

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the Affordable Care Act (section 6401a). Do NOT send in revalidated enrollment forms until you are notified to do so by your Medicare Administrative Contractor. You will receive a notice to revalidate between now and March 2013. For more information about provider revalidation, review MLN Matters® Special Edition Article SE1126, which is at <http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM7478

Related Change Request (CR) #: 7478

Related CR Release Date: October 7, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2316CP

Implementation Date: January 9, 2012

## Hospice Claims Processing Procedures When Required Face-to-Face Encounters Do Not Occur Timely

### Provider Types Affected

Hospice providers submitting claims to Medicare Contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

### What You Need to Know

When a required face-to-face encounter occurs prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and prior to, but no more than 30 calendar days prior to every recertification thereafter, it is considered timely. A timely face-to-face encounter would be evident when examining the face-to-face attestation, which is part of the recertification, as that attestation includes the date of the encounter. **If the required face-to-face encounter does not occur on time, the beneficiary is no longer certified as terminally ill, and consequently is not eligible for the Medicare Hospice benefit.** When this occurs, the hospice must

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discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes.

When a discharge from the Medicare hospice benefit occurs due to failure to perform a required face-to-face encounter timely, the claim should include the most appropriate patient discharge status code and occurrence code 42, as described in Chapter 11, Section 30.3 of the "Medicare Claims Processing Manual," which is attached in its revised form to CR7478. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements, and the patient (or representative) signs a new election statement. Requirements for eligibility and election are found in the "Medicare Benefit Policy Manual," Chapter 9, Section 10 and Section 20.2. You will find this Manual on the Centers for Medicare & Medicaid Services (CMS) Hospice Center website.

Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, we would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

Occurrence span code 77 does not apply to the above described situations when the face-to-face encounter has not occurred timely.

While the face-to-face encounter itself must occur prior to, but no more than 30 calendar days prior to, the start of the third benefit period recertification and each subsequent recertification, its accompanying attestation must be completed before the claim is submitted.

## Background

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To be eligible for the Medicare hospice benefit, a beneficiary must have Medicare Part A, and must be certified as terminally ill by a physician (42 CFR 418.20). The Medicare hospice benefit requires that a written certification or recertification be on file prior to the submission of a claim, in order to cover and pay for hospice services. A number of elements comprise a complete certification or recertification, including the physician's prognosis of the patient's life expectancy, a physician narrative, and clinical information or other documentation supporting the diagnosis. Section 3132(b) of the Affordable Care Act added a new element. Effective January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each patient prior to the start of the 180th-day recertification, and each subsequent recertification, in order to determine continued eligibility for the hospice benefit.

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This Affordable Care Act requirement was based on a recommendation by the Medicare Payment Advisory Commission (MedPAC). In its March 2009 Report to Congress, MedPAC wrote that additional controls are needed to ensure adequate accountability for the hospice benefit. MedPAC reported that greater physician engagement is needed in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. The Commission reported that measures to ensure accountability would also help ensure that hospice is used to provide the most appropriate care for eligible patients.

In the November 17, 2010, Home Health Prospective Payment System Final Rule, CMS interpreted the 180th-day recertification mentioned in Section 3132(b) of the Affordable Care Act to occur at the third benefit period (see 75 FR 70436-70437). In that same Final Rule, CMS required that as of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the third benefit period, no more than 30 calendar days prior to the third benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care (75 FR 70438). When a required face-to-face encounter does not occur within these timeframes, it is not timely, and the beneficiary is not certified as terminally ill. Therefore, when a required face-to-face encounter does not occur timely, the beneficiary is not eligible for the Medicare hospice benefit.

Finally, the physician or nurse practitioner who performs the face-to-face encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification, and must be clearly titled.

## Additional Information

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The official instruction, CR7478, issued to your RHHI, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2316CP.pdf> on the CMS website.

If you have any questions, please contact your RHHI, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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