Hospice Billing-Getting the best start to your Medicare Collections

Jill Schuerman, Founder and CEO
Objectives

• Know how to use the HIQA/HIQH to look for hospice eligibility
• Know how to determine benefit period information for certifications
• Know how to determine current episodes of care for the new tiered payment system
• Know the difference between a Medicare Replacement HMO and an insurance that creates a potential MSP situation.
Objectives Continued

• Know the basics of submitting the Notice of Election, Notice of Change, and when Notice of Termination/Revocations is needed.

• Know when you can apply for an exception to the 5 day NOE rule, and how to bill for that exception.

**No conflicts of interest, commercial support, endorsement of products, off-label use of products accompany these presentations.**
Eligibility

Requesting and Understanding
Using E Services for Online Access
Available 24-7
Requesting Eligibility

You **must have the following five pieces** of information about the beneficiary to access information:

- HICN Number
- Last Name
- First Name
- Gender
- Date of Birth (MMDDCCYY format)

Date Range should be entered to include up to 12 months prior to the date of the request, i.e. 8/11/2015-8/10/2016 to retrieve as much history as possible.

This is the CGS online request. Palmetto Eservices has the same system. [http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf](http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf)
Understanding Eligibility

Effective Date: The start of Eligibility for Medicare Part A benefits. If blank, the beneficiary is not eligibility to receive Hospice Benefits.

Termination Date: The termination date for Part A Eligibility. If blank, they have not been terminated.

Inactive Periods-Watch for inactive periods due to unlawful, deported, or incarcerated reasons.

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Understanding Eligibility

End Stage Renal Disease (ESRD)

Watch for effective date and other information. The insurance type lists the primary payer, with MCR as secondary payer.

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Understanding Eligibility

Medicare Advantage policies are replacement HMO or PPO’s. The patient’s benefits will generally end with the Advantage Policy and Original Medicare takes over again. Please ensure the patient is aware of this.

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Understanding Eligibility

Medicare Part D information is listed so you can coordinate with them on non-covered medications.


This is from the CGS online request. Palmetto Eservices has the same system. http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
Understanding Eligibility

MSP Tab shows when a beneficiary has a primary payer other than Medicare, and gives you the primary insurance information. You need to verify eligibility with the insurance company, and most likely do a clinical preauthorization. Medicare will be secondary, so you will need to file your NOE within the 5 day limit, and follow the certification requirements of both the insurance company and Medicare.

This is from the CGS online request. Palmetto Eservices has the same system.  http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
Benefit Periods
Determining Benefit Periods

Look at the hospice usage for this patient. They had a hospice period 9/10-11/8/2012 (60 days), and another 11/9-12/16/2012 (38 days). Since they most recently are in their 60 day periods, you will need a F2F before the new Admission. You will need to contact the provider listed to determine their Benefit periods and end date since billing is only through 12/16/2012 and why they termed.

This is from the CGS online request. Palmetto Eservices has the same system. http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
Episodes of Care
Determining Episodes of Care

The high tier rate is paid to you for a beneficiary’s first 60 days of hospice care, or the first 60 days after a 60 day break in care.

The low tier rate is paid to you for any beneficiary not meeting this criteria.

Look at the hospice usage for this patient. They had a hospice period 9/10-11/8/2012 (60 days), and another 11/9-12/16/2012 (38 days).

This is from the CGS online request. Palmetto Eservices has the same system. http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
Determining Episodes of Care cont’d.

You may need to contact the prior hospice to determine their end date. If less than 60 days ago, you would be paid at the lower tier rate. If more than 60 days ago, you would be paid at the higher tier rate.

This is from the CGS online request. Palmetto Eservices has the same system.  http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
Using DDE Access

Beginning July 1, 2016, the JM Direct Data Entry (DDE) hours of availability for Monday to Friday will be 6 a.m. ET to 8 p.m. ET.
Section 2 – Checking Beneficiary Eligibility

HIQA Inquiry Screen - Field definitions and completion requirements are provided in the table following Figure 1.

Field Name | Description
---|---
RESPONSE CODE | Data in this field (a `C` for Display on CRT) is automatically inserted by the system.
CLAIM NUMBER | Enter the beneficiary/patient’s Medicare number as shown on the Medicare card in this field.
SURNAME | Enter the first six (6) letters of the beneficiary/patient’s last name.
INITIAL | Enter the initial of the beneficiary/patient’s first name.
DATE OF BIRTH | Enter the beneficiary/patient’s date of birth in MMDDCCYY format.
SEX CODE | Enter the beneficiary/patient’s sex. Valid values are:
F = Female
M = Male
REQUESTOR ID | Identifies person submitting the inquiry or person requesting printed output. Enter ‘1’ in this field.
PRINTER DEST | Leave this field blank (system default printer). This field is for the Printer device that the response will be directed to if a ‘P’ or ‘E’ is typed in the Response Code field.
INTER NO | Identifies the Medicare contractor processing the claim. Enter one of the following for a beneficiary/patient in Palmetto GBA’s jurisdiction:
11201 = Part A South Carolina
11501 = Part A North Carolina
11301 = Part A Virginia
11401 = Part A West Virginia
11004 = Home health or hospice
PROVIDER NO | The six-digit number assigned by Medicare to the provider rendering medical service to the beneficiary/patient.
HOST-ID | Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations:
GL = Great Lakes
MA = Middle Atlantic
SE = Southeast
GW = Great West
PA = Pacific
SO = South
KS = Keystone
NE = Northeast
SW = Southwest

HIQA in DDE

If you run the HIQA directly in the DDE, it will look like this. The system will tell you the correct name, date of birth, and HCN Number. Eligibility shows for Part A, start and end, if appropriate.

Any insurance listed under PPO on page 1 is a Medicare Advantage Plan, and would NOT be an MSP. It would go away with election of hospice.

This is from the Palmetto DDE  
HIQA in DDE Cont’d.

Pages 2 and 3 give you the latest 4 benefit periods, with dates, days used, as well as if the benefit period has ended. (See revocation indicator at bottom of the Benefit Period Columns. 1 means there has been a discharge or revocation, 0 means the benefit period has not ended.)

You would use this information to determine the benefit period for your admission, as well as the episode of care days.

This is from the Palmetto DDE
HIQA in DDE Cont’d.

Pages 2 and 3 give you the latest 4 benefit periods, with dates, days used, as well as if the benefit period has ended. (See revocation indicator at bottom of the Benefit Period Columns. 0 means the benefit period has not ended.)

You would use this information to determine the benefit period for your admission, as well as the episode of care days.

This is from the Palmetto DDE
HIQA in DDE Cont’d.

If there are pages 16 or more, those show the MSP policies that will be primary to Medicare.

Always print your Online pages for Eligibility, Benefit periods and MSP or your DDE pages 1-3 and 16 and up as proof of when you ran the inquiry and what was on the CWF at the time.

This is from the Palmetto DDE
Understanding CR 8877
NOE and NOTR
Notice of Election (NOE) (81A)
NOE

• Notice of Election (NOE) and Notice of Termination/Revocation of Election (NOTR) Policy

• Effective date October 1, 2014

• CMS has issued Change Request 8877, which among other things, now stipulates a required timeframe for filing a hospice Notice of Election (NOE) and Notice of Termination/Revocation of Election (NOTR), and the consequences \textit{(lost revenue)} when a NOE is filed late. The effective date of this change begins with dates of service 10/1/2014.
Admission and NOE

You must file Hospice NOEs within 5 calendar days after the effective date of the hospice election. A timely-filed NOE is one that is submitted to the Medicare contractor and accepted error free. If you do not have an accepted NOE within this 5 calendar day period, Medicare will not cover and pay for days of hospice care from the effective date of the election to the date of the accepted NOE.

Example:
Admission date is 10/10/2014 (Fri).
Day 1 = Sat. 10/11/2014
Day 2 = Sun. 10/12/2014
Day 3 = Mon. 10/13/2014
Day 4 = Tues. 10/14/2014
Day 5 = Weds. 10/15/2014
10/15/2014 is the NOE Due Date.

If the NOE Receipt date is 10/16/2014, the hospice reports 10/10 through 10/15 as non-covered days (6 non-covered days or approximately $900 in revenue per admission for even 1 day late) using occurrence span code 77. Therefore, 6 days non-covered for being one day late.
NOE

• If you fail to file a timely NOE, you may request an exception which, if approved, waives the consequences of failing to file a complete and timely NOE. The first claim is submitted with a specific code and detailed comments on page 4. Depending on your MAC, either they will read the notes and make their determination to cover or not cover, or they may create a specific type of non medical ADR. If that is the case, at that time you will need to provide Medicare with the documentation of your reason. If approved, they will cover the days. If not, the days will remain non-covered.
When the hospice did not file the NOE timely, it may request an exception on the claim (do not request an exception on a NOE). Examples of valid qualifying exceptions are as follows:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate
- An event that produces a data filing problem due to a Centers for Medicare & Medicaid Services (CMS) or Medicare contractor systems issue that is beyond the control of the hospice. Example: sequential billing requirements that require a second hospice to remove its timely filing NOE and claims so a previous provider can bill.
- Sequence issues with your own agency readmissions are not grounds for exceptions. Co-Owned agencies are considered one agency for this purpose.
NOE

• A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its’ user ID from its’ Medicare contractor or

• Other circumstances determined by the Medicare contractor or the CMS to be beyond the control of the hospice. This exception will be evaluated on a case by case basis.

• Please note that sequence issues within your own agency is not grounds for appeal. Co-owned agencies are now considered one agency for this purpose.
Notice of Change
81C
• **Transfers**
An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, but is a transfer.

• To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:
  • the name of the hospice from which the individual has received care,
  • the name of the hospice from which they plan to receive care, and
  • the date the change is to be effective.—Date to be mutually agreeable between both hospices. New hospice must admit within 24 hours of the transfer date.
Notice of Change-81C

• **Benefit Periods for Transfers**
  Because the benefit period does not change in a transfer situation, if the patient is in the third or later benefit period and transfers hospices, a face-to-face encounter is not required *if* the receiving hospice can verify that the originating hospice had the encounter *and* it is a valid face-to-face encounter.

• Due to sequential billing, hospices that are transferring a beneficiary to another hospice must submit their last claim, indicating the transfer, prior to the receiving hospice submitting their Notice of Transfer (type of bill 8XC). Receiving hospices who submit their claims before the transferring hospice submits their last claim may have their claims canceled.
Notice of Termination or Revocation (NOTR) (81B)
• **Live Discharge and NOTR**

• If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, you must file a NOTR within 5 calendar days after the effective date of a beneficiary’s discharge or revocation. (The NOTR is not needed if the patient is discharged due to death or transferred to another hospice.)

• **Caution:** Although you have a 5 day window to submit the NOTR, you want to submit and have processing at least one day before the potential readmit. Else you risk the NOE for the readmit not processing and losing days there. Suggestion is to submit on day 2, once you know the patient that went to the hospital is actually not admitted, and wants back on your service. You would not report the discharge or the readmission.
Filing NOE and NOTR
NOE’s are entered directly into the DDE in this manner. The screens here show the required fields. Pages 1 and 3 are required.

Although you can not submit an NOE electronically, there are softwares that “type” the info into the DDE for you.

http://cgsmedicare.com/hhh/education/materials/claim_page_1_noe.html
NOE’s are entered directly into the DDE in this manner. The screens here show the required fields. Pages 1 and 3 are required.

Although you can not submit an NOE electronically, there are softwares that “type” the info into the DDE for you.

http://cgsmedicare.com/hhh/education/materials/claim_page_3_noe.html
NOTR’s are entered directly into the DDE in this manner. The screens here show the required fields. Pages 1 and 3 and 4 are required.

Although you can not submit an NOTR electronically, there are softwares that “type” the info into the DDE for you.

http://cgsmedicare.com/hhh/education/materials/claim_page_1_noe.html
CGS has received clarification from the Centers for Medicare & Medicaid Services (CMS) that a diagnosis code is not required on the (NOTR). However, providers should be aware that if a diagnosis code is reported, please ensure the ICD-10 code is valid.

http://cgsmedicare.com/hhh/education/materials/notr_claim_page_3
**NOTR Page 4-**

Comments for reason of discharge

<table>
<thead>
<tr>
<th>REMARKS</th>
<th>Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the reason for discharge. Include your initials and the date the remark was entered. You can use the discharge situations below to determine the appropriate remarks.</td>
<td></td>
</tr>
<tr>
<td><strong>Situation</strong></td>
<td><strong>Enter</strong></td>
</tr>
<tr>
<td>Patient revokes their hospice election</td>
<td>The beneficiary revoked effective (mm/dd/yy)</td>
</tr>
<tr>
<td>The beneficiary’s condition improves and he/she is no longer considered terminally ill (patient is unable to be recertified).</td>
<td>The beneficiary was discharged due to no longer considered terminally ill effective (mm/dd/yy)</td>
</tr>
<tr>
<td>The beneficiary moves out of the geographic area that the hospice defines in its policies as its service area.</td>
<td>The beneficiary moved out of our service area (mm/dd/yy)</td>
</tr>
<tr>
<td>&quot;Discharge for cause&quot; Extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient</td>
<td>The beneficiary was discharged for cause effective (mm/dd/yy)</td>
</tr>
</tbody>
</table>

Questions?
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