February 13, 2020, Hospice Coalition Questions and Answers
To: Hospice Coalition Members
From: Palmetto GBA Provider Outreach and Education (POE)
Time: 12:30 p.m. ET

Attachment A: Hospice Appeals Reports (PDF, 496 KB)
Attachment B: Hospice CAP Updates (PDF, 44 KB)
Questions for Response
Billing

1. Please provide an update to the corrective actions for adjusting Tiered Payments as this has not been functional since 2016. The current status posted on the website is as follows:

Hospice Payment Rates for Routine Home Care (RHC) on and after January 1, 2016.

Current Status as 11/26/2019: The fix that was implemented on October 21, 2019, was not successful. Additional research is being done. We will provide an update as soon as available. No provider action is required at this time.

Answer: The latest update for this issue was provided on 1/21/2020. As a result of additional research, it has been determined that this issue occurs when an adjustment is made to an adjustment. A resolution to this issue has not yet been scheduled.

2. A hospice has a new biller and their prior employee left suddenly and was not able to train the new biller. Please provide information on what resources the biller can access to learn how to use Direct Data Entry (DDE). Is there online training that they may have overlooked that will assist them?

Answer: Palmetto GBA offers several resources for DDE guidance. One is the DDE User's Guide. The DDE User's Guide is separated into six sections and they are:

- Introduction and Connectivity
- Checking Beneficiary Eligibility
- Inquiries (Main Menu Option 01)
- Claims and Attachments (Main Menu Option 02)
- Claims Correction (Main Menu Option 03)
- Online Reports (Main Menu Option 04)

Palmetto GBA also developed a Direct Data Entry (DDE) system educational series that consists of five Web-based Training Modules. These self-paced training modules provide an overview of DDE and are designed to give you the information you need to know to become a proficient DDE user. The following training modules are available:

- DDE Module 1: Introduction to DDE
- DDE Module 2: Inquiry Applications
- DDE Module 3: Claims

- DDE Module 3A: MSP Claims
- DDE Module 4: Reports

Palmetto GBA is also excited to announce the publishing of the Hospice Billing Codes Job Aid. This job aid includes billing codes a hospice would include on claims and election notices.

3. How does a provider get claims reprocessed that were backed out due to another provider needing to submit claims?

a. What happens if the first provider never submits the claims? What does the second provider have to do in this situation to get their claims reprocessed?

Answer: Providers sometimes experience situations where they are unable to resolve a billing dispute with another provider either due to overlapping dates of service or sequential billing.

Hospice providers should ensure that a patient's Medicare eligibility records are reviewed before the patient is admitted. If the patient's Medicare eligibility records reflect that care is or was being provided by another provider and the records do not reflect that the previous provider has finalized their billing, the receiving provider is responsible for contacting the existing/previous provider to request that they complete their billing.

Should a dispute arise, both providers are required under Medicare regulations to make an attempt to resolve the issue between them. If the providers are unable to resolve the dispute, Palmetto GBA may be contacted for assistance.

Palmetto GBA will work with both providers to settle the dispute. Providers seeking assistance from Palmetto GBA to resolve a billing dispute should complete the Billing Dispute Resolution Request form located in the Forms application on the home page. All information on the form is required to assist the provider.

Please refer to "Billing Disputes Resolution Requests" located on the Palmetto GBA website for additional information.

b. What is the process if a provider disagrees with Palmetto GBA's decision not to reprocess claims that were submitted timely but backed out for another provider to complete billing?

Answer: Medicare providers are expected to work together to resolve overlap situations. When a billing dispute arises between Medicare providers for dates of services or patient discharge status and neither party is able to reach a resolution, the Medicare contractor is tasked with assisting the providers with resolving the matter. Providers are encouraged to seek assistance from Palmetto GBA as soon as it is evident that a resolution cannot be reached.

Requests received for claims that are past the timely filing limit will not be processed without good cause as defined in the Medicare Claims Processing Manual. Reference: CMS IOM, Pub.

100-04. Chapter 1, Section 70.7. There are four exceptions where providers can request an extension on the time limit for claims:

- Administrative Error
- Retroactive Medicare Entitlement
- Retroactive Medicare Entitlement Involving State Medicaid Agencies
- Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization

The "Checklist for Timely Filing Extension" article located on the Palmetto GBA website will assist providers in the necessary information necessary when requesting a timely override due to the above four exceptions. Please submit as much detail and information as possible in your submission. If you feel the error was on the part of Palmetto GBA (Ex: incorrect information provided, not following up on a request for help with a billing dispute in a timely fashion, etc.), please indicate this in your request along with supporting evidence and/or documentation.

Palmetto GBA has undertaken an internal project to revise and simplify the process for seeking help with a billing dispute so that it is easier and faster for providers. This effort will help to resolve any inconsistencies that may have occurred previously and minimize the potential timely filing from coming into play. Additionally, Palmetto GBA will be re-engaging with CMS in an attempt of achieving more clarity on the requirements.

Please refer to Resolution Tips for Overlapping Claims and Checklist for Timely Filing Extension job aids located on the Palmetto GBA website for additional information.

4. How do we handle the Hospice Notice of Transfer (NOTR) when a patient revokes for aggressive treatment then readmits within 2–3 days and the NOTR has not processed/paid at the time of the new admission? The Notice of Election (NOE) will not pass. Do we submit the NOE and record the rejection, or do we wait for the NOTR to process?

Answer: Hospice agencies must submit claims and the multiple types of election notices in sequence and within timely NOE filing regulations.

In the example provided, the hospice had already submitted the NOTR and it is processing. Any time after the NOTR is submitted and within five (5) calendar days after the hospice readmission date, the hospice shall file the NOE to be considered timely. The NOE may return if the NOTR has not completed processing. If the NOE returns because the NOTR had not completed processing, the provider may request an exception which, if approved, waives the consequences of filing a NOE late.

As a reminder, if a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice shall file a timely-filed NOTR, unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted and accepted within five (5) calendar days after the effective date of discharge or revocation. If the NOTR or final claim was not filed timely, it may affect the outcome of the exception.

Resource: 90 — Frequency of Billing and Same Day Billing, Chapter 11 — Processing Hospice Claims (PDF, 466 KB).

5. Reason Code U5106 overlap with another provider our 81A Returned to Provider (RTP) must hold and wait for other provider to complete their billing. Once the benefit period is closed, we are to F9 the 81A which causes the NOE to be late and the claim to RTP for U5194. We filed for an exception and it was not granted for "Reason for denial: provider billing error. Correction to NOE not done within the 2-day turnaround." We were told to file a Redetermination. Why can the claim not be reprocessed?

Answer: If the Provider Contact Center (PCC) clearly identifies that the exception was processed incorrectly, they can escalate the claim back to the Claims Department for review of the initial determination. However, complicated exception requests may need to go through the appeal process in order to get the documentation/explanation that cannot be provided through the exception process.

6. Need a new update on the status of U5181 as it was last updated 06/25/2019. This is causing sequential billing to RTP. When a claim RTPs for edit 30995 "Effective January 2020 providers are required to submit claims with the Medicare Beneficiary Identifier (MBI)", we are not able to correct the claim in DDE as it will not allow us to submit it with the new MBI by selecting "Y" and adding a new number. We are told we must submit a new claim. Why?

Answer: Correcting a claim that has RTP, is the equivalent of submitting a new claim for processing and the Medicare ID cannot be changed in the process. If a claim was submitted prior to January 1, 2020, and included the outgoing Health Insurance Claim Number (HICN) and it RTP, a provider had until December 31, 2019, to return the corrected claim with the HICN. On or after January 1, 2020, you must submit claims using MBIs, no matter what date you performed the service, with a few exceptions as outlined in MLN Matters Number: SE18006 (PDF, 212 KB).

The resolution for Claims Payment Issues Log article "Hospice Claims Editing for Reason Code U5181" has not yet been scheduled.

7. When working old date of death claims, we cannot obtain the MBI number thru the MBI Lookup tool. It states the patient is deceased and the claim is past timely filing.

Answer: Users may obtain an MBI as long as the Medicare beneficiary information entered is valid and the beneficiary's date of death is less than 13 months prior to the date the MBI Lookup inquiry is performed.

If the Medicare beneficiary information submitted in the MBI Lookup is valid, but the beneficiary's recorded date of death is more than 13 months prior to the date the MBI Lookup

inquiry is performed, the user will receive a message advising that the date of death exceeds the timely claim filing requirement. The MBI will not be returned.
eServices FAQs

8. Why is Palmetto GBA no longer sending demand letters to providers once they have finalized review determinations from outside CMS contractors such as Unified Program Integrity Contractor (UPIC), Supplement Medical Review Contractor (SMRC), etc.? The overpayments are being recouped without the notice being delivered to us.

Answer: For non-Periodic Interim Payment (PIP) providers, if an overpayment is determined as the result of an outside CMS contractor (e.g., UPIC, SMRC, OIG, etc.), then a demand letter is issued to the provider once the overpayment has finalized either via claims processing or in rare cases a manual overpayment has been confirmed. The overpayments described in this process are Section 935 eligible overpayments, therefore recoupment would not take place until day 41 after a demand letter has been issued.

For PIP providers, the recoupment is handled through the PIP Reconciliation Review process, which occurs 12–18 months after the PIP year end, with additional revised reviews completed if requested by the provider. The provider may see negative adjustments on their remittance advice; however, the actual collection of the overpayment does not occur until the PIP payments are reconciled to the PS&R in the PIP Reconciliation review. In this way, adjustments flow to the PS&R reducing the Medicare allowable reimbursement which will likely create an overpayment due the Medicare program when the reconciliation is completed. Likewise, if adjustments are overturned and Medicare allowable reimbursement increases, the provider may request a revised PIP Reconciliation.

Please note in the past, Palmetto GBA issued manual demand letters and suppressed the adjustments from going to the PS&R. This prevented the potential for duplicate overpayments. However, due to the appeals process and the need to ensure the overpayment was considered and that the beneficiary counts were accurately computed during the hospice cap review, this process is ceased, and all adjustments ultimately flow to the PS&R report. Because the hospice PIP and hospice cap reviews are designed to rely on the PS&R reports, suppressing adjustments and handling overpayments outside of the claims system, potentially compromises the integrity of the PS&R data. We have discussed this with other MACs, and this is a consistent process.

Exceptions:

- RAC adjustments do generate a demand letter; however, the PS&R is designed to accommodate RAC adjustments and categorizes the adjustments appropriately
- Extrapolated overpayments require a manual letter because the overpayment is based on sampled claims

Resource: Medicare Financial Management Manual, Chapter 3 (PDF, 572 KB), Overpayments, and Chapter 4 (PDF, 1.08 MB), Debt Collection.

9. In follow-up to question #8, Palmetto GBA's review determinations are being processed differently than communicated by the contracted agency to the provider and the information determination simply on the remit does not give adequate rationale in a timely manner for follow up and appeal by the provider. Who are we to contact in this matter? Appeals? Claims? Medical Review?

Answer: Typically, MAC processing of a claim adjustment at the request of an outside review contractor (UPIC, SMRC, etc.) will result in the same finalized adjustment as proposed. There are cases where differences will appear, e.g., coinsurance/deductible, may have changed from the time the adjustment was proposed to the time the claim adjustment finalizes. If a provider feels that the claim adjustment was not performed correctly, please contact the PCC at Palmetto GBA. When calling please state the outside review contractor that performed the review. If the PCC is unable to assist the provider, they will connect you with the appropriate area.

10. In a recent UPIC review, we submitted our responses and can see in the system that we have denials, but we've never received a letter from the UPIC. When we called the UPIC, they said we would get letters with instructions to send to our Medicare Administrative Contractor (MAC), but we've never received those. What steps do we need to take to ensure we have an opportunity to appeal if those claims are not paid?

Answer: Based on the question, it appears this issue is related to a PIP provider. Similar to the response to #8, the provider will not receive a demand letter for outside review contractor denials (unless it is RAC). The provider should use the remittance advice as their source of communication and submit the appeal based on information provided by the outside review contractor; in this case the UPIC.

The provider has 120 days from the date of the denial to submit the appeal. If the provider is a non-PIP provider, they will receive a demand letter once the claim adjustment is finalized. If a demand letter has not been received, you can receive a copy of the demand letter via eServices or by reaching out to the PCC.

Medical Review and Targeted Probe and Educate (TPE)

11. A physician signature is not legible on the written CTI and their name is not printed on the form. If the physician completes an attestation statement to affirm that is their signature, will that suffice to avoid a denial based on the signature legibility?

Answer: If the signature is illegible, a signature log, attestation statement or other documentation may be submitted to determine the identity of the author.

Resource: Section 3.3.2.4 — Signature Requirements, Chapter 3 — Verifying Potential Errors and Taking Corrective Actions (PDF, 610 KB).

12. We have several questions related to the various Targeted Probe and Educate (TPE) audits. First let us say that we appreciate the expediency with which Palmetto GBA has reviewed submitted records and issued claim decisions. In addition, we appreciate that medical review staff has called about missing documentation and given us an opportunity to submit it instead of immediately denying the claim.

Answer: We appreciate your feedback.

13. Please provide an update on all hospice TPE audits in process.
a. Number of providers impacted for each audit?

Answer:

- Non-Cancer Length of Stay (NCLOS) – 103
- Continuous Home Care (CHC) – 50
- General Inpatient Care (GIP) – 66
- Hospice Bene Sharing – 76
- RHC – 286

b. How long the audits will continue to add new providers for Round 1?

Answer: As TPE is provider specific, we periodically pull data for each edit to determine if provider behavior changes. Typically, a few new providers are identified as outliers in our reports. We will continually add providers to probe 1 edits as long as the audit remains a problem area for the jurisdiction.

c. Average charge denial rate for any completed audits?

Answer:
• NCLOS — 13.33 percent

- CHC — Providers have not completed edit effectiveness
- GIP — 4 percent
- Hospice Bene Sharing — Providers have not completed edit effectiveness
- RHC — Providers have not completed edit effectiveness

d. Early insight into areas of concern with each of the TPEs?

- Routine Home Care (Reason Code 51HOR)
  - Election Statement did not meet statutory/regulatory requirements
  - M.D. Narrative was not valid
  - Plan of care (POC) does not cover dates of service
- Hospice Bene Sharing (Reason Code 51HSB)
  - M.D. narrative submitted was not valid
  - Election Statement did not meet statutory/regulatory requirements
- NCLOS (Reason Code 51NCL)

    - Medical Necessity – The documentation submitted does not support medical prognosis of six months or less
    - M.D. Narrative submitted was not valid
    - POC does not cover the dates of service
- General Inpatient Care (Reason Code 51GIP)
    - M.D. narrative submitted was not valid
    - POC does not cover dates of service
    - Election Statement did not meet statutory/regulatory requirements
    - General Inpatient Care was not reasonable and necessary

14. Not all hospices received written notification that they had been selected for a TPE audit in advance of receiving ADRs. Therefore, they were surprised to receive 20 ADRs all at once. Can the TPE Notice of Review letter be uploaded to eServices just as the ADRs are?

Answer: Provider notification letters are mailed to the correspondence address listed in PECOS. If providers want correspondence mailed to a different address, we ask that they update their information in PECOS. If a provider contacts Palmetto GBA regarding sending the letter to a different mailing address, our average turnaround time for issuing the secondary letter is one business day. Palmetto GBA encourages providers to register in our portal as we hope to have results and notification letters available within the portal in the near future.

15. Please explain the parameters for TPE audits for providers participating in the Medicare Care Choice Model (MCCM) project. What provides the exemption from TPE audits for hospice and how is that exemption option communicated to MCCM hospices?

Answer: Medicare beneficiaries participating in MCCM have, by definition, not elected the Medicare hospice benefit. As such, hospice specific TPE activities, which are, by definition, aimed at reducing the improper payment rate associated with hospice claims; would not apply to their MCCM claims. MCCM claims are identified when billed with demonstration code 73.

Resource: Medicare Care Choices Model (MCCM) Frequently Asked Questions.

16. We understand that providers are selected for TPE review due to high claim error rates, unusual billing practices, or high reimbursement per beneficiary.
a. For the RHC TPE audit, since hospices are paid on a per diem, is Palmetto GBA looking at the charges submitted by the hospice which includes medications and visits billed? Or is Palmetto GBA looking only at the reimbursement amount if the claim paid?

Answer: Palmetto GBA internal prioritization reports indicate there was a significant increase in dollars at risk as a whole for RHC from previous to current year. Further analysis indicated care provided in certain places of service had a higher percentage of increase in dollars at risk from previous to current year. Providers identified as outliers in these places of services were selected for TPE. Previously published OIG report outlined concerns for place of service and hospice reimbursement.

Resource: OIG Report — Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (PDF, 1.16 MB).

b. We understand that the RHC audit is not based on Non-Cancerous Length of Stay (NCLOS) data. Pleases elaborate on what internal data analysis criteria was used in determining that this reason code be reviewed. What is this review looking to identify or support?

Answer: As noted in above response, Palmetto GBA internal prioritization reports indicate there was a significant increase in dollars at risk as a whole for RHC from previous to current year. Further analysis indicated care provided in certain places of service had a higher percentage of increase in dollars at risk from previous to current year. Providers identified as outliers in these places of services were selected for TPE. Previously published OIG report outlined concerns for place of service and hospice reimbursement.
The medical record review will be conducted to validate that the hospice coverage requirements outlined in CMS IOM 100-02, Chapter 9 have been met for the claims selected for review during the probe. The ADR letter for each claim selected will outline recommended (but not limited to) documentation to submit to support the hospice coverage requirements.

Resource: OIG Report — Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (PDF, 1.16 MB).

c. For those selected for the RHC or G–code audits, does this mean that a hospice's average length of stay (ALOS) is longer than its peers? Otherwise, what would trigger the audit?

Answer: As noted in above response, Palmetto GBA internal prioritization reports indicate there was a significant increase in dollars at risk as a whole for RHC from previous to current year. Further analysis indicated care provided in certain places of service had a higher percentage of increase in dollars at risk from previous to current year. Providers identified as outliers in these places of services were selected for TPE. Previously published OIG report outlined concerns for place of service and hospice reimbursement.

Resource: OIG Report — Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (PDF, 1.16 MB).

17. What constitutes a claim error for purposes of data analysis to determine if an audit is indicated?

Answer: The 2019 Medicare-Fee-For- Service Supplemental Improper Payment Data categorizes errors by types as outlined below.

- Insufficient Documentation
- Medical Necessity
- Incorrect Coding
- No Documentation
- Other

Insufficient documentation accounted for 71.5 percent and 81.7 percent of the errors nationally for non-hospital based and hospital-based hospices respectively. Please refer to 2019 Medicare-Fee-For-Service Supplemental Improper Payment Data for further analysis. Palmetto GBA receives and monitors jurisdiction specific errors assigned at the service and provider level to also assist in prioritization of medical review activities.

a. If a provider submits claims and then later receives their pharmacy invoice, they would adjust claims to add the medication costs as required. Would this type activity be considered an error?

Answer: Making an appropriate correction to a previously billed claim would not necessarily be considered an error. Providers are encouraged to adhere to all billing guidelines as outlined in the Medicare Claims Processing Manual (but not limited to). Billing patterns captured in data analytics that indicate a provider appears as an outlier from how their peers are billing, may prompt further evaluation.

b. Please give an example of other types of claim errors that are reviewed.

Answer: Palmetto GBA reviews reports and error information from CMS and other Government Agencies such as those listed below. See also response to question 18.

- Office of Inspector General (OIG)
- Government Accountability Office (GAO)
- Reports and errors/denials from other Contractors
- Comprehensive Error Rate Testing (CERT)
- Recovery Auditor
- Jurisdiction Specific Prioritization Reports
- Includes historical claim information related to errors/denials from CMS review contractors

Palmetto GBA publishes global error/denial edit information at palmettogba.com. The NLOS edit information can be found at TPE NCLOS.

c. A hospice recognizes that a coding error is causing service intensity add-on (SIA) visits to be reported incorrectly, both overreporting and underreporting, affecting payment. Would it be a red flag for the hospice to adjust the claims? In those type situations should they do a voluntary refund instead for the overpayment?

Answer: A voluntary refund should be returned to Medicare any time an overpayment has been identified by a provider. Overpayments are Medicare funds that a provider, physician/supplier or beneficiary has received in excess of amounts due and payable by Medicare. Once a determination of overpayment has been made, the amount is a debt owed to the United States Government.

Part A and home health and hospice providers are encouraged to submit their own adjustments to correct their claims. This will set up the overpayment and offset the funds due Medicare from the next claim payment.

If the provider is not able to submit their own adjustments, the appropriate voluntary refund form and payment should be submitted.

Voluntary reporting of an overpayment is an action that will usually be viewed as a positive, not a "red flag," by the review contractors.

Resource: Palmetto GBA's Submit a Voluntary Refund Article.

18. Palmetto GBA published a Comparative Billing Report (CBR) for General Inpatient LOS in June 2019. Per the CBR, the State ALOS was 5.4 days and the JM ALOS was 4.9 days. For the GIP TPE, we understand that providers above the 80th percentile were selected for audit. Logic would suggest that the hospice should have received a CBR just three months prior to the TPE pool being determined. If no CBR was received, what would have triggered the hospice to be included in the TPE?

Answer: All criteria for selecting the CBR universe and the implemented edit were not identical. For example, the time period for which data was gathered for the CBR and edit, would have altered the mean for items such as services, charges, reimbursement.

19. A hospice being under multiple TPE audits at one time is extremely burdensome. Many hospices have a single compliance person with no administrative support. Having to coordinate the compilation of medical records internally and externally is very time consuming and pulls staff away from other responsibilities.

While other provider types may have more than one audit at a time, they often are dealing with a single date of service (physicians) or few days of care (inpatient hospital) and they only have to manage their own records. On the other hand, hospices have to address records from multiple disciplines for an entire month of care, and they have to obtain, review and compile records from external providers (ALFs, SNFs, M.D.s, etc.).

Is there CMS guidance that dictates the timing of audits? If not, we respectfully request that Palmetto GBA allow all records from Round 1 of one audit to be submitted before sending a letter and beginning a new TPE audit.

Answer: If a provider/supplier has multiple National Provider Identifiers (NPIs), each NPI could be subject to TPE review. Additionally, if a provider/supplier submits claims to Medicare for more than one item or service, each item/service could be subject to a separate probe as part of the TPE program. Providers/Suppliers and the specific items and services included in the TPE process are those who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers.

While there is not an established timeframe from CMS on when an audit occurs, Palmetto GBA has diligently tried to ease provider burden by trying to limit the number of claims reviewed (TPE minimum 20) and number of edits per PTAN (two).

20. We have been hit with two TPE audits in the last few months and neither are complete. One was for Neuro and the other for routine care. There is very little information and the process is very long and the impacts to cash flow significant. We are a mid-sized hospice with a great reputation and struggle to absorb the cash flow. There is no information provided on the number of patients to be audited because the letter indicates 20–40. At $5000/month per patient with toward two TPE audits – we could be impacted a cash flow hit $400k/month. If a cash flow problem occurs are there any provisions or instructions Palmetto can provide to help hospices through periods of cash crisis?

Answer: Palmetto GBA tries to accommodate providers by various means when we are alerted of burden or hardships. While Palmetto GBA is evaluating each request independently, we must also be able to validate concerns via claims submissions and other parameters. If providers are experience hardships, Palmetto GBA asks that the provider contact the PCC to alert us of said issues. After evaluation of request, Palmetto will contact provider to discuss options for TPE.

21. Are LCDs still being used in consideration of the TPE audits?

Answer: Yes, reviewers refer to applicable LCDs, NCDs and coverage policies during the TPE review process. Please refer to LCDs, NCDs and Coverage Articles at palmettogba.com.

22. What are the common hospice questions in your Hot Topic Targeted Probe and Educate Teleconferences? Are these topics changing from quarter to quarter?

Answer: The questions and answers are published after each call at palmettogba.com. December 2, 2019 can be found at December 2, 2019 TPE Hot Topic Q&A.

The December 2, 2019 call began with a presentation covering the TPE process. The presentation was published to the event portal in advance of the call and is now published at TPE Presentation (PDF, 112 KB).

23. Can a program like “DocuSign” be used to obtain an electronic signature for the Election Statement for the Medicare Hospice benefit?

Answer: Yes. As long as it is still scribed by the beneficiary or representative, in ink or on a device (tablet, etc.), it’s acceptable.

Not acceptable would be a typed name and a check box stating, “electronic signature”. The DocuSign signatures we are receiving are digital handwritten signatures and those are acceptable for the beneficiary or representative to use.

Levels of Care

24. Is it acceptable for a patient to be GIP in our inpatient facility and then transition into a Respite stay at the IPU when the caregiver is requesting Respite? The family needs more time for further discharge planning such as preparing the house, getting additional caregivers lined up, etc. In addition, they are exhausted from being at the IPU while the patient was unstable.

Answer: Respite care is not intended for scenario, but is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may only be provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility.

Resources: 40.2.2 — Respite Care and 40.1.5 — Short-Term Inpatient Care, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB).

25. Is it appropriate to use respite for a patient in a home situation where there is drug diversion in an attempt to identify with a safer plan in the home?

Answer: Respite care is not intended for scenario, but is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.

26. Could the hospice place the patient in respite more than once that benefit period?

Answer: Yes. A patient can have more than one respite stay per billing period, if respites requirements are meet.
When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed five (5) days, including consecutive respite periods.

Resource: 30.3 — Data Required on the Institutional Claim to A/B MAC (HHH), Chapter 11 — Processing Hospice Claims (PDF, 466 KB).

Discharge or Revocation

27. When a patient is discharged or revokes, what time is the change effective? Is that up to the patient and/or hospice? How does Medicare know the time a patient was discharged so that other providers can bill that same day? Here are situations that prompt the question:

a. A patient chooses aggressive treatment and will receive chemotherapy which is considered aggressive and not part of the hospice plan of care. The patient wants to revoke the same day they will begin chemo. Is it an acceptable practice for the patient to revoke and begin treatment the same day? Will the oncologist be paid without difficulty?

Answer: Yes, a patient may revoke the hospice benefit and begin treatment on the same day. Another provider type may be paid without hospice overlap issues as long as a valid hospice discharge claim has processed and posted a revocation indicator on the election.

Resource: 40.1.9 — Other Items and Services, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB) (see ambulance example).

b. A patient is being placed in a nursing facility in another town and the facility is non-contracted with the hospice and the patient does not want to transfer to another hospice. The first question is, do we discharge due to being out of service area or does the patient revoke? Out-of-service-area discharge seems very appropriate, but the patient needs stretcher transport, which will incur costs, so perhaps a revocation is cleaner and then the hospice is not responsible for the transport charge. Again, would this decision be up to the hospice? And would the ambulance company be eligible for reimbursement if the patient is discharged from hospice in the middle of the day?

Answer: The hospice may discharge patients for "Out of Hospice Service Area" when they relocate or go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice. Services which occur prior to the initial assessment, prior to the plan of care's development and after the discharge is completed are not the responsibility of the hospice.

Resources

- 30.3 — Data Required on the Institutional Claim to A/B MAC (HHH), Chapter 11 — Processing Hospice Claims (PDF, 466 KB)
- 40.1.9 — Other Items and Services, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB) (see ambulance example)

c. For a discharge due to no longer terminally ill, does this have to be effective at midnight the day of discharge or is it up to the patient/hospice?

Answer: Medicare does not mandate a discharge time. Factors for time of discharge must be in the discharge planning process to include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Resource: 20.2.3 — Hospice Discharge, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB).

Other

28. If a face-to-face visit for a current patient is missed, are we required to have the patient complete a new election statement along with the initial and comprehensive assessments?

Answer: Yes. When a discharge from the Medicare hospice benefit occurs due to failure to perform a required face-to-face encounter timely, 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) files an election statement in accordance with CMS regulations.

The timeframes for assessments are:

- A hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24.
- The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than five (5) calendar days after the election of hospice care in accordance with §418.24.

Resource: 20.1 — Timing and Content of Certification, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB).

29. How can a provider receive one-on-one assistance outside calling the call center or using Palmetto GBA's eServices?

Answer: Palmetto GBA prefers that all inquiries come through the PCC as all MACs are required to track all provider contacts in their inquiry tracking system for end of month reporting to CMS. Once a provider has made contact with the PCC, if the Customer Service Representative is unable to assist you, you may be transferred to a supervisor or manager based on their availability. Palmetto GBA offers secure web chat via the website or eServices provider portal, email or telephone inquiries.

For providers that have a large number of complex inquiries each week (defined as more than 25 issues), Palmetto GBA offers concierge service for those providers. Providers are required to submit issues one week in advance of a scheduled teleconference call to allow for research prior to the teleconference call.

The Palmetto GBA Provider Outreach and Education (POE) team offers many educational opportunities tailored to meet the needs of the health care providers we support. You submit an Education Request Form (PDF, 83 KB) for education. This form is for education requests only. You will not be contacted by POE if this form is used for general inquiries.

30. During emergency events, can costs to provide services be sent to the Emergency Management Agency (EMA) for reimbursement? For instance, a patient receives respite during a disaster. Should hospice bill the EMA instead of billing respite to Medicare?

Answer: Agencies should continue to bill Original Medicare for services provided to beneficiaries who meet the requirements of the Medicare Hospice Benefit. Palmetto GBA cannot answer possible reimbursement the EMA.

Old Business

31. Clarification to answer 6B from the June 13, 2019, Hospice Coalition Questions and Answers. We received a few inquiries about it and feel this update is necessary.

6b. Should we have the patient choose the hospice physician as their attending M.D. instead? If so, do we need to do a change of attending form Monday when the physician is back in the office and agrees to be attending? Or can we just leave it as the hospice physician?

Answer: The hospice can offer a hospice physician as an attending M.D., but cannot choose for the patient. The patient's decision to change their choice of attending physician or to not have one should be documented on a change of attending form.

Resource: 40.1.3.1 — Attending Physician Services, Chapter 9 — Coverage of Hospice Services Under Hospital Insurance (PDF, 640 KB).

32. On November 1, 2019, CMS policy ruled that there's nothing prohibiting, when provided, a hospice from billing Advance Care Planning (ACP) codes on a hospice claim. ACP codes are payable in hospice when not part of the AWV. CMS also stated that they would revise the ACP information in Chapter 18 — Preventive and Screening Services of the Medicare Claims Processing Manual to include a hospice reference of coverage.

Next Meeting: June 18, 2020.