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Hospice Physician Recertification Requirements

Note: This article was updated on March 28, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospices billing Medicare Regional Home Health Intermediaries (RHHIs)

Provider Action Needed



STOP – Impact to You

The Medicare hospice benefit requires a written certification be on file with the hospice provider prior to submission of a claim to Medicare. Written recertifications for continued periods of hospice care are often not received within Medicare's designated time limits.



CAUTION – What You Need to Know

Care provided during the timeframe prior to receipt of these recertifications may not be reimbursed for that billing period during which the recertification was not timely submitted.



GO – What You Need to Do

Hospices must use occurrence span code 77 in FL36 of the claim to identify days of care that are not covered by Medicare due to untimely physician recertification.

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Background

The Social Security Act (Section 1814(a)(7)) contains the requirement for Medicare hospices that a physician certify in writing (at the beginning of a benefit period) that a beneficiary is terminally ill.

Medicare beneficiaries entitled to hospital insurance (Part A) who have a terminal illness and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime.

The Medicare hospice benefit requires that a written physician certification be on file in the Hospice patient's record prior to the submission of a claim to the fiscal intermediary. It may happen that written physician recertification for continued periods of hospice care are not received within the designated time limits. Consequently, reimbursement for a portion of a billing period may not be provided for care given to beneficiaries during the timeframe prior to receipt of the recertification. Regional Home Health and Hospice Intermediaries (RHHIs) reported this issue to the Centers for Medicare and Medicaid Services (CMS) during a recent quarterly hospice conference call because considerable intervention is required to process these claims.

RHHIs indicated that when the physician recertification between hospice periods is not received in a timely manner, the benefit period cannot be established in Medicare's systems. The services provided during the billing period (prior to the receipt of the recertification) are noncovered.

Therefore, CMS is directing (in CR 3686) the use of Occurrence Span Code 77 for the noncovered days during the billing period to indicate provider liability for the indicated services.

Following the initial benefit period, subsequent periods of hospice care require a written recertification no later than two calendar days after the first day of each period. The hospice must obtain a written recertification statement from:

- The medical director of the hospice, or
- The physician member of the hospice's interdisciplinary team.

Receipt of the recertification must be obtained within two days of the start of care. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification **must be on file in the hospice patient's record prior to submission of a claim** to the Medicare fiscal intermediary.

Hospices must use Occurrence Span Code 77 to identify days of care that are not covered by Medicare due to untimely receipt of physician recertification.

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Code	Title	Definition
77	Provider Liability – Utilization Charged	Code indicates From/Through dates for a period of non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).

Additional Information

See Chapter 29 (Appeals and Claims Decisions) of the Medicare Claims Processing Manual (Pub. 100-04) for information on the appeals process that should be followed when an entity is dissatisfied with the determination made on a claim at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf> on the CMS website.

Also, see the Medicare Benefit Policy Manual, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>, (Publication 100-02, Chapter 9 (Coverage of Hospice Services Under Hospital Insurance), for additional general information about the Hospice benefit, hospice eligibility requirements, and election of hospice care.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R458CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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