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Hospice Top Claim Errors

4/24/2024

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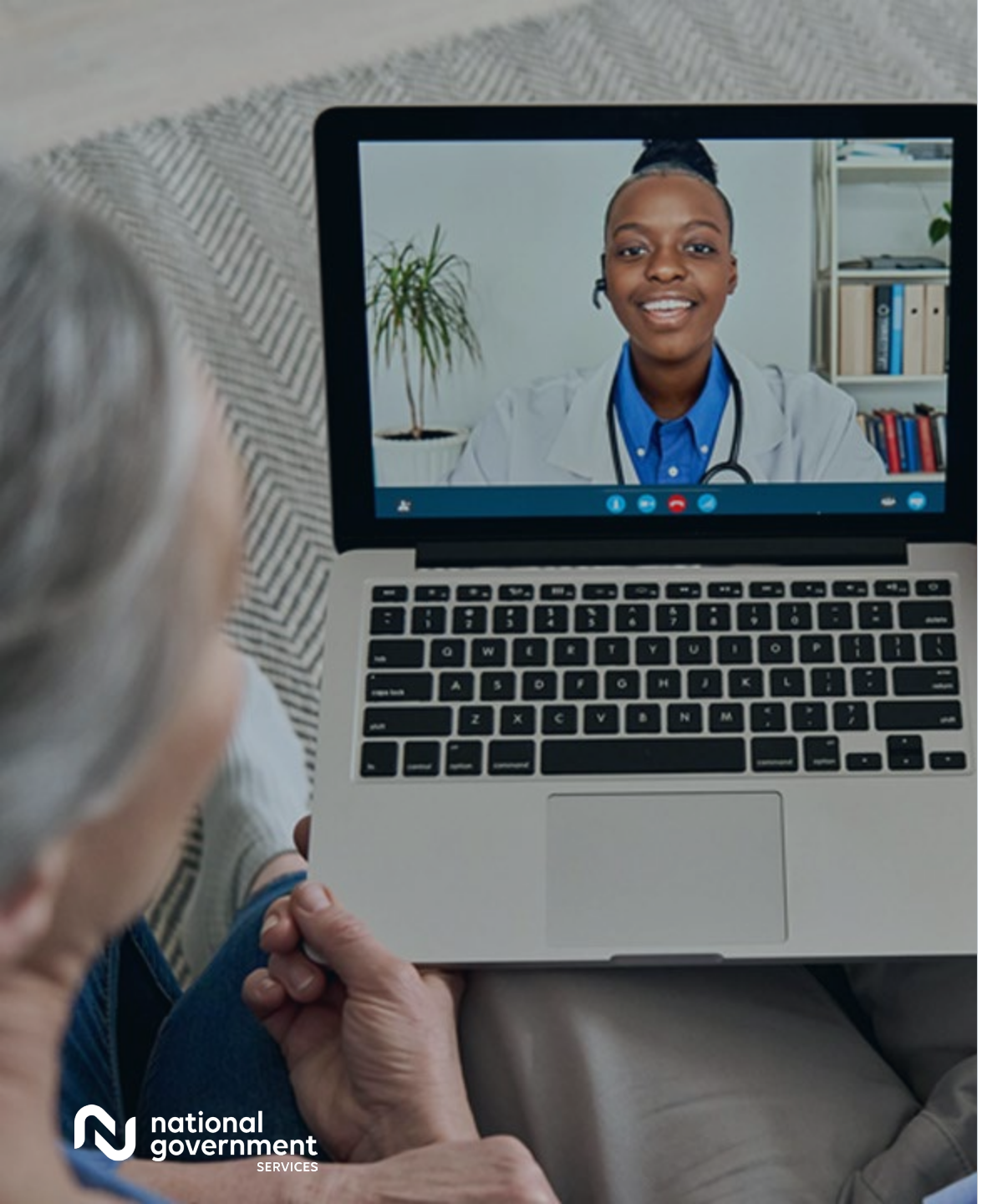

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Objective

Attendees will understand which top rejection and return to provider (RTP) reason codes have recently been assigned to hospice claims. Attendees will also know how to correct the reason code errors and understand the billing guidelines behind the Notice of Election and hospice claims.

Today's Presenter

NGS PROVIDER EXPERIENCE
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- Christa Shipman
  - Provider Outreach and Education Consultant

Agenda

Billing Reminders

Top Rejection Reason Codes

Top Return to Provider (RTP) Reason Codes

Resources

Q&A

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Billing Reminders

Notice of Election

- Purpose: open hospice election period in the Common Working File (CWF) so other providers will note the beneficiary has elected hospice, which in turn prevents inappropriate Medicare payment to non-hospice providers for services related to terminal diagnosis
- Once initial election processed, the CWF maintains beneficiary in hospice status until death or until election termination is received
- Considered timely-filed if received and accepted by MAC within five calendar days after hospice admission date
  - Has receipt date within five calendar days after hospice admission date
  - NOE is processed and has status/location of P B9997
  - NOE is not returned to hospice for corrections
- Medicare will not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted and accepted by the MAC
  - These non covered days are provider liable

Some Things to Keep in Mind…

- Claims can only be submitted after the NOE has processed
- All services provided to the patient by the hospice related to the terminal condition must be submitted on the hospice claim
- Claims must be billed monthly and sequentially
- Claims not submitted in order (sequentially) will be returned
  - There can be no gaps in days billed for sequential claims
- All hospice claims must be billed to Medicare, including patients in a VBID MA plan, and those who have Medicare as a secondary payer
- Hospice claims are subject to one year timely filing

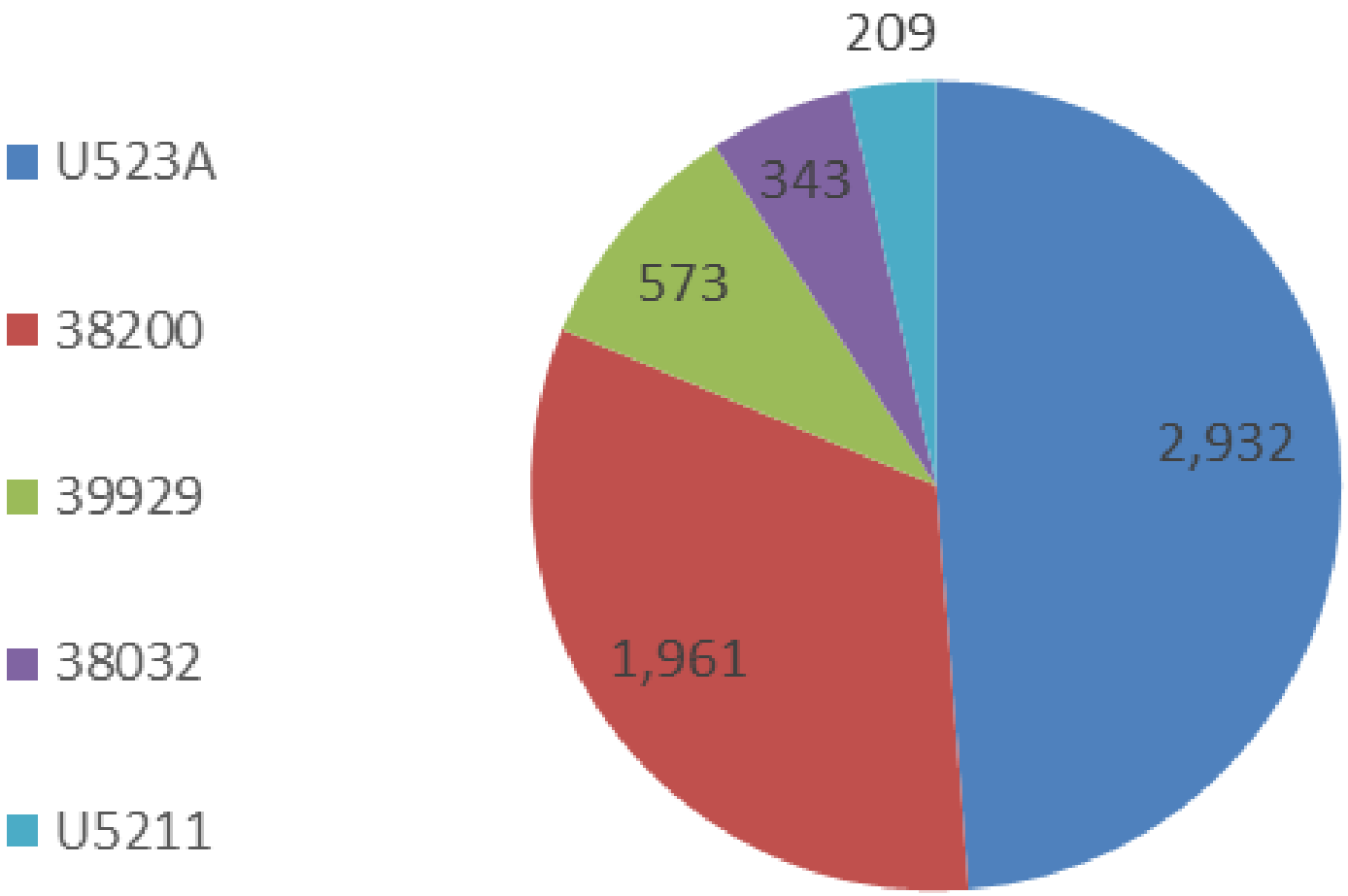
Claim Status/Locations

- Rejections (R B9997)
  - Claims need to be resubmitted
  - In limited situations, claims need to be adjusted

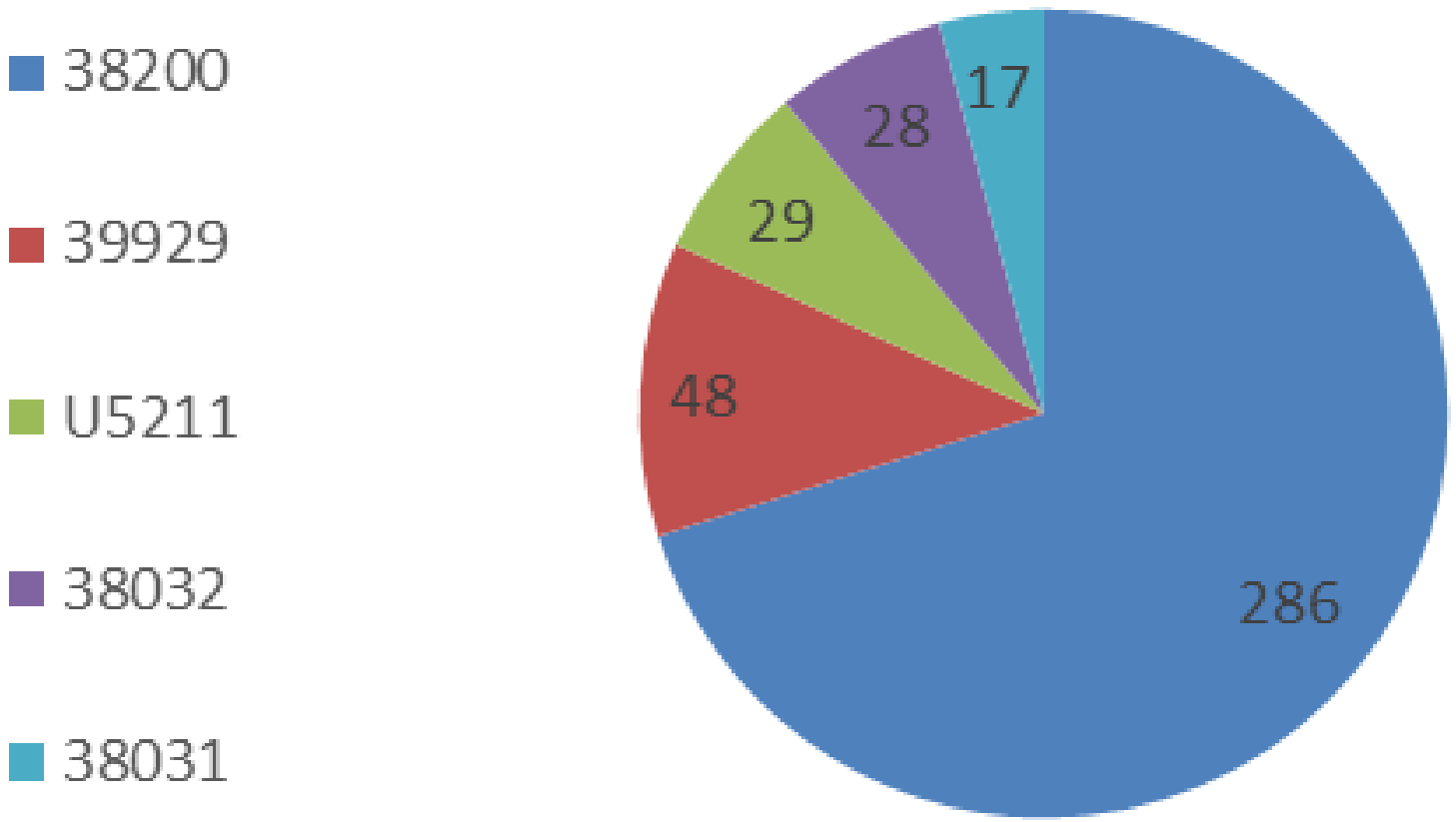
- Returned to Provider (T B9997)
  - Claims need to be corrected and resubmitted

Top Rejection Reason Codes

Top 5 J6 Hospice Rejections



Top 5 JK Hospice Rejections



Rejection Reason Code U523A

RC Narrative: The dates of service are during both a hospice election period and a Medicare Advantage (MA) Plan's period that is in the VBID model.

Background on Reason Code U523A

- The Value-Based Insurance Design (VBID) Model allows for a hospice benefit component
- Currently, when a hospice patient in an MA plan, the Original Medicare plan is responsible for
  - Hospice services provided and billed by a Medicare hospice,
  - Services of the patient's attending physician if the physician is not employed by or under contract with the Medicare hospice
  - Services not related to the treatment of the terminal condition for which the patient has elected hospice
  - Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again (i.e., the first day of the month after the beneficiary has revoked their hospice election)

Understanding Reason Code U523A

- A beneficiary in Original Medicare enrolled in hospice may choose to enroll in a VBID Model-participating plan
  - Original Medicare payments will be made for the new enrollee's care until MAO coverage begins on the first of the month following the new enrollee's request to enroll in the participating plan
  - At the start of the enrollee's new coverage with the Model-participating MAO, all hospice and non-hospice services must be covered by the Model-participating MAO
  - Payment to the Model-participating MAO will be aligned with existing Model guidance on hospice capitation payments, and will also begin with the start of MA coverage
- Hospice providers must continue to send all notices and claims to both the participating MAO and the relevant MAC on a timely basis
  - MAO will process the claim for payment
  - Original Medicare claim will process for informational and operational purposes and reject with RC U523A

Rejection Reason Code 39929

RC Narrative: Each line of charges on this claim has rejected and/or rejected and denied.

- Background/Correction:
  - When line items are assigned different reasons for rejection, the line level reason code will assign 39929, and the line information is found within the claim
  - Review line level rejection information to determine the rejection for each line of the claim
  - Access MAP171D for line item detail information
    - ✓ Hit F2 once or F11 twice from page two of the claim to access MAP171D in DDE
    - ✓ Hover over reason code in the line details in NGSConnex

Rejection Reason Code 38200

RC Narrative: This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same:

- HIC Number
- TOB (all three positions of any TOB)
- Provider number
- Statement from date of service
- Statement through date of service
- Total charges (0001 revenue line)
- Revenue code
- HCPCS and modifiers (if required by revenue code file)

Background/Correcting Reason Code 38200

- FISS will only accept one original billing for the statement dates being billed
- This code is assigned when a processed claim is in the FISS history file
  - Any claim billed with the same information will reject as a duplicate
- Verify billing already submitted
  - Check remit, NGSConnex, or FISS/DDE

Rejection Reason Code U5211

RC Narrative: The statement from/thru date is greater than the date of death on beneficiary master record

- The claim through date cannot go beyond a patient's date of death

Correcting Reason Code U5211

- Review the beneficiary's eligibility record to determine the date of death on file
  - If the date of death is correct, submit an adjustment (type of bill XX7) to your claim, ensuring the 'To' date of the claim and the line item dates of service do not overlap the date of death on file
  - If the date of death is incorrect, contact the Social Security Administration to advise of the incorrect date of death
    - ✓ Monitor the beneficiary's eligibility file for the date of death to be corrected
    - ✓ Once corrected, submit an adjustment (type of bill XX7) to your claim.
      - Do NOT adjust your claim until the incorrect date of death has been corrected or removed

Rejection Reason Code 38031/38032

RC Narrative: The outpatient claim is a duplicate of a previously processed outpatient claim. The following situations exist:

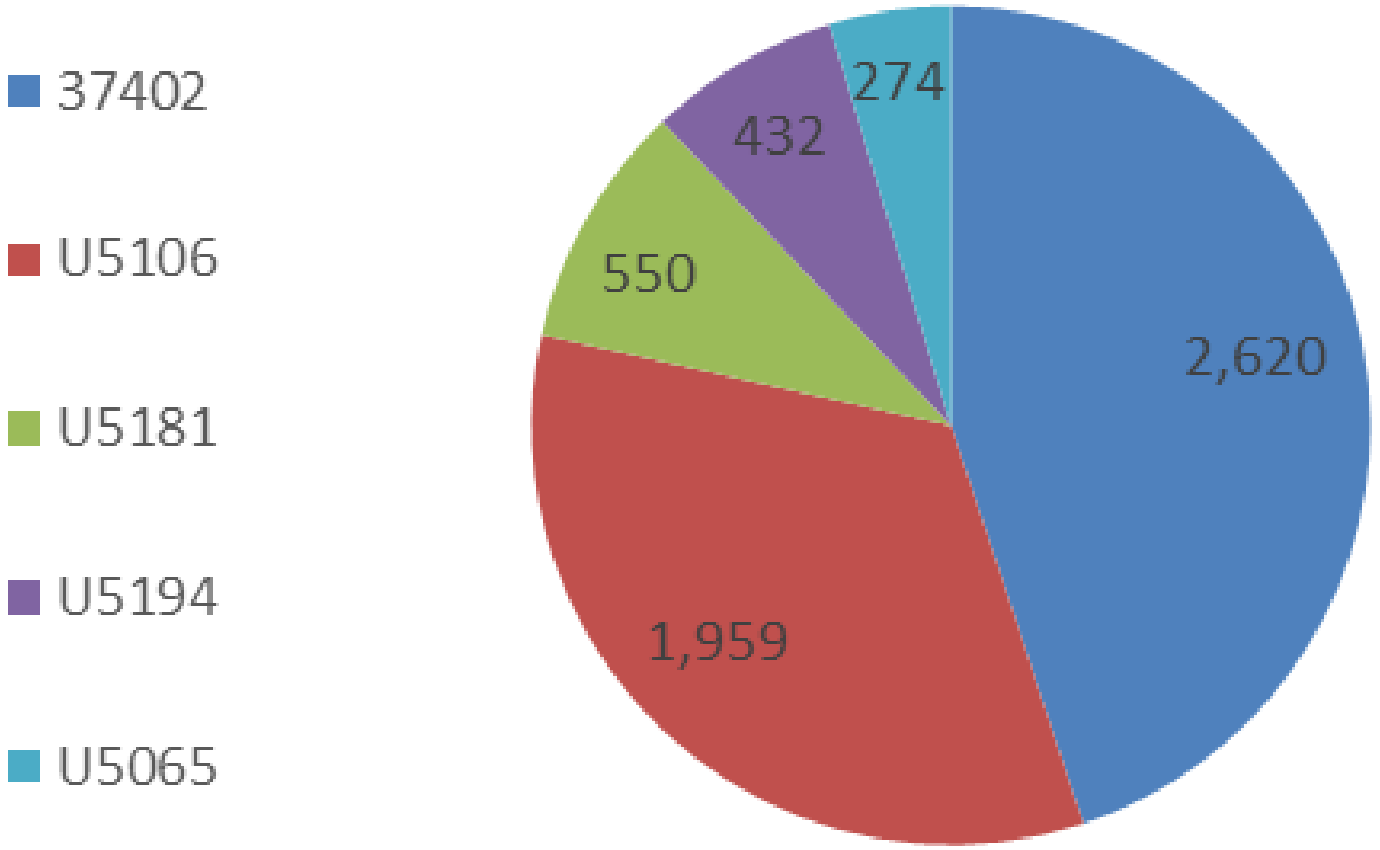
- The ‘statement covers period’ is the same on both bills
- Provider numbers are the same
- At least one revenue code matches
- At least one diagnosis code matches
- Non-pay indicator not “R” and tape to tape flag is not “X”, “Y”, or “Z”
- At least one HCPC code is the same on both claims

Correcting Reason Code 38031/38032

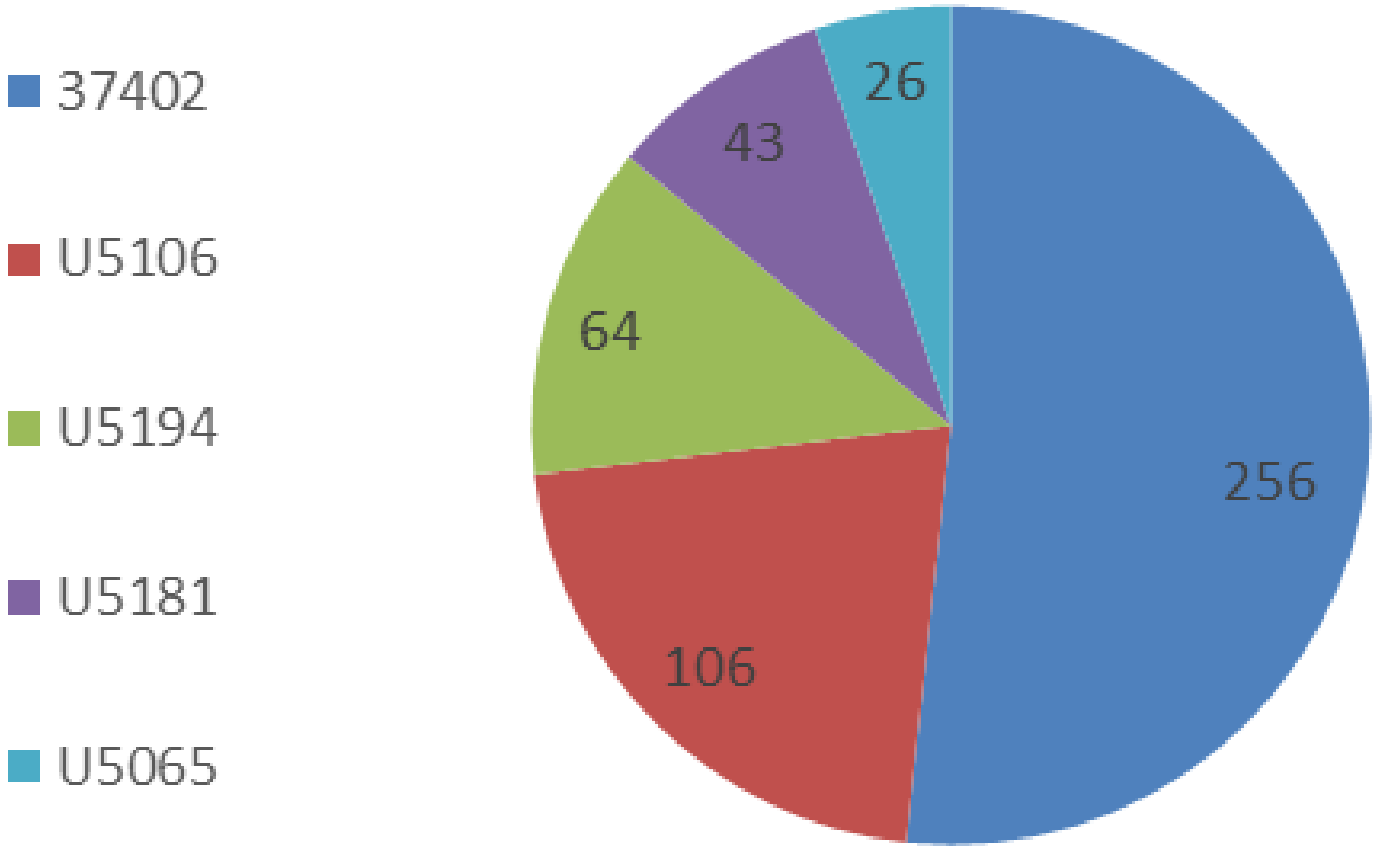
- Develop and implement a process to ensure that duplicate claims are not being submitted
  - If the claim is truly a duplicate, no action is necessary
  - If this is not a duplicate and you are trying to add information to the original claim, submit an adjustment to the processed claim

Top RTP Reason Codes

Top 5 J6 Hospice RTPs



Top 5 JK Hospice RTPs



RTP Reason Code 37402

RC Narrative: Hospice claim (81X or 82X) with from date greater than 04/01/98 and there is no claim with TOB 81X or 82X whose thru date is exactly one day less than this claim's from date.

Background/Correcting Reason Code 37402

- Hospice claims must be submitted sequentially per calendar month billing (not a thirty-day billing period)
  - The previous month's claim must process and finalize before the next month's claim will process
    - ✓ FISS will search the claim history for a prior a claim; there cannot be any skipped dates between the 'To' date and the next month claim's 'From' date
  - When sequential billing requirements are not followed, the claim will RTP; if the prior claim is in the RTP file and needs correcting, that claim must be corrected and finalized before the subsequent claim can be submitted
- Verify the previous month's claim is submitted and in a finalized location prior to billing the subsequent claim
- Verify dates billed are correct and there isn't a gap in the dates billed

RTP Reason Code U5106

RC Narrative: Hospice NOE received to add a new election period with a start date which falls within a previously established hospice election period.

Background/Correcting Reason Code U5106

- The NOE and/or claims post hospice elections and benefit periods to CWF
- There cannot be another NOE submitted that overlaps an already established election/benefit period
- Ensure the NOE is not a duplicate of a previously submitted or processed NOE
- Before submitting an NOE, review the hospice benefit periods (via the IVR, HETS, or NGSConnex) prior to billing to ensure the 'Admit' date on the NOE being submitted is not within the 'Start Date' and 'Term Date' of the benefit period in CWF

RTP Reason Code U5181

RC Narrative: Per the CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 11, Section 30.3, occurrence code 27 is reported on the claim for the billing period in which the certification or recertification was obtained. Therefore:

- If the certification/recertification was done prior to the service dates on the claim, an occurrence code 27 is not appropriate – or
- When the claim dates of service are spanning a current election period, the occurrence code 27 date must equal the start date of the next election period. (Note that the occurrence code 27 date will create the next election period if one is not currently present.) – or
- If billing an occurrence code 27 date for a late recertification, an occurrence span code 77 must also be present for the days that are prior to the late recertification date.

Background/Correcting Reason Code U5181

- Hospices use occurrence code (OC) 27 and the date of election on all NOEs and initial claims following a hospice election.
- OC 27 and the date are also required on all subsequent claims when the claim's dates of service overlap the first day of the next benefit period.
- When OC 27 is required, but not reported, or does not include the correct date, the NOE or claim will receive this reason code.
- Ensure OC 27 is submitted on the NOE; OC 27 date **must match** the 'From' date and 'Admit' date on the NOE

RTP Reason Code U5194

RC Narrative: A hospice NOE with an admission date on or after 10/1/2014 must be received within five calendar days after the effective date of the hospice election. An initial hospice claim (where the from date matches the admit date) has been received where the NOE was not received timely and OSC 77 is either missing or contains invalid dates.

Background/Correcting Reason Code U5194

- The hospice notice of election (NOE) must be received within five calendar days after the effective date of the hospice election.
- When the NOE is not received timely, Medicare will not cover/pay for days of care from the admission date to the date the NOE was submitted/accepted.
- Ensure OSC 77 is reported to identify the span of dates from the date of admission to the date before the NOE was received.
  - All services/charges related to the non-covered days need to be reported as non-covered.

- Note: In order to calculate the five calendar days, day one is the day after the admission date – count five days from that date. E.g., Admission date is 03/10/YY; Day 1 is 03/11/YY, which means Day 5 (the NOE due date) is 03/15/YY.

RTP Reason Code U5065

RC Narrative: The claim from date is prior to the MBI effective date on CWF Xwalk file and the MBI is the oldest occurrence in the HICXWALK file for the beneficiary at CWF.

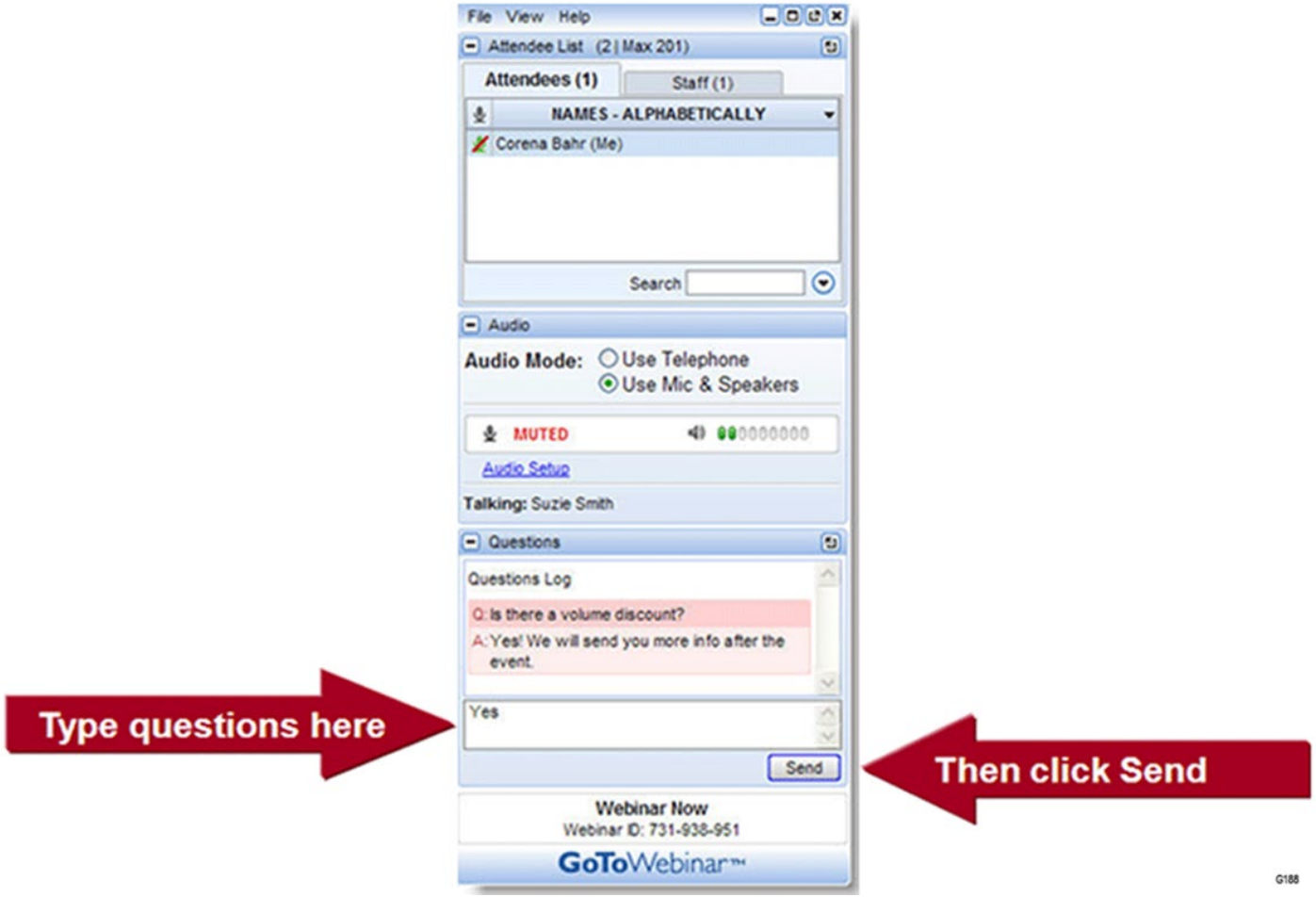
- Hospices may only bill services provided to the patient after the effective date of their Medicare coverage.

Correcting Reason Code U5065

- Verify the effective date(s) for the MBI of the beneficiary prior to billing
- If a new MBI has been issued to the beneficiary, all claims after the effective date of the new MBI must be submitted with the new MBI
  - Dates of service before the MBI change date – use old or new MBIs
  - Span-date claims with a “From Date” before the MBI change date – use old or new MBIs
  - Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs

Resources

Ask a Question Using the Question Box



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- NGS website
- Events
  - Upcoming education sessions
  - Past events material
- Education
  - Medicare Topics
    - ✓ Hospice Billing (job aids)
- Top Claim Errors

CMS Resources

CMS website

- CMS IOM Publication 100-02, Medicare Benefit Policy Manual (cms.gov)
  - Chapter 9 (Coverage of Hospice Services Under Hospital Insurance)
- CMS IOM Publication 100-04, Medicare Claims Processing Manual (cms.gov)
  - Chapter 11 (Processing Hospice Claims)
- Medicare Learning Network (MLN home page | CMS)
  - Resource Materials
  - Training
  - MLN Matters Articles
- Hospice Center | CMS

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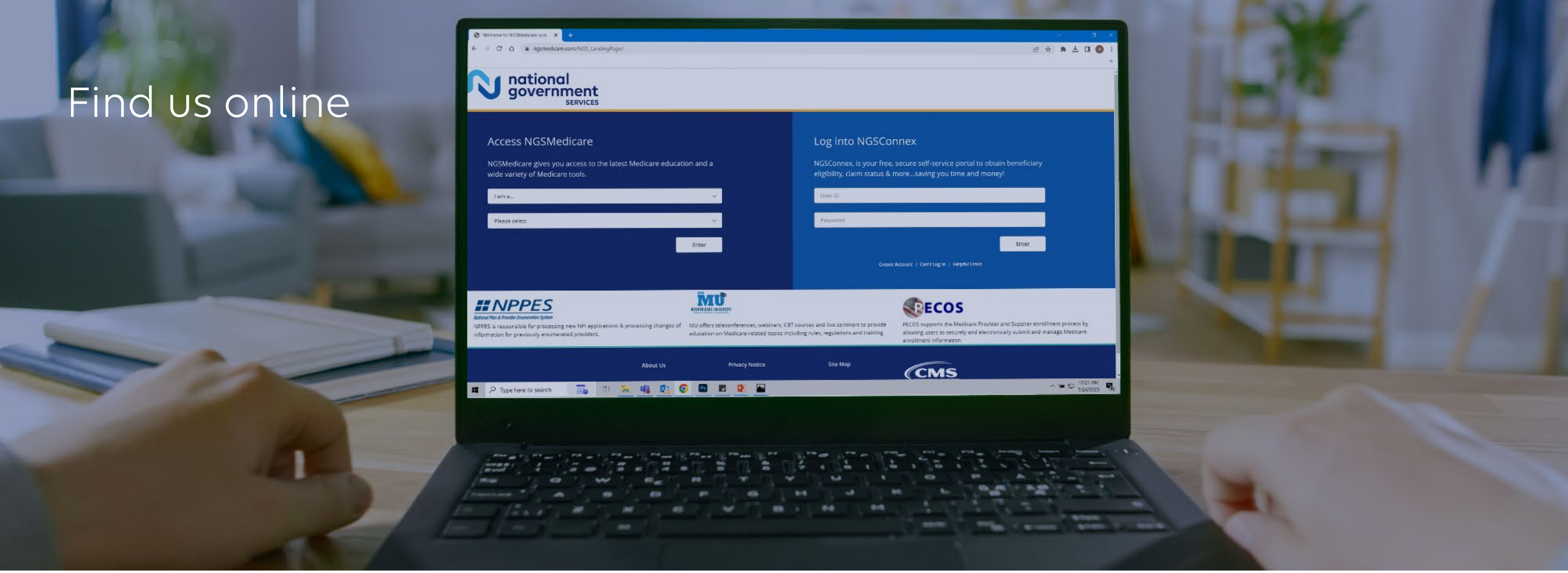

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