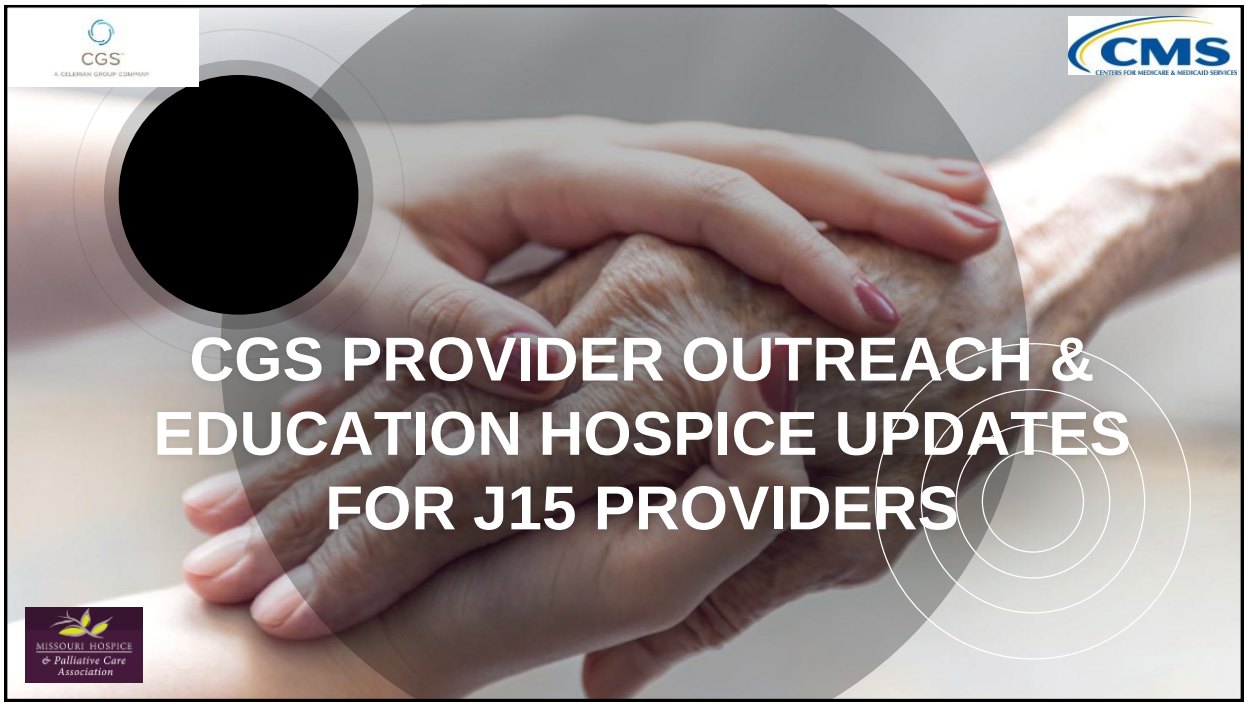
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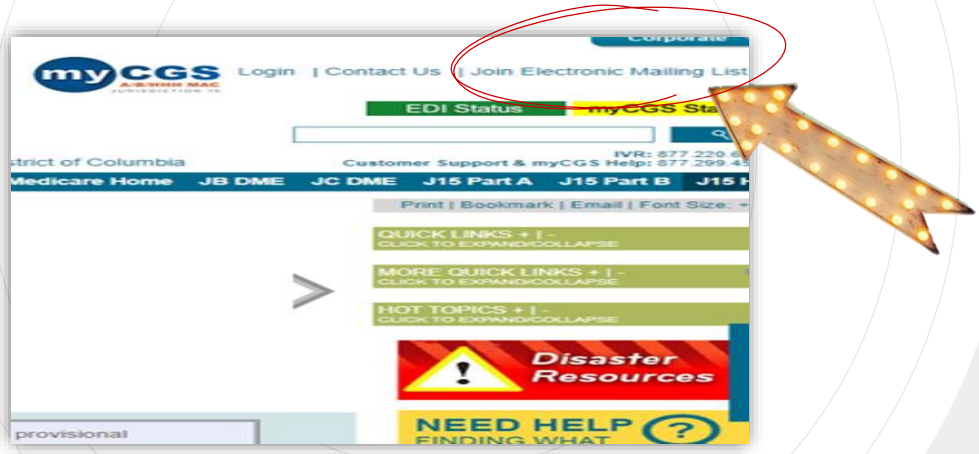
# ARE YOU SIGNED UP FOR LISTSERV?







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# OBJECTIVES

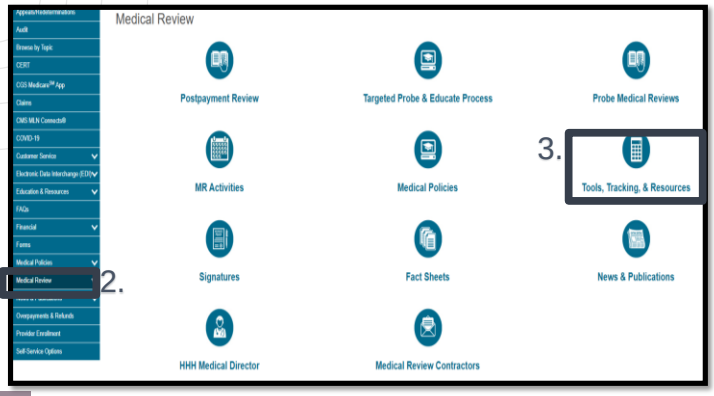
1. Discuss top 5 hospice medical review denial reason codes and review documentation and guidelines applicable to denial reasons
2. Examine any new or revised Medicare home health & hospice coverage requirements
3. Address the most up-to-date billing guidelines and documentation expectations



5

# FINDING THE INFORMATION

1. https://cgsmedicare.com/hhh/index.html









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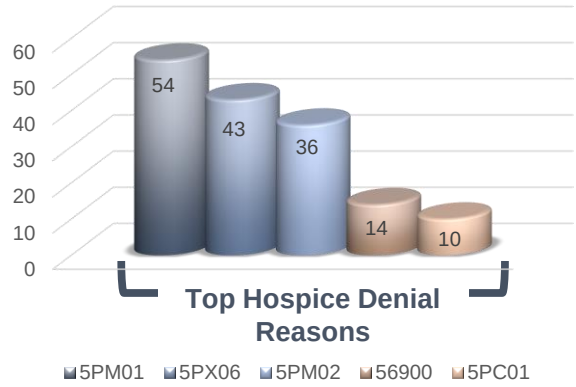
# Hospice Top Medical Review Denial Reasons January – March 2021




**5PM01 (27%)** - According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less.

**5PX06 (21%)** - The notice of election is invalid because it doesn't meet statutory/regulatory requirements..

**5PM02 (18%)** - According to Medicare hospice requirements, the documentation indicates the general inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

**56900 (7%)** - Requested documentation not received/received untimely

**5PC01 (5%)** - The physician narrative statement was not present or was not valid.





7

# Certification



Statement that the patient's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course

- Certifying practitioner's narrative explaining the clinical findings that support the patient's life expectancy of six months or less (can be a part of the certification/recertification form or as an addendum to the form)
- If the narrative is part of the form, it must be located immediately above the physician's signature.
- If the narrative is an addendum, the physician must also sign the addendum immediately following the narrative.
- No check boxes or standard language
- Can not be completed by other hospice personnel
- Include statement indicating that by signing the form the certifying practitioner confirms the narrative was composed based on his/her review of the patient's medical record or his/her examination of the patient

The benefit period dates

Narratives associated with the **third benefit** period and subsequent benefit periods must explain why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.

- Documentation must include the date of the encounter, an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary
- If the encounter was performed by a nurse practitioner, he/she must attest that clinical findings were provided to certifying physician

The certification should be based on the clinical judgment of the hospice medical director (or physician member of the interdisciplinary group (IDG), and the patient's attending physician, if he/she has one. **Nurse practitioners and physician assistants cannot certify or recertify an individual is terminally ill**. If the patient's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

In addition to the initial certification for hospice, the patient must be recertified for each subsequent hospice benefit period.





8

## CERTIFICATION TIMEFRAME REQUIREMENTS

- Verbal or written certification of the terminal illness
  - No later than **2 calendar days** (by the end of the third day) after the start of each benefit period
  - **Initial certifications** may be completed **up to 15 days before** hospice care is elected
  - **Recertifications** may be completed up to 15 days before the start of the next benefit period
- If written certification/recertification cannot be obtained within 2 calendar days, **verbal certification must be obtained**. The hospice must determine who may accept verbal certification from a physician in compliance with state and local law regulations.
- The hospice must ensure the written certification/recertification is signed and dated prior to billing Medicare, or their claim(s) may be denied.





9

## SIGNATURE REQUIREMENTS FOR CERTIFICATION

| Acceptable signatures | Unacceptable signatures |
|---|---|
| • Handwritten signatures<br>• Electronic signatures<br>• Facsimile of original written or electronic signatures<br><br>NOTE: All signatures must be dated. Handwritten signatures must be hand dated. | • Stamped signatures |

For more detailed information on signatures, refer to the "Signature Guidelines for Home Health & Hospice Medical Review" quick resource tool

- **Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, §20.1**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- **Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 3, §3.3.2.4**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf





10

## SIGNATURES

### Initial certifications

- 1st benefit period after hospice election
  - Medical director of hospice or the physician member of the IDG
  - Beneficiary's attending physician

### Recertifications

- Hospice medical director or physician member of the IDG



11

11

## HOSPICE NOTICE OF ELECTION

| | | |
|---|---|---|
| Identification of the hospice that will provide care | Patient or representative's acknowledgement that certain Medicare services are waived by the election | Effective date of the elections<br>· Can be 1st day of hospice care or later<br>· **CAN NOT** be a retroactive date |
| Patient's designated attending physician with detailed information to clearly identify the attending physician. This includes but is not limited to:<br>· Physician's full name<br>· Office address<br>· National Provider Identifier (NPI) | Patient or representative's acknowledgement that the designated physician was their choice | Signature of patient or representative |



12

12

# CHANGE ATTENDING PHYSICIAN

If the patient/representative wants to change their designated attending physician, they must file a signed statement with the hospice. The statement must include the following information:

- **Identification of new attending**
  - Include enough detail to clearly identify the new attending physician
    - This includes, but is not limited to physician's full name, office address, or the NPI.
- **Effective date of the change**
- **Acknowledgement that the change in attending physician was the beneficiary's choice**
- **Patient or representative's signature**
- **Date the statement was signed**

13



13

# PHYSICIAN NARRATIVE

As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms

- Part of the certification or recertification form
  - Must be located immediately above the physician's signature.
- Addendum to the certification or recertification form,
  - Must include physician's signature on the certification or recertification form and
  - Physician must also sign immediately following the narrative in the addendum.
- Include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.
  - The physician may dictate the narrative.
- Must reflect the patient's individual clinical circumstances
  - Cannot contain check boxes or standard language used for all patients.
  - Physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.
- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

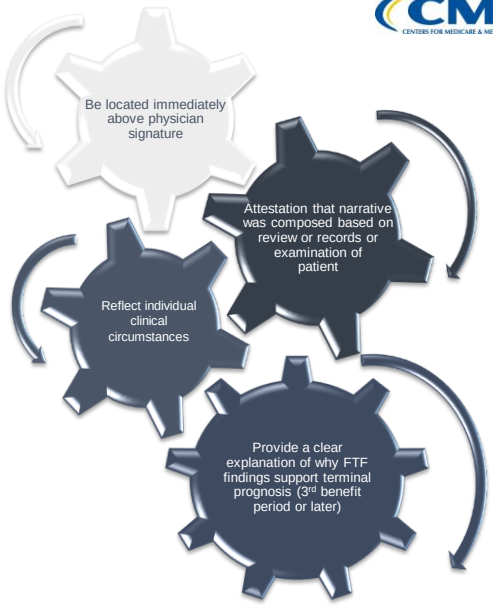
14



14

## The physician narrative must:

1. Be located immediately above the physician's signature
   - If it is an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
2. Include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
3. Reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must provide a summary of the patient's comprehensive medical information in order to compose this brief clinical justification narrative.
4. For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.



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## ELECTION REQUIREMENTS

The fiscal year 2021 Hospice Final Rule (CMS-1733-F ) included new hospice election statement and the hospice election statement addendum requirements. The new requirements for the election statement and addendum are **effective for all hospice elections beginning on or after October 1, 2020.**

**Model Election Statement:**

https://www.cms.gov/files/document/model-hospice-election-statement-modified-july-2020.pdf

**Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

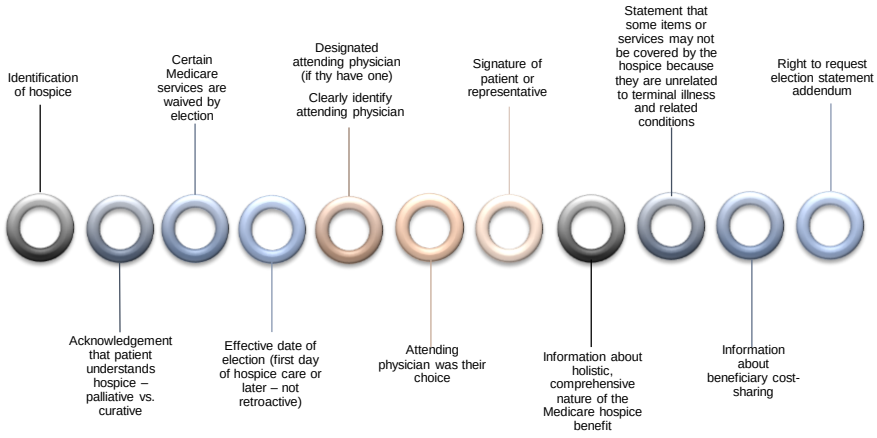
https://www.cms.gov/files/document/model-hospice-election-statement-addendum-modified-july-2020.pdf



16

16

# NOTICE OF ELECTION








17

**Order Number:** 12345678
**CERT:** 6/6/2019 to 9/3/2019

**Printed:** 9/26/2019 5:23 PM
**Eastern Time Zone**

Hospice Agency
123 Main Street
Anytown, USA 123456
Phone: (555)555-5555
Fax: (543) 222-2222

**HOSPICE PHYSICIAN:** Dr. John Brown **CLIENT:** Jane Doe

**Physician Narratives:**

**BRIEF NARRATIVE STATEMENT (REVIEW THE INDIVIDUAL'S CLINICAL CIRCUMSTANCES AND SYNTHESIZE THE MEDICAL INFORMATION TO PROVIDE CLINICAL JUSTIFICATION FOR HOSPICE SERVICES)**

CLIENT IS A _99_____YEAR OLD__FEMALE _____WITH A DIAGNOSIS OF CEREBRAL INFARCTION ___ _____AND THE FOLLOWING CO-MORBIDITIES__ HYPERTENSION, CHRONIC ISCHEMIC HEART DISEASE, HYPOTHYROIDISM, PRURITUS.___ _____ CLIENT HAS HAD THE FOLLOWING TREATMENTS _HOSPITALIZATIONS, REHAB, HOME HEALTH_____PRIOR TO HOSPICE. CLIENT'S NUTRITIONAL STATUS_FAIR_____. WEIGHT LOSS __NONE NOTED_____ _____ FUNCTIONAL DECLINE NOTED____ SIGNIFICANT_____ _____ CLIENT IS SLEEPING ___12-14_____HOURS PER DAY. PAIN_____NONE NOTED_____ _____ CLIENT IS DEPENDENT IN ___MILD ASSIST IN 6_____OUT OF 6 ADLS. CLIENT REQUIRES _____MINIMAL_____ASSISTANCE WITH ADLS AND IADLS.

**ATTESTATION: I CONFIRM THAT I COMPOSED THE NARRATIVE ABOVE AND THAT IT IS BASED ON MY REVIEW OF THE PATIENTS MEDICAL RECORD AND/OR EXAMINATION OF THE PATIENT.**

Dr. John Brown — **PHYSICIAN SIGNATURE (Electronically Signed)**
6/10/2019 — **DATE SIGNED**

**VERBAL CERTIFICATION TAKEN BY:** Desiree Smith **DATE:** 06/06/2019
**APPROVED / PROCESSED BY:** Desiree Smith **DATE:** 06/07/2019
**CERTIFICATION FROM HOSPICE PHYSICIAN:** Dr. John Brown **DATE:** 06/10/2019

**Page 2 of 2**





18

# CERTIFYING TERMINAL ILLNESS

Painting the Picture



19

19

# BEFORE WE DIVE IN……

Let's review hospice certification / recertification requirements

- Timeframe for Certification/ Recertification
- Content of the Certification/Recertification
- Signature Requirements for Certification
- Face-to-Face (FTF) Encounter
- Common Hospice Certification Errors

Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, §20.1
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf



20

20

# PAINTING THE PICTURE: EFFECTIVE DOCUMENTATION OF TERMINAL STATUS

- Documentation is expected to show significant changes in the beneficiary's condition and plan of care.
  - Always include the admission assessment
  - Decline must be evident in documentation
  - Chart or graph may be helpful

- Symptoms
- Appetite
- Presence of infections, wounds that are **stage III or greater**
- Intractable pain.
- Treatment
- Food and liquid oral intake
- Weight gain or loss of **10% or greater over a period of 6 consecutive months**

**Please note:** Documentation of the weight, appetite, ulcers etc. alone does not help paint the picture. Use of comparative data will help clearly illustrate the patient's status and the trending decline in condition. The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month certification.

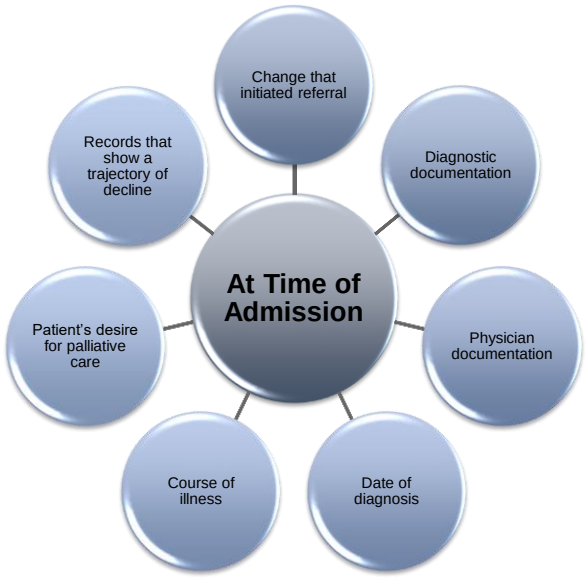


21

21

# DOCUMENTING TO SUPPORT TERMINAL PROGNOSIS AT TIME OF HOSPICE ADMISSION

- What initiated the hospice referral?
- What diagnostic documentation supports the patient's terminal condition?
- What is included in the records to support the terminal prognosis?
- When was the patient diagnosed with the condition?
- Does the patient wish for palliative care or curative treatment?
- Do the records support a trajectory of decline?



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## DOCUMENTING TO SUPPORT TERMINAL PROGNOSIS THROUGHOUT THE HOSPICE ELECTION

Documentation of the weight, appetite, ulcers etc. alone does not help paint the picture. Use of **comparative data** will help clearly illustrate the patient's status and the trending decline in condition.

The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month certification.







## DOCUMENTING WEIGHT

- At least monthly
  - More often if possible
- Take weights in a consistent manner
  - Time of day
  - Clothing
  - Relative to mealtimes
  - Show prior and current weights

Patient's weight June 11, 2021, was 132. Weight on July 15, 2021, was 128, which is a loss of 4 pounds (3%) in 34 days.

Patient lost 3 pounds since the last weight check.

### NON-CLINICAL METHODS

Patient is wearing belt on the last notch which is 3 notches tighter (evidenced by marks on the leather)



Patient's clothing appears to be looser than usual.

Patient's wedding ring is too big for her finger.

# MEASUREMENTS

- Take measurements starting at admission
- Measurements can be taken from:
  - Upper arm
  - Girth
  - Leg
- Include **the policy** with documentation that explain how and where measurements are taken

**BE CONSISTENT**





25

# PAIN

- Document the level of pain
- 0-10 scale (preferred)
- Consistent method of measuring pain
- Use methods that the patient/caregiver understand
- Colors
- Small, Medium, Big
- Wong-Baker FACES Pain Rating Scale

## NON-CLINICAL

- Patient was holding her abdomen while I was talking to her.
- Patient said that she didn't feel like going for a walk today
- Patient winced when I was helping him to the bathroom.




26

# RESPONSIVENESS

- Does the patient react to your presence?
- Is the patient receptive to care?
- Does the patient seem frightened of you?
- Does the patient remember you from the last visit?
- Is the patient unresponsive?
- Respond to touch? Smell? Light? Pain?
- Fades in and out of alertness?

## Non-Clinical

- Patient did not remember the conversation we had about his daughter during our last visit. He typically enjoys sharing stories about her.
- Patient appeared to be scared when I tried to help her get dressed.
- I had to prompt the patient repeatedly to continue conversation. Usually very talkative.







# ADDITIONAL ASSESSMENT INFORMATION TO SUPPORT A TERMINAL PROGNOSIS

- **ADLs**
- **Vital signs**
  - Clinical - respirations, blood pressure, pulse, temperature, etc.
    - Graphs easily illustrate change
  - Non-clinical
    - Patient was breathing harder than normal.
    - Patient was having difficulty talking d/t SOB
- **Lucidity**
  - Clinical
    - Can the patient follow the conversation?
    - Decisions – simple or complex
    - Current events
  - Non-clinical
    - Patient couldn't remember her daughter's name
- **Strength**
  - Clinical
    - Hand squeeze
      - Has there been a change?
      - Can the patient raise his/her hands to do this?
    - Standing
      - Assisted or unassisted
      - Length of time
      - Safely
  - **Non-clinical**
    - Patient could not open the jar of pickles for her lunch.
    - Patient needed assistance getting out of his chair. Normally, he can do this independently.

# DOCUMENTING TERMINAL STATUS

- Include interdisciplinary group (IDG) meeting notes
- Information from other staff members

## Common Errors

- Documentation by different disciplines show different level of decline and no explanation is included
- No measurable signs or symptoms for comparison
- Insufficient support of terminal status in documentation



29

29

# LEVELS OF HOSPICE CARE



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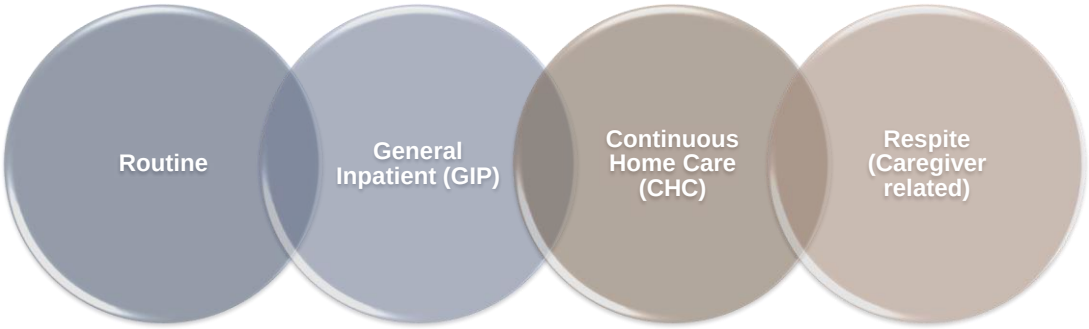
# LEVELS OF HOSPICE CARE






31

31

## Hospice Levels of Care

Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 9 §40.1.5, 40.2.1, and 40.2.2 PDF

Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 11 §30.1 PDF

Most hospice care is considered "routine care", and is provided to the beneficiary in their home, in accordance with the beneficiary's needs. However, there are times while under hospice care, that the beneficiary needs additional services, and the Medicare hospice benefit allows for these needs by providing additional levels of care. When a beneficiary needs additional services, or another level of care, it should be clear in the documentation what precipitated the change, and any attempts to maintain the beneficiary in routine care prior to the change.

There are four hospice levels of care. Routine home care is billed when none of the other levels of care is appropriate. Click on the following links to learn more about each level of care, and the requirements for that level of care to be billed to Medicare.

- Continuous Home Care (CHC)
- Respite Care
- General Inpatient Care (GIP)

***Updated: 07.25.12***

**https://www.cgsmedicare.com/hhh/coverage/Coverage_Guidelines/Levels_of_Care.html**



32

32

## GENERAL INPATIENT CARE

Beneficiary's medical condition warrants a short-term inpatient stay for pain control or symptom management that cannot be provided in other settings

- Medication adjustment, observation, treatment to stabilize patient
- NOT appropriate to use GIP when caregiver support has broken down unless coverage requirements for GIP level are met
- Intensity of care that cannot be managed in any other setting
- Services must conform with the written plan of care
- May only be provided in Medicare participating facilities
  - Hospice inpatient facility
  - Skilled nursing facility (SNF)
  - Hospital

**Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 9 §40.1.5**
http://www.cgsmedicare.com/hhh/coverage/Coverage_Guidelines/General_Inpatient_Care.html

## RESPITE CARE

- Caregiver relief
- Need for higher level of care, but caregiver unable to provide
- Paid per diem (daily)
- No GIP/symptoms; therefore, GIP level of care not appropriate
- Five (5) consecutive days
- Medicare participating hospital or hospice inpatient facility, or a Medicare participating nursing facility
- Multiple respite stays but not consecutive)



33

33

## DOCUMENTING THE CHANGE IN LEVEL OF CARE

- Document **current level** of care and **new level** of care
- **Date** when level of care changed
- **Location** where care is being provided



34

34

# DOCUMENTING THE NEED FOR GIP CARE

- Pain management requiring skilled nursing
- Aggressive treatment for pain control
- Complicated technical deliver of medication
  - Can include teaching caregiver delivery
- Frequent evaluation
- Frequent medication adjustment
  - PRN medication
- **Symptom changes**
  - Sudden deterioration
  - Uncontrolled nausea/vomiting
  - Unmanageable respiratory distress
  - Uncontrolled delirium, agitation

**SAMPLE DOCUMENTATION TO SUPPORT GIP LEVEL OF CARE**

Mr. Jones has become increasingly **agitated**. He rates his pain **10/10 within 45 minutes** of the last pain med administration. Respirations are increased at **28 breaths per minute**; he is **diaphoretic** and complains of chest "tightening". **Adjustments to medications have not been effective** at home.

The record shows **changes in medication**, **PRN** doses administered, **no relief** for the patient.







# POTENTIAL ISSUES WITH GIP DOCUMENTATION

- Long stays
- Inappropriate use
- No discharge planning
- Documentation not supporting GIP level of care
- GIP level of care for caregiver breakdown when medical symptoms/care do not support GIP
- A patient in the dying process does **NOT** make the patient eligible
- Discharge planning days are **NOT** covered
- An inpatient unit is **NOT** an automatic step down from the hospital
- Location does **NOT** determine level of care

## INAPPROPRIATE USE OF GIP CARE GENERAL INPATIENT CARE (GIP)

- For routine admission and care plan formation
- Ongoing assessment of managed symptoms
- No available caregiver for in-home care
- Caregiver relief
- General fall risk and/or supervision need



37

37

## DOCUMENTING GIP CARE

### Inappropriate Documentation

- "Patient in general inpatient unit for end-of-life care."
- "Patient is comfortable. No chest pain, no dyspnea, no fever, good appetite. No signs and symptoms of disease present."
- "Patient's wife was assured she did not have to worry about discharge as long as her husband continued to decline."

### Unacceptable Verbiage

- "Patient in general inpatient unit for end-of-life care."
- "Patient is comfortable. No chest pain, no dyspnea, no fever, good appetite. No signs and symptoms of disease present."
- "Patient's wife was assured she did not have to worry about discharge as long as her husband continued to decline."
- "Admit patient to the unit for general fatigue."
- "Inpatient level of care for general symptom control."
- "Psychosocial crisis: none of the nursing homes with available beds are acceptable to patient."



38

38

# HELPFUL TIPS

**Document at least daily:**

- Pain ratings
- Vital signs
- Weights
- Intake and output
- Descriptions and other objective data
- Body language if unable to communicate

**Include Quantitative Data**

- A discharge plan should be documented daily for all GIP patients
- Discharge and disposition planning begins before admission
- Medicare does not pay for additional days for discharge plan
- How crisis remains ongoing
- Completed interventions to resolve the crisis
- Patient's response







# GENERAL INPATIENT LEVEL OF CARE RESOURCES

- Short-Term Inpatient Care - Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9, §40.1.5)
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- Hospice Denial Fact Sheet / Denial Reason 5PM02: Reduced Level of Care (Medical Necessity), Denial Reason 5PX03: Reduced Level of Care (Technical)
  https://cgsmedicare.com/hhh/education/materials/pdf/hospice_5prlm_factsheet.pdf

# COMMON HOSPICE CERTIFICATION ERRORS

- Predating physician(s) certification signatures
- Not having both the hospice medical director and attending physician (if applicable) sign the initial certification as required
- Not having verbal certifications by both the medical director and attending physician (if applicable)
- The physician's narrative does not include a statement attesting that it was composed by the physician
- The physician narrative is missing
- The attestation statement is missing
- Not clearly stating the dates the certification period encompasses
- No physician(s) signatures
- Illegible physician signatures
- Physician did not date his/her signature





41

## HOSPICE DENIAL FACT SHEET

**Denial Reason 5PM01:** Six-Month Terminal Prognosis Not Supported

| | |
|---|---|
| **What is the six-month terminal prognosis?** | To be eligible for the hospice benefit, the patient must be considered to be terminally ill. Terminally ill means that the patient's life expectancy is 6 months or less, if the illness runs its normal course.<br><br>As a condition of payment under the Medicare hospice benefit, the six-month terminal prognosis must be supported in the medical record. The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month prognosis. Diagnosis alone may not support terminal prognosis; therefore, documentation in the medical record must support the terminal status. |
| **What should be documented to clearly support the six-month terminal prognosis?** | Documentation is essential in "painting the picture", especially for patients that:<br>• Have remained on the hospice benefit for a long period of time; or<br>• Have chronic illnesses with a more general decline.<br><br>Documentation to support the terminal prognosis at the time of the hospice admission may include:<br>• Changes in condition to initiate the hospice referral<br>• Diagnostic documentation to support terminal illness<br>• Physician assessments and documentation<br>• A date of diagnosis<br>• A course of the illness<br>• The patient's desire for palliative, curative care<br>• Records that show a trajectory of decline<br><br>Documentation to support the terminal prognosis throughout the hospice election:<br>• Changes in the patient's weight<br>• Diagnostic lab results<br>• Changes in pain (type, location, frequency)<br>• Changes in responsiveness<br>• Skin condition (turgor)<br>• Changes in the level of dependence for ADLs<br>• Changes in anthropomorphic measurements (abdominal girth, upper arm measurements)<br>• Changes in vital signs (RR, BP, pulse)<br>• Changes in strength<br>• Changes in lucidity<br>• Changes in intake/output<br>• Increasing ER visits or hospitalizations<br><br>Things to remember:<br>• Documentation to support terminal prognosis should be objective and include quantifiable values/measures (ex. Pounds, 4 on a scale of 1-5, inches, etc.)<br>• Documentation must "paint a picture" of the patient, their conditions and symptoms which support a life expectancy of 6 months or less.<br>• Avoid the use of vague statements such as: "disease progressing" or "slow decline" |

HOSPICE DENIAL FACT SHEET Denial Reason 5PM01: Six-Month Terminal Prognosis Not Supported

| | |
|---|---|
| **Where do I find more information?** | • CGS's "Suggestions for Improved Documentation to Support Medicare Hospice Services" Quick Resource Tool: https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_documentation_tool_h-021-01_07-2011.pdf<br>• CGS's Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patient's" Quick Resource Tool: https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_clinical_factors_recert_tool_h-020-01_07-2011.pdf<br>• Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 §20.1: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf<br>• Hospice Local Coverage Determination (LCD), "Determining Terminal Status": http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33015&ContrId=298&ver=19&ContrVer=2&CntrctrSelected=298*2&CntrctrSt=298&name=CGS+Administrators%2c+LLC+(15004)%2c+HHH+MAC&LCDIdt=&ver=2&bc=AgACAAIAQAAA |

PAGE 1
Originated February 3, 2014 | Revised July 22, 2020


https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_5PTER_FactSheet.pdf





42

## SUGGESTIONS FOR IMPROVED DOCUMENTATION
### *to Support Medicare Hospice Services*

The following list is a guide for hospice providers and their staff to improve documentation of Medicare covered hospice services by including complete and accurate documentation. This list is intended only as a guide, and is not inclusive, nor does it ensure payment. Remember, the documentation must present a visual picture of the patient, their condition and symptoms to support the terminal prognosis.

**Documentation to Support Hospice Admission**

- Change in or deterioration of condition to intiate hospice referral
- Diagnostic documentation to support anticipated life expectancy of six months or less
- Physician assessment and documentation
- Patient or their representative must elect hospice care (signed election statement)

**Documentation to Support Hospice Services**

- Change in patient's weight (pounds, kilograms)
- Worsening lab results
- Change in pain
  - Type (ache, throb, sharp)
  - Intensity (Level 0-10)
  - Location (upper, lower)
  - Frequency (constantly, hourly, daily)
  - Medication usage (dosage, frequency, effectiveness)
- Change in responsiveness (alert, less responsive, unresponsive
- Skin integrity (fragile, intact, tears easily, broken wounds)
- Dependence on assistance with Activities of Daily Living (ADLs)
  - Dress (assisted, unassisted)
  - Bathe (assisted, unassisted)
  - Ambulate safety and ability (assisted, unassisted)
  - Ambulation distance (feet, steps)
- Change in anthropomorphic measures
  - Mid arm circumference (MAC) or thigh circumference measurement (inches, centimeters)
  - Abdominal girth (inches, centimeters)
- Change in signs and symptoms
  - Respiratory rate (increased, decreased)
  - Dyspnea
  - Oxygen flow rate (liters per minute)
  - Hyper/hypotension
  - Radial/apical pulse (tachycardic, bradycardiac, regular, irregular)
  - Edema (level 1-4, pitting, non-pitting)
  - Turgor (slow, normal)
- Incontinence (frequency)
- Change in strength/weakness
- Change in lucidity (oriented, confused)
- Change in intake/output
  - Amount (cups, liters, ounces, teaspoons, mgs, ml, cc)
  - Frequency

**Documentation to Support Higher Level of Care**

- Requirements to support GIP or CHC levels of care
  - Uncontrolled signs/symptoms
  - Ineffective intervention(s) at routine level of care prior to GIP or CHC
- Caregiver need for relief to qualify for respite care
- Continued higher level of care is reasonable and medically necessary
- Time of initiation of and discharge from high level of care
- Services consistent with plan of care

**Prior to Claim Submission Ensure the Following**

- Election statement was signed and dated prior to start of care according to Medicare regulations
- Certification/recertification was signed and dated according to Medicare regulations
- IDG Plan of Care (POC) with updates completed by IDG every 15 days

**Additional Quantifiable Values may include:**

- Size (inches, centimeters)
- Timeframe (hours, days, weeks, months)
- Saturation (percent)
- Frequenty (hourly, daily, weekly)
- Speech pattern (repetition, word count, word salad)



https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_Documentation_Tool_H-021-01_07-2011.pdf





43

## HOSPICE Documentation Checklist Tool

**Election Statement Addendum** - *Effective October 1, 2020*

Does the Election Statement Addendum include the following information?

- Titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"
- Name of the hospice
- Individual's name and hospice medical record identifier
- Identification of the individual's terminal illness and related conditions
- List of the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by hospice because they have been determined by hospice to be unrelated to the terminal illness and related conditions
- Written clinical explanation, in language the individual (or representative) can understand, why the identified is considered unrelated
  - General statement decision made for each patient and they should share this clinical explanation with other health care providers
- References to relevant clinical practice, policy, or coverage guidelines
- Purpose of the addendum
- Right to immediate advocacy
- **Name and signature of the individual (or representative) and date signed, statement signing is only acknowledgement of receipt not necessarily agreement with the hospice's determination**
- ***Addendum must be delivered in writing within 5 days from date of the election if requested at time of admission to hospice or within 72 hours of the request during the course of care (after the hospice election date)***
  - *If there are any changes to the content on the addendum during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative)*

**Election Statement**

Does the Election Statement include the following information:

- Identification of the hospice that will provide care
- Acknowledgement the beneficiary has been given a full understanding of the nature of hospice care, **palliative versus curative**
- Acknowledgement certain Medicare services are waived by the election of hospice
- Effective date of the election
  - May be the first day of hospice care or a later date, but cannot designate a retroactive effective date
- Designated attending physician information (if any) including, but not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician
- Beneficiary's acknowledgement the designated attending physician was their choice

**Effective October 1, 2020:**

- Indication that services unrelated to the terminal illness and related conditions are exceptional and unusual and hospice should be providing virtually all care needed
- Information on individual cost-sharing for hospice services
- Right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined unrelated to the terminal illness and related conditions and would not be covered by the hospice
- Information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including right to immediate advocacy and BFCC-QIO contact information

Is the Election Statement signed by the beneficiary or authorized representative?

**Certification Of Terminal Illness**

**Certification/Recertification**

Is the certification statement signed and dated by the hospice medical director or a hospice physician member of the IDG no later than 2 calendar days after hospice care is initiated (that is, by the end of the third day), but no earlier than 15 days before hospice care is elected?

- **If initial certification, must also be signed by the beneficiary's attending physician (if any).**

If written certification was not obtained within 2 calendar days, is a verbal certification obtained and documented within 2 calendar days including?

- Identification of the physician providing oral certification
- A statement that the patient is terminally ill with a 6 month or less medical prognosis
- Hospice staff signed and dated entry in the patient's medical record of oral certification receipt.

https://cgsmedicare.com/hhh/education/materials/pdf/j15_hospice_doc_checklistre.pdf





44

# HOSPICE Documentation Checklist Tool

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## Certification Of Terminal Illness

Does the certification include:

- A statement that the patient is terminally ill with a 6 months or less medical prognosis
- A narrative written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of 6 months or less
  - Narrative shall include a statement, located directly above the physician's signature and date, that attests to the fact that by signing the form, the physician confirms that he/she **composed** the narrative based on his/her review of the patient's medical record or his/her examination of the patient
  - Narrative must be located immediately above the physician's signature
- Benefit period dates (from and thru date)
- Physician signature and date
- Effective for recertifications on/after January 1, 2011, narratives associated with the third benefit period and subsequent benefit periods must explain why the clinical findings of the face-to-face encounter support a life expectancy of six months or less. Documentation must include the date of the encounter, an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary. If the encounter was performed by a nurse practitioner or a non-certifying physician, he/she must attest that clinical findings were provided to the certifying physician.

## Face-to-Face (if applicable)

***On or after January 1, 2011 a face-to-face is required for all beneficiaries entering their third or later benefit period***

Did the face-to-face encounter occur no more than 30 days before the third benefit period recertification and each subsequent recertification?

- A face-to-face encounter may occur on the first day of the benefit period and still be considered timely.

Did the hospice physician or nurse practitioner who performed the encounter attest in writing that he/she had a face-to-face encounter with the patient, including the date of the encounter?

- 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
- If the face-to-face is a separate addendum, the certification period dates (from and thru) must appear on the addendum
- **Only the individual who performs the face-to-face encounter may attest to the completion of the visit.**

If a nurse practitioner or non-certifying hospice physician performed the face-to-face encounter, did they attest the clinical findings were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less?

Is the attestation signed and dated by the physician or nurse practitioner who performed the encounter?

## [illegible]

Does the documentation "paint the picture," especially for patients that:

- Have remained on the hospice benefit for a long period of time; or
- Have chronic illnesses with a more general decline.

Does the documentation support the six-month terminal prognosis?

| Documentation at the time of hospice admission may include: | Documentation throughout the hospice election may include: |
|---|---|
| • Changes in condition to initiate the hospice referral<br>• Diagnostic documentation to support terminal illness<br>• Physician assessments and documentation<br>• A date of diagnosis<br>• A course of the illness<br>• The patient's desire for palliative, not curative care<br>• Records that show a trajectory of decline<br>• Increasing ER visits or hospitalizations | • Changes in:<br>- Patient's weight<br>- Pain (type, location, frequency)<br>- Responsiveness<br>- Level of dependence for ADLs<br>- Anthropomorphic measurements (abdominal girth, upper arm measurements)<br>- Vital signs (RR, BP, pulse)<br>- Strength<br>- Lucidity<br>- Intake/output<br>• Skin condition (turgor)<br>• Diagnostic lab results (when available) |

Is the documentation objective and include quantifiable values/measures (ex. Pounds, 4 on a scale of 1-5, inches, etc.)?

Does the documentation avoid the use of vague statements such as: "disease progressing" or "slow decline"?

## Level of Care (LOC)

Does the documentation support the level of care billed?

- When and why the LOC was changed.

If Continuous Home Care (CHC) is billed, is a minimum of 8 hours of nursing, hospice aide, and/or homemaker care provided during a 24-hour day (begins and ends at midnight) and at least 50% or greater of the total care provided is nursing delivered by an RN/LPN/LVN?

If Respite Care is billed does the beneficiary reside in their home and not a facility (such as a long term care facility)?

If General Inpatient Care is billed does documentation show the beneficiary requires care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings?

- Medication adjustment
- Observation
- Psycho-social monitoring
- Other stabilizing treatments

## Resources

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

CMS Model Example of Hospice Election Statement
https://www.cms.gov/files/document/model-hospice-election-statement-modified-july-2020.pdf

CMS Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"
https://www.cms.gov/files/document/model-hospice-election-statement-addendum-modified-july-2020.pdf

Originated April 13, 2018 | Revised November 19, 2020


https://cgsmedicare.com/hhh/education/materials/pdf/j15_hospice_doc_checklistre.pdf



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45

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# Hospice Coverage Guidelines

Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 PDF

Medicare pays for hospice care when qualifying criteria are met and documented. It is essential for hospice agencies to have a complete understanding of these criteria, as you have the right, and responsibility, in collaboration with the physician, to decide the beneficiary qualifies for services. The agency then must understand what services are covered, and how to document these services.

To be eligible to elect the hospice benefit under Medicare, the beneficiary must be entitled to Part A of the Medicare benefit and be certified by a physician as terminally ill. A beneficiary is considered to be terminally ill if the medical prognosis for life expect is six months or less if the illness runs its normal course.

Hospice services are provided by various healthcare workers that make up the Interdisciplinary Group (IDG). The services provided by the IDG are directed by the Plan of Care (POC) that is specific for each individual beneficiary.

Refer to the topics below for additional information about hospice eligibility and the services provided under the Medicare hospice benefit.

| Hospice Eligibility | Hospice Services |
|---|---|
| • Election Requirements<br>• Discharge, Revocation and Transfers<br>• Hospice Plan of Care<br>• Certification/Recertification Requirements<br>  ◦ Hospice Face-to-Face Encounter<br>  ◦ Hospice Face-to-Face Encounter Calendar Quick Resource Tool<br>• Benefit Periods<br>• Eligibility of Beneficiaries in a Skilled Nursing Facility<br>• Veteran's Administration and Hospice<br>• Home Health and Hospice<br>• Hospice and End Stage Renal Disease (ESRD)<br>• Hospice Local Coverage Determination (LCD)<br>• Documentation<br>• Expedited Determination Process<br>• Advance Beneficiary Notice | • Interdisciplinary Group<br>• Nursing Services<br>• Medical Social Worker<br>• Physician Services<br>• Medical Supplies/Drugs and Biologicals<br>• Hospice Aide/Homemaker<br>• Therapies<br>• Bereavement Counseling<br>• Hospice Levels of Care<br>  ◦ Continuous Home Care<br>  ◦ Respite<br>  ◦ General Inpatient Care |

https://www.cgsmedicare.com/hhh/coverage/Hospice_Coverage_Guidelines.html

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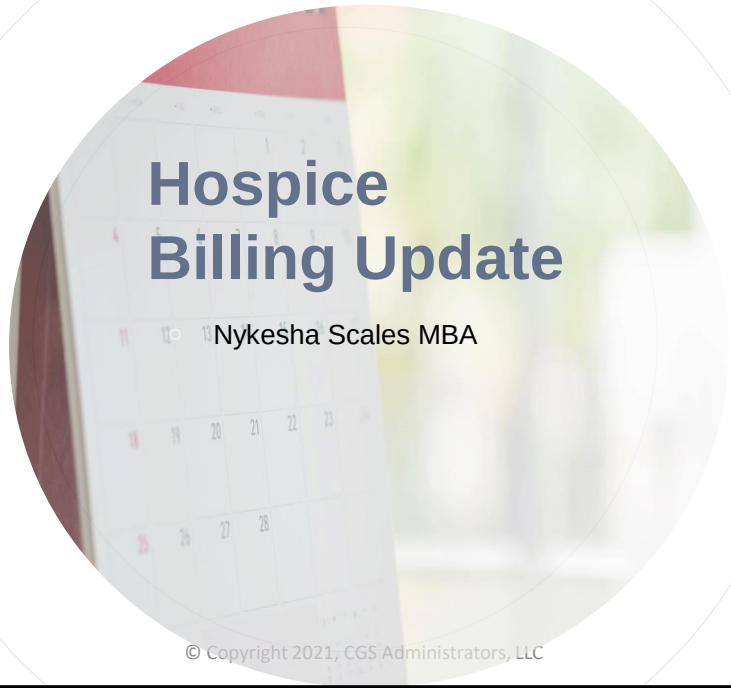
46

# An Overview of Coverage Requirements



47

47



# Hospice Billing Update

Nykesha Scales MBA



48

48

## Hospice Election Requirements

Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, §10, §20.2.1 and 40.1.3.1

To receive hospice services under the Medicare Hospice Benefit, the patient (or his/her authorized representative) must elect hospice care by signing an election statement. Each hospice designs and prints their own election statement.

The fiscal year 2021 Hospice Final Rule (CMS-1733-F ) included new hospice election statement and the hospice election statement addendum requirements. **The new requirements for the election statement and addendum are effective for all hospice elections beginning on or after October 1, 2020.**

As you develop your own Hospice election statements and certifications of terminal illness, please review the Model Example of Hospice Election Statement and the Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" for specific requirements you must include for valid documentation.

The hospice's election statement **must include** the following items of information:

- Identification of the particular hospice that will provide care to the patient;
- The patient's or representative's (as applicable) acknowledgment that the patient has been given a full understanding of hospice care, ***particularly the palliative rather than curative nature of treatment***;
- The patient's or representative's acknowledgment that the patient understands that certain Medicare services are waived by the election;
- The effective date of the election, which can be the first day of hospice care or a later date, but cannot be a retroactive date;
- The patient's or representative's designated attending physician (if they have one). Include enough detail to clearly identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or National Provider Identifier (NPI). (Effective for hospice elections on/after October 1, 2014.)
- The patient's or representative's acknowledgement that the designated attending physician was their choice. (Effective for hospice elections on/after October 1, 2014.)
- The signature of the patient or their representative.
- Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- A statement that, although it would be rare, there could be some necessary items or services that will not be covered by the hospice because the hospice has determined that these items or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- The statement would also include information about possible beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that expedited advocacy is available through the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) review if the beneficiary (or representative) disagrees with the hospice's determination.

**NOTE:** If the patient/representative wants to change their designated attending physician, they must file a signed statement with the hospice. The statement must include the following information:

- Identification of the new attending physician. Include enough detail to clearly identify the new attending physician. This may include, but is not limited to, the physician's full name, office address, or the NPI;
- The date the change is effective;
- An acknowledgement that the change in attending physician was their choice;
- The patient's or representative's signature; and
- The date the statement was signed.

Any hospice election statement, or statement changing the designated attending physician, that is missing any one of the bulleted items above, is considered incomplete, and may result in the claim being denied.

***See Slide 16 for link to templates**

https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/election_requirements.html







# Keep in Mind

- Hospices may still develop & design their election statement (same for the addendum)
- New requirements for the election statement & addendum, effective for all hospice elections beginning on or after October 1, 2020.

Reminder!

# Addendum Reminders

The addendum must be titled "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs**"

The hospice election statement addendum would only be required for Medicare hospice beneficiaries who **request** the information.

Condition of Payment/Timeframes

The addendum could also be furnished to:

- Their representatives
- Non-hospice providers
- Medicare contractors who request such information



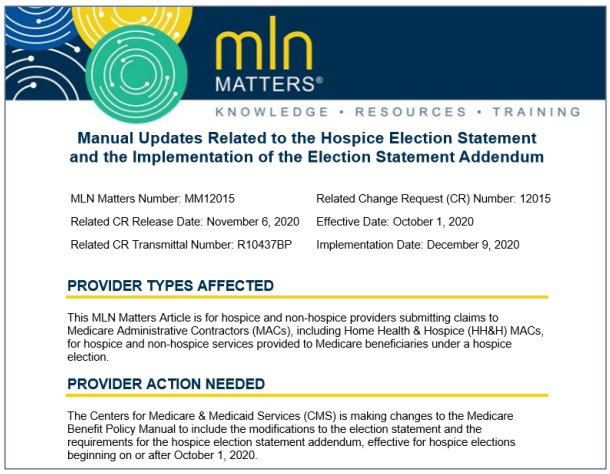
51

51

# Must See

**Article includes:**

- Background
- Modifications to the Hospice Election Statement Content Requirements
- Hospice Election Statement Addendum Content Requirements
- Timeframe for Furnishing the Hospice Election Statement Addendum
- Hospice Election Statement as a Condition for Payment



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**Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum**

MLN Matters Number: MM12015 | Related Change Request (CR) Number: 12015

Related CR Release Date: November 6, 2020 | Effective Date: October 1, 2020

Related CR Transmittal Number: R10437BP | Implementation Date: December 9, 2020

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is for hospice and non-hospice providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs, for hospice and non-hospice services provided to Medicare beneficiaries under a hospice election.

**PROVIDER ACTION NEEDED**

The Centers for Medicare & Medicaid Services (CMS) is making changes to the Medicare Benefit Policy Manual to include the modifications to the election statement and the requirements for the hospice election statement addendum, effective for hospice elections beginning on or after October 1, 2020.

***https://www.cms.gov/files/document/mm12015.pdf***



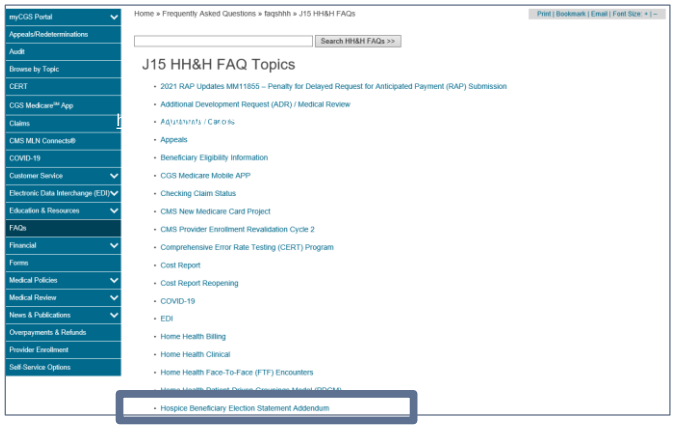
52

52

## Recently Updated- Hospice Beneficiary Election Statement Addendum Frequently Asked Questions (FAQs)

**Update: FY 2022 Hospice Final Rule Effective 10.1.2021**

https://www.cgsmedicare.com/medicare_dynamic/faqs/faqshhh/j15hhh.aspx










## VBID Model Hospice Benefit Component Overview | CMS Innovation Center

## Top Three Things Hospice Providers Need to Know

1. You must send all notices and claims to both the participating MAO and your MAC. The MAO will process payment, and the MAC will process the claims for informational and operational purposes and for CMS to monitor the Model.
2. If you contract to provide hospice services with the plan, be sure to confirm billing and processing steps before January 1, 2021, as they may be different.

   Note: While we encourage you to reach out to participating MAOs about contracting opportunities, you are not required to contract. If you choose not to contract, the participating MAO must continue to pay you at least equivalent to Original Medicare rates for Medicare-covered hospice care.

3. The Model does not permit prior authorization requirements around hospice elections or transitions between different levels of hospice care.



55

55

## CGS Billing Errors – Hospice 9/2020 – 8/2021

| Reason Code | Billing Error | # of Errors |
|---|---|---|
| 37402 | Sequential billing error | 20,633 |
| 38200 | Duplicate | 13,447 |
| U5106 | NOE falls within current hospice election | 9,388 |
| 34952 | Service facility NPI not included | 6,903 |
| U5181 | Occ cd 27 required when cert date falls within DOS | 6,536 |



56

56

# CGS Billing Errors – Hospice for Missouri
## 9/2020 – 8/2021

| Reason Code | Billing Error | # of Errors |
|---|---|---|
| 37402 | Sequential billing error | 1,860 |
| 38200 | Duplicate | 962 |
| U5106 | NOE falls within current hospice election | 939 |
| U5181 | Occ cd 27 required when cert date falls within DOS | 770 |
| 34952 | Service facility NPI not included | 738 |



57

57

## Top Claim Submission Errors Webpage

### June 2021

| Home Health Top CSEs | Short Narrative | Monthly Total |
|---|---|---|
| 38157 | Duplicate RAP | 8,938 |
| 38107 | FISS can't match claim billed to processed RAP | 5,871 |
| 37253 | No OASIS assessment found | 1,986 |
| U5381 | Overlapping episode of another HHA | 1,904 |
| 38200 | Duplicate Claim | 1,622 |
| U5391 | No matching request for anticipated payment (RAP) | 1,258 |
| 31018 | Episode "TO" date not 60 days greater than "FROM" date | 1,135 |
| U5387 | The patient status code is "30" and the through date does not equal the episode end date on file. | 1,096 |
| U538F | RAP or final claim overlaps an existing period of care with the same provider number | 903 |
| C7010 | No condition code 07 to indicate services unrelated to hospice election | 776 |
| **Hospice Top CSEs** | **Short Narrative** | **Monthly Total** |
| 37402 | Hospice sequential billing error | 1,767 |
| 38200 | Duplicate claim | 776 |
| U5106 | NOE falls within current hospice election | 752 |
| U5181 | Occurrence code 27 required when certification date falls within dates of service | 556 |
| 34952 | Service facility NPI not included | 502 |
| U523A | The dates of service on this claim are during both a Hospice election period and Medicare Advantage Plan Period that is Value-Based Insurance Design (VBID) Model. No resolution is required by providers. Refer to the U523A Reason Code Search and Resolution information for details. | 405 |
| 39929 | The hospice claim was rejected due to an untimely Notice of Election (NOE) | 346 |
| U5194 | Hospice claim received for untimely NOE & occurrence span code 77 is missing or invalid | 338 |
| 31605 | The dates of services on the claim cannot be within the span code 77 dates unless the charges are non-covered | 254 |
| 31503 | The total units on the level of care lines (0651, 0652, 0655, 0656) do not equal the number of days in the billing period. | 187 |

**Reason Code Search and Resolution** ▲ Top

For information about other reason codes, refer to the Reason Code Search and Resolution Web page. Note that this resource does not include a complete list of reason codes, just the most frequent.

https://www.cgsmedicare.com/hhh/education/materials/cses.html



58

58

# Targeted Probe & Education (TPE)

- **Resources:**
  - CGS TPE Web page, https://www.cgsmedicare.com/hhh/medreview/tpe_process.html
  - CGS MR Activity Log (topics found here), https://www.cgsmedicare.com/hhh/medreview/activitylog.html
  - CMS TPE Web page, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html
  - CGS TPE Did You Know, https://www.cgsmedicare.com/hhh/medreview/tpe_faqs.html
  - CR 10249, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1919OTN.pdf



59

59

# COVID-19 Resources

CGS Webpage, https://cgsmedicare.com/hhh/topic/covid-19.html

Job Aid, https://www.cgsmedicare.com/hhh/pubs/news/2021/02/cope20503.html

Information to assist Medicare Part A, home health, and hospice providers with proper billing of single claims for COVID-19 vaccines and monoclonal antibody infusions.

For additional information related to roster billing and centralized billing, reference the CMS Medicare Billing for COVID-19 Vaccine Shot Administration page.



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## Reason Code 7CS17: Billing COVID-19 Vaccine Administration for Beneficiaries with Medicare Advantage Plans

Some home health and hospice claims submitted for the COVID-19 vaccine administration have been rejected with reason code 7CS17 because the patient is enrolled in a Medicare Advantage (MA) Plan.

As indicated on the Centers for Medicare & Medicaid Services Medicare Billing for COVID-19 Vaccine Shot Administration website, claims for the COVID-19 vaccine administration for patients who are enrolled in a MA Plan, should be submitted to the Medicare Administrative Contractor (MAC), like CGS, not the MA Plan.

To avoid claims rejecting with reason code **7CS17**, providers need to include **condition code 78** (newly covered Medicare service for which a Health Maintenance Organization (HMO) does not pay).

If your COVID-19 vaccine administration claim has been rejected with 7CS17, and the patient is enrolled in an MA Plan, please resubmit your claim.



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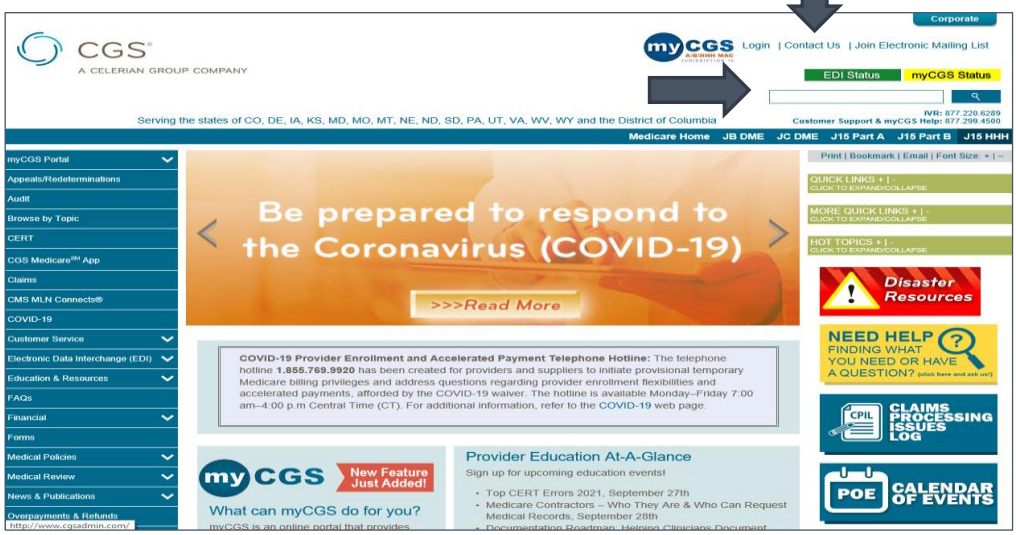
## CGS HH&H Web page

http://www.cgsmedicare.com/hhh/index.html



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# Claims Processing Issues Log

| Date Reported | Description of Issue |
|---|---|
| 09.01.2021 | Claims with a HIPPS code indicating a community admission are cycling when the Common Working File (CWF) finds an applicable post-acute stay in an inpatient rehabilitation unit or a psychiatric unit of a Critical Access Hospital (CAH). |
| 08.31.2021 | Claims are receiving reason code 39910 in error when the corresponding Request for Anticipated Payment (RAP) is received 30 days or more after the claim From date. |
| 08.31.2021 | Coinsurance or deductible should not be applied to COVID-19 vaccine and monoclonal antibodies claims with condition codes MA and 78. |
| 02.03.2021 – Closed | Some home health claims are receiving reason code C727D/C727E inappropriately indicating there is an inpatient stay within 14 days before the start of the home health period of care. |
| 01.29.2021 | Some LUPA claims are being incorrectly rejected with claim reason code 39929 and line level reason code 37363 indicating the request for anticipated payment (RAP) was submitted untimely. |
| 09.25.2020 – Closed | Low Utilization Payment Adjustment (LUPA) claims are incorrectly being sent to the Return to Provider (RTP) file because the Common Working File (CWF) believes a Request for Anticipated Payment (RAP) is needed. Reason codes affected are U5387 and U5391. Other reason codes, which begin with the letter U may also be affected. |
| 01.04.2019 | This issue is a result of the recent hospice redesign as explained in SE18007 and is causing hospice claims with older dates of service that are being adjusted to go to the Return to Provider (RTP) file (T B9997) with reason codes U5150 and U5151 indicating issues with the hospice master record. |

- HHH Resolved Issues

https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html



63

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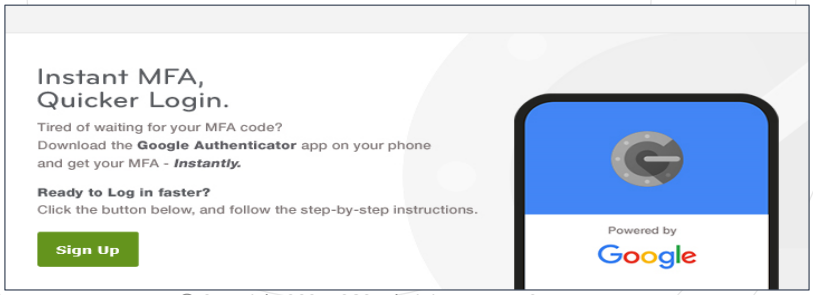
# myCGS A/B/HHH MAC JURISDICTION 15

https://www.cgsmedicare.com/mycgs/mycgs_user_manual.html

- **'My Account' Tab**




64

64

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myCGS Visit the myCGS Web Portal: https://www.cgsmedicare.com/mycgs

**Sign Up for E-mail Notifications:** By clicking, "Join Electronic Mailing" list in the top right corner of https://www.cgsmedicare.com

**GET EVEN MORE RESOURCES:**

- CMS MLN Web page: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo. *This includes the MLN Connects, MLN articles, and more.*
- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
- CMS e-mail updates at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

Download the CGS Medicare App: Get it on iTunes Store | GET IT ON Google Play

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# THANK YOU



## CGS Provider Contact Center: 1.877.299.4500

- Option 1: Customer Service
- Option 2: Electronic Data Interchange (EDI)
- Option 3: Provider Enrollment (PE)
- Option 4: Overpayment Recovery (OPR)

**POE Mailbox:** J15_HHH_Education@cgsadmin.com

Missouri Hospice & Palliative Care Association



66

# REFERENCES & RESOURCES







## HOSPICE REFERENCES AND RESOURCES

- **August 4, 2011 "Medicare Program: Hospice Wage Index for Fiscal Year 2012" Final Rule**
  http://www.gpo.gov/fdsys/pkg/FR-2011-08-04/pdf/2011-19488.pdf
- **"Hospice Face-to-Face (FTF) Encounters for Recertification" Quick Resource Tool**
  https://cgsmedicare.com/hhh/education/materials/pdf/hospice_ftf_encounters.pdf
- **Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, §10, §20.2.1 and 40.1.3.1**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- **Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 §20.1**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf
- **Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 9 §40**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- **Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 11, § 30.3**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
- **MLN Matters Special Edition Articles SE1631 and SE1628**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1631.pdf
- **MM7337External PDF– "Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation"**
  https://cgsmedicare.com/hhh/coverage/hospice_ftf_encounter.html
- **MM7478External PDF– "Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely"**
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7478.pdf
- **November 17, 2010 "Home Health Prospective Payment System Rate Update for Calendar Year 2011External PDF" Final Rule, pgs 70435-70454**
  https://www.govinfo.gov/content/pkg/FR-2010-11-17/pdf/2010-27778.pdf