DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8877 Revised | **Related Change Request (CR) #: CR 8877**

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Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election. This CR Rescinds and Fully Replaces CR8777

Note: This article was revised on August 19, 2015, to add a reference to MLN Matters® Article MM9114 available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9114.pdf**, which informs MACs about changes to hospice rules regarding election, revocation and designation of attending physician. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospices submitting claims to Home Health & Hospice Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

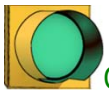
STOP – Impact to You

New editing instructions for hospice primary diagnoses and newly required timeframes for submitting information to your MAC might impact your reimbursement.

CAUTION – What You Need to Know

Change Request (CR) 8877 provides:

- Education for providers regarding new editing instructions for diagnoses that are not appropriate for reporting as principal diagnoses on hospice claims;
- Provider education for newly required timeframes for filing a hospice Notice of Election (NOE) and Notice of Termination/Revocation of Election (NOTR), and also for the exceptions process available when a hospice NOE is filed late; and
- A clarification of the differences between Healthcare Common Procedure Coding System (HCPCS) site of service codes Q5003 and Q5004.



GO – What You Need to Do

Make sure your billing staffs are aware of these changes.

Background

Principal Diagnosis Coding Instructions

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Coding Guidelines require you to report diagnosis coding on your hospice claim. The principal diagnosis reported on the claim should be the diagnosis most contributory to the terminal prognosis. The coding guidelines state that when the provider has established, or confirmed, a related definitive diagnosis, codes listed under the classification of *Symptoms, Signs, and Ill-defined Conditions* are not to be used as principal diagnoses. Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines and that require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines. According to the ICD-9CM/ICD-10-CM Coding Guidelines both “debility” and “adult failure to thrive” are considered nonspecific, symptom diagnoses. Specifically, you should not use ICD-9-CM codes 799.3 (Debility, unspecified) and 780.79 (Other malaise and fatigue), ICD-10-CM code R53.81 (Other malaise); and ICD-9-CM code 783.7 and ICD-10-CM code R62.7 (adult failure to thrive) as principal hospice diagnoses on a hospice claim form. When any of

these diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Additionally, there are several dementia diagnosis codes that cannot be used as the principal diagnosis, and require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that are classified as unspecified or which have principal diagnosis code sequencing guidelines. These dementia codes (most of which are those found under the ICD-9-CM/ICD-10-CM classification, "Mental, Behavioral, and Neurodevelopmental Disorders") are typically manifestations from an underlying physiological condition; and are not appropriate as principal diagnoses because of etiology /manifestation guidelines or sequencing conventions. You must code the underlying condition as the principal diagnosis, and the aforementioned dementia conditions would be appropriate as secondary diagnoses.

ICD-9-CM/ICD-10-CM diagnosis codes 294.10/F02.80 (Dementia in diseases classified elsewhere without behavioral disturbance), and 294.11/F02.81 (Dementia in diseases classified elsewhere with behavioral disturbance) are included in an existing Medicare Code Editor edit, which does not allow these diagnoses to be coded as principal. This Medicare Code Editor edit will be implemented as a "Manifestation code as principal diagnosis" edit in the Integrated Outpatient Code Editor (IOCE). Additionally, new edits for the codes in CR8877's Attachment A will be implemented, as these codes are part of sequencing or other coding convention in the coding guidelines.

You should only use unspecified codes when the medical record documentation (at the time of the encounter) is insufficient to assign a more specific code. However, if the underlying neurologic condition causing dementia may be difficult to code because the medical record may not provide sufficient information, and there are codes listed under "Diseases of the Nervous System" that do provide for appropriate principal code selection under those circumstances, you are encouraged to look at the coding conventions under that classification for coding dementia conditions on hospice claims.

You should be aware that if you report any of these diagnoses, mentioned above, as a principal diagnosis, the claim will be returned to you for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Newly Required Timeframes for Information to MACs

When electing hospice care, the beneficiary waives the right to Medicare payment for any Medicare services related to the terminal illness, and related conditions, during a hospice election; except when those services are provided by:

- The designated hospice ;
- Another hospice under arrangements made by the designated hospice; or
- The individual's attending physician, who is not an employee of the designated hospice; as noted in 42 CFR 418.24(d) which is available at **http://www.gpo.gov/fdsys/granule/CFR-2012-title42-vol3/CFR-2012-title42-**

vol3-sec418-24/content-detail.html on the Internet. Prompt filing of the NOE with the MAC is required to properly enforce this waiver, and prevent inappropriate payments to non-hospice providers. The effective date of hospice election is the same as the hospice admission date.

Upon discharge from hospice or revocation of hospice care, the beneficiary immediately resumes the Medicare coverage that had previously been waived by the hospice election. As such, hospices should record the beneficiary's discharge or revocation in the claims processing system promptly. Doing so protects the beneficiary from experiencing possible delays in accessing needed care.

You must file Hospice NOEs within 5 calendar days after the effective date of hospice election. A timely-filed NOE is a NOE that is submitted to the Medicare contractor and accepted by the MAC within 5 calendar days after the hospice admission date. If you do not file the NOE within this 5 calendar day period, Medicare will not cover and pay for the days of hospice care from the effective date of election to the date of NOE filing. These days will be a provider liability, and you should not bill the beneficiary for them.

You should report these non-covered days on the claim with an occurrence span code 77, and report the charges related to the level of care for these days as non-covered; or the claim will be returned to you.

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 using occurrence span code 77.

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 four circumstances that may qualify the hospice for an exception to the consequences of filing a late NOE are:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the hospice;
3. 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 MAC; or,

4. Other circumstances determined by the MAC to be beyond the hospice's control.

If one of the four circumstances described above prevents you from filing your NOE within the time requirements, you must submit the associated claim with occurrence span code 77 used to identify the non-covered, provider liable days. You must also report a KX modifier with the Q HCPCS code reported on the earliest dated level of care line on the claim. The KX modifier prompts your MAC to request the documentation supporting your request for an exception.

Your MAC will determine if a circumstance that a hospice encountered qualifies for an exception; and if it approves the request for an exception, it will re-process the claim without the provider liable days for late-filing of the NOE. If, however, it does not approve your request for an exception, your MAC will process the claim as submitted.

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, unless you have already filed a final claim. A NOTR (bill type 8XB) contains the same data elements as an NOE (bill type 8XA) and is entered via Direct Data Entry in the same way.

Clarification of the Differences between HCPCS Codes Q5003 and Q5004

CR8877 clarifies the differences between site of service HCPCS codes Q5003 (Hospice care provided in nursing Long Term Care (LTC) facility or non-skilled Nursing Facility (NF)) and Q5004 (Hospice care provided in Skilled Nursing Facility (SNF)). This clarification does not represent a change in policy regarding the correct usage of these two codes.

Q5004 should be used for hospice patients in a Skilled Nursing Facility (SNF), or in the SNF portion of a dually-certified nursing facility. There are four situations in which this would occur:

1. If the beneficiary is receiving hospice care in a solely-certified SNF;
2. If the beneficiary is receiving general inpatient care in the SNF;
3. If the beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition unrelated to the terminal illness and related conditions, and is receiving hospice routine home care; this is uncommon; or
4. If the beneficiary is receiving inpatient respite care in a SNF.

If a beneficiary is in a nursing facility but doesn't meet the criteria above for Q5004, the site should be coded as Q5003, for a long term care nursing facility.

Additional Information

You may want to review MM8923 which alerts providers to changes to the remittance advice messages applied to hospice claims when days are non-covered due to late filing of a Notice of Election, which will indicate that these days are appealable.

The official instruction, CR8877 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3032CP.pdf** on the CMS website. Attachment A of CR8877 is a list of invalid ICD-9/ICD-10 principal diagnosis codes.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.