The Least You Need to Know: Change Request (CR) 8877, released August 22, updates the CMS Internet Only Claims Processing Manual with the necessary “operating instructions” to implement the changes in the FY 2015 Hospice Wage Index Final Rule: the Notice of Election timeframe change, the Notice of Termination/Revocation requirement and timeframe, and allowable principal hospice diagnoses. The one unpleasant surprise is the breadth of the dementia diagnosis codes that will no longer be allowable for use as principal hospice diagnoses. The one pleasant surprise is a rewrite of two Q codes; this was unrelated to any final rule changes and will be addressed in FYI 6.22.

Additional Information: This CR provides Claims Processing Manual updates and Medicare Administrative Contractor (MAC) requirements required for implementation of three changes from the FY 2015 Hospice Wage Index Final Rule. Each is addressed below (for an in-depth discussion of the reasons for the changes, see FYI 6.18 and FYI 6.19).

New Timeframes for Filing the Medicare Notice of Election (NOE)

As of October 1, if the NOE is not submitted to and accepted by the MAC within 5 calendar days after the effective date of the election, no payment will be made for the days from the start of care through the day before the NOE has been submitted and accepted.

Some notes:

- “Calendar days” means what is says - calendar days – not working days.
- It is five calendar days AFTER the effective date of the election. So, for an election with an effective date of October 1st, the NOE would have to have been submitted and accepted by 6th.
- If the NOE is filed after the 6th day, the date that the NOE is submitted and accepted is the first allowable payment date. That means no payment for the days between election and acceptance.
- In billing lingo, the NOE is also known as an 8xA (the x changes depending on type of hospice).
- Updated manual language starts on page 12 of the CR (link above).

Exceptions Process for Late-Filed NOEs

In the final rule, CMS provided three reasons for exceptions from timely filing for which a provider would not be penalized and then tossed in #4 - other situations determined by CMS to be beyond the control of the hospice.

The question on everyone’s mind, however, has been how to handle delays due to the pesky hospice sequential billing rules. CMS provides the answer - a new modifier (KX) to be added to the Q HCPCS code for the earliest dated level of care revenue code line on the claim. Updated manual language starts on page 29 of the CR (link above).

What the KX Modifier Means: The hospice has met the requirements in the medical policy and has documentation indicating an exception condition applies.

What type of documentation will be required? No one knows at this point; expect more guidance from your MAC.
New Timeframe for Filing a New Notice: The Notice of the Termination / Revocation (NOTR)

This isn’t exactly a new notice – it has always existed (see sidebar) but was not used in quite this way.

As of October 1, hospices must submit a NOTR within 5 calendar days after the effective date of the discharge or the revocation unless the final claim has been filed within that timeframe. Although at this time there is no financial penalty for missing the required filing deadline, CMS will be tracking compliance and did not close the door on the possibility for future penalties.

Notes

- “Calendar days” means what is says - calendar days – not working days.
- If a provider files late, the beneficiary may well be the one suffering negative consequences as he or she may not be able to access needed services and supplies (the recent part D disaster comes to mind here). Don’t let that happen.
- In billing lingo, the NOTR is also known as an 8xB (the x changes depending on type of hospice).
- Updated manual language starts on page 12 of the CR (link above).

Dementia Codes as Principal Diagnoses on Hospice Claims

In addition to reminding hospices that neither debility nor adult failure to thrive will be accepted as principal hospice diagnoses, CMS also included a list of dementia codes in CR 8877 – there are 28 of them on the ICD-9-CM list – that will no longer be accepted. The list starts on page 9 of the CR (link above).

What about those patients for whom dementia is the most contributory factor for terminal status? That is the question of the month and, at this point, no one has the definitive answer. In some cases, the hospice or attending physician may be able to identify an underlying condition, in others not.

Medicare Claims System Notices

Check with your billing department – they are very familiar with Medicare “notices” because they use them all the time. Filing the various types of notices updates the Medicare database to reflect important beneficiary-specific status changes needed by all providers’ billing departments.

There are five events that require a notice; each has a letter designation and none is new.

<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Hospice benefit period initial election notice</td>
</tr>
<tr>
<td>B</td>
<td>Termination/revocation notice of previously posted hospice election</td>
</tr>
<tr>
<td>C</td>
<td>Change of provider</td>
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<tr>
<td>D</td>
<td>Void/cancel hospice election</td>
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<tr>
<td>E</td>
<td>Hospice Change of Ownership</td>
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Coding expert Judy Adams will return to our webinar stage in mid-September to help you sort this out. She’ll record the webinar; we’ll provide you with the link and handouts via e-mail so that you can access it at your convenience.
Actions of a Prudent Hospice™

NOE & NOTR

ONE. We still don’t have some of the more detailed billing instructions; expect more information directly from your MAC over the next weeks. There are some questions that just cannot be answered until then.

TWO. Implement a failsafe tracking system starting on the day of election. When it gets to day 3 and the NOE has not been submitted and accepted, determine why not and get it done.

THREE. Check with your billing department to find out what current processes are in place to determine if the NOE has been accepted.

FOUR. Billing reports should include weekly reports of any NOEs that were not submitted and accepted, what the issue was and days lost.

FIVE. Determine how your software vendor can support you in tracking submitted and accepted claims and reports on days lost.

Diagnosis Codes

ONE. Claims with a disallowed principal DX will RTP – return to provider – for a “more definitive” DX. This does not mean that the claim has been denied or that an ADR has been issue; instead it means that the claim has been totally rejected and will not be considered for payment until it comes back with an allowable principal diagnosis. This will disrupt cash flow and require time to establish an allowable principal terminal diagnosis.

TWO. Review all current beneficiaries’ principal DX codes to ensure none are on the “no longer accepted” list. Work with the attending and hospice physician to determine the underlying condition and provide a new code as the principal DX.

THREE. Ensure close communication with your billing department; operations needs to be informed immediately when a claim RTPs due to coding.

FOUR. Ensure the admissions department knows what DX are on the “no longer accepted list”.

FIVE. Work with your software vendor to see how they can support not allowing the “no longer accepted” list dx to be listed as principal DX on the Medicare claim.