCC) (HHH Only)

- The Average Speed of Answer (ASA) is the average time, in seconds, that all calls waited before being connected to a CSR.
  - Metric Goal: < 60 seconds
  - Palmetto GBA performance: **48** seconds
  - **Metric Exceeded**

- The Call Completion is the percentage of calls received and completed without encountering a busy signal.
  - Metric Goal: 80 percent
  - Palmetto GBA performance: 87.5 percent
  - **Metric Exceeded**

- PCC Written Inquiries Completed within 45 business days of the date of receipt
  - Metric Goal: 95 percent
  - Palmetto GBA performance: 99.8 percent
  - **Metric Exceeded**

Medical Review (MR) (HHH Only)

- Medical Review Timeliness in 60 days
  - Metric Goal: 100percent
  - Palmetto GBA performance: 100percent
  - **Metric Met**

Provider Enrollment (HHH Only)

- 855 A Change of Information

Percent Completed within 60 days - Paper

- Metric Goal: **80** percent
- Palmetto GBA performance: 82.2 percent
- **Metric Exceeded**

Percent Completed within 90 days - Paper

- Metric Goal: **90** percent
- Palmetto GBA performance: 94.5 percent
- **Metric Exceeded**

Percent Completed within 120 days - Paper

- Metric Goal: **95** percent
- Palmetto GBA performance: 98.3 percent
- **Metric Exceeded**

Percent Completed within 45 days – Web-based

- Metric Goal: **90** percent
- Palmetto GBA performance: **77.6 percent**
- **Metric Not Met**

Percent Completed within 60 days – Web-based

- Metric Goal: **95** percent
- Palmetto GBA performance: **94.4 percent**
- **Metric Not Met**

Percent Completed within 90 days – Web-based

- Metric Goal: **99** percent
- Palmetto GBA performance: 100 percent
- **Metric Exceeded**

ATTACHMENT B

Hospice Discharges & Revocations
Change Request (CR) 7473
Effective January 1, 2012

Note: **Information included in this chart is relevant through June 30, 2012.**
Please refer to an updated version of the Hospice Discharge & Revocations Chart which includes updates from CR 7677

Discharge Reason	Discharge Status Code	Occurrence Code (OC)	Condition Code (CC)	Impact on Medicare Hospice Benefit (MHB)	Common Working File (CWF)	Billing Reminders
Beneficiary moves out of the hospice's service area.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation	NA	NA	Current hospice benefit will terminate	Claim will terminate the current hospice benefit period as of the "through" date on the claim.	Do not report OC 42
Beneficiary **transfers** to another hospice.	**50:** Beneficiary is transferring to home hospice **OR** **51:** Beneficiary is transferring to a hospice medical facility.	NA	NA	Current hospice benefit period will **not** be terminated.	Claim will not terminate the current hospice benefit period.	Effective date of receipt January 1, 2012. Do not use discharge status code 01. Patient discharge status code 20 is not used on hospice claims. Do not report OC 42 Admitting/receiving hospice must submit a notice of change of provider (TOB 8XC)

Disclaimer: The information provided in this job aid was current as of March 7, 2012. Any changes or new information superseding the information in this document will be provided in articles and publications.

Discharge Reason	Discharge Status Code	Occurrence Code (OC)	Condition Code (CC)	Impact on Medicare Hospice Benefit (MHB)	Common Working File (CWF)	Billing Reminders
Discharge for cause; There is **no transfer involved**, and the hospice determines the beneficiary meets their internal policy regarding discharge for cause.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation	NA	H2	If any discharge status code is used other than still a patient, patient's death or transfer, the current hospice benefit will terminate as the "Through" date on the claim.	If any discharge status code is used other than still a patient, patient's death or transfer, the current hospice benefit will terminate as the "Through" date on the claim.	Do not report OC 42
Revocation Beneficiary no longer wants the Medicare hospice benefit.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation	Report OC 42 and the date of revocation on the final claim	NA	Current hospice benefit period will be terminated.	Claim will terminate the current hospice benefit period as of the OC 42 date.	

Key points:

Discharge Status Codes
Medicare contractors will set the revocation indicator on a beneficiary's hospice benefit period when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 is not present.

- Medicare contractors will set the end date of the beneficiary's hospice benefit period to match the claim "Through" date when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 is **not** present.
- Medicare contractors will set the end date of the beneficiary's hospice benefit period to match the occurrence code 42 date when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 **is** present.

Reminder!
Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing should conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months.

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ATTACHMENT B

Hospice Discharges & Revocations
CR 7677: Out of Service Area Discharges Condition Code 52
Effective July 1, 2012

This chart has been updated to include information outlined in CR 7677.

Discharge Reason	Discharge Status Code	Occurrence Code (OC)	Condition Code (CC)	Impact on Medicare Hospice Benefit (MHB)	Common Working File (CWF)	Billing Reminders
Beneficiary unavailable/in-availability to receive hospice services from the hospice which has been responsible for the patient.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation.	NA	52	Current hospice benefit period will be terminated	Claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim.	Effective for dates of service on or after July 1, 2012. Examples of when such a code could be used include, but are not limited to: Patients who relocate to another part of the country or go on vacation outside of the hospice's service area. A hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, as a result is unable to provide hospice services to that patient. Do not report OC 42, patient status 30, or condition code H2.

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ATTACHMENT B

Discharge Reason	Discharge Status Code	Occurrence Code (OC)	Condition Code (CC)	Impact on Medicare Hospice Benefit (MHB)	Common Working File (CWF)	Billing Reminders
Beneficiary **transfers** to another hospice.	50 - Beneficiary is transferring to home hospice OR 51- Beneficiary is transferring in a medical facility.	NA	NA	Current hospice benefit period will not be terminated.	Claim will not terminate the current hospice benefit period.	Effective date of receipt, January 1. 2012 Do not use discharge status code 01. Patient discharge status code 20 is not used on hospice claims. Do not report OC 42 Admitting/receiving hospice must submit a notice of change of provider (TOB 8XC)
Hospice determines that the beneficiary is no longer terminally ill.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation	NA	NA	Current hospice benefit period will be terminated.	Claim will terminate the current hospice benefit period as of the "through" date on the claim.	Effective for dates of service on or after July 1, 2012. Hospices may no longer use OC 42 for this situation. Occurrence Span Code (OSC) 77 is not appropriate when a required face-to-face encounter is not timely.

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ATTACHMENT B

Discharge Reason	Discharge Status Code	Occurrence Code (OC)	Condition Code (CC)	Impact on Medicare Hospice Benefit (MHB)	Common Working File (CWF)	Billing Reminders
Discharge for cause; and the beneficiary **is transferring to another hospice**. The hospice determines the beneficiary meets their internal policy regarding discharge for cause.	If patient is transferring to another hospice report (discharge status codes 50 or 51).	NA	H2	Current hospice benefit period will not be terminated if discharge status codes 50 or 51 are used.	If a discharge status code 50 or 51 is used, the claim will not terminate the current hospice benefit.	Admitting hospice must submit a notice of change of provider (TOB 8XC) The discharging hospice does not report OC 42, patient status 30 or condition code 52
Discharge for cause; There is **no transfer involved**, and the hospice determines the beneficiary meets their internal policy regarding discharge for cause.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation.	NA If beneficiary is **not transferring to another hospice**, use appropriate discharge that best describes the beneficiary's situation.	H2	If any other appropriate discharge status code is used, the current hospice benefit will terminate as the "Through" date on the claim.	If any other appropriate discharge status code is used, the current hospice benefit will terminate as the "Through" date on the claim.	Do not report OC 42, patient status 30 or condition code 52
Revocation Beneficiary no longer wants the Medicare hospice benefit.	Report appropriate NUBC discharge status code that best describes the beneficiary's situation.	Report OC 42 and the date of revocation on the final claim.	NA	Current hospice benefit period will be terminated.	Claim will terminate the current hospice benefit period as of the OC 42 date.	

Disclaimer: The information provided in this job aid was current as of March 7, 2012. Any changes or new information superseding the information in this document will be provided in articles and publications.

Billing Reminders: CR 7677

Effective with dates of service on or after July 1, 2012, hospice claims will return to provider (RTP) where:

- Both condition code 52 and condition code H2 are present;
- Condition code 52 is present and the patient status code is 30;
- Condition code H2 is present and the patient status code is 30;
- Condition code H2 is present with occurrence code 42; or
- Condition code 52 is present with occurrence code 42.

ATTACHMENT C

Electronic Data Interchange (EDI) Updates on ANSI v5010

Each week Palmetto GBA along with all of Medicare contractors must report to the Centers for Medicare & Medicaid Services (CMS) the volume of claims being submitted on v4010 and the volume on v5010. The information below was reported for the week ending February 24, 2012. This information includes all Part A, Home Health, and Hospice providers.

Total Claims submitted on v4010:	27%
Total Test Claims submitted on v5010:	<.1%
Total Claims submitted on v5010:	73%
Total Submitters submitting v4010:	67%
Total Submitters testing v5010:	3%
Total Submitters submitting v5010:	30%
Total providers submitting v4010:	65%
Total providers testing v5010:	3%
Total providers submitting v5010:	32%

Common issues that Palmetto GBA sees for 5010 include:

- Providers not being supplied with complete 999 and 277CA report information from their billing services and clearinghouses. The reports provide complete error codes and brief descriptions. A complete Edit spreadsheet is available on the CMS Web site at **http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp#TOPofPage**. The accepted claims display the DCN on the 277CA report and can be used to track the claim status.
- Claim files are rejecting on the front end for using the same file id twice within twelve months. This is located within the header record on each 837 file submitted.

CMS is composing a top ten error listing that Palmetto GBA will post on our Web site under the 5010 section.

Any issues that involve the front end, Common Edits and Enhancement Module (CEM) related, are posted on the EDI System Status on the Web site and updated as resolutions are found.

The March 31, 2012 deadline for compliance of sending 5010 without being penalized, is approaching and will be enforced beginning April 1, 2012.

ATTACHMENT D

Print Form

Palmetto GBA.
PARTNERS IN EXCELLENCE

Billing Dispute Resolution Request Form

Provider Information

Date Submitted:

(Note: All requests must pertain to a claim with dates of service that are within the timely filing guidelines. If the billing dispute pertains to a claim that is already past the timely filing limit, no action will be taken.

Provider Name: Provider Number:

NPI: TIN:

Contact Person/Name: Contact Number:

Patient/Beneficiary Information

First Name: Last Name:

HIC Number: Date of Birth:

Claim Information

Date(s) of Service: (Enter all that apply)

From: Through:

DCN(s) (Enter all that apply):

Note: A separate form must be completed for each patient/beneficiary.

Contact Resolution Information

The following information is required to establish the provider's attempt to resolve the billing dispute prior to contacting Palmetto GBA for assistance.

Name of Agency Contacted: Date Agency Contacted:

Method of Contact: ☐ Phone ☐ Letter ☐ Fax ☐ Other

Name of Individual Contacted:

Is the agency out of business? ○ Yes ○ No

If yes, please explain:

Identify the Situation

Billing Overlap ☐

This situation applies to instances where two providers are billing for overlapping dates of service, which may include a transfer situation.

ATTACHMENT E

Palmetto GBA
2010 Hospice Cap Overpayments by State
AS OF March 6, 2012

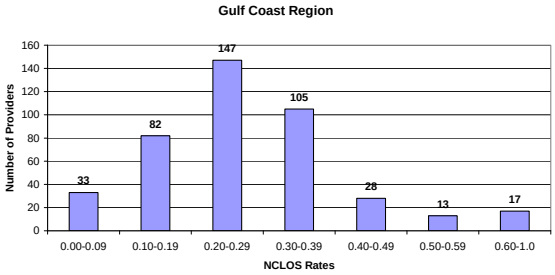
Item #	State Code	State	Total Providers	Completed	With O/P	% completed with O/P	Total Cap O/P Amount	Average O/P Amount
1	1	Alabama	123	87	1	1%	$382,110	$382,110
2	3	Arizona	5	2	0	0%	$0	$0
3	4	Arkansas	39	37	0	0%	$0	$0
4	5	California	10	9	0	0%	$0	$0
5	6	Colorada	1	0	0	0%	$0	$0
6	7	Connecticut	2	2	0	0%	$0	$0
7	8	Delaware	2	1	0	0%	$0	$0
8	9	Washington DC	1	1	0	0%	$0	$0
9	10	Florida	38	35	0	0%	$0	$0
10	11	Georgia	133	99	1	1%	$1,275,674	$1,275,674
11	14	Illinois	93	87	0	0%	$0	$0
12	15	Indiana	82	76	0	0%	$0	$0
13	16	Iowa	1	0	0	0%	$0	$0
14	17	Kansas	2	2	0	0%	$0	$0
15	18	Kentucky	24	24	0	0%	$0	$0
16	19	Louisiana	123	91	1	1%	$43,155	$43,155
17	22	Massachusetts	4	2	0	0%	$0	$0
18	23	Michigan	4	4	0	0%	$0	$0
19	24	Minnesota	2	1	0	0%	$0	$0
20	25	Mississippi	111	44	2	5%	$905,589	$452,795
21	26	Missouri	13	13	1	8%	$170,871	$170,871
22	28	Nebraska	3	0	0	0%	$0	$0
23	29	Nevada	1	1	0	0%	$0	$0
24	31	New Jersey	5	4	0	0%	$0	$0
25	32	New Mexico	36	32	1	3%	$418,824	$418,824
26	33	New York	1	1	0	0%	$0	$0
27	34	North Carolina	79	74	0	0%	$0	$0
28	36	Ohio	105	100	0	0%	$0	$0
29	37	Oklahoma	128	100	6	6%	$4,197,771	$699,629
30	39	Pennsylvania	15	6	0	0%	$0	$0
31	42	South Carolina	78	54	0	0%	$0	$0
32	43	South Dakota	1	0	0	0%	$0	$0
33	44	Tennessee	54	49	0	0%	$0	$0
34	45	Texas	319	253	0	0%	$0	$0
35	46	Utah	2	2	0	0%	$0	$0
36	49	Virginia	15	12	0	0%	$0	$0
37	51	West Virginia	1	1	0	0%	$0	$0
38	52	Wisconsin	5	3	0	0%	$0	$0
TOTAL			1,661	1,309	13	1%	$7,393,994	$568,769
TOTAL for 2009 Cap Year			1421	1421	314	22%	$154,368,303	$491,619

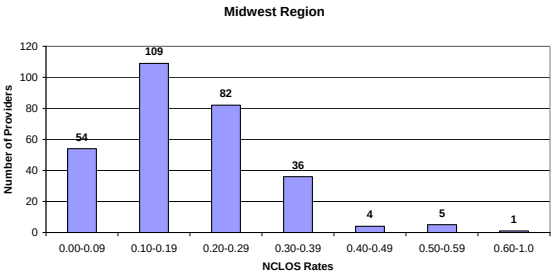
ATTACHMENT E

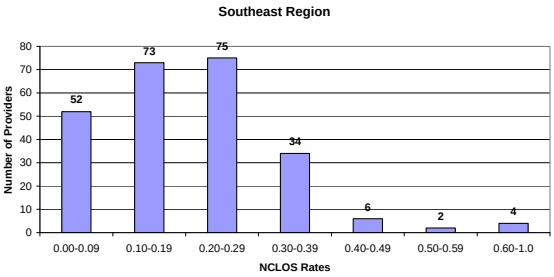
Palmetto GBA
2010 Hospice Cap Overpayments by State
AS OF March 6, 2012

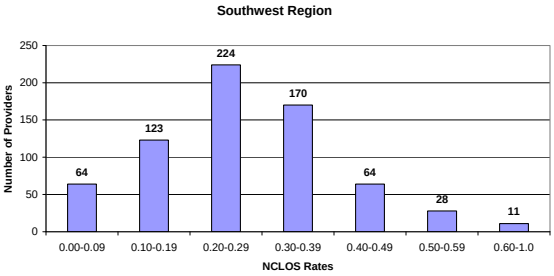
Item #	State Code	State	Total Providers	Completed	With O/P	% completed with O/P	Total O/P Amount	Average O/P Amount
1	1	Alabama	123	87	1	1%	$382,110	$382,110
2	4	Arkansas	39	37	0	0%	$0	$0
3	10	Florida	38	35	0	0%	$0	$0
4	11	Georgia	133	99	1	1%	$1,275,674	$1,275,674
5	14	Illinois	93	87	0	0%	$0	$0
6	15	Indiana	82	76	0	0%	$0	$0
7	18	Kentucky	24	24	0	0%	$0	$0
8	19	Louisiana	123	91	1	1%	$43,155	$43,155
9	25	Mississippi	111	44	2	5%	$905,589	$452,795
10	32	New Mexico	36	32	1	3%	$418,824	$418,824
11	34	North Carolina	79	74	0	0%	$0	$0
12	36	Ohio	105	100	0	0%	$0	$0
13	37	Oklahoma	128	100	6	6%	$4,197,771	$699,629
14	42	South Carolina	78	54	0	0%	$0	$0
15	44	Tennessee	54	49	0	0%	$0	$0
16	45	Texas	319	253	0	0%	$0	$0
TOTAL			1,565	1,242	12	1%	$7,223,123	$0

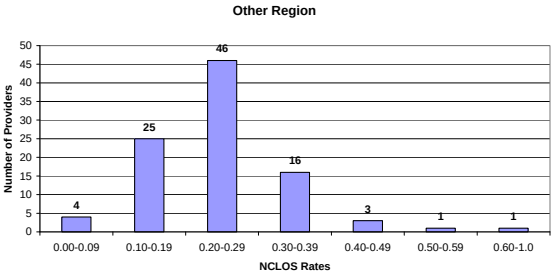
ATTACHMENT F - NCLOS Rates by Region





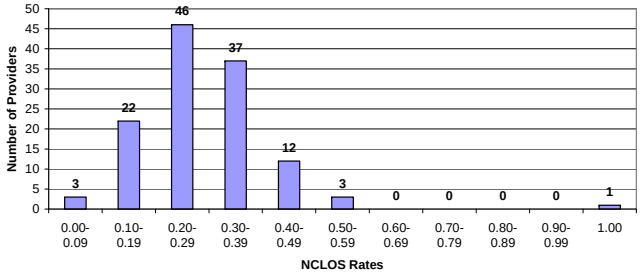




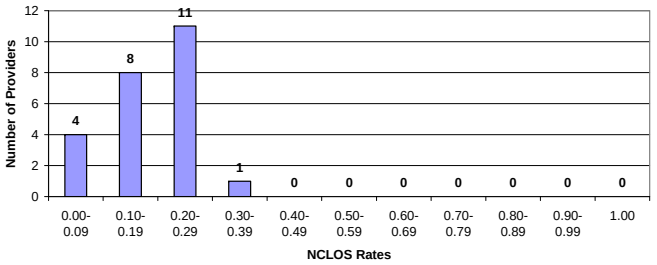


Attachment G – NCLOS Rates by State

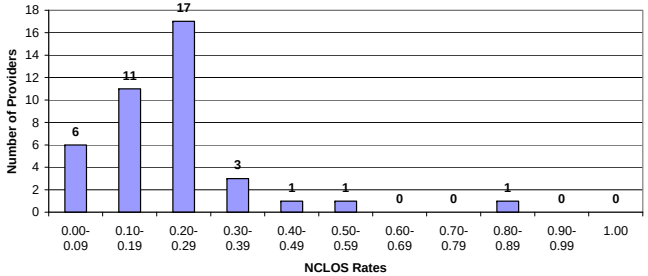
Alabama



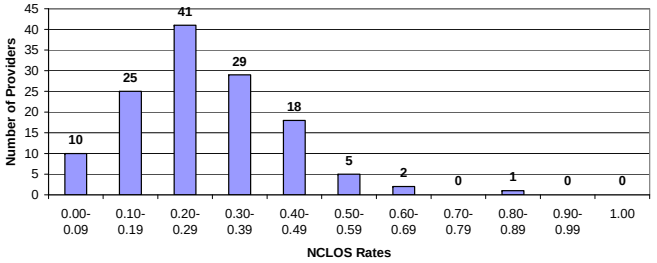
Kentucky



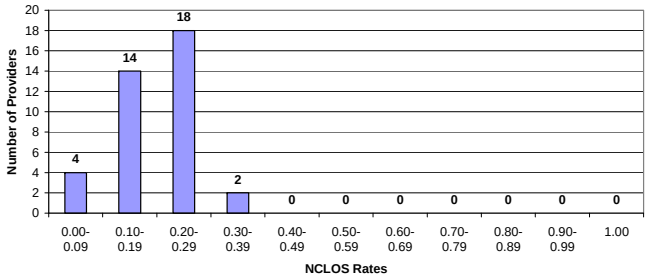
Arkansas



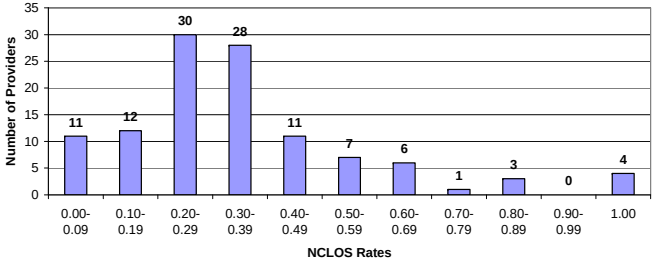
Louisiana



Florida

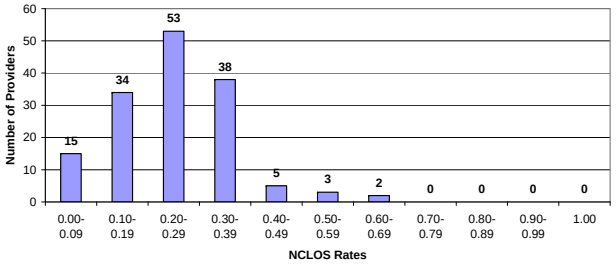


Mississippi

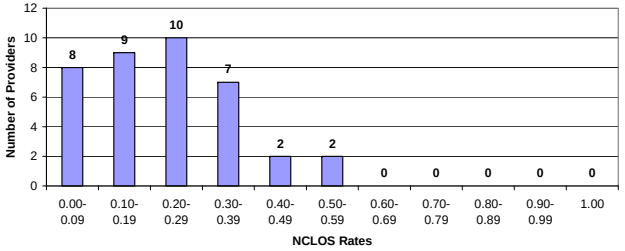


Attachment G – NCLOS Rates by State

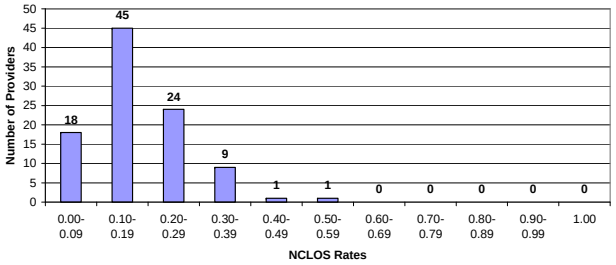
Georgia



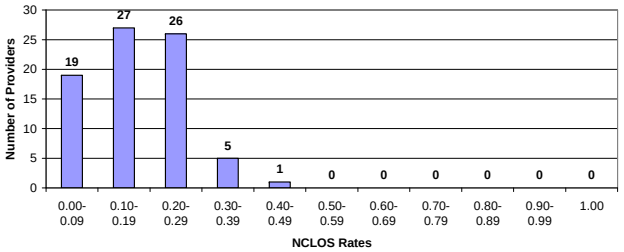
New Mexico



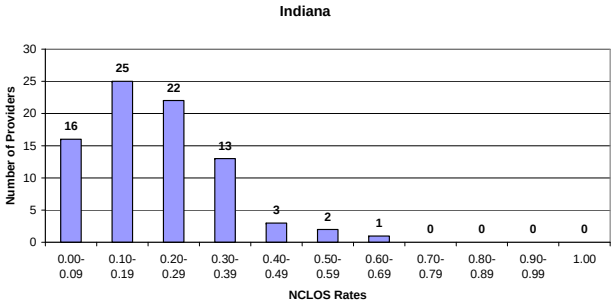
Illinois



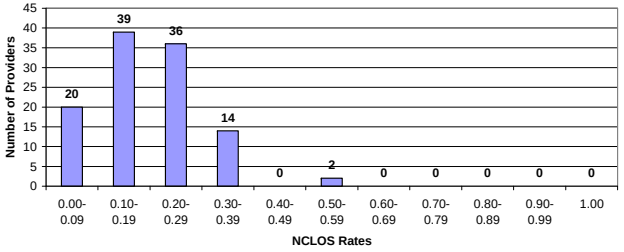
North Carolina



Indiana



Ohio



ATTACHMENT H: NCLOS Rates by LCD Policy – 2011 1st Half

Gulf Coast Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	166	0.25
Adult Failure to Thrive	160	0.26
Alzheimer	204	0.32
HIV	90	0.14
Heart	136	0.22
Liver	62	0.09
Other Digestive	49	0.06
Pulmonary	121	0.19
Renal	38	0.05
Stroke & Coma	100	0.16
Symptoms, Signs & Ill-Defined	108	0.18
Total (All Conditions)	139	0.22

Midwest Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	156	0.19
Adult Failure to Thrive	139	0.22
Alzheimer	189	0.29
HIV	152	0.22
Heart	107	0.16
Liver	49	0.06
Other Digestive	52	0.07
Pulmonary	94	0.14
Renal	36	0.04
Stroke & Coma	78	0.12
Symptoms, Signs & Ill-Defined	98	0.14
Total (All Conditions)	115	0.17

Southeast Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	141	0.24
Adult Failure to Thrive	138	0.21
Alzheimer	191	0.30
HIV	110	0.13
Heart	130	0.20
Liver	68	0.09
Other Digestive	57	0.06
Pulmonary	118	0.18
Renal	47	0.06
Stroke & Coma	92	0.15
Symptoms, Signs & Ill-Defined	105	0.17
Total (All Conditions)	128	0.20

Southwest Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	176	0.24
Adult Failure to Thrive	163	0.26
Alzheimer	224	0.34
HIV	102	0.18
Heart	152	0.23
Liver	71	0.08
Other Digestive	64	0.08
Pulmonary	135	0.20
Renal	43	0.06

ATTACHMENT I: NCLOS Rates by LCD Policy – 2011 2nd Half

Gulf Coast Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	176	0.25
Adult Failure to Thrive	169	0.27
Alzheimer	225	0.36
HIV	117	0.16
Heart	156	0.25
Liver	68	0.08
Other Digestive	61	0.08
Pulmonary	142	0.22
Renal	44	0.06
Stroke & Coma	119	0.19
Symptoms, Signs & Ill-Defined	127	0.21
Total (All Conditions)	156	0.25

Midwest Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	162	0.22
Adult Failure to Thrive	154	0.25
Alzheimer	206	0.33
HIV	114	0.19
Heart	121	0.19
Liver	51	0.06
Other Digestive	59	0.07
Pulmonary	106	0.16
Renal	39	0.05
Stroke & Coma	87	0.14
Symptoms, Signs & Ill-Defined	107	0.16
Total (All Conditions)	128	0.20

Southeast Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	151	0.24
Adult Failure to Thrive	142	0.22
Alzheimer	201	0.31
HIV	134	0.14
Heart	134	0.21
Liver	67	0.08
Other Digestive	58	0.07
Pulmonary	127	0.19
Renal	48	0.07
Stroke & Coma	99	0.15
Symptoms, Signs & Ill-Defined	98	0.14
Total (All Conditions)	134	0.21

Southwest Providers		
Policy	**Average Length of Stay (In Days)**	**Policy Specific NCLOS Rate**
ALS	180	0.26
Adult Failure to Thrive	184	0.30
Alzheimer	248	0.39
HIV	102	0.14
Heart	172	0.27
Liver	79	0.10
Other Digestive	70	0.09
Pulmonary	156	0.25
Renal	47	0.06

Hospice Monthly Billing Requirement

Palmetto GBA is reminding the hospice provider community that they must bill in monthly increments.

The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 11 – Processing Hospice Claims, Section 90 states: "*Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing should conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months"*.

The CMS IOMs are located at: **www.cms.gov/manuals/**

Further, the Code of Federal Regulations (CFR) 42 Part 418 – Hospice Care outlines the Medicare Conditions of Participation. This part of the CFR implements Sections of the Social Security Act (the Act) which specifies services covered as hospice care and the conditions that a hospice program must meet in order to participate in the Medicare program. This section of the Act also specifies coverage and payment policy. Upon approval and subsequent issuance of hospice agency certification, the provider agrees to the regulations set forth in 42 CFR Part 418 – Hospice Care.

Hospice providers should only bill one claim per month, per patient in order to be in compliance with Medicare regulations. Hospice providers may not submit weekly claims and claims may not span from one month to the next.

For admissions, the first claim will be dated from admission through the end of the month even if this initial claim spans only several days. Subsequent claims will be submitted as the entire calendar month until a discharge claim is submitted.

There are instances whereby a hospice may need to submit a claim for a period of time less then a calendar month. The following types of bill (TOB) are the only exception to the monthly calendar billing requirement and may be acceptable:

- TOB 811/821 - 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. This is considered a discharge claim.
- TOB 812/822 – Interim First Claim. This code is used for the first of an expected series of payment bills for a hospice course of treatment. As mentioned above, this is an admission claim.

- TOB 814/824 – 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 is the discharge date, transfer date, or date of death.

Additional information may be found at: CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Section 50.2.3 and 50.2.4.

Hospice Reversal Rate — **4th Quarter 2011**

				Quarter	
				Total	Percent
Redetermination Cases	Oct	Nov	Dec		
Affirmed	120	152	167	439	61%
Dismissed	0	14	4	18	3%
Reversed (Partial or Complete)	62	98	102	262	36%
Total Cases	**182**	**264**	**273**	**719**	100%
QIC Cases	Oct	Nov	Dec		
Affirmed	78	56	20	154	95%
Dismissed	3	0	2	5	3%
Reversed (Partial or Complete)	0	2	1	3	2%
Total Cases	**81**	**58**	**23**	**162**	100%
ALJ Cases	Oct	Nov	Dec		
Affirmed	15	10	18	43	28%
Dismissed	0	0	0	0	0%
Reversed (Partial or Complete)	83	22	7	112	72%
Total Cases	**98**	**32**	**25**	**155**	100%

Totals by State

State	Redeterminations				QIC			ALJ		
	Autodeny	Affirmed	Dismissed	Reversed	Affirmed	Dismissed	Reversed	Affirmed	Dismissed	Reversed
AL	2	14	1	16	4	0	0	0	0	9
AR	0	0	0	0	0	0	0	0	0	0
CA	0	4	0	0	6	0	0	1	0	15
DE	0	15	0	10	8	0	0	0	0	0
FL	0	97	1	43	95	1	2	26	0	45
GA	0	23	0	17	2	0	0	0	0	1
IL	0	4	0	3	2	0	0	0	0	0
IN	0	1	0	3	0	0	0	0	0	1
KY	0	0	0	1	0	0	0	1	0	0
LA	3	8	1	3	0	0	0	0	0	0
MS	0	38	3	26	6	0	0	0	0	1
NC	2	10	4	1	5	2	0	4	0	14
NJ	0	1	0	1	1	0	0	2	0	0
NM	0	0	0	1	0	0	0	0	0	1
OH	0	1	1	9	1	1	1	4	0	9
OK	0	86	4	41	13	1	0	2	0	2
PA	0	0	0	0	1	0	0	1	0	2
SC	0	120	2	67	2	0	0	0	0	5
TN	0	1	0	0	6	0	0	0	0	3
TX	1	14	1	16	2	0	0	2	0	4
VA	0	2	0	4	0	0	0	0	0	0