

FOREWORD

A. Function of the Hospice Manual.-- This manual makes available to the hospice in a form suitable for ready reference, informational and procedural material needed for the prompt and accurate filing of claims for services furnished under the provisions of the Health Insurance for the Aged Act (Medicare). It also contains information the hospice may need to answer questions which patients often ask about the program and should help to assure that the law is applied nationally without regard to where covered services are furnished. The hospice's intermediary will issue any necessary additional instructions on matters which concern the relationship between the hospice and the intermediary.

B. Contents and Organization.--

1. Contents.-- The manual provides instructions for implementation of the provisions of Medicare law and regulations particularly as they relate to the hospice benefits. It amplifies the basic statutory provisions for coverage of services and the requirements which must be met for Medicare payment to be made. The procedures and documentation required have been devised to satisfy the administrative needs of the program.

2. Organization. -- Four chapters are included in the manual.

a. Chapter 1 -- General Information About the Program.-- This chapter contains a brief description of the scope of the hospice program and the requirements for beneficiary entitlement, and a description of the financing and administration of the Medicare program.

b. Chapter 2 -- Coverage of Services.-- This chapter details those services reimbursable to hospice under the Medicare program and outlines the requirements for payment.

c. Chapter 3 -- Admission and Billing Procedures -- This chapter provides instructions for the preparation and submission of the hospice admission notice, and the provider billing form.

d. Chapter 4 -- Payments -- Guidelines are provided for computing the payment for services furnished by hospices.

A table of contents for each chapter provides designated section heads. A detailed index will be provided at a later date to facilitate locating specific information.

C. Hospice Manual Revisions -- The manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, supplements and revised sections, pages, or chapters are issued as the need presents itself. Changed material will be indicated in the left margin of a page in the following manner:

Line on which change begins.

Line on which change ends.

The revision transmittal sheet identifies new page numbers and the pages replaced and summarizes the principal changes in the material being issued. When a major change in policy or procedures is involved, the background and effective date for the change is provided. If, at a later date, you wish to refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

D. Use of the Revision Transmittal Check Sheet.-- Immediately after the title page, a check sheet has been provided on which receipt of revisions can be recorded. Revised manual transmittals should be filed in transmittal number order to avoid discarding a more recent page in favor of an older one.

If it appears that you have been skipped in the distribution of a particular transmittal, the transmittals are not always distributed in strict numerical sequence. Allow 10 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.

E. Effective Dates for Hospice Manual Issuances.-- Hospice Manual transmittals specify whether the material involves a change in policy or procedures, new policy or procedures, or simply a clarification of existing policy or procedures. For new laws or policies or procedures or changes in the old, the transmittals also specify the effective date, which indicates at which point in the adjudicative process the policies apply. New policies or procedures or changes in the the old almost invariably carry prospective dates. However, a proposed policy issuance which corrects a prior stataement of policy may be given retroactive effect to be specified on the transmittal. A clarification is intended only to improve the understanding of policies that are in effect and an effective date is not specified.

F. Intermediary as Information Source -- Your intermediary will answer any questions you may have about Medicare policies and procedures.

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Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs--hospital insurance (HI) (Part A) and supplementary medical insurance (SMI) (Part B).

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services (DHHS) to the Administrator of the Health Care Financing Administration (HCFA). Congress has provided substantial administrative roles for the State and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine or the manner in which medical services are provided. The patient is free to choose any participating institution, agency, or person offering services. The responsibility for treatment and control of care remains with the individual's physician and the hospice or other facility or agency furnishing services. The individual may keep or obtain any other health insurance he/she desires.

102. FINANCING THE PROGRAM

Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund which is used for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits for persons who are not Social Security or Railroad Retirement beneficiaries are financed by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B (SMI) is financed by monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

104. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program (e.g., hospitals, skilled nursing facilities (SNFs), hospices, home health agencies (HHAs), outpatient physical therapy (OPT), comprehensive outpatient rehabilitation facilities (CORFs), occupational therapy and speech pathology providers, and end-stage renal disease (ESRD) facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of the Act, a participating provider is prohibited from making a distinction in the treatment of patients on the ground of race, color, or national origin, in the use of equipment, other facilities, or in the assignment of personnel to provide services.

The DHHS is responsible for investigating complaints of noncompliance.

106. FRAUD AND ABUSE - GENERAL

Sections 106 - 106.3 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

108. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The DHHS has overall responsibility for administering the hospital insurance and voluntary SMI program. Two major agencies are involved -- HCFA and the Public Health Service.

108.1 The Health Care Financing Administration.--Is responsible for policy formulation. The central and regional offices are responsible for the general management and operations of the program. In brief, HCFA's responsibilities include the following:

- o Determining an individual's entitlement to benefits in consultation with the Social Security Administration (SSA);
- o Determining the nature and duration of services for which benefits may be paid;
- o Establishing, maintaining, and administering agreements with State agencies, providers of services, and intermediaries;
- o Formulating major policies regarding conditions of participation for providers (except SNFs) in consultation with the Public Health Service;
- o Developing and maintaining statistical research and actuarial programs;
- o Managing general finances of the program; and
- o Determining reasonable costs and amounts to be paid to providers, physicians, and suppliers.

108.2 The Public Health Service.--Is responsible for administering the professional health aspects of the program. In brief, their responsibilities include the following:

- o Consulting and recommending to HCFA the health and safety standards and other guidelines needed for determining whether providers of services meet the conditions of participation under the program;
- o Consulting and advising State agencies concerning the application of standards for providers; and
- o Coordinating programs and activities necessary in studying the utilization of hospice and other medical care services under the program.

110. STATE AGENCIES.

The States, by agreement with the Secretary, are assigned administrative functions to the extent that each is willing and capable of discharging such responsibilities.

A. Certification-- Institutions desiring to participate in the Medicare or Medicaid programs must meet participation conditions for certification. State agencies certify to the DHHS whether hospices, hospitals, SNFs, HHAs, independent laboratories, portable X-ray facilities, and other types of institutions satisfy, and continue to satisfy, health care quality requirements for participation in the Medicare program.

The State function of making certifications is intended to be a natural adjunct to ongoing State activities (such as the licensing of health care facilities and the setting of State standards for institutional and health care).

B. Consultation-- A State consults with providers of services that need and request participation condition assistance. This is an integral part of the certification process.

120. ROLE OF PART A INTERMEDIARIES

The Part A intermediary is an organization that has entered into an agreement with the Health Care Financing Administration to process Medicare claims for providers of services, e.g., hospitals, hospices, skilled nursing facilities (SNFs), outpatient physical therapy (OPT) and speech pathology providers, comprehensive outpatient rehabilitation facilities (CORFs) and rural health clinics.

Intermediaries make payments to providers, assist providers in the development and application of safeguards against unnecessary use of covered services, furnish consultative services to providers to enable them to establish and maintain the requisite fiscal data, serve as a center for and communicate to providers information or instructions furnished by the Secretary, conduct audits of provider records, and assist in the appeals process. They also provide information and advice to any institution, facility or agency that wishes to qualify as a provider of service.

125. ROLE OF PART B CARRIERS

The law authorizes the Secretary to enter into contracts with organizations to serve as carriers in the operation and administration of the non-provider Part B program. This includes determining the amount of payment made to physicians and suppliers. Other major functions include, for example, controlling overutilization of covered services, communicating with the health care community and beneficiaries with respect to matters pertaining to the Part B program, and establishing and maintaining procedures for the beneficiary hearings process.

Provider Participation in Medicare

130. DEFINITION OF PROVIDER

A. Providers of Service.--A provider of services (or provider) is a hospital, SNF, home health agency (HHA), CORF, hospice, and for the limited purpose of furnishing OPT or speech pathology services, a clinic, rehabilitation agency, or public health agency which meets the applicable eligibility requirements of title XVIII of the Act and regulations issued thereunder (e.g., the conditions of participation). Title XVIII distinguishes providers (institutions which care for patients awaiting, receiving or recuperating from treatment by medical practitioners) from suppliers and uses the term "suppliers" to include therapists, practitioners and certain non-providers who furnish supplementary health services, e.g., laboratories and chiropractors.

B. Participating Providers.--To be a participating provider, a provider must be in compliance with applicable provisions of title VI of the Civil Rights Act of 1964 (see §104) and must enter into an agreement that it will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts and that it will return any money incorrectly collected from the individual or other person on his/her behalf or make such other dispositions as are required. A provider may establish restrictive admission criteria if these apply only to non-Medicare patients or equally to non-Medicare and Medicare patients.

A provider which has executed an agreement becomes qualified to participate when the agreement is accepted. For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a recordkeeping capability sufficient to determine the appropriate Medicare payments.

132. TERM OF AGREEMENT WITH HOSPICE

An agreement with a hospice is not time limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary or involuntary termination.

132.1 Advance Directive Requirements.--Effective December 1, 1991, participating hospices must comply with the advance directive provisions of §4206 of OBRA 1990. Therefore, an agreement per §1866 of the Act with a hospice includes that the hospice must, in accordance with written policies and procedures, for all adult individuals: inform them, in writing, of State laws regarding advance directives; inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that State law permits, for a hospice or any agent of a hospice that, as a matter of conscience, cannot implement an advance directive); document in the individual's medical record whether the individual has executed an advance directive; not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require an individual to do so); and educate staff and the community on issues concerning advance directives.

140. INTERMEDIARY DESIGNATIONS

A. Designated Hospice Intermediaries.--HCFA has designated regional intermediaries to service hospices. In the case of a hospice based in another Medicare provider (e.g., a hospital or SNF), the designated regional intermediary processes bills and makes payments. Audit, cost report settlement and other fiscal functions are performed by the intermediary serving the parent provider.

EXCEPTION: A hospice that as of June 20, 1988 was receiving payment from a designated regional intermediary may continue to be served by that intermediary even if that intermediary is not the designated regional intermediary or the alternative designated regional intermediary for the particular State in which the hospice is located.

Following are the regional intermediaries designated to service hospices in their respective jurisdictions.

- Associated Hospital Service of Maine--Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

- Independence Blue Cross (Philadelphia)--Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia.

- Blue Cross and Blue Shield of South Carolina--Kentucky, North Carolina, South Carolina, and Tennessee.
- Aetna Life and Casualty--Alabama, Florida, Georgia, and Mississippi.
- Blue Cross and Blue Shield United of Wisconsin--Michigan, Minnesota, New Jersey, New York, Puerto Rico, the Virgin Islands, and Wisconsin.
- Health Care Service Corporation (Chicago, Illinois)--Illinois, Indiana, and Ohio.
- New Mexico Blue Cross and Blue Shield, Inc.--Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.
- Blue Cross of Iowa, Inc.--Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming.
- Blue Cross of California--Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada, and Washington.

B. Alternative Designated Regional Hopice Intermediaries.--If you do not wish to receive payment from a regional intermediary, you may submit a request to your HCFA regional office (RO) to receive payment through an alternative regional intermediary designated by HCFA. The request must be submitted in writing to the regional office at least 120 days (but not more than 180 days) before the end of the current fiscal year. The request should be signed by an authorized representative and explain why service by the alternative regional intermediary is being requested. Send a concurrent written notice of the request for a change of intermediary must be sent to your intermediary.

Since changes of intermediary can be costly and disruptive to the program, HCFA determines, based on the reasons given and other pertinent factors, if a change to the alternative designated regional intermediary is warranted and would contribute to more effective and efficient program operations. Where HCFA approves of the change, it becomes effective on the first day following the close of the fiscal year in which you gave timely notice.

o Following are the alternative designated regional intermediaries and their respective jurisdictions:

- Blue Cross of Iowa, Inc.--Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota,

- Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, the Virgin Islands, Virginia, Washington, West Virginia, and Wisconsin.

- Blue Cross of California--Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming.

C. Hospice Changing Ownership.--Hospices which undergo a change of ownership continue with the same intermediary that served the previous owner.

D. Provider Chains.--A hospice chain provider may request to be served under an arrangement involving a lead hospice intermediary serving its home office and regional intermediaries serving the individual facilities of the chain. The lead intermediary handles the chain's home office audit, desk review and all cost reports. The lead intermediary determines the scope of individual provider audits and negotiates the final settlements for each cost report. The designated regional intermediaries servicing the individual facilities process and pay claims. Submit your request to the RO which has jurisdiction of the State in which your home office is located. HCFA reviews the request and determines whether the arrangement is in the best interest of the program.

Alternatively, a hospice chain may request to be served by a single designated regional intermediary. The chain must demonstrate that the change is consistent with effective and efficient administration of the Medicare program. If the chain claims the change will result in cost savings or other efficiencies, these must be quantified in terms of savings to the Government. The following factors, among others, will be considered in determining whether the request for a single intermediary will be granted:

1. Timely Notice.--A request for a single intermediary must be submitted in writing at least 120 days (but not more than 180 days) before the end of the hospice's current fiscal year. Submit the request to the RO which has jurisdiction of the State in which your home office is located.

2. Size.--The chain must comprise a minimum of 10 participating facilities. However, where it has facilities in 3 contiguous States, it may be eligible if it comprises 5 facilities.

3. Central Controls.--The chain must demonstrate that effective central controls are exercised, assuring substantial uniformity in the operating procedures, utilization controls, personnel administration, and fiscal operations of the individual providers.

4. Intermediary Capacity.--Based on the chain's size and location of the individual facilities, the elected intermediary must have the resources and capacity to effectively serve the chain.

NOTE: An intermediary would not become generally available to serve other providers in those areas where it has been approved to serve chain providers only.

Hospital Insurance

144. HOSPITAL INSURANCE--A BRIEF DESCRIPTION

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers post hospital extended care in skilled nursing facilities, post hospital care furnished by a home health agency in the patient's home or hospice care for terminally ill patients. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, skilled nursing facilities, home health agencies and hospices) are generally made to the provider based on the reasonable cost of the covered services furnished or prospective payments which are intended to approximate such costs.

144.1 Inpatient Hospital Services.--The items and services covered include: bed and board; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training under approved teaching programs; and costs of blood after the first 3 pints in a benefit period and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to have payment made on his behalf for up to 90 days of inpatient hospital services in each benefit period. He is responsible for a deductible amount in each benefit period and a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each day after the 60th day and through the 90th day of inpatient hospital services during a benefit period. In addition, a beneficiary has a 60-day lifetime reserve available for inpatient hospital services. If he elects to use this reserve, he will be responsible for a coinsurance amount for each day used equal to one-half of the inpatient hospital deductible for the benefit period in which such reserve days are used.

Each year, HCFA calculates the standard deductible amount for inpatient hospital stays. The year in which the benefit period begins determines not only the deductible amount to be applied during such benefit period, but also the coinsurance amounts for inpatient hospital services and extended care services furnished in the same spell of illness.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically-related inpatient diagnostic study. Where an individual is in a qualified psychiatric hospital on the first day for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 150-day period immediately before his first day of entitlement must be counted in determining the the lifetime limitation of 190 covered inpatient psychiatric hospital days in a psychiatric hospital. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

Payment may be made for emergency inpatient hospital services furnished by nonparticipating U.S. hospitals when the threat of life or health of the individual necessitates the use of the most accessible hospital. Payment may also be made for emergency inpatient hospital and certain related Part B services in Canada and Mexico where the foreign hospital is more accessible from the site of the emergency than the nearest participating U.S. hospital.

Inpatient hospital services and related Part B services provided to a United States resident in a hospital in Canada or Mexico which is closer or more accessible to his U.S. residence than the nearest participating U.S. hospital is covered whether or not an emergency existed.

144.2 Posthospital Extended Care Services.--In each benefit period payment may be made for the reasonable cost of up to 100 days of posthospital extended care services, except that the patient is responsible for a coinsurance payment after the 20th day. The beneficiary must have been in a hospital receiving inpatient hospital services for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to a skilled nursing facility (SNF).

Where the person became entitled to HI at or after age 65, the hospital discharge must have occurred on or after the first day of the month in which he attained age 65. If his current entitlement began before age 65; i.e., he became entitled to HI under the disability or chronic renal disease provisions of the law, the hospital discharge must have occurred while he was so entitled. The 3 consecutive calendar days requirement can be met by stays totalling 3 consecutive days in one or more hospitals.

An SNF provides skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law and meet the health and safety conditions prescribed by the Secretary of Health and Human Services (HHS), and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency.

The term SNF does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis for Medicare purposes. Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital.

144.3 Posthospital Home Health Services.--Prior to July 1, 1981, home health services under hospital insurance include up to 100 home health visits, after the beginning of one benefit period and before the beginning of the next. The visits must be furnished a patient within 1 year of his most recent discharge from a hospital where he was an inpatient for at least 3 consecutive calendar days (counting the day of admission, but not the day of discharge). If, after his hospitalization, he had a covered stay in a skilled nursing facility, the one year during which the patient may receive home health services begins with the discharge from the skilled nursing facility. A plan of treatment must be established within 14 days after the hospital or skilled nursing facility discharge. Home health services are also provided under supplementary medical insurance.

To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be confined to his home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy, or speech therapy. A beneficiary who requires one or more of these services in the treatment of his illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his behalf for the skilled nursing, physical or speech therapy he needs, as well as for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, a patient who does not require intermittent skilled nursing or physical or speech therapy cannot qualify to have payment made under the program for any home health services furnished him. Excluded as home health services are the costs of housekeepers, food service arrangements, and transportation to outpatient facilities.

To be covered, the home health services must be needed for a condition for which the patient required inpatient hospital services or extended care services. Discharge from the hospital must have occurred in a month in which the patient has attained age 65 or was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.

Effective July 1, 1981, the 100 visit limitation under Parts A and B, and the prior inpatient stay requirement under Part A were eliminated. In addition, a person may qualify for home health services based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech therapy, or occupational therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program, a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health and Human Services. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases; such an agency may qualify only under supplementary medical insurance.

Home health services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, skilled nursing facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home. The services of an intern or resident-in-training are covered if the agency has an affiliation with or is under common control of a hospital providing such medical services and the agency bills for such services.

144.4 Hospice Care.--Coverage of hospice care is provided under hospital insurance in lieu of the benefits described in §§144 through 144.3. The definition of hospice, and a description of hospice benefits are fully treated in Chapter II.

Beneficiary Entitlement to Hospital Insurance Benefits

148. HOSPITAL INSURANCE ENTITLEMENT FOR THE AGED (PART A).

An individual is entitled to hospital insurance (HI) protection beginning with the first day of the month in which he is age 65 or over and is entitled to monthly social security benefits (to be distinguished from supplementary security payments). Such entitlement also extends to aged qualified railroad retirement beneficiaries. The Social Security Act extends the same coverage to persons under age 65 qualifying as disabled under Title II of the Act and those having end-stage renal disease.

Hospital insurance coverage ends with the month the individual ceases to be entitled to such monthly social security benefits and/or ceases to be a qualified railroad retirement beneficiary. In the rare cases where HI terminates for an aged individual because of termination of his monthly benefits, he may obtain premium HI by filing a timely application. Death also terminates HI; the HI coverage continues through the date of death.

Disclosure of Information

155. DISCLOSURE OF HEALTH INSURANCE INFORMATION--GENERAL.

Records and information acquired in the administration of Title XVIII and XIX of the Social Security Act may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Administrator of HCFA. Regulations of HCFA regarding the disclosure of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information in the hospice's own records of a patient (e.g., name, date of birth, sex, marital status, address, medical records) is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. The hospice's own records, are subject to the requirements in the "Conditions of Participation: that patients' medical records be kept confidential (20 C.F.R. Part 405.1026). These records may also be subject to State or local laws governing disclosure.

When a hospice receives a request for information about a Medicare beneficiary, a Medicare claim, or related information which it may not disclose, the inquirer should be referred to the appropriate intermediary for further consideration of his request.

156. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY, OR IN CONNECTION WITH A CLAIM.

156.1 Disclosure to the Beneficiary or His Authorized Representative.--

A. General.-- Information directly relating to the beneficiary, such as Medicare entitlement or eligibility data, may be disclosed to the individual or his authorized representative (including his representative payee).

B. Medical Information.--Hospices may not forward medical information to intermediaries on a confidential basis, expressed or implied, since under the Privacy Act any medical information obtained by an intermediary is subject to disclosure to the individual to whom it pertains, or to another person authorized by the individual to have access to it.

Some hospices may document findings on medical forms preprinted "confidential," or routinely stamp all records "confidential," whether or not such records are ever intended for disclosure to an intermediary. Such records, when transmitted to the intermediary, will be accepted only if accompanied by a signed statement that the hospice understands the information is subject to disclosure to the patient under the Privacy Act and any words or statements that the transmitted records are confidential may be disregarded if the patient or his representative requests them from the intermediary or from HCFA. The repeated preparation and forwarding of separate signed statements can be obviated if the hospice signs an appropriate general statement of understanding with the intermediary that medical information may be disclosed to the individual under the Privacy Act, even if it is routinely designated "confidential."

156.2 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.--Disclosure by the hospice to persons other than the individual or his authorized representative of any records, reports, or other information about the individual is authorized without his consent in connection with any claim or other proceeding under the Social Security Act only when disclosure is necessary for the proper performance of the duties of:

- A. Any officer or employee of the Department; or
- B. Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

156.3 Disclosure to Third Parties for Other Than Program Purposes.--Information obtained from HCFA or its intermediary is confidential and may be disclosed only under conditions prescribed in rules and regulations, or on the express authorization of the Administrator of the HCFA. However, certain limited information about the Medicare eligibility status of beneficiaries and related claims information may be released to third party payers with the beneficiary's express authorization.

A. Information Which May Be Released.--Subject to necessary authorization, only the following records may be released:

1. Beneficiary health insurance claim number
2. Coinsurance
3. Dates of entitlement to Medicare
4. Copies of Medicare claims forms
5. Medicare report of eligibility
6. Explanation of Medicare Benefits (EOMB)

Requests for other information desired for complementary insurance purposes should be referred to the intermediary.

B. Form of Authorization.--Make certain that information is not released without the required authorization. The authorization must:

1. Be in writing;

2. Be signed and dated by the individual or someone authorized to act on his behalf;
3. Specify the name of the provider being authorized to disclose information;
4. Specify what information the individual is authorizing the provider to disclose;
5. Specify the names of the third party payers to whom the information is being released;
6. Specify the purpose for which the information is being released; and
7. Specify an expiration date for the authorization which should not exceed 2 years from the date it was signed and specify that it may be revoked at any time.

156.4 Disclosure of Itemized Statement to an Individual for Any Item or Service Provided.--

A. General.--Section 4311 of the Balanced Budget Act of 1997 requires that if a Medicare beneficiary submits a written request to a health services provider for an itemized statement for any Medicare item or service provided to that beneficiary, the provider must furnish this statement within 30 days of the request. The law also states that a health services provider not furnishing this itemized statement may be subject to a civil monetary penalty of up to \$100 for each unfulfilled request. Since most institutional health practices have established an itemized billing system for internal accounting procedures as well as for billing other payers, the furnishing of an itemized statement should not pose any significant additional burden.

B. 30-Day Period to Furnish Statement.--You will furnish to the individual described above, or duly authorized representative, no later than 30 days after receipt of the request, an itemized statement describing each item or service provided to the individual requesting the itemized statement.

C. Suggested Contents of Itemized Statement.--Although §4311 of the Balanced Budget Act of 1997 does not specify the contents of an itemized statement, suggestions for the types of information that might be helpful for a beneficiary to receive on any statement include: beneficiary name, date(s) of service, description of item or service furnished, number of units furnished, provider charges, and an internal reference or tracking number. If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are: amounts paid by Medicare, beneficiary responsibility for co-insurance, and Medicare claim number. The statement should also include a name and telephone number for the beneficiary to call if there are further questions.

D. Penalty.-- A knowing failure to furnish the itemized statement shall be subject to a civil monetary penalty of up to \$100 for each such failure.

157. DISCLOSURE OF INFORMATION ABOUT HOSPICES BY HCFA

The following information about hospices participating in the Medicare program may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

157.1 Medicare Reports.--

- A. Provider Survey Report and Related Information.--Information concerning survey reports

of hospices as well as statements of deficiencies, based on survey reports are available at the local Social Security office where the program is located. The following data may be released under this provision:

1. The official Medicare report of a survey.
2. Statements of deficiencies which have been conveyed to the hospice following a survey.
3. Plans of correction and pertinent comments submitted by the hospice relating to Medicare deficiencies cited following a survey.

State agencies certify whether institutions or other entities meet the Medicare conditions of participation for hospices. (See § 110.) A State agency may disclose information it obtains relating to the qualifications and certification status of hospices it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of hospices are made available to the public. After the survey reports and other formal evaluations are prepared by personnel of HCFA, the evaluated hospice is given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The hospice's comments are incorporated in the report if pertinent.

Program validation review reports are generally released only by HCFA central office.

Generally, informal reports and other evaluations of the performance of hospices which are prepared by the intermediary are available to the public.

C. Hospice Cost Reports.--

1. General.--Requests by any member of the public either to inspect or to obtain a copy of a hospice cost report must be submitted to HCFA or the intermediary in writing and must identify the hospice and specific cost report(s) in question.

Intermediaries are required to respond to requests in writing within 10 working days after receipt of a written request. A copy of the response to the requestor will be sent simultaneously to the hospice putting the hospice on notice that its report has been requested by a particular person. If a request is for a report submitted by a former owner of a hospice, copies of the intermediary's response to the requestor will go to both the present owner and the former owner of the hospice.

2. Information That May be Disclosed.-- Disclosure by the intermediary is limited to cost report documents which hospices are required by HCFA regulations and instructions to submit. These documents include the statistical page, trial balance of expenses, and cost finding schedules or documents required by HCFA as part of the regular cost report process. (Where a hospice, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, these documents are subject to the same disclosure rules as official forms.)

3. Information That May Not be Disclosed.-- If a hospice chooses to submit with its cost report additional information not specifically required by regulations or instructions, the intermediary will not disclose such information unless it is contained within an official document. For example, some hospices may submit supplementary analyses of certain expenses, financial statements (other than the statement of income and expenses and the balance sheets as required in accordance with cost reporting instructions), or income tax returns, etc., that are not required by the program. These items would not be disclosed by the intermediary as part of the cost reports.

Except where a hospice has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the intermediary requires the hospice to submit in support of its cost representations would also not be disclosed by the intermediary as part of the cost report. In addition, the following are not disclosed by the intermediary as part of a cost report: audits, schedules, letters, notes, general comments; comments on results of desk reviews (including copies of the actual desk review documents), intermediary notices and comments (including transmittal letters), audit adjustment summaries that are required to be prepared by intermediaries and auditors, and information pertaining to an individual patient.

NOTE: Any of the information indicated above that is not to be disclosed by the intermediary may be subject to disclosure under the Freedom of Information Act upon review by the HCFA Central Office, or a U.S. District Court in response to a request for such information. The description of what will be made available by an intermediary as part of a cost report pertains only to requests that indicate that the requestor specifically wants cost reports.

157.2 Disclosure of Medicare Statistics.-- Numerous statistics on hospices are available to the public. They include, but are not limited to, the following:

- A. Information as to whether a hospice participates in the Medicare Program
- B. Amount of Medicare reimbursement
- C. Overpayment data
- D. Medicare inpatient statistics (e.g., total inpatient days, number of admissions, average length of stay).

158. **COST TO A HOSPICE WHICH REQUESTS INFORMATION AVAILABLE TO THE PUBLIC.**

Hospices are required to pay appropriate fees for information they may request pertaining to other providers, Medicare contractors, or State agencies. A hospice may report such fees as allowable costs only if it demonstrates the information is necessary in developing and maintaining patient care services.

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
REGIONAL OFFICES

| <u>STREET ADDRESS</u> | <u>MAILING ADDRESS</u> | <u>STATES</u> |
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Alaska
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Oregon
Washington

300. ADMISSION PROCEDURES

When a Medicare beneficiary is admitted to a hospice program, or as soon thereafter as practical, verify eligibility in order to process the bill. Obtain this eligibility information directly from the patient, or through your intermediary's on-line limited Medicare eligibility data. Contact your intermediary to obtain technical instructions regarding how access may be obtained along with hardware/software compatibility details.

Disclosure of HCFA eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and may be used only for verifying a patient's eligibility for benefits under the Medicare program. Penalties for misuse include being found guilty of a misdemeanor, and a fine of not more than \$5,000.

This information does not represent definitive eligibility status. If the individual is not on file, use the admission and billing procedures in effect independent of this data access.

Obtain the patient's, or the patient representative's, signed hospice election statement. (Must be obtained no later than the first day for which payment is claimed.)

Obtain the patient's HICN.

Obtain the physician's certification for Hospice care. (Must be obtained within 2 calendar days of admission.) (See §302.1, [FL 17](#).)

Complete the admission notice. (See §302.)

The intermediary checks HCFA's records and notifies you of the beneficiary's entitlement to Part A Medicare benefits.

301. OBTAINING THE HICN

It is important that the patient's HICN be obtained and accurately recorded on the admission and billing forms because the claim cannot be processed if it is missing or incorrect. A social security number is not sufficient for processing a claim.

When a patient is admitted, ask for his/her HI card, Temporary Notice of Medicare Eligibility or other notice he/she has received from SSA, an intermediary, or HCFA which shows the claim number. If the patient cannot furnish it, contact the SSO in accordance with §301.7. If a patient or prospective patient is within 3 months of age 65, is disabled or has ESRD, and has not applied for hospital insurance entitlement, advise him/her to contact the SSO or have someone do so on his/her behalf. You make arrangements with the SSO to routinely bring such cases to their attention.

301.1 Health Insurance Card.--Individuals who have established entitlement to HI are issued HI cards by SSA, or the RRB if they are railroad beneficiaries. The HI card serves as a source of essential information necessary in the processing of claims under the Medicare program. It shows the beneficiary's name, HICN, and effective date of entitlement to hospital insurance and/or medical insurance. (Section 399, Exhibit 1A, displays the HI card, and §301.4 explains the numbering system as an aid in recognizing valid numbers.)

A HI card is acceptable without a signature, however, ask the patient to sign it.

301.2 Temporary Notice of Medicare Eligibility.--The SSO may issue a temporary HI eligibility notice pending the issuance of a HI card when the beneficiary is in need of medical services. (See §399, Exhibit 1C.) Enter the patient's name and claim number on the admission notice. The intermediary will use that information to check HCFA's records, and respond to you about the patient's eligibility.

301.3 Social Security Award Certificate.--HI Beneficiaries receive a Social Security Award Certificate, (see §399, Exhibit 1B) showing the HICN, dates of entitlement to Part A and/or Part B, and the following statement:

"This notice may be used if Medicare services are needed before you receive your health insurance card."

301.4 Identifying HICNs.--Most HICNs are 9-digit numbers with letter suffixes, e.g., 000-00-0000-A. However, it may also be a 6 or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix/suffix of the claim number, or even the claim number itself, to change.

A. HICNs Assigned by SSA.--The potentially valid HICN assigned by SSA to entitled beneficiaries is a 9-digit number followed by one of the following suffixes:

000-00-0000-A

000-00-0000-B, B1-B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT,
BW, BY

000-00-0000-C1-C9, CA-CK, D1-D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN,
DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ

000-00-0000-E, E1-E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM

000-00-0000-F1, F2, F3, F4, F5, F6, F7, F8

000-00-0000-J1, J2, J3, J4

000-00-0000-K1-K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM

000-00-0000-W, W1-W9, WB, WC, WF, WG, WJ, WR, WT

B. Numbers Assigned by the RRB.--The RRB began using the social security number in its numbering system in 1964. The numbers assigned prior to that time are 6-digit numbers assigned in numerical sequence, and have no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers, when used as claim numbers by the RRB, always have letter prefixes. (In rare cases, when a qualified railroad retirement beneficiary has a claim number with less than 6 digits; add sufficient zeros between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

All-Inclusive List of Potentially Valid RRB HICNs.--

| | |
|-----------------------------------|---------------------------------|
| A-000000, or A-000-00-0000 | PA-000000, or PA-000-00-0000 |
| MA-000000, or MA-000-00-0000 | PD-000000, or PD-000-00-0000 |
| WA-000000, or WA-000-00-0000 | H-000000 |
| WD-000000, or WD-000-00-0000 | MH-000000 |
| CA-000000, or CA-000-00-0000 | WH-000000 |
| WCA-000000, or WCA-000-00-0000 | WCH-000000 |
| | PH-000000 |
| | JA-000000 |
| WCD-000000, or WCD-000-00-0000 | |

C. Special Health Insurance Only Claim Numbers.--Some individuals who are not entitled to Social Security retirement, survivors, or disability insurance benefits, nor qualified for railroad retirement, are entitled to HI benefits.

They use Social Security numbers with these suffixes:

000-00-0000-T, TA, TB, TC, TD, TE, TF, TG, TH,
TJ, TK, TL, TM, TN, TP, TQ, TR,
TS, TT, TU, TV, TW, TX, TY, TZ, and
000-00-0000M
000-00-0000MI

| Suffix T indicates the individual is entitled to free hospital or free hospital and medical insurance, and is not entitled to monthly benefits.

| Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage and is paying a premium.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits, and has refused hospital insurance benefits.

301.5 Changes in HICNs.--Changes in an individual's entitlement to social security or railroad retirement benefits may result in a completely different HICN being assigned; e.g., an individual not entitled to monthly benefits (000-00-0000) marries and becomes entitled to wife's benefits on her husband's account (III-II-IIIIB).

301.6. Notice of Hospital (or Medical) Insurance Utilization or Explanation of Benefits.--If the patient cannot furnish his HI card or one of the notices described in §301 when admitted, he/she may use a utilization form which shows his/her claim number. Form HCFA-1533, Medicare Hospital, Skilled Nursing Facility, and Home Health Benefits Records (see § 399, Exhibit 2) is mailed to a beneficiary shortly after Part A inpatient hospital, or SNF benefits have been paid on his behalf. An Explanation of Medicare Benefits (EOMB) is sent to a beneficiary by the carrier after payment of a SMI claim. An EOMB is also sent to the beneficiary by the intermediary after the beneficiary receives Part B outpatient services. The beneficiary receives a utilization notice after payment on his or her behalf for Part B inpatient and outpatient hospital and SNF services.

301.7. Contacts With the SSO to Obtain HICNs.--When a beneficiary cannot furnish an HI claim number, request it from the SSO. Establish a working procedure for obtaining HICNs.

NOTE: The SSO also helps a beneficiary replace a lost or destroyed HI card.

A. Information Required by the SSO.--If the patient's social security number is available, the SSO usually requires no additional information to locate the HICN, or to determine that the patient has not established HI entitlement.

If the social security number is not available, furnish the following information:

- o The patient's name and a statement as to whether or not he/she ever applied for Social Security monthly benefits, railroad retirement benefits, or Medicare benefits;
- o If the patient says he/she applied, the name of the person whose social security number the application was based, e.g., his/her own or the spouse's number;
- o The full name of the patient's father, the maiden name of the patient's mother, and the patient's date and place of birth; and
- o The patient's address.

If you cannot furnish all the identifying information, furnish as much as possible.

B. The SSO's Reply.--The SSO furnishes the HICN as soon as possible. If it is not readily available, the SSO informs you of the action it is taking, i.e., that a claim number has been requested from SSA records, it is developing an application, or an application is pending.

If an application for hospital insurance benefits is taken as a result of the request for a claim number, or is pending when you request a claim number, the SSO gives you the claim number when processing is completed. You may then send the notice of admission to the intermediary.

302. NOTICE OF ELECTION (NOE)

When a Medicare beneficiary elects hospice services, complete Form Locators (FLs) 1, 4, 12, 13, 14, 15, 17, 32, 51, 58, 60, 67, 82, 83, and 85 of the Uniform (Institutional Provider) Bill (Form HCFA-1450) which is an election notice. Also, complete Form HCFA-1450 when the election is for a patient who has changed an election from one hospice to another.

Send the HCFA-1450 to the intermediary. Forward the HCFA-1450 by mail, or by messenger or telephone depending upon your arrangements with the intermediary. Also, send a copy to the carrier servicing your area. Annotate the copy with a reference to the Medicare Carriers Manual, §4175.2.

If a patient enters the hospice before the month, he/she becomes entitled to Medicare benefits, e.g., before age 65, do not send the election notice before the first day of the month in which he/she becomes 65.

302.1 Completing the Uniform (Institutional Provider) Bill (Form HCFA-1450) Notice of Election.--This form, also known as the UB-92, was developed to be suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for your notice of election. Items not listed need not be completed, although you may complete them when billing multiple payers.

FL 1. (Untitled) - Provider Name, Address, and Telephone Number

Required.--The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Required.--Enter the three-digit numeric type of bill code: 81A, B, C, D, or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit - Type of Facility

- 8 - Special facility or hospital ASC surgery (requires special information in second digit below).
- 9 - Reserved for National Assignment.

2nd Digit - Classification (Special Facility Only)

- 1 - Hospice (Nonhospital based)
- 2 - Hospice (Hospital based)

| <u>3rd Digit - Frequency</u> | <u>Definition</u> |
|---|---|
| A - Hospice Admission Notice | Use when the hospice is submitting Form HCFA-1450 as an Admission Notice. |
| B - Hospice Termination/Revocation Notice | Use when the hospice is submitting Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election. |
| C - Hospice Change of Provider Notice | Use when Form HCFA-1450 is used as a Notice of Change to the hospice provider. |
| D - Hospice Election Void/Cancel | Use when Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election. |
| E - Hospice Change of Ownership | Use when Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice. |

FL 12. Patient's Name

Required.--Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required.--Enter the patient's full mailing address, including street number and name, post office number or RFD, city, State, and Zip code.

FL 14. Patient's Birthdate

Required.--Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

FL 15. Patient's Sex

Required.--Enter an "M" for male or an "F" for female. This item is used in conjunction with FLs 67- 81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Required.--Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FL 32. Occurrence Code and Date

Required.-- Enter a code and associated date to indicate the physician's signed certification of the new hospice period. Code structure:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|--|--|
| <u>27</u> | <u>Date of Hospice Certification or Re-Certification</u> | <u>Code indicates the date of certification or re-certification of the hospice benefit</u> |

period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.

FLs 51A, B, and C. Provider Number

Required.--Enter the six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, and C. Insured's Name

Required.--Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, and C. Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67. Principal Diagnosis Code

Required.--Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. HCFA only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260, or HCFA approved errata and supplements to this publication. HCFA approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

FL 82. Attending Physician I.D.

Required.--Enter the UPIN and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians;
- SLF000 for providers to report that the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted unless the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 IDs may be audited.

FL 83. Other Physician I.D.

Required.--Enter the word "employee" or "nonemployee" here to describe the relationship the patient's attending physician has with you. "Employee" also refers to a volunteer under your jurisdiction.

FL 85-6. Provider Representative Signature and Date

Required.--A hospice representative makes sure the required physician's certification, and a signed hospice election statement are in the records before signing Form HCFA-1450. A stamped signature is acceptable.

302.2 Intermediary Reply to Notice of Election.--The reply to the notice of election is furnished according to your arrangements. Whether the reply is given by telephone, mail or wire, it is based upon the intermediary's query to HCFA master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

303. BILLING PROCEDURES

Use the Uniform (Institutional Provider) Bill (Form HCFA-1450) to bill for all covered hospice services.

303.1 Completion of the Uniform (Institutional Provider) Bill (Form HCFA-1450) for Hospice Bills.--This form, also known as the UB-92, is suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. Items not listed need not be completed although you may complete them when billing multiple payers.

FL 1. (Untitled) - Provider Name, Address, and Telephone Number

Required.--The minimum entry is the provider's name, City, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Required.--This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (Only Codes used to bill Medicare are shown.)

1st Digit - Type of Facility

8 - Special facility or hospital ASC surgery (requires special information in second digit below).

9 - Reserved for National Assignment

2nd Digit - Classification (Special Facility Only)

1 - Hospice (Nonhospital based)

2 - Hospice (Hospital based)

3rd Digit - FrequencyDefinition

0 - Nonpayment/zero claims

Use this code when you do not anticipate payment from the payer for the bill, but are informing the payer about a period of nonpayable confinement or termination of

care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you.

- | | |
|-----------------------------------|--|
| 1 - Admit Through Discharge Claim | Use this code for a bill encompassing an entire course of hospice treatment for which you expect payment, i.e., no further bills will be submitted for this patient. |
| 2 - Interim - First Claim | Use this code for the first of an expected series of payment bills for a hospice course of treatment. |
| 3 - Interim - Continuing Claim | Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted. |
| 4 - Interim - Last Claim | Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (FL 6) is the discharge date or date of death. |
| 5 - Late Charge Only | Use for outpatient claims only. Late charges are not accepted for Medicare inpatient or ASC claims. |
| 7 - Replacement of Prior Claim | Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill. |
| 8 - Void/Cancel of a Prior Claim | This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information. |

FL 6. Statement Covers Period (From-Through)

Required.--Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient's entitlement began. The "From" date is used to determine timely filing. Since the 12-month hospice "cap period" (see §§405 and 407) ends each year on October 31, hospice services for October and November cannot be submitted on the same bill. Use October 31 as a cutoff date. Submit separate bills for October and November.

FL 12. Patient's Name

Required.--Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required.--Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

FL 14. Patient's Birthdate

Required.--Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

FL 15. Patient's Sex

Required.--Enter an "M" for male or an "F" for female. This item is used in conjunction with FLs 67- 81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Required.--Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FL 22. Patient Status

Required.--This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code Structure

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to another short-term general hospital
- 03 Discharged/transferred to SNF
- 04 Discharged/transferred to an ICF
- 05 Discharged/transferred to another type of institution (including distinct part) or referred for outpatient services to another institution
- 06 Discharged/transferred to home under care of organized home health service organization
- 07 Left against medical advice or discontinued care
- *09 Admitted as an inpatient to this hospital
- 20 Expired (or did not recover - Christian Science patient)
- 30 Still patient or expected to return for outpatient services
- 40 Expired at home (Hospice claims only)
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
- 42 Expired - place unknown (Hospice claims only)
- 50 Hospice - home
- 51 Hospice - medical facility

*If a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began more than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

Required.--Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) or FL 84 (remarks) to record additional occurrences and dates.

3-12

04-00

ADMISSION AND BILLING PROCEDURES

Rev. 55

303.1 (Cont.)

Use the following codes where appropriate:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|--|---|
| 24 | Date Insurance Denied | Enter the date of receipt of a denial of coverage by a higher priority payer. |
| 23 | Cancellation of Hospice Election Period (INTERMEDIARY USE ONLY) | Code indicates date on which a hospice period of election is cancelled by an intermediary as opposed to revocation by the beneficiary. |
| 27 | Date of Hospice Certification or Re-Certification | Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. |
| 42 | Date of Discharge | Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.) |
| C4-C9 | | Reserved for National Assignment. |
| D0-D9 | | Reserved for National Assignment. |

FL 36. Occurrence Span Code and Dates

Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|---------------------------------|---|
| M2 | Dates of Inpatient Respite Care | Code indicates From/Through dates of a period of inpatient respite care for hospice patients. |

FLs 39, 40, and 41. Value Codes and Amounts

Required.--The only value codes that apply to hospice benefits are those that indicate Medicare payment is secondary to another payer. Enter the appropriate code(s) and related dollar amount(s) where the primary payer is other than Medicare, and where the primary payer has made payment at the time of billing Medicare. If the primary payer has denied payment, indicate this with zeros in the value amount. Enter the date of the denial and occurrence code 24 in the appropriate occurrence field. The value codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). If more than one value code is shown for a billing period, show codes in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used up before the second line is used). The amount of payment shown in the value field is deducted from the intermediary's payment to the hospice.

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|--|--|
| 12 | Working Aged Beneficiary/Spouse With an EGHP | Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a |

- conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 13 ESRD Beneficiary in a Medicare Coordination Period With an EGHP Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 14 No-Fault, Including Auto/Other Insurance Enter this code to indicate the amount shown is that portion of a higher priority no-fault insurance payment including auto/other insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 15 Workers' Compensation (WC) Enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 16 Public Health Service (PHS), Other Federal Agency Enter this code to indicate the amount shown is that portion of a higher priority PHS or other Federal agency's payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment.

61 Location Where Service is Delivered (HHA and Hospice) MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator, right justified to the left of the dollars/cents delimiter. Value code 61 is required to accompany only revenue codes 651 and 652.

FL 42. Revenue Code

Required.--Assign a revenue code for each payment rate. Enter the appropriate three-digit numeric revenue code on the adjacent line in FL 43 to explain each charge in FL 47.

NOTE: Use revenue code 657 to identify your charges for services furnished to patients by physicians employed by you, or receiving compensation from you. In conjunction with revenue code 657, enter a physician procedure code in the right hand margin of FL 43 (to the right of the dotted line adjacent to the revenue code in FL 42). Appropriate procedure codes are available to you from your intermediary. Procedure codes are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

Use these revenue codes to bill Medicare.

| <u>Code</u> | <u>Description</u> | <u>Standard Abbreviation</u> |
|-------------|------------------------|--|
| 651* | Routine Home Care | RTN Home |
| 652* | Continuous Home Care | CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour.) |
| 655 | Inpatient Respite Care | IP Respite |
| 656 | General Inpatient Care | GNL IP |
| 657 | Physician Services | PHY Ser (must be accompanied by a physician procedure code) |

* Reporting of value code 61 is required with these revenue codes.

FL 43.--Revenue Description

Not Required.--Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under FL 42.

FL 46.--Units of Service

Required.--Enter the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

FL 47.--Total Charges

Required.--Enter the total charges for the billing period by revenue code (FL 42) on the adjacent line in FL 47. The last revenue code entered in FL 42 ("000I") represents the grand total of all charges billed. The total is in FL 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

FLs 50A, B, and C.--Payer Identification

Required.--If Medicare is the primary payer, enter "Medicare" on line A. If Medicare is not the primary payer, identify the primary payer on line A and enter Medicare on line B or C, if appropriate.

FL 51A, B, and C.--Provider Number

Required.--Enter your six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, and C.--Insured's Name

Required.--Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, and C.--Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67.--Principal Diagnosis Code

Required.--Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study that's chiefly responsible for the patient's admission.

FL 82.--Attending Physician I.D.

Required.--Enter the UPIN and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians that are assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Services' physicians, including the Indian Health Services;
- VAD000 for Department of Veterans' physicians;
- RET000 for retired physicians;
- SLF000 for providers to report that the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted unless the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 IDs may be audited.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

If more than one referring physician is indicated, enter the UPIN of the physician requesting the service with the highest charge.

FL 83. Other Physician I.D.

Required.--Enter the word "employee" or "nonemployee" to describe the relationship the patient's attending physician has with you.

FL 84. Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

FL 85-6. Provider Representative Signature and Date

Required.--A hospice representative makes sure that the required physician's certification, and a signed hospice election statement are in the records before signing Form HCFA-1450. A stamped signature is acceptable.

303.2 Billing for Covered Medicare Services Unrelated to Hospice Care.--Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and are furnished during a hospice election period, are billed to the intermediary or carrier for non-hospice Medicare payment. These services are billed by the provider, in accordance with existing procedures, as a new admission with appropriate query and billing actions.

303.5 Frequency of Billing.--Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--Inpatient billing under PPS is normally done after discharge. However PPS hospitals not receiving periodic interim payments (PIP) may bill 60 days after an admission, and every 60 days thereafter.

Each PPS interim bill must include all diagnoses, procedures and services from admission to the through date. Repeat charges included on the prior bill on the subsequent interim adjustment bill.

Your initial PPS interim claims must have a patient status of 30 (still patient). Submit all interim PPS bills with the following designation:

-- 112 - for interim bill (first claim);

When you submit a bill subsequent to the first, submit it in the adjustment format as one of the following:

- o A 117 bill with a patient status of 30 (still patient); or
- o A 117 discharge bill with a patient status of:
 - 01 - Discharged to home or self-care;
 - 02 - Discharged/transferred to another short-term general hospital;
 - 03 - Discharged/transferred to SNF;
 - 04 - Discharged/transferred to ICF;
 - 05 - Discharged/transferred to another type of institution (including distinct parts), or referred for outpatient services to another institution;
 - 06 - Discharged/transferred to home under care of organized home health service organization;
 - 08 - Discharged to home under care of a home IV therapy provider; or
 - 20 - Expired (or did not recover - Christian Science Patient).

SNFs and non-PPS hospitals (i.e., excluded units or hospitals) bill upon discharge or after 30 days (and if necessary, every 30 days thereafter). You may bill more frequently if you bill electronically.

Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed earlier. The from date must be the day after the through date on the earlier bill. If you receive PIP, you do not submit interim bills.

For hospice short-term inpatient care, submit the monthly bill designating the inpatient services with revenue code 655 or 656, as appropriate. Submit the bill in your normal manner if the inpatient hospice care is provided under your auspices. If the inpatient care is furnished by another entity, and they are billing Medicare directly, use occurrence span code 74 to show the period of inpatient care, as described under outpatient billing.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). These instructions also apply to Home Health Agency and hospice services under Part A. This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

| <u>Service</u> | <u>Revenue Code</u> |
|-----------------------------------|-------------------------------------|
| - DME Rental | 290-299 |
| - Therapeutic Radiology | 330-339 |
| - Therapeutic Nuclear Medicine | 342 |
| - Respiratory Therapy | 410-419 |
| - Physical Therapy | 420-429 |
| - Occupational Therapy | 430-439 |
| - Speech Pathology | 440-449 |
| - Home Health Visits | 550-599 |
| - Hospice Services | 650-659 |
| - Kidney Dialysis Treatments | 820-859 |
| - Cardiac Rehabilitation Services | 482, 943 |
| - Psychological Services | 910-919 (in a psychiatric facility) |

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Bill other one-time Part B services upon completion of the service.

Bills for outpatient surgery must contain, on a single bill, all services provided on the day of surgery except for kidney dialysis services, which are billed on a 72X bill type. These services normally include:

- o Nursing services, services of technical personnel, and other related services;
- o The patient's use of the hospital's facilities;
- o Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- o Diagnostic or therapeutic items and services (except lab services);
- o Blood, blood plasma, platelets, etc.; and
- o Materials for anesthesia.

303.6 Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines.--

A. General.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B. Coverage Requirements.--Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and its administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

C. Billing Requirements.--Provide the influenza virus, pneumococcal pneumonia and hepatitis B vaccines to those beneficiaries who request them including those who elected the hospice benefit. These services are coverable when furnished by you. Bill services for the vaccines to your local carrier on the HCFA-1500. Payment is made using the same methodology as if you were a supplier. If you do not have a supplier number, contact your local carrier to obtain one. If you have any other specific billing questions, contact your carrier to obtain assistance.

D. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

| | |
|-------|---|
| 90657 | Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use; |
| 90658 | Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use; |
| 90659 | Influenza virus vaccine, whole virus, for intramuscular or jet injection use; |
| 90732 | Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use; |
| 90744 | Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use; |
| 90745 | Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use; |
| 90746 | Hepatitis B vaccine, adult dosage, for intramuscular use; |
| 90747 | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use; |
| 90748 | Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use. |

These codes are for reporting of the vaccines only. The provider bills for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

NOTE: Hospices should contact their local carrier for instructions on simplified billing for influenza virus vaccine and pneumococcal pneumonia vaccine.

303.7 Clarification of Reimbursement for Transfers that Result in Same Day Hospice Discharge and Admission.--In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for the day of discharge and admission.

304. MEDICAL REVIEW OF HOSPICE CLAIMS

To assure that appropriate payments are made for services provided to individuals electing hospice care, the intermediary is required to request and review medical records (including the written plans of care) from you.

The purpose of the MR is to assure that the services provided were:

- o Covered hospice services;
- o Stipulated in the plan(s) of care;
- o Necessary for the palliation or management of the beneficiary's terminal illness; and
- o Appropriately classified for payment purposes as specified in Chapter 4.

Submit all medical records and documentation to your intermediary within 30 days of the date your intermediary requests them. If you do not, the claim is denied, and you are liable for the costs of the noncovered services.

In addition, your intermediary may, at times, find it necessary to access information at your site. Any records related to a beneficiary must be made available. The intermediary may also find it necessary to visit the beneficiary and/or their relatives at home to verify that Medicare payment is appropriate. At the time the beneficiary elects hospice benefits, they are asked to sign a separate form consenting to Medicare home visits. However, if the patient refuses to sign the consent form, hospice benefits are not affected. The consent form (see Exhibit 4) makes both you and the patient aware of the possibility of such visits and the fact that they are necessary to determine the quality of delivered health care services. The consent form makes it clear that the patient and/or the family member has the right to refuse entry at any given time.

As a result of MR, an intermediary may reclassify care from one rate category to another. For example, if continuous home care was provided to a patient whose condition did not require the level of care described in §230.2 (or did not receive it), the intermediary makes payment for the services at the routine home care rate.

305. CLAIMS PROCESSING TIMELINESS

A. Claims Processing Timeliness Requirements.--"Clean" claims must be paid or denied within the applicable number of days from the date of their receipt as follows:

| <u>Time Period for Claims Received</u> | <u>Applicable Number of Days</u> |
|--|----------------------------------|
| 01-01-93 through 09-30-93 | 24 for EMC & 27 for paper claims |
| 10-01-93 and later | |

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| 10-01-93 and later | |

See subsection D for the definition of a clean claim. All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMCs are subject to the above requirements.

The count starts on the day after the receipt date and ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if the span is 30 days or less, the requirement is met.

B. Payment Floor Standards.--Your intermediary does not pay, issue, mail, or otherwise pay for any claim it receives from you within the waiting period as indicated below. The length of the waiting period is determined by the date a claim is received. Your intermediary starts its count on the day after the day of receipt. For example, a paper claim received October 1, 1993, can be paid on or after October 28, 1993. An electronic claim received November 1, 1993, can be paid on or after November 15, 1993.

| <u>Claims Receipt Date</u> | <u>Waiting Period (Calendar Days)</u> |
|----------------------------|---------------------------------------|
| 01-01-93 through 09-30-93 | 14 for EMC & 26 for paper claims |
| 10-30-93 and later | 13 for EMC & 26 for paper claims |

NOTE: No payment claims are not subject to the payment floor standards.

C. Interest Payment on Clean Non-PIP Claims Not Paid Timely.--Interest must be paid on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- o Claims requiring external investigation or development by your intermediary;
- o Claims on which no payment is due; or
- o Full denials.

Interest is paid on a per bill basis at the time of payment.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6 month basis effective every January 1st and July 1st. Effective January 1, 2000, you may access the Treasury Department's new web page--www.publicdebt.treas.gov/opd/opdprmt2.htm semi annually for the new rate. Your intermediary notifies you of any changes to this rate.

Interest is calculated using the following formula:

$$\text{Payment amount} \times \text{rate} \times \text{days} \div 365 \text{ (366 in a leap year)} = \text{interest payment.}$$

The interest period begins on the day after payment is due and ends on the day of payment.

| EXAMPLES: | Clean Paper Claim | Clean Electronic Claim |
|-------------------|-------------------|------------------------|
| Date Received | November 1, 1993 | November 1, 1993 |
| Payment Due | November 28, 1993 | November 15, 1993 |
| Payment Made | December 3, 1993 | December 2, 1993 |
| Interest Begins | December 2, 1993 | December 2, 1993 |
| Days for Which | | |
| Interest Due | 2 | 1 |
| Amount of Payment | \$100 | \$100 |
| Interest Rate | 5.625% | 5.625% |

Use the following formula:

o For the clean paper claim-- $\$100 \times .05625 \times 2$ divided by 365 = \$.0308 or \$.03 when rounded to the nearest penny.

o For the clean electronic claim-- $\$100 \times .05625 \times 1$ divided by 365 = \$.0154 or \$.02 when rounded to the nearest penny.

When interest payments are applicable, your intermediary indicates for the individual claim the amount of interest on their remittance record to you.

D. Definition of "Clean Claim"--A "clean" claim is one that does not require your intermediary to investigate or develop external to their Medicare operation on a prepayment basis.

Examples of clean claims are those that:

o Pass all edits (intermediary and Common Working File (CWF)) and are processed electronically;

o Do not require external development by your intermediary and are not approved for payment by CWF within 7 days of your intermediary's original claim submittal for reasons beyond your intermediary's or your control;

o Are investigated within your intermediary's claims, medicare review, or payment office without the need to contact you, the beneficiary, or other outside source;

o Are subject to medical review but complete medical evidence is attached by you or forwarded simultaneously with EMC records in accordance with your intermediary's instructions. If your intermediary requests medical evidence see first item under subsection E; or

o Are developed on a postpayment basis.

E. Other Claims--Claims that do not meet the definition of "clean" claims are "other" claims. Other claims require investigation or development external to your intermediary's Medicare operation on a prepayment basis. Other claims are those that are not approved by CWF for which your intermediary identifies as requiring outside development. Examples are claims on which your intermediary:

- o Requests additional information from you or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;
- o Requests information or assistance from another contractor. This includes requests for charge data from the carrier or any other requests for information from the carrier;
- o Develops MSP information;
- o Requests information necessary for a coverage determination;
- o Performs sequential processing when an earlier claim is in development; and
- o Performs outside development as a result of a CWF edit.

306. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

A. Background.--CLIA of 1988 changes clinical laboratories' certification. Effective September 1, 1992, clinical laboratory services are covered only if the entity furnishing laboratory services has been issued a CLIA number. However, laboratories may be paid for a limited number of laboratory services if they have a CLIA certificate of waiver or a certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

B. General.--Do not bill for laboratory tests. The survey process is used to validate that laboratory services in a hospice are being provided in accordance with the CLIA certificate. You are responsible for verifying CLIA certification prior to ordering laboratory services under arrangements.

C. CLIA Number.--Use the following CLIA positions:

o Positions 1 and 2 of the CLIA number are the State code (based on the laboratory's physical location at time of registration);

o Position 3 is an alpha letter "D"; and

o Positions 4-10 are a unique number assigned by the CLIA billing system. (No other laboratory in the country will have this number.)

D. Certificate for Physician-Performed Microscopy Procedures.--Effective January 19, 1993, a laboratory that holds a certificate for physician-performed microscopy procedures may perform only those tests specified as physician-performed microscopy procedures and waived tests, as described in §306 E. below, and no others. The following codes may be used:

HCPCS Code Test

Q0111 Wet mounts, including preparations of vaginal, cervical or skin specimens;

Q0112 All potassium hydroxide (KOH) preparations;

Q0113 Pinworm examinations;

Q0114 Fern test;

Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous; and

81015 Urine sediment examinations.

E. Certificate Of Waiver.--Effective September 1, 1992, all laboratory testing sites (except as provided in 42 CFR 493.3(b)) must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States.

A grace period starting May 1, 1993, and ending on July 31, 1993, has been granted to allow providers time to adapt to the new coding system. Physicians, suppliers, and providers may submit claims for services furnished during this grace period with 1992 or 1993 lab codes.

Claims for services provided prior to the grace period (prior to May 1, 1993) must reflect 1992 codes, even if received after the end of the grace period (after July 1, 1993). Claims with dates of services prior to May 1, 1993, which reflect 1993 codes, are denied.

Services furnished on or after September 1, 1992, by laboratories that have a certificate of waiver are limited to the following eight procedures:

| <u>HCPCS Code</u> | | <u>Test</u> |
|-------------------|-------------|--|
| <u>1992</u> | <u>1993</u> | |
| Q0095 | 81025 | Urine pregnancy test; visual color comparison tests; |
| Q0096 | 84830 | Ovulation test; visual color comparison test for human luteinizing hormone; |
| Q0097 | 83026 | Hemoglobin; by copper sulfate method, non-automated; |
| Q0098 | 82962 | Glucose, blood; by glucose monitoring devices cleared by the FDA specifically for home use; |
| 82270 | 82270 | Blood, occult; feces; |
| Q0100 | 81002 | Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy; |
| Q0101 | 85013 | Microhematocrit; spun; and |
| Q0102 | 85651 | Sedimentation rate, erythrocyte; non-automated. |

Effective January 19, 1993, a ninth test was added to the waived test list:

| | |
|--------------|--|
| <u>Q0116</u> | <u>Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.</u> |
|--------------|--|

F. Certificate of Registration.--Initially, you are issued a CLIA number when you apply to the CLIA program.

306.1 Focused Medical Review (FMR).--This section has been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

307. CREDIT BALANCE REPORTING REQUIREMENTS -- GENERAL

The Paperwork Burden Reduction Act of 1980 was enacted to inform you about why the Government collects information and how it uses this information. In accordance with §§1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, §1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, complete a Medicare Credit Balance Report (HCFA-838), to ensure that monies owed to Medicare re repaid in a timely manner.

The HCFA-838 is specifically used to monitor identification and recovery of "credit balances" due to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- o Paid twice for the same service either by Medicare or by Medicare and another insurer;
- o Paid for services planned but not performed, or for non-covered services;
- o Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance or amounts;
- o A hospital which bills and is paid for outpatient services included in a beneficiary's inpatient claim. Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the HCFA-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to §§300 and 301 that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

307.1 Submitting the HCFA-838.--Submit a completed HCFA-838 to your intermediary within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program.

307.2 Completing the HCFA-838.--The HCFA-838 consists of a certification page and a detail page. An officer or the Administrator of your facility must sign and date the certification page. If no Medicare credit balances are shown in your records for the reporting quarter, you must still have the officer or Administrator sign the form and submit it to attest to this fact.

The detail page requires specific information on each credit balance on a claim-by-claim basis. The detail page provides space to address 17 claims. You may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you report. Submit the detail page(s) on computer diskette, which is available from your intermediary. Submit the certification page in hard copy.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE Part B pertains only to services you provide which are billed to your intermediary. It does not pertain to physician and supplier services billed to carriers.

Complete the HCFA-838 providing the information required in the heading area of the detail page(s) as follows:

- o The full name of the facility;
- o The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- o The month, day and year of the reporting quarter, e.g., 12/31/93;
- o An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- o The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- o The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1- The last name and first initial of the Medicare beneficiary, (e.g., Doe, J.).

Column 2- The Medicare Health Insurance Claim Number (HICN) of the Medicare beneficiary.

Column 3- The 1-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

Column 4- The 3-digit number explaining the type of bill, e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions, §303.)

| | |
|---------------|---|
| Columns 5/6 - | <u>The month, day and year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 1/1/93).</u> |
| Column 7- | <u>The month, day and year (e.g., 1/1/93) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and ICN number correspond to the most recent payment.</u> |
| Column 8- | <u>An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)</u> |
| Column 9- | <u>The amount of the Medicare credit balance that was determined from your patient/accounting records.</u> |
| Column 10 - | <u>The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the HCFA-838 to your intermediary.)</u> |
| Column 11 - | <u>A "C" when you submit a check with the HCFA-838 to repay the credit balance amount shown in column 9, or an "A" if you submit an adjustment request.</u> |
| Column 12 - | <u>The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if you make full payment.</u> |
| Column 13 - | <u>The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons".</u> |
| Column 14 - | <u>The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability. For code description, see §303.)</u> |
| | <u>12 - Working Aged</u> <u>13 - End Stage Renal Disease</u> <u>14 - Auto No Fault/Liability</u> <u>15 - Workers' Compensation</u> <u>16 - Other Government Program</u> <u>41 - Black Lung</u> <u>42 - Department of Veterans Affairs (VA)</u> <u>43 - Disability</u> |

Column 15 - The name and address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the HCFA-838, it is not to be reported on a subsequent period report.

307.3 Payment of Amounts Owed Medicare.--Pay all amounts owed Medicare as shown in column 9 of the credit balance report at the time you submit the HCFA-838. (See §307.7.) Make payment by check or by submission of adjustment requests. Submit adjustment requests in hard copy or electronic format.

If you use a check to pay credit balances, submit adjustment requests for the individual credit balances that pertain to open cost reporting periods. Your intermediary will assure that monies are not collected twice.

If the amount owed Medicare is so large that immediate repayment would cause financial hardship, request an extended repayment schedule.

Interest is assessed on Medicare credit balances not timely repaid applying 42 CFR 405.376. In part this means:

o Interest accrues on outstanding amounts beginning from the due date of a timely-filed Medicare credit balance report if the report is not accompanied by payment in full.

o Interest is charged on the entire amount shown on a Medicare credit balance report beginning from the day after the report was due if the report is not timely-filed.

o Interest is charged on outstanding amounts beginning from the date a credit balance occurred, in those instances where a credit balance(s) was omitted from a Medicare credit balance report or was not accurately reported.

o Interest will not be charged on Medicare credit balances resulting from MSP provisions until they are past due in accordance with the 60-day repayment provision of 42 CFR 489.20. Once due, interest is assessed on outstanding Medicare credit balances resulting from MSP provisions in the same manner as any other outstanding Medicare credit balance, as discussed above.

307.4 Records Supporting HCFA-838 Data.--Develop and maintain documentation that shows that each patient record with a credit balance (transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for preparation of the HCFA-838. At a minimum, your procedures should:

- o Identify whether or not the patient is an eligible Medicare beneficiary;
- o Identify other liable insurers and the primary payer; and
- o Adhere to applicable Medicare payment rules.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the HCFA-838 or for not maintaining documentation that adequately supports the credit balance data reported to HCFA. Your intermediary will review your documentation during audits/reviews performed for cost report settlement purposes.

307.5 Provider-Based Home Health Agencies (HHAs).--Provider-based HHAs are to submit their HCFA-838 to their Regional Home Health Intermediary even though it may be different from the intermediary servicing the parent facility.

307.6 Exception for Low Utilization Providers.--Providers with extremely low Medicare utilization do not have to submit a HCFA-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-1, §2414.B, or files less than 25 Medicare claims per year.

307.7 Compliance with MSP Regulations.--MSP regulations at 42 CFR 489.20 require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a HCFA-838 and adherence to HCFA's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the HCFA-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it in the HCFA-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the HCFA-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the HCFA-838, but within the 60 days allowed.

EXHIBIT IMedicare Credit Balance Report Certification

The Medicare Credit Balance Report is required under the authority of §§1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS, OR OMITTS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by _____ (Provider Name(s) and Number(s)) for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations, and instructions.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Public reporting burden for this collection of information is estimated to average 6 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to:

Health Care Financing Administration,
P.O. Box 26684
Baltimore, Maryland 21207 and to:

Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, D.C. 20503.

Paperwork Reduction Project (0938-0600)

EXHIBIT II

This page is reserved for

The Medicare Credit Balance Report

(HCFA-838)

399. EXHIBITS

- Exhibit 1A. Health Insurance Cards
- Exhibit 1B. Social Security Award Certificate
- Exhibit 1C. Temporary Notice of Medicare Eligibility
- Exhibit 2. Medicare Hospital, Skilled Nursing Facility, and Home Health Benefits Record (Form HCFA-1533)
- Exhibit 3. Uniform (Institutional Provider) Bill (Form HCFA-1450)
- Exhibit 4. Hospice Home Visit Consent Form

THIS IS SPACE FOR HEALTH INSURANCE CARDS

THIS PAGES IS RESERVED FOR

Exhibit 1-B

Social Security Award Certificate

THIS IS SPACE FOR (TEMPORARY NOTICE OF MEDICARE ELIGIBILITY)

Exhibit 2

THIS IS SPACE FOR (MEDICARE HOSPITAL, SKILLED NURSING FACILITY
AND HOME HEALTH BENEFITS RECORD)
HCFA -1533

THIS IS SPACE FOR (MEDICARE HOSPITAL, SKILLED NURSING FACILITY
AND HOME HEALTH BENEFITS RECORD)
HCFA -1533

Exhibit 3

THIS IS SPACE FOR UB-82 HCFA-1450)

Exhibit 4

HOSPICE HOME VISIT CONSENT FORM

| | | | | |
|---|------------|--------------------|----------------------------------|---------------|
| 1. Patient's last name | First name | MI | 2. Health insurance claim number | |
| 3. Patient's address (Street number, City, State, Zip Code) | | | 4. Date of birth | 5. Sex M F |
| 6. Hospice name and address (City and State) | | 7. Provider number | | |
| 8. Date of Hospice Election | | | | |

This consent form permits the fiscal intermediary medical review personnel to conduct home visits with you and/or your family members in order to ensure that quality care is provided and that Medicare payments for the services received are appropriate.

You and/or your family members have the right to refuse entry into your home at any time. Refusal to sign the home visit consent form or to permit entry into your home after consent is given will not affect payment for hospice services.

I understand the explanation described above and give my permission for home visits.

Beneficiary
Signature _____ Date _____

Signature of hospice representative _____

401. GENERAL

With the exception of payment for physician services (see §406), Medicare reimbursement for hospice care is made at one of four predetermined rates for each day in which a Medicare beneficiary is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the application of the statutory "cap" on overall payments and the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary. The statutory "cap" (calculated by the Medicare intermediary) and the limitations on payment for inpatient care are described in sections that follow.

402. LEVELS OF CARE

There are four levels of care into which each day of care is classified:

- A. Routine Home Care
- B. Continuous Home Care
- C. Inpatient Respite Care
- D. General Inpatient Care

For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For levels A, C, and D only one rate is applicable for each day. For level B, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

402.1 Routine Home Care.--The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition.

402.2 Continuous Home Care.--The hospice is paid the continuous home care rate when continuous home care is provided. (See §230.2A.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

402.3 Inpatient Respite Care.--The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See §230.2B.) Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

402.4 **General Inpatient Care.**--Payment at the inpatient rate is made when general inpatient care is provided. (See §230.1E.) None of the other fixed payment rates (i.e., routine home care) are applicable for a day on which the patient receives hospice inpatient care except as described in §402.5.

402.5 **Date of Discharge.**--For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

403. HOSPICE PAYMENT RATES

The hospice rates, before area wage adjustments, for each of the categories of care described above, are as follows:

| | |
|-----------------------------|-------------------------------------|
| Routine Home Care Rate | \$97.11 |
| Continuous Home Care Rates | \$566.82 Full Rate-24 hours of care |
| | \$23.62 Hourly Rate |
| Inpatient Respite Care Rate | \$100.46 |
| General Inpatient Care Rate | \$432.01 |

These rates are in effect for services provided on or after October 1, 1998 through September 30, 1999.

404. LOCAL ADJUSTMENT OF PAYMENT RATES

The payment rates above are adjusted for regional differences in wages. The hospice wage index is published in the *Federal Register* each year, and is effective October 1 of that year through September 30 of the following year. Current wage index values can be obtained from the *Federal Register* Notice announcing the update or from your intermediary. To select the proper index for your area, first determine if your hospice is located in one of the Urban Areas listed in Table A of the *Federal Register* notice. If so, use the index for your area. If you are not listed as one of the Urban Areas, use the index number of the rural area for your State, listed in Table B of the *Federal Register* notice.

Once you determine the index for your area, the computation of the rates for your hospice can be made using the following tables in this section. Table I indicates the portion of each of the rates subject to the wage index. Table II is an example of the computation of wage adjusted rates for a hospice located in Baltimore, Maryland, using the index number of 1.0549. Table III is used to compute the rates applicable to your hospice. The wage adjusted continuous care rate can then be divided by 24 to determine the hourly billing rate.

TABLE I

| | National rate | Wage compo- nent subject to index | Un- weighted amount |
|------------------------|------------------|---|---------------------------|
| Routine Home Care | \$97.11 | \$66.72 | \$30.39 |
| Continuous Home Care | 566.82 | 389.46 | 177.36 |
| Inpatient Respite | 100.46 | 54.38 | 46.08 |
| General Inpatient Care | 432.01 | 276.53 | 155.48 |

TABLE II

| | National Rate | Wage Compo- nent subject to index | Index for Balto., MD | Adjusted Wage Component | Non-wage Component | Adjusted Rate |
|------------------------|------------------|---|-------------------------------|-------------------------------|-----------------------|------------------|
| Routine Home Care | \$97.11 | \$66.72 | 1.0549 | \$ 70.38 | \$ 30.39 | \$100.77 |
| Continuous Home Care | 566.82 | 389.46 | 1.0549 | 410.84 | 177.36 | 588.20 |
| Inpatient Respite | 100.07 | 54.38 | 1.0549 | 57.37 | 46.08 | 103.45 |
| General Inpatient Care | 432.01 | 276.53 | 1.0549 | 291.71 | 155.48 | 447.18 |

TABLE III

| | National Rate | Wage compo- nent subject to index | Index for your area [±] | Adjusted wage component (col. 2 x col.3) | Non-wage Compo- nent | Wage Adjusted Rates for your area (col. 4 + col. 5) |
|------------------------|------------------|---|---|--|----------------------------|--|
| | col. 1 | col. 2 | col. 3 | col.4 | col. 5 | col.6 |
| Routine Home Care | \$ 97.11 | \$ 66.72 | — | — | \$ 30.39 | — |
| Continuous Home Care | 566.82 | 389.46 | — | — | 177.36 | — |
| Inpatient Respite | 100.07 | 54.38 | — | — | 46.08 | — |
| General Inpatient Care | 432.01 | 276.53 | — | — | 155.48 | — |

Continuous Home Care Rate, adjusted for wages = \$ ÷24 hours = \$ ____ Hourly Rate

405. LIMITATION ON PAYMENTS FOR INPATIENT CARE

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (11/1 - 10/31). For purposes of this computation, if the intermediary determines that the inpatient rate should not be paid, any days for which you receive payment at a home care rate are not counted as inpatient days. The limitation is calculated by your intermediary as follows:

- o The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2.

- o If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.

- o If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

1. calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. multiplying excess inpatient care days by the routine home care rate.

3. adding together the amounts calculated in 1. and 2. above.

4. comparing the amount in 3. above with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement is refunded by the hospice.

406. PAYMENT FOR PHYSICIAN SERVICES

Payment for physician services provided in conjunction with the hospice benefit is made in different ways:

A. Administrative Activities.--Payment for physicians' administrative and general supervisory activities is included in the payment rates listed in §403. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group.

B. Patient Care Services.--Payment for physicians' direct patient care services furnished by hospice employees or under arrangement with the hospice is made in the following manner:

- o Formulate a charge and bill the intermediary for these services.
- o The intermediary pays you at the lesser of the actual charge or 100 percent of the Medicare reasonable charge for these services. This payment is in addition to the daily rates.
- o Payment for physicians' services is counted with the payments made at the daily payment rates to determine whether the hospice cap amount has been exceeded.
- o No payment is made for physician services furnished voluntarily. However, some physicians may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if you are obligated to reimburse the physician for the services. A physician must treat Medicare patients on the same basis as other patients in the hospice; a physician may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.

EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the intermediary and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.

C. Attending Physician Services.--Payment for patient care services rendered by a physician designated by the hospice patient as the attending physician is made in the following manner:

- o Patient care services rendered by an attending physician who volunteers services to the hospice is made in accordance with subsection B. (This is because physicians who volunteer services to the hospice are, as a result of this volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3).
- o Patient care services rendered by an independent attending physician (a physician who is not considered employed or under contract with the hospice) are not part of the hospice benefit. These physicians bill the Medicare carrier directly. Payment for services to hospice patients is made directly by the carrier to the independent attending physician at 80 percent of the reasonable charge.

Only the independent attending physician's personal professional services to the patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.

The hospice must notify the Medicare carrier of the hospice election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

This reimbursement is not counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

407. CAP ON OVERALL REIMBURSEMENT

Overall aggregate payments made to a hospice are subject to a "cap amount," calculated by the intermediary at the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicare beneficiaries during this period are compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. "Total payment made for services furnished to Medicare beneficiaries during this period" refers to payment for services rendered during the cap year beginning November 1st and ending October 31, regardless of when payment is actually made. Payments are measured in terms of all payments made to hospices on behalf of all Medicare hospice beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap. For example, payments made to a hospice for an individual electing hospice care on October 5, 1997, pertaining to services rendered in the cap year beginning November 1, 1996, and ending October 31, 1997, are counted as payments made during the first cap year (November 1, 1996 - October 31, 1997), even though that individual is not counted in the calculation of the cap for that year. (The individual is, however, to be counted in the cap calculation for the following year since the election occurred after September 27 - see below).

The hospice cap is to be calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, we require that the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1997, runs from October 1, 1997 through October 31, 1998. Similarly, the first cap period for hospice providers entering the program after November 1, 1996 but before November 1, 1997 ends October 31, 1998.

The "cap amount" is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount of \$6,500. This amount will be adjusted in future years to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers

(U.S. city average), published by the Bureau of Labor Statistics (BLS), from March 1984 to the fifth month of the accounting year. Section 407.1 explains how the statutory cap amount of \$6,500 is to be adjusted in future years. Hospices that began operations before January 1, 1975, are eligible for an exception to the application of this cap. You must apply and be approved to receive this waiver. Send applications to:

Health Care Financing Administration
Chronic Care and Purchasing Policy Group, CHPP
C5-02-23
7500 Security Boulevard
Baltimore, MD. 21244-1850

The computation and application of the "cap amount" is made by the intermediary at the end of the cap period. The material is presented here for your benefit as an aid to planning. You are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the intermediary. This must be done within 30 days after the end of the cap period.

Follow these rules in determining the number of Medicare beneficiaries who have elected hospice care during the period:

- o The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.
- o The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicare beneficiary during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of beneficiaries to be counted in each cap period.

Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)

When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary. It is inequitable to count the patient's stay in the hospices as equivalent if there were marked differences in the lengths of stay. Consequently, a calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay. The intermediary servicing the hospice program in which the beneficiary dies or exhausts the hospice benefit is responsible for determining the proportionate lengths of stay for all preceding hospices. This intermediary is also responsible for disseminating this information to any other intermediaries servicing hospices in which the beneficiary was previously enrolled. Each intermediary then adjusts the number of beneficiaries reported by these hospices based on the latest information available at the time the cap is applied.

EXAMPLE: John Doe, a Medicare beneficiary, initially elects hospice care from hospice A on September 2, 1997. Mr. Doe stays in hospice A until October 2, 1997 (30 days) at which time he changes his election and enters hospice B. Mr. Doe stays in hospice B for 70 days until his death on December 11, 1997. The intermediary servicing hospice B is responsible for determining the proportionate number of Medicare beneficiaries to be reported by each hospice that delivered hospice services to Mr. Doe. This intermediary determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in hospice A and 70 days in hospice B). Since Mr. Doe was in hospice A for 30 days, Hospice A counts .3 of a Medicare beneficiary for Mr. Doe in its hospice cap calculation (30 days/100 days). Hospice B counts .7 of a Medicare beneficiary in its cap calculation (70 days/100 days). The intermediary servicing hospice B makes these determinations and notifies the intermediary servicing hospice A of its determination. These intermediaries are then responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

Readjustment of the hospice cap may be required if information previously unavailable to the intermediary at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the example above, if the intermediary servicing hospice A had calculated and applied the hospice cap on November 30, 1997, information would not have been available at that time to adjust the number of beneficiaries reported by hospice A, since Mr. Doe did not die until December 11, 1997. The intermediary servicing hospice A would have to recalculate and reapply the hospice cap to hospice A based on the information it later received from the intermediary servicing hospice B. The cap for hospice A after recalculation would then reflect the proper beneficiary count of .3 for Mr. Doe.

An additional step is required when more than one Medicare certified hospice provides care to the same individual, and the care overlaps 2 cap years. In this case, each intermediary must determine in which cap year the fraction of a beneficiary is reported. If the beneficiary entered the hospice before September 28, the fractional beneficiary is included in the current cap year. If the beneficiary entered the hospice after September 27, the fractional beneficiary is included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, hospice A includes .3 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 1996, and ending October 31, 1997, since Mr. Doe entered hospice A before September 28, 1997. Hospice B includes .7 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 1997, and ending October 31, 1998, since Mr. Doe entered hospice B after September 27, 1997.

Where services are rendered by two different hospices to one Medicare patient, and one of the hospices is not certified by Medicare, no proportional application is necessary. The intermediary counts one patient and uses the total cap for the certified hospice.

We do not expect that the situation of beneficiaries changing to other hospices occurs frequently, thus we do not anticipate that the effect on hospice payments is significant.

407.1 Adjustments to Cap Amount.--The original cap amount of \$6,500 per year is to increase or decrease for accounting years that end after October 1, 1984 by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. As indicated in 42 CFR 418.309, the hospice cap is applied on the basis of a cap year beginning November 1 and ending the following October 31.

For example, for the cap amount for the period ending October 31, 1998, we calculate using the March 1998 price level in the medical care expenditures category of 239.8 and divide by the March 1984 price level of 105.4 to yield an index of 2.275 (rounded). The new hospice cap amount is the product of \$6500 (base year cap) multiplied by 2.214. Therefore, the cap amount for the period ending October 31, 1997, is \$14,788.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.

EXAMPLE:

10/01/97 - Hospice A is Medicare certified.

10/01/97 to 10/31/98 - First cap period (13 months) for hospice A.

Statutory cap for first Medicare cap year (11/01/96 - 10/31/97) = \$14,394

Statutory cap for second Medicare cap year (11/01/97 - 10/31/98) = \$14,788

Weighted average cap calculation for hospice A:

One month (10/01/97 - 10/31/97) at \$14,394 = \$ 14,394

12 months (11/01/97 - 10/31/98) at \$14,788 = \$177,456

13 month period \$191,850 divided by 13 = \$14,758 (rounded)

In this example, \$14,758 is the weighted average cap amount used in the initial cap calculation for hospice A for the period October 1, 1997 through October 31, 1998.

NOTE: If hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

408. APPEALS

A. Individual Determinations.--

1. Beneficiary Appeals.--A hospice beneficiary is entitled to the full range of appeal rights for cases involving a denial of benefits in accordance with the procedures in Part 405, Subpart G of the regulations (i.e., 42 C.F.R. §§405.701 et seq.). In these cases, a beneficiary may request a reconsideration regardless of the amount in controversy. If the beneficiary is dissatisfied with the reconsideration determination, he may request a hearing before an Administrative Law Judge (ALJ) if the amount in controversy is at least \$100. If dissatisfied with the ALJ's decision, he may request an Appeals Council review. If \$1,000 or more remains in controversy following the Appeals Council review or Appeals Council denial of a request for review, the beneficiary may file suit in a United States District Court.

2. Hospice Appeals.--A hospice, as is the case with any Medicare Part A provider, is entitled to appeal a claim filed on behalf of an individual only if the individual does not exercise his appeal rights and if the initial determination involves: (1) An intermediary finding that the items or services are not reasonable and necessary (§1862(a)(1) determination), and (2) An intermediary finding that either they or the beneficiary provider, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage. The authority for such provider appeal is found in §1879(d) of the Act.

In the following circumstances, a hospice has the full range of appeal rights specified in Subpart G (i.e., reconsideration, ALJ hearing, Appeals Council review and judicial review), if amounts in controversy are met and the beneficiary does not exercise his appeal rights.

a. When an intermediary finds that items or services furnished to a beneficiary are not covered because they are not reasonable and necessary for the palliation or management of terminal illness and further finds that the beneficiary or the hospice, or both, should have known this. (The hospice may not combine claims from more than one beneficiary to reach the \$100 minimum for an ALJ hearing.)

b. When a hospice submits a claim requesting payment at the continuous home care rate, the intermediary is obliged to determine the medical necessity for continuous home care (i.e., an 1862(a)(1) determination).^{*} If the intermediary decides that continuous home care is not medically necessary and pays the claim at the routine care rate, the hospice may appeal the benefit reduction if the intermediary finds that either the beneficiary or the hospice, or both, knew or should have known that the services were not covered at the continuous home care level. (The hospice may not combine claims from more than one beneficiary to reach the \$100 minimum for an ALJ hearing.)

^{*}To constitute continuous home care, care must be provided for at least 8 hours. (See §230.2.) If such care is not provided for a minimum of 8 hours, a technical denial occurs (not an 1862(a)(1) determination) and the hospice has no appeal rights.

3. Beneficiary Representation by Hospice.--To be represented by a hospice, the beneficiary must execute a form SSA-1696-U4, Appointment of Representative, in addition to the appropriate reconsideration or hearing request. The SSA-1694-U4 form must contain the signed acceptance of an authorized official of the hospice being appointed.

When the appeal involves either services that constitute custodial care or are not reasonable and necessary and thus the application of the limitation of liability provisions under §1879 of the Act, the hospice representative (attorney or non-attorney) must waive in writing any right to payment from the beneficiary for these services. The intermediary must obtain the written waiver even when the claim is initially paid under the limitation of liability provision, i.e., when it finds that neither the hospice nor the beneficiary is liable. This waiver requirement is intended to insure against conflict of interest.

A hospice representative (including an attorney) cannot charge the beneficiary a fee in connection with such representation.

The costs incurred by a hospice in representing a beneficiary in an unsuccessful appeal are not allowed as reasonable costs in determining its Medicare reimbursement.

B. Provider Payment Determinations.--A hospice dissatisfied with an intermediary determination, as set out in a notice issued to the hospice at the end of the cap year may request and obtain an intermediary hearing if the amount of program reimbursement in controversy with respect to matters for which the hospice has a right to review is at least \$1,000, but less than \$10,000. Where the dispute involves \$10,000 or more, jurisdiction lies with the Provider Reimbursement Review Board (PRRB). A request for a hearing must be filed no later than the 180th calendar day following the date the hospice received notice of the intermediary's determination. The hearing is conducted consistent with the procedures in Part 405, Subpart R of the regulations (i.e., 42 C.F.R. §§405.1800 et seq.), and a decision by the PRRB is subject to review only by the Administrator of HCFA. There is no judicial review of the final administrative decision.

Examples of types of reimbursement issues for which a hospice may request a hearing are as follows:

1. Calculation and application of the hospice cap.
2. Calculation of reimbursement where the hospice is found to have exceeded the 80/20 ratio of home care to inpatient care days.

The methods and standards for the calculation of the hospice payment rates established by HCFA, as well as questions as to the validity of the applicable law, regulations, or HCFA rulings, are not subject to administrative review.

NOTE: Generally, matters involving payment to a hospice of an incorrect payment rate with respect to one or more of the categories of hospice care (this may, for example, result from the use of a money amount other than the applicable payment rate calculated by HCFA or from an incorrect adjustment of such rate to reflect local differences in wages) are expected to be resolved by the intermediary. However, if these matters are unresolved at the end of the cap year, the hospice has a right to a hearing.

409. COST REPORTING AND RECORDKEEPING REQUIREMENTS

A. Cost Reports.--HCFA is developing cost reporting forms and instructions and will distribute them to hospices upon completion so that any needed changes can be made in their recordkeeping systems. The information collected through these cost reports will be used to update reimbursement rates in the future. In no case will cost reports be required more often than annually.

B. Final Settlement.--There are no retroactive adjustments made to the reimbursement rates discussed above, other than application of the limits discussed in §§405 and 407 above. The cost reports are used strictly for data collection.

C. Accounting Requirements.--The cost data submitted must be on the accrual basis of accounting and in accordance with generally accepted accounting principles. All books and records shall be retained for 5 years. HCFA reserves the right to audit any cost or utilization data collected. Sufficient documentation must be maintained for audit purposes, and to support the allocation of costs.

410. HOSPICE COINSURANCE

The payment rates in §403 have been reduced by a coinsurance amount on outpatient drugs and biologicals and inpatient respite care as required by law. No other coinsurance or deductibles may be imposed for services furnished to beneficiaries during the period of an election, regardless of the setting of the services. You may charge beneficiaries for the applicable coinsurance amounts.

410.1 Coinsurance on Outpatient Drugs and Biologicals.--The statute specifies that you may charge the beneficiary a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than \$5, for each prescription furnished on an outpatient basis. The payment rates have been reduced by average coinsurance expected to be collected. If you intend to charge coinsurance, establish a "drug copayment schedule" that specifies each drug and the copayment to be charged. The charges included on the schedule must approximate 5 percent of the cost of the drugs or biologicals to you, up to the \$5 maximum. Additionally, the cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. Submit this schedule to the intermediary, who will review it in advance to assure that it is reasonable.

410.2 Coinsurance on Inpatient Respite Care.--You may charge the beneficiary a coinsurance amount equal to 5 percent of the amount HCFA has estimated to be the cost of respite care, after adjusting the national rate for local wage differences. The following table may be used to calculate the amount that a hospice may charge for respite coinsurance.

| | |
|---|-------------|
| Wage Adjusted Inpatient Respite Care | |
| Rate for your area (from Table III, p. 4-5) | \$ |
| | ÷95% |
| Rate for Inpatient Respite Care Including Coinsurance | |
| | <u>x 5%</u> |
| Coinsurance amount your hospice may charge | \$ |

No retroactive adjustments will be made to coinsurance amounts already collected from beneficiaries for inpatient respite care days as a result of any reimbursement adjustments made, such as application of the limitation on payments for inpatient care (see §405).

The total amount of coinsurance for inpatient respite care for any beneficiary during a hospice coinsurance period may not exceed the amount of the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. A hospice coinsurance period begins with the first day for which an election for hospice services is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on which no such election is in effect for the beneficiary.

Example: Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care under a final election period. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, the maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

The hospice is responsible for billing and collecting the coinsurance amounts from the beneficiary.

411. PROHIBITION AGAINST BILLING OTHERS FOR COVERED SERVICES

Section 1866 of the Social Security Act requires providers (including hospice providers) to file an agreement with the Secretary of Health and Human Services in order to be qualified to participate and to be eligible for payment under the Medicare program. In this agreement the hospice agrees not to charge (and accordingly may not charge) any individual or any other person for items or services for which the individual is entitled to have payment made under the hospice provision. Where items and services are not subject to the Medicare secondary payer provision, Medicare is the primary payer for all covered benefits and another insurer should not be billed for these items or services. (The secondary payer provision may be in effect if the patient or spouse is employed and has coverage under the employer's health insurance program.) For example, a hospice may not bill a third party such as an insurance company or the American Cancer Society for covered palliative drugs and biologicals for which payment is made through the Medicare rates.

If a hospice furnishes, at the request of a beneficiary, items or services in addition to those that are covered under the hospice provision, the hospice may charge the beneficiary for these items or services.

200. ELIGIBILITY AND COVERAGE

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the conditions of participation for hospices, and has a valid provider agreement. **An individual may elect to receive Medicare coverage for an unlimited number of election periods of hospice care. The periods consist of two 90-day periods, and an unlimited number of 60-day periods.**

201. ELIGIBILITY REQUIREMENTS

In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Obtain the certification that an individual is terminally ill in accordance with the following procedures.

For the first 90-day period of hospice coverage, obtain, no later than 2 calendar days after hospice care is initiated (that is, by the end of the third calendar day), **certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).** If the written certification is not obtained within 2 calendar days following the initiation of hospice care, a verbal certification **must** be made within 2 days following the initiation of hospice care, with a written certification **obtained before billing for hospice care.** If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day of certification, **i.e., the date verbal certification is obtained.** These certifications may be completed up to 2 weeks before hospice care is elected. The attending physician is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

For the subsequent periods, obtain, no later than 2 calendar days after the first day of each period, **a verbal certification statement from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. A written certification from the medical director of the hospice or the physician member of the interdisciplinary group must be on file in the beneficiary's record prior to the submission of a claim to the intermediary. The certification must include: (1) the statement that the individual's medical prognosis is that his or her life expectancy is 6 months or less if the terminal illness runs its normal course and (2) the signature(s) of the physician(s).** Retain the certification statements.

204. ELECTION OF HOSPICE CARE

If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative authorized by State law to elect or revoke hospice care or terminate medical care on behalf of a terminally ill individual. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

An individual must waive all rights to Medicare payments for the duration of the election of hospice care for the following services:

- o Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

o Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services provided by:

- The designated hospice (either directly or under arrangement);
- Another hospice under arrangements made by the designated hospice; or
- The individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

204.1 Use of Election Periods.--The two 90-day election periods must be used before the **unlimited number of 60-day periods**. Although **these** benefit periods need not be used consecutively, an election to receive hospice care is considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

204.2 Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries.--A Medicare beneficiary who resides in an SNF or NF may elect the hospice benefit if:

- o The residential care is paid for by the beneficiary; or
- o The beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary's care by Medicaid, and
- o The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.

The State Medicaid agency pays the hospice the daily amount allowed by the State for room and board while the patient is receiving hospice care, and the hospice pays the facility. Room and board services include the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

Whenever Medicaid is involved, send a copy of the election form to the State Medicaid agency at the time of election, and also notify this agency when the patient is no longer receiving hospice care.

In States that offer the hospice benefit under the Medicaid program, dually eligible beneficiaries must elect the benefit under both programs at once.

204.3 HMO Enrollees.--An HMO enrollee may elect the hospice benefit. After the hospice election, Medicare pays the hospice for hospice services and pays the HMO for attending physician services and services not related to the patient's terminal illness. (See 42 CFR 417.531 and 417.585.)

210. ELECTION, REVOCATION, AND CHANGE OF HOSPICE

Each hospice designs and prints its own election statement. The election statement must include the following items of information:

- o Identification of the particular hospice that will provide care to the individual;
- o The individual's or representative's acknowledgment that he/she has been given a full understanding of hospice care;
- o The individual's or representative's acknowledgment that he/she understands that certain Medicare services are waived by the election;
- o The effective date of the election; and
- o The signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation. The individual forfeits coverage for any remaining days in that election period. The individual may at any future time elect to receive hospice coverage for any other hospice election periods for which he/she is eligible. An individual may not designate an effective date earlier than the date that the revocation is made.

The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice may discharge a patient if it discovers that the patient is not terminally ill. Discharge may also be necessary when the patient moves out of the service area. Notify the intermediary of the discharge so that hospice services and billings are terminated as of that date. In this situation, the patient loses the remaining days in the benefit period. General coverage under Medicare is reinstated at the time the patient revokes the benefit or is discharged.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he/she is eligible.

An individual may change, once in each election period, the designation of the particular hospice from which he/she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file, with the hospice from which he/she has received care and with the newly designated hospice, a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which he or she plans to receive care and the date the change is to be effective. A change of ownership of a hospice is not considered a change in the individual's designation of a hospice, and requires no action on the individual's part.

230 . REQUIREMENTS FOR COVERAGE

To be covered, a certification that the individual is terminally ill must have been completed as set forth in §201. The individual must elect hospice care in accordance with §210, and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care and reasonable and necessary for the palliation or management of the terminal illness and related conditions.

In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care. At least one of the persons involved in developing the initial plan must be a nurse or physician. This plan must be established on the same day as the individual's assessment if the day of assessment is to be a covered day of hospice care. Date the plan of care on the day it is first established. The other two members of the basic interdisciplinary group (the attending physician, and the medical director or physician designee) must review the initial plan of care and provide their input into the process of establishing the plan of care within 2 calendar days following the day of assessment. A meeting of group members is not required within this 2-day period; input may be provided by telephone.

230.1 Covered Services.--All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

- A. Nursing Care.--Nursing care provided by or under the supervision of a registered nurse.
- B. Medical Social Services.--Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.
- C. Physicians' Services.--Physician's services performed by a physician (as defined in 42 CFR 410.20 except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.
- D. Counseling Services.--Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.
- E. Short-Term Inpatient Care.--Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. A hospice may not arrange to provide inpatient services to a Medicare beneficiary in a V.A. or military hospital because Medicare cannot pay for services for which another government agency has paid or is obligated to pay. Services provided in an inpatient setting must conform to the written plan of care.

Medicare covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient care, which is for pain control and symptom management.

General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management which cannot be feasibly provided in other settings while he or she prepares to receive hospice home care, general inpatient care is appropriate.

Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring, or a patient whose family is unwilling to permit needed care to be furnished in the home.

Inpatient respite care may be furnished to provide respite for the individual's family or other persons caring for the individual at home.

Note that hospice inpatient care in an SNF or NF serves to prolong current benefit periods for general Medicare hospital and SNF benefits. This could potentially affect patients who revoke the hospice benefit.

F. Medical Appliances and Supplies, Including Drugs and Biologicals.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances include covered durable medical equipment as described in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

G. Home Health Aide and Homemaker Services.--Home health aide services may only be provided by individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

H. Physical Therapy, Occupational Therapy and Speech-Language Pathology Services.--Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

I. Other Items and Services.-- Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Social Security Act, is a covered service under the Medicare hospice benefit. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

EXAMPLE: A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

230.2 Core Services.--Nursing services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

If you are located in a nonurbanized area, you may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements if you can demonstrate that you made a good faith or diligent effort to hire these specialties. Determinations as to urbanized and nonurbanized areas are based on the current Census Bureau of the designations. The location of a hospice that operates in several areas is considered to be the location of its central office. To qualify for the nursing services waiver, you must have been operational on or before January 1, 1983.

Determinations as to whether you were operational on or before January 1, 1983 are based on:

- o Proof that you were established to provide hospice services prior to 1983 (e.g., newspaper advertisements, dated correspondence on hospice letterhead, dated invoices, articles of incorporation, governing body minutes);
- o Evidence that you furnished hospice-type services to patients on or before that time (e.g., dated copies of medical records, dated nursing notes, dated pharmaceutical orders); and
- o Evidence that hospice care was a discrete activity rather than an aspect of a provider's patient care program prior to January 1, 1983.

Determinations of good faith or diligent efforts to hire appropriate personnel are based on the following evidence:

- o Recruitment efforts through advertisements in local newspapers;
- o Job descriptions for nurses, physical therapists, occupational therapists, speech-language pathologist, and dietary counselors;
- o Evidence that salary and benefits are competitive for the area; and
- o Any other recruiting activities (e.g., recruiting efforts at health fair and contacts with appropriate personnel at other providers in the area).

A waiver remains in effect for a 1-year period. A waiver may be extended for two additional 1 year periods. Prior to each additional year, request the extension and certify that the employment market for appropriate personnel has not changed significantly since the initial waiver was granted if this is the case. No additional evidence is required with this certification.

Send requests for this waiver and any extensions with supporting documentation to your regional office for review. Regional offices have the authority to review, and approve, or deny the waiver application.

230.3 Special Coverage Requirements.--

A. Continuous Home Care.--Provide continuous home care only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver.

Provide a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours in the evening. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care.

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Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.

NOTE: When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care.

Nursing care in the hospice setting can include skilled observation and monitoring when necessary and skilled care needed to control pain and other symptoms.

Continuous home care is covered only as necessary to maintain the terminally ill individual at home.

B. Respite Care.--Respite care 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 be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

C. Bereavement Counseling.--Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service, but it is not separately reimbursable.

D. Special Modalities.--Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy. No additional Medicare payment may be made regardless of the cost of the services.

Limitation on Liability of Beneficiary and Provider
Where Medicare Claims Are Disallowed

270. LIMITATION OF LIABILITY FOR HOSPICE CLAIMS--GENERAL

Section 1879 of the Social Security Act (the act) provides relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. In hospice cases, §1879 of the Act provides relief where services are not reasonable and necessary for the palliation or management of terminal illness. In such situations, the beneficiary is not liable for the charges for the services. Liability falls on the hospice if it is determined the hospice knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. However, the Medicare program will accept liability, i.e., will make payment to a hospice even though a noncovered service is involved, if neither the beneficiary nor the hospice knew or could reasonably be expected to have known, that the services were not covered under Medicare.

This provision does not apply to any services rendered by a hospice prior to the date on which its Medicare agreement is accepted by the Secretary, even though the effective date of the agreement may be earlier. This is so because a beneficiary dealing with a nonparticipating provider could not reasonably have expected Medicare coverage.

Section 1879 permits a hospice to appeal a determination that services were not reasonable or necessary or constitute custodial care when it is determined that liability rests entirely with the hospice, or when the beneficiary is partially or completely liable for the noncovered items or services and it has been determined that the beneficiary will not exercise his appeal rights. (See §408.A.2.) Section 1879 also provides that the Medicare program will indemnify, i.e., make direct payment to (see §277), the beneficiary or other person(s), subject to the coinsurance amounts, for any payments made by the beneficiary or other persons to a liable provider that are not refunded or credited, for items or services which have been determined to be noncovered, as specified in §271. Any payments made as indemnification shall be treated as overpayments to such provider and withheld from future Medicare benefits due that provider. (See §277.2.)

271. APPLICABILITY OF LIMITATION OF LIABILITY TO ITEMS OR SERVICES FURNISHED BY HOSPICES.

A. The limitation of liability provision applies to hospice denials ordinarily under two specific statutory exclusions from coverage;

o Items or services that are not reasonable and necessary, either for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (excluded by §1862(a)(1)(A)), or for the palliation or management of terminal illness (excluded by §1862(a)(1)(C)). (See §230ff.); or

NOTE: Hospice patients receive a covered level of care every day they are under the care of a hospice. Denials consist of reclassification of days of care (resulting in changes in payment level) when it is determined that the patient did not require continuous home care or general inpatient care to achieve palliation and that routine home care was sufficient for this purpose.

o Items or services that constitute custodial care, i.e., not a covered level of care (excluded by §1862(a)(9)). (See §230ff.)

B. The following examples illustrate types of hospice service denials which cannot involve the limitation of liability provision.

- o Services payable under State or Federal workers' compensation.
- o Services denied because the patient has not been certified to be terminally ill; or
- o Services denied because the patient has already received 210 days of hospice benefits.

272. DETERMINING LIABILITY FOR HOSPICE CLAIMS UNDER SECTION 1879--GENERAL

Whether a beneficiary or a hospice knew or could reasonably have been expected to know that items or services were not covered is a matter of judgment. For this reason, for hospice care furnished on or after May 1, 1987, and through October 31, 1988, decisions as to the limitation of liability for hospice claims normally will not be developed case-by-case, but will be made on the basis of whether or not the hospice is entitled to a favorable presumption that it lacked knowledge of the non-coverage of services. However, under the law, use of the favorable presumption for hospices will be discontinued after that date.

272.1 Determining Beneficiary's Liability.--For the beneficiary, the presumption will be made that he did not know that services would not be covered unless the evidence indicates that written notice was given to the beneficiary. In some cases, the beneficiary may have been given notice in a previous claim that a type of care would not be covered. More commonly, you will have given notice to the beneficiary that a particular course of treatment would not be covered or that coverage ended at a particular time.

A. Beneficiary Determined to be Liable.--When the intermediary determines that the beneficiary is liable, the beneficiary is responsible for the payment of expenses incurred for items or services determined to be noncovered under Medicare.

B. Beneficiary Determined to be Without Liability.--Unless evidence indicates that the beneficiary knew or had reason to know that the items or services he or she received were noncovered because they were not reasonable or necessary, the intermediary presumes that the beneficiary did not know the services would not be covered.

If the intermediary determines that both the beneficiary and you did not know and could not have been expected to know that the services were not reasonable and necessary, all days for which the beneficiary received the benefit of limitation of liability are charged to the beneficiary's utilization record of hospice days as though covered under Medicare. For situations where the beneficiary's liability has been waived but for which you are liable, all days for which the beneficiary received benefit of limitation of liability are not charged to the beneficiary's utilization record of hospice days.

272.2 Determining Hospice Liability.--

A. General.--You are held liable for noncovered services if the intermediary determines that you:

- o had knowledge of the noncoverage of services in a particular case,
- or
- o could reasonably have been expected to have such knowledge.

B. The Favorable Presumption Provision.--For hospice care furnished on or after May 1, 1987, and through October 31, 1988, you are given an opportunity to qualify for a favorable presumption that you did not have knowledge and that you could not reasonably have been expected to have knowledge that the services you provided would be denied as not reasonable and necessary for the palliation or management of terminal illness.

As a means of determining whether you are entitled to such a favorable presumption, a denial rate criterion has been established which is intended to indicate whether you can make accurate judgments concerning the coverage or noncoverage of services in most cases. If you do not meet the denial rate criterion, you are not considered to have taken all reasonable measures to obtain knowledge of noncoverage and therefore are not granted a favorable presumption.

If you meet the denial rate criterion (see §§273ff), all of your claims for hospice services denied because the services are not reasonable and necessary for the palliation or management of terminal illness are processed under the favorable presumption that you had no knowledge of noncoverage unless the evidence in a particular case shows that, in fact, you had such knowledge. When you do not meet the denial rate criterion, the favorable presumption is not applicable and your liability is not ordinarily limited in cases denied as not reasonable or necessary. However, even though you have been found not to meet the criterion, and a favorable presumption cannot be extended to your claims, you may allege that in an individual claim you did not know and could not have been expected to know that the care was not covered. In such situations, the intermediary considers the evidence submitted in support of your allegation.

C. Hospice Is Determined to Be Liable--Right to Appeal.--If you are determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary, you may appeal such a decision by an intermediary under certain conditions (see §408).

D. Hospice and Beneficiary Determined to Be Without Liability.--If the intermediary determines that neither you nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment (see §276).

273. CRITERIA FOR PRESUMING THAT HOSPICE MEETS LIMITATION OF LIABILITY REQUIREMENTS

To determine whether you have knowledge of Medicare coverage rules and can apply them, your intermediary collects statistics to ascertain whether your denial rate does not exceed 2.5 percent. (See §273.3 for determining denial rate for services provided that are denied under §1862(a)(1)(C) as not reasonable and necessary for the palliation or management of terminal illness.)

273.1 Reevaluating Favorable Presumption.--You are reevaluated at least every 3 months to determine whether you are entitled to a favorable presumption. The intermediary may set a shorter time for reevaluation in special situations if you have a drastic fluctuation in your denial rates.

The intermediary notifies you in writing when there is a change in your qualification for favorable presumption.

273.2 Reevaluating Hospice's Qualifications for Favorable Presumption for a Prior Period.--Occasionally, new information may indicate that an earlier determination that you qualified for a favorable presumption was erroneous. In such a situation, the intermediary may retrospectively reevaluate and redetermine your compliance with the requirements for a favorable presumption for a prior period.

If the reevaluation of your compliance so establishes, the intermediary may determine that you had, or could reasonably have been expected to have had, reasonable and necessary, for the palliation or management of terminal illness, during the prior period in question.

Even though the intermediary determines, after reevaluation, that you were in compliance with the appropriate denial rate criterion, it may rebut your favorable presumption in any individual case in which the evidence is clear and obvious that you should have known at the time the services were furnished that they were not covered.

273.3 Determining Denial Rates for Hospices.--Specified data will be recorded for those cases in which a Medicare beneficiary receives services prior to an event terminating program hospice coverage. Terminating events include: (1) Hospice notice; (2) intermediary notice; (3) exhaustion of benefits; (4) discharge; or (5) death.

The intermediary records the following data:

A. All days (excluding "grace days" under §1879; see §276) that you billed as covered which occurred prior to a terminating event, that is, all such days in the universe of claims.

B. All days determined by you to be covered but determined by the intermediary to be noncovered because the services provided were not medically reasonable and necessary for the palliation or management of terminal illness (§1862(a)(1)(C) exclusion), that is, all such days in the universe of claims.

o Where 1 or more hours of continuous home care are denied on a day billed as a continuous home care day, then the entire day is counted as a denied day.

o Days denied other than under the §1862(a)(1)(C) exclusion should not be included in B.

The denial rate is calculated by dividing "A" into "B." For the denial rate criterion to be met, the number of days in "B" must not exceed 2.5 percent of the number of days in "A."

273.4 Time Period for Calculating the Denial Rate.--Each calendar quarter, or more frequently if necessary, the intermediary calculates your denial rate based on the data collected during the preceding calendar quarter. The denial rate is calculated by the end of the month following the end of the quarter.

For example, data compiled during 1/1 through 3/31 is used to calculate the denial rate. This calculation is made by 4/30. If shorter times, e.g., 1 or 2 month periods, are used, the principles above are adapted to the shorter times.

273.5 Effect of Change in Favorable Presumption.--You will be advised of any changes in your favorable presumption by the end of the month following the end of the quarter for which the denial rate was calculated.

For example, if there is a loss of favorable presumption based on data compiled from 1/1 through 3/31, you will retain your favorable presumption for services rendered from 1/1 through 3/31 and up to the date of the notice of change of favorable presumption status but no later than the last day of the month following the end of the quarter (in this case, 4/30).

All claims processed involving services furnished on or after the date of notice are processed under the new favorable presumption determination.

273.6 Treatment of Determinations Later Reversed.--Where an initial payment or denial of payment determination which was included in the denial rate calculation is reversed as a result of reconsideration, hearing, reopening or other review, the number of your denied Medicare days will be adjusted (no adjustment is necessary to the total number of days). In the case of days initially denied, but later determined to be covered, such days will be subtracted from your denied Medicare days. Days initially found to be covered, but later determined to be noncovered, are added to your denied Medicare days. (Where the review merely affirms the initial payment or denial of payment decision, no adjustment action is necessary.) The subtraction or addition of such days are applied to the period during which the intermediary took action on the reversal, that is, to the current denial rate calculation.

NOTE: Days payable only under the limitation of liability provision are considered noncovered days and are not counted as covered in the denial rate calculations.

274. DETERMINING WHETHER HOSPICE HAD KNOWLEDGE OF NONCOVERAGE OF SERVICES

You are considered not to have had knowledge of noncoverage of services in a particular claim unless there is evidence to the contrary. Such evidence to the contrary may include the following:

- A. Denial Rate Criterion.--You did not meet the criterion for a favorable presumption.

NOTE: If you do not meet the criterion for favorable presumption, you may qualify for payment, under limitation of liability, of the noncovered services in a denial only where you can demonstrate through objective evidence that, even if you have had a favorable presumption, you would not have known that the services were noncovered.

Where you meet the criterion for a favorable presumption, you qualify thereby for payment, under limitation of liability, of the noncovered services in the case of a denial where there is a reasonable doubt as to whether any of the conditions listed in the following subsections is met; that is, you receive the benefit of the doubt in this regard. However, the favorable presumption is rebutted and no payment is made where it is clear and obvious in a denial that any one of the conditions listed in the following subsections is met.

- B. Hospice Notices.--

o You submitted a no-payment claim, or submitted a claim for payment only at the request of the beneficiary;

o You issued a written notice of noncoverage to the beneficiary.

C. HCFA Directives.--HCFA has informed you in writing of the noncoverage of a particular service or category of services. For example, specific instructions in this

manual provide examples of hospice services that qualify for Medicare coverage. Thus, where it is clear and obvious from review of a particular medical record that the patient received only noncovered services, as opposed to the covered services described in this manual and/or other HCFA directives, you are expected to have knowledge of noncoverage.

D. Intermediary Notices.--

o A one-time written notice from the intermediary to you that a particular item or service is not covered, e.g., acupuncture, is sufficient notice for all subsequent claims involving that service.

o The intermediary notified you by telephone and/or in writing that the care is not covered or that covered care has ended. The date of the telephone notice is the effective date of notification.

o The intermediary issued a general provider bulletin or newsletter advising that a specific item or service is not considered reasonable and necessary in a hospice setting.

E. Patently Unnecessary Services.--An immediate finding of liability in fraud and abuse cases as well as in any other situations will be made where you furnish and claim payment for services that are so patently unnecessary that all hospices could reasonably be expected to know that the services are not covered under Medicare. Generally, this would be the case where abuse has been identified in a particular claim. Abuse exists when a provider furnishes services that are inconsistent with accepted sound medical practices, are clearly not within the concept of reasonable and necessary services as defined by law or regulations, and, if paid for, would result in an unnecessary financial loss to the Medicare program.

274.1 Notifying Patient of Noncoverage.--If you are aware that the services furnished a patient are not covered, advise the patient (or his representative) in writing prior to or at the time of start of care (or at the time the type of care changes) that the care is noncovered and that no claim for Medicare reimbursement will be submitted. If the beneficiary insists that you submit a claim for payment, indicate that the bill is being submitted at the beneficiary's request, and why you consider the care to be noncovered. In such a case, neither you nor the beneficiary would be entitled to limitation of liability. (Such denials are not counted in determining denial rates for application of the criteria in §273ff, but statistics will be kept to determine whether the criteria in §273ff continue to be met.)

Establish a procedure for notifying beneficiaries and physicians promptly when a decision of noncoverage is made. The procedure should provide for a written notice of noncoverage to the beneficiary or person acting on his behalf on the day that services were to be started or on the day you found the care to be noncovered or on the day the intermediary telephones a decision of noncoverage to you.

274.2 Improper Hospice Coverage Decisions.--The intermediary will review cases which you consider noncovered and for which you have asked the intermediary for a determination. If in a substantial number (in excess of 5 percent) the intermediary finds that covered services are involved, it will infer that you do not know the standards for coverage and are not in a position to give effective notices of noncoverage to beneficiaries. In such cases, you will be denied a favorable presumption, even if you meet the denial rate criterion in § 273ff.

275. ESTABLISHING WHEN BENEFICIARY IS ON NOTICE OF NONCOVERAGE

If the beneficiary has previously been informed in writing that the type or level of services were noncovered as a result of similar prior care, the beneficiary is liable for payment for the services based upon the prior notice, but only if it is clear that the beneficiary (or the person acting on his behalf) should have known that the circumstances were the same as in the situation previously found to be noncovered. With this exception, the beneficiary is presumed not to have known nor to have been expected to know that care would not be covered unless or until one of the following occurs with respect to the beneficiary or the person acting on his behalf.

A. Hospice Is Source of Notice.--You advised the beneficiary or the person acting on his behalf in writing prior to start of care at a certain level that that level of care is noncovered.

NOTE: See §287.2 for Hospice Model Letter, giving notice of noncoverage to beneficiary.

B. Intermediary Is Source of Notice.--The beneficiary's first notification of noncoverage is received from the intermediary (e.g., intermediary denial notice).

275.1 Determining Date of Notice.--

A. For Beneficiaries.--In determining when the beneficiary received notice of a noncovered type or level of care, the date of the written notice is used, but only if the beneficiary is receiving hospice services and is capable of handling his own affairs (i.e., able to sign and negotiate checks).

If you are unable to deliver notice of noncoverage personally to a person acting on behalf of a beneficiary, give notice by telephone and mail a written confirmation of the telephone notice. The date of the telephone call is considered the date the person acting on behalf of the beneficiary received notice of noncoverage.

B. For Hospices.-- If you are notified of noncoverage by an intermediary, the intermediary uses the date that it first notified you of noncoverage, as annotated in its records in accordance with §274D.

Where you determine that a particular type or level of care is no longer required, the intermediary uses the date of your written notice to the beneficiary of such noncoverage, as indicated in subsection A.

275.2 Documentation of Notice.--Retain copies of all notices or noncoverage you have given to the beneficiary, because the fact of notice to the beneficiary may be an important element in the event of an appeal on the issue of limitation of liability.

276 . PAYMENT UNDER LIMITATION OF LIABILITY

When it is determined during a beneficiary's stay that a particular type or level of care is not covered on a given day but both the beneficiary and you are entitled to limitation of liability, the Medicare program may make payment for the noncovered services up to the date of notice and also for a grace period of 1 day (24 hours) after the date of notice to you or to the beneficiary, whichever is earlier. (See §§274 and 275 for definition of notice.)

If you are given notice as described above, advise the beneficiary in writing of the determination made. Your written notice to the beneficiary is given on the same date you received notice from the intermediary. If you fail to give the beneficiary such timely notice, the beneficiary is protected from liability until he receives the notice.

For example, if you receive notice of a day of noncovered level of care from the intermediary on February 15 but fail to advise the beneficiary until February 19, the beneficiary is protected from liability through February 19, the date on which he first received notice. However, you are entitled to program payment only through the date, February 15, on which you received notice, and for whatever grace period is allowed thereafter. If you received notice from the intermediary on February 15 but failed to give the beneficiary notice until the next day, February 16, the beneficiary and you are protected from liability under the grace period only for the additional day, February 16.

Indemnification Procedures under Limitation of Liability

277. INDEMNIFICATION PROCEDURES FOR CLAIMS FALLING WITHIN THE LIMITATION OF LIABILITY PROVISION

Section 1879(b) of the Act provides that when a provider is held liable for the payment of expenses incurred by a beneficiary for noncovered items or services and such provider requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program indemnifies the beneficiary or other person(s). Further, any such indemnification payments are considered overpayments to the provider.

277.1 Determining the Amount of Indemnification.--In accordance with §1879(B) of the Act, the beneficiary or other person(s) are indemnified for actual amounts paid to you, rather than the rates paid by the Medicare program. Additionally, §4096 of P.L. 100-203 (OBRA of 1987) revises certain limitation of liability requirements for indemnification under §1879(b) of the Act. Under this provision, a beneficiary qualifying for indemnification for denied items and services furnished on or after January 1, 1988, is no longer responsible for paying deductible and coinsurance charges related to the denied claim. Where such indemnification payment is made, the beneficiary's Medicare utilization record is not charged for the denied items and services furnished.

277.2 Notifying the Provider.--After the intermediary has determined the indemnification amount, you are notified of the proposed indemnification action. The essential elements of this written notice are:

- o An explanation of the items and services for which you are liable with reference to the original notice to you;
- o A statement of the provision of §1879 which allows the program to indemnify the beneficiary and recover an overpayment from the provider;
- o An explanation of the amount determined payable;
- o A statement that the amount determined to be payable will be paid and that it constitutes an overpayment to you which will be recovered from future Medicare payments made to you;
- o A statement encouraging you to refund any amount(s) already collected; and
- o The opportunity for you to question the amount determined payable by the intermediary, in writing, within 15 days.

278. HOSPICE MODEL LETTER TO ESTABLISH BENEFICIARY NOTICE OF MEDICARE NONCOVERAGE

Make an original and two copies of the letter. (If the intermediary requires that it receive a copy of the letter, make one more copy.) You must give or mail the original to the beneficiary. Send the first copy to the beneficiary's attending physician, and keep the second copy. When a copy is given a beneficiary or person acting on his behalf your copy should contain the signature of the beneficiary or person acting on his behalf, acknowledging the date he received the notice. Where personal delivery is not possible, your copy must reflect the date the beneficiary was notified by telephone and the date the notice was mailed.

A. Heading of Letter.--

1. Hospice Designation.--The hospice's name and address should appear at the top of the letter.
2. Date Line.--The date the letter is given or mailed to the beneficiary or his representative.
3. Address Line.--Enter the name of the beneficiary or person acting on his behalf. If the letter is mailed, enter the address of the beneficiary or person acting on his behalf. Be sure to position the name and address properly if a window envelope is used.

4. Re Line--Where the letter is addressed to a person acting on behalf of the beneficiary, always enter the name of the beneficiary. In all cases, enter in this space the beneficiary's Medicare number and the date of start of care.

B. Body of Letter--Check appropriate item(s):

ITEM 1 . Check where you determine prior to, or at the start of a certain type or level of care, that the services to be furnished the beneficiary will not be covered.

ITEM 2. Check where you are advised of the noncoverage of a type or level of services by your Medicare intermediary. Insert the first date the services are no longer covered as determined by the intermediary.

After the above items, indicate the name and address of your intermediary.

ITEM 3. Check where an in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. When this item is checked, the Model Letter should be mailed out on the same day as contact was attempted. (See §275.1A.)

C. Signature of Administrative Officer--The letter should be signed by the administrative officer or his agent.

D. Verification of Receipt of Notice--Check and complete the appropriate item to verify that notice of noncoverage was issued to the beneficiary or to the person acting on behalf of the beneficiary. Only one item should be checked:

ITEM A. Check and complete where contact is made in person (i.e., this notice is personally delivered). If the beneficiary or the person acting on behalf of the beneficiary refuses to sign the verification, your copy of the Model Letter should be annotated accordingly, indicating the circumstances and persons involved.

ITEM B. Check and complete where only telephone contact was made.

MODEL LETTER EXHIBIT 1

NAME OF HOSPICE
ADDRESS
DATE

TO: NAME
ADDRESS

RE:NAME OF BENEFICIARY
MEDICARE NUMBER
DATE OF ADMISSION

The item checked below explains that all or part of the hospice services which the Medicare beneficiary received or was to receive from this hospice are not covered by Medicare.

- 1. The medical information available at the time of, or prior to, start of care shows that certain specific services to be furnished by this hospice do not meet the requirements for coverage under Medicare. However, should you request us to file a claim with Medicare, you will receive a formal determination from the Medicare intermediary as to the noncoverage of the hospice services.
- 2. The Medicare intermediary advises that the type or level of services furnished no longer qualify as covered under Medicare beginning _____. The Medicare intermediary will send you a formal determination as to the noncoverage of the hospice services.

The Medicare intermediary servicing this hospice is (Name and address of Medicare intermediary).
- 3. We regret that this may be your first notice of the noncoverage of the hospice services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

(Signature of Administrative Officer)

VERIFICATION OF RECEIPT OF NOTICE

- A. This is to acknowledge that I received this notice of noncoverage of services under Medicare on (date of receipt).

(Signature of beneficiary or person
acting on behalf of beneficiary)

- B. This is to confirm that we advised you of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

(Signature of Administrative Officer)

KEEP THIS COPY FOR YOUR RECORDS
No Action On Your Part Is Required

280 . MEDICARE AS SECONDARY PAYER.

Medicare is the secondary payer for:

- o Services covered under workers' compensation (§281);
- o Services which are reimbursable under automobile medical, no-fault or any liability insurance (§282 and §283);
- o Services reimbursable by an employer group health plan (EGHP) in the case of:
 - Beneficiaries entitled to Medicare solely on the basis of end stage renal disease (ESRD), during a period of up to 12 months (§284);
 - Beneficiaries age 65 or over where the individual has employer group health plan coverage through his own employment or the employment of a spouse of any age (§285); and
- o Services reimbursable by a large group health plan in the case of certain disabled beneficiaries (§286).

In addition, where the Veterans Administration has authorized the care, Medicare payment is not made. (See §292.)

Workers' Compensation

281. GENERAL

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation (WC) law or plan of the United States or any State. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs; e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of

companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post exchanges), and offshore oil field workers. The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of the individual State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

281.1 Definitions.--

o Workers' Compensation Law or Plan.-- A government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

o Workers' Compensation Agency.--Any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.

o Workers' Compensation Carrier.-- Any insurance carrier authorized to write WC insurance under the State or Federal law, the State compensation fund where the State administers the WC program, and the beneficiary's employer where the employer is self-insured.

o Lump-Sum Commutation Settlement--A lump sum payment which compensates for all future medical expenses and disability benefits related to the work injury or disease.

o Lump-Sum Compromise Settlement--A settlement which provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

o HCFA's Claim-- The amount that is determined to be owed to the Medicare program. It was paid out by Medicare, less any applicable procurement costs.

281.2 Effect of Payments Under Workers' Compensation Plan--

A. General--No Medicare payment may be made if WC has paid an amount:

- o Which equals or exceeds the Medicare payment without regard to coinsurance;
- o Equals or exceeds the provider's charges for Medicare covered services; or
- o Which the provider accepts or is required under the WC law to accept as payment in full.

B. Coinsurance--Payments made under WC cannot be applied to pay the Medicare coinsurance amount.

C. Benefit Utilization-- The effect on primary payments on days of coverage for hospice care are discussed in §288.

281.3 Secondary Medicare Payments--

A. General--If WC pays for Medicare covered services an amount which is less than your charges and less than the amount payable by Medicare, and you do not accept and are not required, under the WC law, to accept the payment as payment in full, Medicare secondary payments can be made.

B. Amount of Secondary Payments--The Medicare secondary payment is the Medicare payment that ordinarily would have been made, minus the amount paid by WC for Medicare covered services. (See §287 - §289 for further details.)

C. Limitation on Right of Hospice to Charge Beneficiary--You may not charge a beneficiary or any other party for Medicare-covered services, if you have been paid by WC an amount that equals your charges or equals or exceeds the Medicare payment. This prohibition is based on the terms of your Medicare participation agreement, under which you may bill a Medicare beneficiary only for coinsurance amounts and for noncovered services.

281.4 Workers' Compensation Cases Involving Liability Claims.--Most State laws provide that if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, the services do not come under the WC exclusion to the extent of the nonpayment or recovery by WC. However, the provision which makes Medicare secondary for services covered under liability insurance may apply. Consider these cases under the policies in §§283ff.

281.5 Possible Coverage Also Under Auto Medical or No-Fault Insurance or Employer Group Health Plan.--Where services are covered in part by WC and also under automobile medical or no-fault insurance, or there is primary coverage by an employer group health plan, Medicare is the residual payer only. (See §§282ff., 284, 285 and 286 respectively.)

Accordingly, whenever WC pays in part for hospice services and you do not accept and are not obligated to accept such payment as payment in full, assure that a claim is submitted to any other insurer that is primary to Medicare.

If the services are related to an automobile accident, ascertain whether your records show coverage under automobile medical or no-fault insurance. Where the records do not show such coverage, contact the beneficiary to ascertain whether such coverage exists.

If there is no coverage under automobile medical or no-fault insurance, but there is indication of primary employer group health plan (EGHP) coverage under §§284, 285 or 286, bill the other insurer for the services not paid for by WC. Follow the instructions in these sections as appropriate, and bill the other insurer because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is an EGHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident and there is no indication of primary EGHP coverage under §§284 or 285 bill Medicare for secondary Medicare payments determined in accordance with §281.3.

In any instances in which Medicare makes secondary payments, show the appropriate value code as defined in §303.1 (items 46 - 49).

281.6 Handling of Cases Involving Work-Related Conditions.--

A. General.--Information you supply is the primary means of alerting intermediaries to actual or potential WC coverage in specific cases involving work-related conditions. A condition would be considered to be work related if it resulted from (1) an accident that occurred on the job, or (2) from an occupational disease. If any of the following conditions apply, annotate items 35-39 of the HCFA-1450 with condition code 02:

- o The physician or the patient states that the condition is work related;
- o The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;
- o The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis and "black lung" disease in the case of a coal miner) (see §245.18); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic or mercury poisoning;
- o The beneficiary previously received WC for the same condition;
- o There is indication that a WC claim is pending;
- o There is other indication that the condition arose on the job.

B. Responsibility of Provider to Document Cases in Which There Is a Possibility of Workers' Compensation Coverage.--Inquire of the beneficiary whether the condition is work related. Where the patient or his physician indicates that the condition is work related or there is other indication that the condition is work related (see subsection A), ask the patient whether WC is expected to pay for the services.

If the patient denies that WC benefits are payable for a condition which you believe may be covered by WC, attach a supplementary statement to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

281.7 Workers' Compensation Has Paid or Is Expected to Pay.--

A. General.--Where there is indication that WC may pay for the services, bill the WC carrier. If WC pays only a portion of the charges, secondary Medicare payment can be made as described in §§287A--289.

B. Workers' Compensation Pays in Full.--If the WC payment for Medicare payment covered services equals or exceeds your charges or the Medicare for the services in the absence of the WC coverage, or if you are obligated to accept the WC payment as payment in full, no Medicare payment is due. Any excess of the WC payment over the Medicare payment will not be subtracted from your Medicare reimbursement.

281.8 Workers' Compensation Denies Payment.--If the WC claim is denied, determine whether any other Medicare secondary payer provisions apply and bill as appropriate. If no other primary payers are available, submit (1) a bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in items 28-32, and (2) a supplementary statement calling attention to the fact that WC has denied payment or annotate item 94, remarks, with the reason for the denial.

Automobile Medical and No Fault Insurance

282 SERVICES REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO-FAULT INSURANCE

Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under automobile medical or no fault insurance (including a self-insured plan). Medicare is secondary to automobile medical or no fault insurance even if State law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis, they are subject to recovery.

If services are covered under automobile medical or no fault insurance, the automobile insurer must be billed first. If the automobile insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted to supplement the amount paid by the automobile insurer.

Liability Insurance

283 SERVICES REIMBURSABLE UNDER LIABILITY INSURANCE

283.1 General.--Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under a liability insurance policy or plan (including a self-insured plan). (If Medicare payments have been made but should not have been because of this provision, or if the payments were made on a conditional basis, they are subject to recovery.)

If a Medicare beneficiary has filed or plans to file a liability claim against a party that allegedly caused an injury or illness, Medicare will initially pay for services related to that injury or illness (if they are otherwise covered). Since liability claims are usually not settled or adjudicated until after protracted negotiations and possible litigation, payment by a liability insurer cannot reasonably be expected merely because a beneficiary has filed a liability claim. However, Medicare payment is conditioned on recovery from the beneficiary, if the beneficiary later receives a judgment on, or settlement of, the claim which results in payment by a liability insurer or a self-insured party.

o Effect on Coinsurance.--Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under liability insurance are not counted toward the applicable coinsurance amounts. (See §§287-§289 for amount of secondary payments.)

283.2 Definitions.--

o Automobile.--Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

o Liability Insurance.--Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages.

o Self-Insured Plan.--A plan under which an entity (or an individual) carries its own risk instead of insuring itself with a carrier. The plan established for the Federal government under the Federal Tort Claims Act is also a self-insured plan.

o Uninsured Motorist Insurance.-- Liability Insurance under which the policy holder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law.

o Accident.--Any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable.

283.3 Provider Billing Rights and Responsibilities.--

A. Difference Between Liability Insurance and Other Primary Insurers.--Liability insurance differs from the other insurance policies or plans that, under the Medicare law, are primary to Medicare. In the case of other types of insurance which are primary to Medicare, i.e., automobile medical and no fault insurance, employer group health plans, and workers' compensation, there is a contractual relationship between the injured party and the third party payer. Thus, you have the right to bill the third party payer.

In the case of liability insurance, unlike the other policies or plans, there is no direct or indirect contractual or quasi-contractual relationship between you and the liability insurer of the alleged tortfeasor. A party alleging injury has a relationship to the liability insurer only through the tortfeasor and must try to prove negligence by the tortfeasor. In contrast, you have no standing to sue the tortfeasor; your relationship is solely with the injured party whom you have furnished Medicare covered services.

B. Medicare Must Be Billed.--Although services are needed because of an accident (as defined in §283.2), you must bill Medicare for conditional primary payments even if you believe that there is a reasonable likelihood that a liability insurer will pay promptly. However, before billing Medicare for primary benefits, first attempt to determine whether there are potential primary payers other than a liability insurer, e.g., an automobile no-fault insurer or an employer group health plan. Bill them before billing Medicare.

C. Prohibition Against Billing Liability Insurer.--Do not bill liability insurers instead of Medicare. The criteria for extension of the time limit for filing claims do not apply, if the late filing of a Medicare claim is due to you not following instructions by billing liability insurance instead of Medicare.

D. Prohibition Against Billing Beneficiary.--Do not bill a beneficiary for covered services even though the beneficiary has received payment from a liability insurer for the injury or illness for which the services were furnished. This rule applies whether or not you have claimed or accepted conditional primary Medicare benefits. Since these are covered services, the beneficiary is protected by the provider agreement, i.e., do not bill a beneficiary for such services, except for any coinsurance amounts.

E. Prohibition Against Filing a Lien Against Liability Settlements.--Do not file a lien against a beneficiary's liability insurance proceeds. To do so is tantamount to billing the beneficiary and is a violation of the provider agreement.

283.4 Provider Actions.--

A. Information Obtained from Patient or Representative At Time of Start of Care, or From Hospital or SNF.--Ask Medicare patients, or the patient's representative, at the time of start of care, if the services are for treatment of an injury or illness which resulted from an automobile or other accident or for which he or she otherwise holds another party responsible. If the services are for treatment of an accident, ask the beneficiary for the name and address of any automobile medical, no-fault or liability insurance company or any other party that may be responsible for payment of medical expenses which resulted from the accident. Some or all of this information may be available from the hospital or SNF where a beneficiary's inpatient stay preceded the hospice services.

B. Provider Billing.--If you learn that automobile medical or no-fault insurance is payable for otherwise covered services, bill the insurance company as primary insurer. See §§282 for policies regarding services covered by automobile medical or no-fault insurance.

If payment cannot reasonably be expected from an automobile medical or no-fault insurer (and none of the other Medicare secondary provisions applies), bill Medicare even though the individual has filed or plans to file a liability insurance claim.

EXAMPLE: Mr. Gray, a Medicare beneficiary, has elected hospice care after filing a claim for product liability due to his developing lung cancer. He claimed that the cancer resulted from smoking cigarettes. Since the liability claim was still pending at the time of the start of care, the hospice billed Medicare in the usual manner indicating value code 14 and "0" amount in item 46-49, in addition it indicates in remarks of the HCFA-1450 that a conditional claim was being filed per §283. Medicare paid the following amounts during the 92 days before Mr. Gray's death: Routine Home Care-54 days = \$3,228.14, Continuous Home Care - 80 hours = \$1,068.80, Inpatient Respite Care-10 days = \$623.10, General Inpatient Care-18 days = \$4781.16. A total \$9,701.20.

After Mr. Gray's death, the case was settled out of court and the estate received \$250,000. When the intermediary learned of the settlement, it recovered from the estate the amount it paid the hospice.

C. Request From Insurance Company or Attorney.--Notify the intermediary promptly if you receive from an attorney or insurance company a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) or services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

284 LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

284.1 General.--Medicare benefits are secondary to benefits payable under an employer group health plan in the case of individuals who are entitled to benefits solely on the basis of end stage renal disease (ESRD), during a period of up to 12 months, which is defined in §§284.4 and 284.5. Medicare is secondary during the period specified in §§284.4 and 284.5 even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare's or otherwise excludes or limits its payments to Medicare beneficiaries.

Under this provision, hospices must bill the EGHP first and if the EGHP does not pay for the services in full, Medicare may pay secondary benefits in accordance with §287B.

There may be instances where there is more than one primary insurer (e.g., automobile medical insurer and EGHP). In such cases, the primary insurers customarily coordinate benefits. Medicare is secondary to all primary insurers.

Consider the possible application of this limitation on benefits when billing for items or services furnished to ESRD beneficiaries who are in their first year of entitlement.

NOTE: These instructions do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

284.2 Definitions.--

A. Employer.--The term "employer" as used in these instructions means, not only individuals and organizations engaged in a trade or business, but also embraces organizations exempt from income tax, such as religious, charitable, and educational institutions as well as the governments of the United States, the States, Territories, Puerto Rico, Guam, the Virgin Islands, and the District of Columbia, including their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision the term "employer" is defined without regard to number of employees.

B. Employer Group Health Plan or Employer Plan--These terms mean any health plan that is of, or contributed to by, an employer and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. It includes the Federal Employees Health Benefits program but not the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). "Employee pay-all" plans, i.e., group health plans under the auspices of an employer that do not receive any contributions from the employer, also meet the definition of EGHP.

In the absence of evidence to the contrary, any health plan (including a union plan) in which a beneficiary is enrolled because of the current or former employment of the beneficiary or of a member of the beneficiary's family, meets this definition.

C. Secondary--For purposes of this instruction, the term "secondary," when used with respect to Medicare payment, means that Medicare will be residual payer to all employer plans under which the Medicare beneficiary is covered and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation exclusion (§281ff.) and automobile medical, no-fault and liability insurance provisions (§§282 and 283) in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP.

D. Coordination Period--The term "coordination period" means a period of up to 12 months determined in accordance with §§284.4 and 284.5 during which Medicare benefits are secondary to benefits payable under employer group health plans.

284.3 Retroactive Application--If the intermediary notifies you, or you learn from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, take the following actions:

- o ascertain whether there is employer plan coverage and if so, the name and address of the employer plan, where that information is not already annotated on the claim,
- o check your records and ascertain whether Medicare paid primary benefits for other services for which an employer plan may be primary, and
- o notify the intermediary of the results of your development efforts on each of these claims.

This information is necessary for Medicare to determine its proper payment. If the employer plan pays or has already paid you for all or part of the services, submit a corrected bill to the intermediary along with the employer plan's explanation of benefits (EOB). The intermediary will recoup from you the amount of conditional Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

284.4 Determining the Months During Which Medicare May Be Secondary Payer.--Medicare may be secondary payer to EGHPs for items and services furnished during a period of up to 12 consecutive months which begins with a month after September 1981. The 12-month period begins with the earlier of:

- o the month in which a regular course of renal dialysis is initiated or
- o in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

NOTE: In the extremely rare case of an untimely application by an individual who receives a transplant, the 12-month period could begin with the first month in which the individual would have been entitled to Medicare benefits if he/she had filed a timely application for such benefits. It is not necessary to consider this possibility absent a specific indication, e.g., information in file that the transplant occurred before the first month of entitlement. If further development is required, contact the Social Security office.

When the 12-month period begins before the month the individual becomes entitled to Medicare, Medicare pays secondary benefits for the portion of the period during which the individual is entitled to Medicare benefits. This is the coordination period. (See §284.2.) Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare will usually be the secondary payer for the first 9 months of an individual's entitlement. However, for those individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 12 months of the individual's Medicare entitlement.

The following examples illustrate how to determine the number of months in which Medicare pays secondary benefits for various situations in which benefits are payable by an EGHP:

EXAMPLE 1: Individual Became Entitled to Medicare After a Waiting Period.--

- o Janice started a regular course of dialysis in October 1986. The 12-month period begins in October 1986 (the month in which Janice started a regular course of dialysis) and the waiting period consists of October, November and December 1986. Medicare is secondary payer from January through September 1987.
- o Peter started a regular course of dialysis in January 1987 and was hospitalized and received a kidney transplant in March 1987. The 12-month period begins with January 1987. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1987. Medicare is secondary payer from March through December 1987.

EXAMPLE 2: Individual Became Entitled to Medicare Without a Waiting Period.--In October 1987 John began a regular course of dialysis. In December 1987 John began a course of self-dialysis training. Since the self-dialysis training course was initiated during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1987, the first month of dialysis. In this situation the first month of entitlement coincides with the beginning of the 12-month period. Thus, the coordination period extends from October 1987 through September 1988. Medicare is secondary payer during this period.

284.5 Effect of Changed Basis for Medicare Entitlement.--If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective.

284.6 Subsequent Periods of ESRD Entitlement.--If an individual has more than one period of entitlement based solely on ESRD, a coordination period will be determined for each period of entitlement in accordance with §§284.4 and 284.5.

284.7 Identification of Cases in Which Medicare May Be Secondary to Employer Group Health Plans.--Investigate cases in which information available to you (e.g., the beneficiary's Medicare card) indicates that the beneficiary is entitled to Medicare based on end stage renal disease for 1 year or less at the time the services were rendered to ascertain whether the services were rendered during the 12-month period described in §§284.4 and 284.5. Determine whether the services were rendered in the 12-month period by checking your own records or, if the potential Medicare payment is \$50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 12-month period described in §§284.4 and 284.5, inquire of the beneficiary if he/she is insured under any health insurance plan which provides coverage to the beneficiary through the employer or through a union. If the response is yes, ask the beneficiary for the name and address of the plan and the beneficiary's identification number.

If the information you obtain does not indicate employer group plan coverage but Medicare was the secondary payer on a previous claim based on ESRD, verify the absence of EGHP coverage by inquiring of the beneficiary or the beneficiary's representative. If you verify the absence of EGHP coverage, annotate the bill to that effect (e.g., EGHP coverage lapsed, benefits exhausted). If the information you obtain indicates that EGHP coverage exists, obtain the information cited above from the beneficiary or the beneficiary's representative.

284.8 Action Where Medicare Is Secondary to Employer Group Health Plan.--

A. **General.**--If you determine, based on your development, that Medicare may be secondary to an employer plan, bill the EGHP for primary benefits during the period of up to 12 months (defined in §284.4 and §284.5) in which Medicare is secondary for ESRD

beneficiaries. If the plan payment is less than the charges for Medicare covered services and less than the amount of Medicare payment, and you do not accept and are not obligated to accept the EGHP payment as payment in full, Medicare may pay secondary benefits.

B. Billing Medicare for Primary Benefits.--If an EGHP has denied your claim for primary benefits, annotate item 94 "Remarks" of the Medicare claim form with the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 28 - 32. No attachment is needed. However, do not bill Medicare if the reason for the EGHP denial is that the EGHP offers only secondary coverage of services covered by Medicare. Medicare primary benefits are not paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage.

If you are paid conditional primary Medicare benefits and later receive payment for the same services from an employer plan, submit a corrected bill to the intermediary and include a copy of the employer plan's explanation of benefits. The intermediary determines if secondary Medicare reimbursement is due you if Medicare had not paid primary conditional benefits and recoups from you the amount of conditional Medicare benefits paid in excess of any amount Medicare is obligated to pay as secondary payer.

B. Billing Medicare for Secondary Benefits.--If an employer plan payment for Medicare covered services is less than your charges and less than the Medicare payment in the absence of the employer plan payment, and you do not accept and are not obligated to accept the plan payment as payment in full, secondary Medicare benefits may be payable on the claim. (See §§287-§289 for further details.)

284.9 Employer Group Health Plan Pays in Full.--If an employer plan payment for Medicare covered services equals or exceeds your charges or the Medicare payment for the services in the absence of employer plan coverage, or if you accept or are obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the Medicare payment will not be subtracted from your Medicare reimbursement.

284.10 Limitation on Right of Hospice to Charge Beneficiary.--Do not charge a beneficiary or any other party for Medicare covered services, if you have been paid by an employer plan at least an amount equal to any applicable Medicare coinsurance amount.

284.11 EGHP Erroneously Pays Primary Benefits.--If you determine that an EGHP has inappropriately paid primary benefits, bill Medicare as primary payer and refund to the EGHP the amount it paid, except for an amount equivalent to Medicare coinsurance amounts, and charges for noncovered services.

Limitation on Payment for Services to Employed Aged
Beneficiaries and Spouses

285. LIMITATIONS ON PAYMENT FOR SERVICES TO THE EMPLOYED AGED AND THE AGED SPOUSES OF EMPLOYEES WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

285.1 General.--Medicare benefits are secondary to benefits payable under employer group health plans (EGHPs) for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. Section 285.3 further defines individuals subject to this limitation on payment.

If primary Medicare benefits have been paid for services furnished to an individual who meets the criteria in §285.3, recover the excess Medicare payment in accordance with §285.13.

In general, where an individual meets the criteria in §285.3, bill the EGHP first and, if (1) the plan payment is less than your charges for Medicare covered services, (2) the plan payment is less than the payment by Medicare, and (3) you do not accept and are not obligated to accept the EGHP payment as payment in full, Medicare secondary benefits may be payable in accordance with §287B.

Employers (as defined in §285.2A) are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as the primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage of items and services covered by Medicare.

Where an EGHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §§287-289, to supplement the amount paid by the EGHP for Medicare covered services. If an EGHP denies payment for particular services because they are not covered by the plan, primary Medicare benefits may be paid for them if covered by Medicare.

An EGHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on the Medicare intermediary. Medicare continues to evaluate claims under existing guidelines derived from the law and regulations to assure that services are in fact covered by the program regardless of employer plan involvement.

285.2 Definitions.--

A. Employer.--The term "employer" as used in these instructions means not only individuals and organizations engaged in a trade or business, but also includes organizations exempt from income tax, such as religious, charitable, and educational institutions. Included are the governments of the United States, the States, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, Puerto Rico and the District of Columbia.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Where such an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over, primary coverage beginning with the point in time at which the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees drops below 20 after the employer has met the requirement. The "20 or more employees" requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the employer's group health plan is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Self-employed individuals who participate in the plan are not counted as employees for purpose of determining if the 20 or more employees requirement is met. There is no requirement that an employer provide coverage to self-employed individuals. However, any coverage provided to self-employed persons by an employer of 20 or more employees must be primary to Medicare.

Assume for purposes of the requirement that EGHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer allegation that the 20-employee requirement is not met or a multiemployer plan's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payer.

B. Employed Individual.--

1. General.--The term "employed individual" as used in these instructions refers not only to employees but also self-employed persons such as directors of corporations and owners of businesses. If a self-employed individual enrolls in an EGHP which meets the definition in subsection C, the employer plan is primary for that individual and the individual's spouse. The term "employed individual" also includes members of the clergy and members of religious orders who are reimbursed for their services by a church, religious order, or other employing entity.

2. Individuals Who Receive Disability Payments.--A person age 65 or over receiving disability payments from an employer is considered employed if such payments are subject to taxes under the Federal Insurance Contributions Act (FICA). Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 1985 at age 66. His employer began paying him disability payments as of January 1986. Since sick pay is taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1986. Beginning with July 1986 Medicare becomes the primary payer as the sick payments are no longer considered wages under FICA.

3. Members of the Clergy and Religious Orders.--The following guidelines apply in determining the employment or retirement status of members of the clergy and members of religious orders, where an EGHP alleges that such an individual is retired.

(a) A member of the clergy or a member of a religious order who has not taken a vow of poverty is

- o considered employed if he or she is receiving from a church, religious order or other employing entity cash remuneration for services rendered whether or not the individual's earnings are exempt from social security coverage, and

- o considered retired if the church, religious order or other employing entity states that the individual is retired and that he or she receives only retirement pay from the entity rather than remuneration for services rendered.

(b) A member of a religious order who has taken a vow of poverty is considered retired if the order submits a written statement that

- o an election of coverage under §3121(r) of the Internal Revenue Code of 1954 is in effect for the order of the subdivision to which the member belongs, i.e., the order has agreed to waive its exemption from payment of Federal Insurance Contributions Act (FICA) taxes on behalf of members of the order, and

- o the individual has retired including the date of retirement; and

- o it has or will report the retirement on its tax return. (The noncash compensation of members of religious orders who have taken a vow of poverty is "deemed earnings" for social security and tax purposes depending on the level of services they render. Religious orders are required to report retirement of members on their tax returns.)

4. Individuals Age 65 and Older Who Receive Disability Payments.--A person who is age 65 or older and is receiving disability payments from an employer is considered employed if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 1985 at age 66. His employer began paying him disability payments as of January 1986. Since sick pay is taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1986. Beginning with July 1986, Medicare becomes the primary payer as the sick payments are no longer considered wages under FICA.

5. Insurance Agents.--The following guidelines apply in determining the status of insurance agents. (See subsection C to determine when an insurance company's plan meets the definition of an EGHP.)

o A self-employed insurance agent is considered employed if he actually conducts business on behalf of the company. The fact that a self-employed insurance agent is authorized to represent the company; e.g., to write policies on behalf of the company, does not itself confer the status of "employed individual."

NOTE: An insurance company that offers EGHP coverage to any self-employed insurance agent who writes policies on behalf of the company, must offer the same coverage under the same circumstances to older and younger agents. For example, a company that provides EGHP coverage for younger insurance agents who sell at least \$10,000 of insurance during a calendar year is required to furnish the same coverage under the same conditions to agents age 65 and over, including "retirees" who sell at least \$10,000 of insurance during the same time period.

o Since a full-time life insurance agent is considered an employee for social security purposes, such an individual is also considered an employee for purposes of the working aged provision. (See subsection C for the effect of this rule in determining whether a plan is an EGHP.)

6. Senior Federal Judges.--Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the "remuneration" they receive as senior judges is not considered wages for social security retirement test purposes. Since they are considered retired for social security purposes, they are also considered retired for purposes of the working aged provision.

7. Volunteers.--Volunteers are not considered employed unless they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Social Security Act, VISTA volunteers are considered employed by the Federal Government since they receive remuneration.

8. Directors of Corporations.--Directors of corporations, i.e., persons serving on a Board of Directors of a corporation, who are not officers of the corporation, are self-employed. (Officers of a corporation are employees.) Directors who receive no remuneration for serving on the Board ("unpaid directors") are not considered employed.

However, remuneration may consist of "deferred compensation;" i.e., amounts earned but not payable until some future date, usually when the individual reaches age 70 and is no longer subject to the social security retirement test. A director receiving deferred compensation is an employed individual.

C. Plan.--The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to employees. An arrangement by more than one employer is considered to be a single plan if the arrangement provides for common administration of the health benefits, for example, by the employers directly, or by a benefit administrator, or by a multiemployer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

D. Employer Group Health Plan or Employer Plan (EGHP).--These terms mean any health plan that is of, or contributed to by, an employer of 20 or more employees and which provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. This includes a multiemployer group health plan that has at least one employer with 20 or more employees. These plans may identify members who are employees of employers with fewer than 20 employees. Such members and their spouses are considered not to meet the conditions in §285.3. Similarly, if an employer of fewer than 20 employees enrolls in the EGHP that is offered to employees, that employer is not considered to meet the conditions in §285.3.

A plan that does not have any employees as enrollees, e.g., a plan for self-employed persons only, does not meet the definition of EGHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan would not be considered an EGHP. But if the plan includes full-time life insurance agents or other employees or former employees, it would be considered an EGHP. (Subsection B.5 states that full-time life insurance agents are considered employees.)

The Federal Employees Health Benefits program meets the definition of an EGHP. Employee-pay-all plans, i.e., group health plans which are under the auspices of an employer and which do not receive any contribution from the employer, also meet the definition of EGHP. Coverage by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is secondary to Medicare, since it is not considered to meet the definition of an EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employee's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. (See §285.4I.)

E. Secondary.--The term "secondary" when used with respect to Medicare payment, means that Medicare is the residual payer to all EGHPs under which the Medicare beneficiary is covered by reason of current employment and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation and automobile and liability insurance exclusions (§§281,282, and 283) in appropriate cases in determining the extent of Medicare's liability.

(Also refer to §285.7C regarding claims in which there is an EGHP and another primary and/or secondary payer involved, e.g., an EGHP, an automobile insurer and a retirement plan.)

F. Age 65 through 69.--Means a period beginning with the first day of the month in which an individual attains age 65 and ending with:

o For services furnished on or after July 18, 1984, the last day of the month before the month the individual attains age 70, or

o For services furnished before July 18, 1984, the last day of the month in which the individual attains age 70.

An individual attains a particular age on the day preceding his or her birthday.

285.3 Individuals Subject to Limitation on Payment.--

A. General.--Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

1. For services on or after May 1, 1986 is age 65 or over; for services before May 1, 1986, is age 65 through 69,

2. Is entitled to Part A (hospital insurance) of Medicare on the basis of the individual's own social security or railroad retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and

3. Is either

o Employed and covered by reason of that employment by an EGHP; or

o The spouse of an employed person, covered by an EGHP by reason of that person's employment, and the employed person is:

-- For services on or after May 1, 1986, any age;

-- For services on or after January 1, 1985, through April 30, 1986, any age through 69; or

-- For services on or after January 1, 1983 through December 31, 1984, age 65 - 69.

B. Re-employed Retirees and Annuitants.--If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that he furnishes to other employees (i.e., non-retirees). Medicare is secondary payer to the EGHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for consultants who are former employees if the employer provides coverage for other such consultants.

285.4 Individuals Not Subject to the Limitation on Payment--This Medicare secondary provision does not apply to:

o. Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions, i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement may be on the basis of age 65. (See §284 for secondary Medicare payment instructions where an ESRD beneficiary under age 65 has EGHP coverage.)

o. Individuals who are enrolled in Part B only.

o. Individuals enrolled in Part A on the basis of a monthly premium.

o. Anyone who is under age 65. (Effective for items and services rendered on or after January 1, 1987 through December 31, 1991, §9319 of OBRA provides that Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.

o. With respect to services rendered before May 1, 1986, anyone who is over age 69 and age 65-69 spouses of employees over age 69.

o. Individuals covered by a health plan other than an EGHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group.

o. Employees of employers of fewer than 20 employees.

o. Members of multiemployer plans whom the plan identified as employees of employers with fewer than 20 employees.

o. Retired beneficiaries (other than spouses of employed individuals) who are covered by EGHPs as a result of past employment and who do not have EGHP coverage as the result of current employment.

285.5 Identification of Individuals Subject to This Limitation on Payment --In order to obtain the information needed to ascertain whether to bill an EGHP as primary payer, ask all Medicare Part A beneficiaries age 65 or over (other than beneficiaries with ESRD) or their representatives, whether they qualify under the rules in §285.3.

If the criteria in §285.3 appear to be met, bill the employee plan first. (See §285.7.) If Medicare is determined to be the primary payer, annotate the Medicare billing form to that effect.

285.6 Identification of Prior Claims that May Involve Employer Plan Payment--Intermediaries may identify prior claims for services furnished on or after January 1, 1983, to individuals who meet the criteria in §285.3, and on which it paid primary benefits. Where such a prior claim is identified, the intermediary instructs you to ascertain from your records whether there is indication that the individual was employed, and if so, to bill the employer plan identified in the current claim for the prior stay (unless the information available to the intermediary on the prior claim clearly shows why the employer plan should not be billed as primary). Submit an adjustment bill when the employer plan payment is received.

285.7 Action by Hospice Where Employer Group Health Plan Is Primary Payer.--

A. General.--Seek reimbursement from the EGHP before billing Medicare when there is indication that an EGHP is primary payer, i.e., where the services were rendered to an individual who meets the criteria in §285.3, and there is no evidence that the definitions in §285.2 are not met. The EGHP is billed as primary payer even where there may be EGHP coverage for only part of the stay (e.g., split stays where the beneficiary terminates employment during the stay and EGHP coverage terminated concurrently).

B. Employer Group Health Plan Pays in Full.--If an employer plan payment for Medicare covered services equals or exceeds your charges or the Medicare payment for the services in the absence of employer plan coverage, or if you accept or are obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the Medicare payment will not be subtracted from your Medicare reimbursement.

C. Submittal of Bill to Medicare after Employer Plan Has Made Payment.--If an EGHP pays primary benefits to you, secondary Medicare benefits may be payable in accordance with §§287-§289 to supplement the amount paid by the EGHP. If the EGHP primary payment is less than your charges for Medicare covered services, and is less than the Medicare and you are not obligated to accept the EGHP payment as payment in full, submit a bill for secondary benefits.

D. Multiple Insurers.--There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual who meets the criteria in §285.3 is also covered under his own EGHP, and under the EGHP of an employed spouse who meets the criteria in §285.3 or under automobile insurance. In such cases, the other primary payers customarily coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supercede Federal law that makes Medicare secondary payer to certain EGHPs for individuals and spouses age 65 or over. Therefore, where the individual has EGHP coverage based on current employment in addition to EGHP coverage as a retiree, Medicare is secondary to EGHP coverage based on current employment and primary to the EGHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

285.8 Limitation on Right of Hospice to Charge Beneficiary.--You may not charge a beneficiary or any other party other than an insurer which is primary under of the law for Medicare covered services if you have been paid or could have been paid by an EGHP an amount which equals or exceeds any applicable coinsurance amount. This applies to situations where an insurer is primary under the Medicare law but refuses to make primary payments. Under such circumstance contact your intermediary and advise it of the facts why primary payment was refused. The intermediary then determines whether conditional Medicare payments can be made.

285.9 Employer Plan Denies Claim for Primary Benefits.--

A. Primary Medicare Benefits.--Where an employer plan denies a claim for primary benefits because, for example, the employer does not employ 20 or more employees; or the beneficiary is not entitled to benefits under the plan; or benefits under the EGHP are exhausted for the services involved; or the services are not covered by the EGHP, submit a claim for Medicare primary benefits, unless you have reason to believe that the EGHP should pay primary benefits for the services. For example, if the EGHP offers only secondary coverage of services covered by Medicare, and the EGHP does not allege that the employer has fewer than 20 employees, do not bill Medicare. Medicare primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage.

B. Annotation of Claims Denied by EGHP's.--Whenever an EGHP denies a claim for primary benefits, annotate in item 94 "Remarks" of the Medicare claim form the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 28 - 32. No attachment is needed to the Medicare claim. The annotation is needed to avoid needless recoupment efforts under §285.10.

285.10 Action by Intermediary to Recover Incorrect Payments.--

A. General.--If primary Medicare benefits are paid to a hospice and the intermediary learns that an EGHP should have paid primary benefits for the items and services, the intermediary either recovers directly from the EGHP or from you. When recovering from a hospice, the intermediary instructs you to file a claim with the EGHP for primary benefits, and upon receipt of the EGHP payment, to refund to Medicare the amount Medicare paid less the amount received from the EGHP.

B. Recovery from the Hospice.--After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary follows up with you in 45 days to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary recovers the Medicare primary payment from you, except where the reason you do not file a claim with the EGHP is because the beneficiary declines to sign the claims form. In that case, the intermediary recovers the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability. When you receive an EGHP refund, credit amounts paid by the EGHP toward the coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare coinsurance already paid. You may retain any excess EGHP payment over the Medicare payment. (See §285.7B.)

If duplicate payment was or will be made to you, i.e., you received or expect to receive both primary EGHP payments and primary Medicare benefits, the intermediary recovers from you the Medicare overpayment which is the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer. If Medicare paid you and the EGHP paid the beneficiary, the beneficiary is liable.

If the intermediary has not received an adjustment bill within 120 days of notifying you to file a claim with the EGHP, the intermediary follows up to determine the status of the claim. If the EGHP has denied the claim for a reason the intermediary would find acceptable if the intermediary requested payment from the EGHP directly, the recovery action may be cancelled. If the EGHP has denied the claim for any other reason, or has not responded to your claim, the intermediary attempts to recover from the EGHP. Advise the intermediary immediately if you receive payment from the EGHP.

C. Recovery When a State Medicaid Agency Has Also Requested a Refund.--Where both Medicare and Medicaid have paid you incorrect benefits and you recover an amount from an EGHP, you are obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim do you have the right to reimburse Medicaid or any other entity.

285.11 Advice to Providers, Physicians and Beneficiaries.--In your professional and public relations activities, inform providers, physicians, and beneficiaries that claims are directed first to the EGHP where there is EGHP coverage for the services involved.

285.12 Incorrect EGHP Primary Payments.--Your intermediary may advise you that an EGHP has incorrectly paid you primary benefits e.g., primary payments made by the EGHP of an employer of less than 20 employees. In such cases, bill Medicare as primary payer and refund to the EGHP any amount it paid in excess of the Medicare coinsurance amounts and charges for noncovered services.

285.13 Claimant's Right to Take Legal Action Against an EGHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action and to collect double damages from an EGHP that fails to pay primary benefits or fails to make appropriate reimbursement to Medicare for services for which the EGHP is primary payer.

285.14 Special Rules For Services Furnished By Source Outside EGHP Prepaid Health Plan.--

A. Services By Outside Sources Not Covered.--Where Medicare is secondary payer for a person enrolled in an employer sponsored prepaid health plan (e.g., Health Maintenance Organization (HMO)/Competitive Medicare Plan (CMP)), Medicare does not pay for services obtained from a source outside the prepaid employer health plan if:

- o The same type of services could have been obtained as covered services through the prepaid employer health plan, or
- o The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

286. MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

A. General.--Under §1862(b)(4) of the Social Security Act, Medicare is secondary payer to "large group health plans" for "active individuals" (as defined in subsection C3) under age 65 entitled to Medicare on the basis of disability. Under the law a large group health plan (LGHP) may not "take into account" that an "active individual" is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member, as explained in subsection C.3. Apply the instructions in §§285.7 - 285.12 in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" as defined in subsection C1, for the purpose of applying them to disabled individuals.

B. Effective Date.--This provision is effective for items and services furnished on or after January 1, 1987 and before January 1, 1992. The effective dates are fixed by law.

C. Definitions.--

1. Large Group Health Plan.--A "large group health plan" means any health plan of, or contributed to by an employer or by an employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with the employer in a business relationship, or their families. The plan covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term employer for purpose of this provision has the same meaning as the term has for purpose of the working aged provision. That definition is in §285.2A. It includes the Federal government and other governmental entities. The tax penalty for nonconforming LGHPs does not apply to Federal and other governmental entities. (See subsection I.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceding calendar year is considered to meet the above definition of LGHP. If the plan is a multiemployer plan, such as a union plan, which covers employees of some small employers and also employees of at least one employer that meets the 100 or more employees requirement, Medicare is secondary for all employees enrolled in the plan including those that work for small employers. This differs from the rule for multiemployer plans under the working aged. (See §285.4.)

2. Nonconforming Large Group Health Plan.--A "nonconforming large group health plan" means an LGHP that at any time during the calendar year takes into account that an active individual is eligible for or receives benefits based on disability, e.g., an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with subsection C.3.

NOTE: Although the term "large group health plan" includes a plan for former employees or persons formerly associated with the employer in a business relationship, or their families, these individuals are not included within the definition of "active individual" in subsection 3, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes. (See the tax penalty described in subsection I.)

3. Active Individuals Subject to This Limitation on Payment.--An "active individual" is an employee, an employer (e.g., proprietor or partner), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees) or a member of the family of any of these persons such as the spouse, parent or child of such an individual. Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. In other cases, the disabled person may be the "family member" of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is not an employee as defined in subsection 4, but who is covered under an LGHP of a spouse, parent, or any other family member, is considered to be an "active individual."

4. Employee.--An employee is (1) an individual who is actively working for an employer or (2), since disabled persons are not usually working, a person whose relationship to an employer is indicative of employee status. Whether or not such a person is an employee is established by the unique facts applicable to the person's relationship to the employer. The question to be decided is whether the employer treats a disabled individual who is not working as an employee, in light of commonly accepted indicators of employee status rather than whether the person is categorized in any particular way by the employer. In general, an individual who is not actively working will be considered an employee if any of the following factors is present:

- o The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code.

- o The individual is termed an employee under State or Federal law or in accordance with a court decision.

- o The employer pays the same taxes for the individual as he pays for actively working employees.

- o The individual continues to accrue vacation time or receives vacation pay.

- o The individual participates in an employer's benefit plan in which only employees may participate.

- o The individual has rights to return to duty if his/her condition improves.

- o The individual continues to accrue sick leave.

D. Individuals Not Subject to This Limitation on Payment.--Medicare is not secondary for:

o Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. However, in accordance with §284ff, Medicare is secondary payer for persons under age 65 with ESRD during a period of up to 12 months regardless of the number of employees.

o Individuals who are covered by an EGHP of employer(s) of less than 100 employees, unless the EGHP is a multiemployer plan in which there is at least one employer of 100 or more employees. (See subsection C.1.)

o Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee (and who does not meet any of the criteria in subsection C.4.) or the spouse of a retired former employee.

E. Action by Hospice to Identify Individuals Subject to This Limitation on Payment.--Providers are instructed to identify individuals who meet the conditions in subsection C.3. by asking every Medicare beneficiary under age 65 (1) if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and, (2) if so, whether the individual has group health coverage through an employer. If the individual responds affirmatively to both questions, request the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits, except where you have information that clearly shows that the employer plan is not primary payer. If the individual responds that he or she does not meet either (1) or (2) above, or you have otherwise determined that the employer plan is not primary payer, bill Medicare for primary benefits and annotates item 57A on Form HCFA-1450, "Medicare."

Retain a record of this development or other information on which you based your determination that Medicare is primary payer for audit purposes and to ensure that you have developed for other primary payer coverage.

F. When Medicare Can Pay Secondary Benefits.--If you bill the employer plan first, Medicare may pay secondary benefits in accordance with §287B, to supplement the employer plan payment, only if all of the following conditions are met:

- o the plan payment is less than the charges for Medicare covered services,
- o the plan payment is less than the Medicare payment, and

o you do not accept and are not obligated to accept the plan's payment as payment in full. (See §§287-289 for further details regarding Medicare secondary payments.)

G. Recovery of Primary Medicare Payments.--Under the law, the government may recover incorrect primary Medicare benefits from any LGHP which is primary payer. To recover Medicare payments the government:

- o may bring legal action against the LGHP and may collect double damages,
- o may take legal action to recover its benefits from any entity that has been paid by the LGHP for items and services furnished an individual who meets the conditions in subsection C.3,
- o may join or intervene in any legal action against the LGHP related to the events that gave rise to the need for the items or services, and
- o is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from an LGHP.

H. Claimants' Right to Take Legal Action Against Large Group Health Plan.--Any claimant including an individual who received services, and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

I. Tax Penalty for Noncompliance.--An excise tax is imposed by §5000 of the Internal Revenue Code (IRC) on any employer or employee organization that contributes to a nonconforming LGHP (see subsection C2 for definition) during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

J. Recovery Notice to Nonconforming Large Group Health Plan.--When recovering incorrect primary payments from a nonconforming LGHP, include in your letter to the plan, a statement that it is obligated to pay primary benefits in this case, in accordance with §1862(b)(4) of the Medicare law, as amended by §9319 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). Explain that State laws and contract provisions are not applicable if they conflict with the Federal requirement even if they were in effect prior to January 1, 1987. Also inform the plan that, under this provision of the law, an LGHP which fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer is subject to legal actions described in subsections G and H, and to the tax penalty described in subsection I.

287. AMOUNT OF MEDICARE SECONDARY PAYMENTS

A. General.--If a primary payment is made for Medicare covered services which is less than your charges and less than what Medicare normally would have paid if it were primary payer, and you do not accept, and are not required under the law to accept, the

payment as payment in full, secondary Medicare payment can be made. The amount of secondary payment is the lowest of the following:

1. Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges), minus any Medicare coinsurance that may apply.
2. The Medicare payment that ordinarily would have been made, minus the amount paid by the primary insurer for Medicare covered services.

EXAMPLE 1: Bill Miner, a Medicare beneficiary, is suffering from cancer due to an overdose of radiation which has been attributed to a work related accident. He has been found permanently disabled by WC and all medical expenses associated with this disease are reimbursable by WC. WC, however, does not pay for inpatient respite care.

Mr. Miller elected to receive hospice care beginning with 3/31/88. The hospice billed the WC carrier for its services. The WC carrier paid a total of \$5,687.10 which represented the hospice's charges for all of the hospice's services 3/1/88 through 3/31/88, except for the 5 days of respite care. When the hospice received the payment from WC, it billed the Medicare intermediary for secondary payments. The intermediary paid for 5 days of inpatient respite care at the hospice's payment rate of \$62.31 per day. The total Medicare secondary payment, therefore, is \$311.55. The beneficiary is responsible for any coinsurance.

The hospice indicates value code 15 and the amount paid by the WC's carrier towards Medicare covered services in items 46-49 of the HCFA-1450. (See §303.1.)

EXAMPLE 2: A Medicare beneficiary who had EGHP coverage based on employment which provided a maximum of \$3,500 days of hospice care, utilized the following Medicare covered hospice services: Routine Home Care-54 days= \$3,228.14, Continuous Home Care - 80 hours= \$1,068.80, Inpatient Respite Care - 10 days = \$623.10, General Inpatient Care-18 days = \$623.10. A total \$9,701.20. The hospice billed their normal charges first to the EGHP until the \$3,500 maximum was used up (e.g., the covered charges under EGHP were applied in chronological order) the hospice then bills Medicare at its normal payment rate for those units of care that remain unpaid.

In the situation as is indicated in the example above, the amount paid by the primary payer for Medicare covered services and value code 12 are shown in items 46-49 of the HCFA - 1450. (See §303.1.) If you cannot determine the Medicare services covered by the EGHP payment, follow the instructions in §289. For determining the utilization of benefit days see §288.

EXAMPLE 3: Mrs. Appel is entitled to Medicare because of disability. She is also covered by an LGHP through her husband's employment. On April 1, 1988 she elected hospice coverage and through April 30, 1988 she received the following services: 5 days of inpatient hospital care, 20 visits by a public health nurse and the remainder of the time she only received routine home care. Mrs. Appel's LGHP paid \$1,600 for her hospital stay and \$800 for the nurse's home visits. The Medicare secondary payment is computed as follows:

From the total amount that Medicare would have paid if it were primary payer, the total amount of the LGHP payment for Medicare covered services is subtracted:

The total amount of the Medicare payment that would have been paid is obtained by adding the Medicare general inpatient hospital care payment of \$1,414.00 and the payment for the home care \$1,622.00, giving a sum of \$3,036. From this amount the LGHP payment is subtracted; \$3,036 - \$2,400 = \$636. Thus giving a total Medicare secondary payment of \$636.

Indicate value code 43 and the amount paid by the LGHP towards the Medicare covered services in items 46-49 of the HCFA-1450. (See §303.1.)

B. Computing the Amount of the Medicare Coinsurance Where the Services are Covered By Workers' Compensation, Automobile Medical, No Fault or Liability Insurance.--The coinsurance for these situations is computed as follows:

o The coinsurance on inpatient respite care is equal to 5 percent of the Medicare payment which Medicare would have paid if it were primary payer, minus the primary payer's payment.

o The coinsurance on outpatient drugs and biologicals is equal to 5 percent of the reasonable cost to you of the drug or biological, minus the amount of the primary payer's payment for the drugs or biologicals, but not more than \$5, for each prescription furnished on an outpatient basis.

In these situations the coinsurance is the responsibility of the beneficiary.

C. Computing the Amount of the Medicare Coinsurance Where Beneficiary Is Enrolled in Employer Group Health Plan.--The coinsurance is computed as follows:

o The coinsurance on inpatient respite care is equal to 5 percent of the Medicare payment that ordinarily would have been made.

o The coinsurance on outpatient drugs and biologicals is equal to 5 percent of the reasonable cost to you of the drug or biological.

The primary payer's payment is applied to the coinsurance

288. EFFECT OF PRIMARY PAYMENT ON UTILIZATION

For services rendered prior to January 1, 1989, if the primary payer's payment is less than the amount Medicare pays as primary payer, the beneficiary is charged with utilization as follows:

If a payment by a primary insurer for a particular day exceeds .5 of what the Medicare payment would have been for that day, then that day will not be charged as a day of Medicare utilization. If the primary payment is less than .5, then it will count as a day of utilization.

EXAMPLE: Mr. John Doe elected hospice benefits and received the following services:

General Inpatient Services--9 days. These days were fully covered by his employer group health plan which paid \$2,700 (the Medicare payment for the same 9 days would have been \$2,390).

Routine Home Care--15 days. The EGHP paid \$975 and the Medicare payment would have been \$960 in the absence of the EGHP payment.

Respite Care--4 days. The EGHP did not pay for this care.

Since the 9 days of General Inpatient Care and the 15 days of Routine Home Care were entirely paid for by the EGHP, these days are not charged against the beneficiary's days of hospice utilization. The 4 days as respite care are charged to the beneficiary's utilization.

289. DETERMINING AMOUNT OF PRIMARY PAYMENT THAT APPLIES TO MEDICARE SERVICES

Where you cannot determine the services covered by the primary payment amount, apply a ratio of Medicare covered charges to total charges for the period of hospice care to the primary payment amount to determine the portion attributable to Medicare covered services. Show the amount determined as the amount paid by the primary payer for Medicare covered services in items 46-49 of the HCFA-1450.

EXAMPLE: Total charges were \$5000. Medicare covered charges were \$4000. The primary payment was \$3000. Determine the allocation of the primary payment as follows:

$$\$4,000/\$5,000 \times \$3,000 = \$2,400$$

Show \$2,400 in value codes (items 46-49) of the HCFA- 1450.

290. RIGHT OF RECOVERY

All Medicare payments are conditioned on reimbursement to the appropriate Medicare Trust Fund, when notice or other information is received that payment with respect to the same items or services has also been made by a primary insurer.

The Medicare law expressly provides that:

- o The Government may recover benefits it paid for services that are covered by a primary payer plan, from the plan or from any entity that has been paid by the primary plan.

- o The Government is subrogated to the right of any entity to receive payment from a primary insurer. "Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the Government is given

whatever rights the beneficiary or any other entity had against the primary payer or the employer to the extent that Medicare has made payments to or on behalf of the beneficiary.

o The Government may join, initiate or intervene in any WC or liability claim where the compensability of the injury or illness is at issue.

291. PRIVATE RIGHT OF ACTION

Any beneficiary, has the right to take legal action against the responsible entity that fails to pay primary benefits, and can collect double damages. If such litigation is successful, the Medicare program can recover the amount paid by Medicare.

292 . RULES RELATING TO VETERANS BENEFITS

The VA may authorize non-Federal providers to render services at its expense, Medicare may not pay for such authorized services, and the charges for such services may not be credited to any Medicare coinsurance even in cases where the Federal agency has not yet paid for them.

300. ADMISSION PROCEDURES

When a Medicare beneficiary is admitted to a hospice program, or as soon thereafter as practical, verify eligibility in order to process the bill. Obtain this eligibility information directly from the patient, or through your intermediary's on-line limited Medicare eligibility data. Contact your intermediary to obtain technical instructions regarding how access may be obtained along with hardware/software compatibility details.

Disclosure of HCFA eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and may be used only for verifying a patient's eligibility for benefits under the Medicare program. Penalties for misuse include being found guilty of a misdemeanor, and a fine of not more than \$5,000.

This information does not represent definitive eligibility status. If the individual is not on file, use the admission and billing procedures in effect independent of this data access.

Obtain the patient's, or the patient representative's, signed hospice election statement. (Must be obtained no later than the first day for which payment is claimed.)

Obtain the patient's HICN.

Obtain the physician's certification for Hospice care. (Must be obtained within 2 calendar days of admission.) (See §302.1, **FL 17**.)

Complete the admission notice. (See §302.)

The intermediary checks HCFA's records and notifies you of the beneficiary's entitlement to Part A Medicare benefits.

301. OBTAINING THE HICN

It is important that the patient's HICN be obtained and accurately recorded on the admission and billing forms because the claim cannot be processed if it is missing or incorrect. A social security number is not sufficient for processing a claim.

When a patient is admitted, ask for his/her HI card, Temporary Notice of Medicare Eligibility or other notice he/she has received from SSA, an intermediary, or HCFA which shows the claim number. If the patient cannot furnish it, contact the SSO in accordance with §301.7. If a patient or prospective patient is within 3 months of age 65, is disabled or has ESRD, and has not applied for hospital insurance entitlement, advise him/her to contact the SSO or have someone do so on his/her behalf. You make arrangements with the SSO to routinely bring such cases to their attention.

301.1 Health Insurance Card.--Individuals who have established entitlement to HI are issued HI cards by SSA, or the RRB if they are railroad beneficiaries. The HI card serves as a source of essential information necessary in the processing of claims under the Medicare program. It shows the beneficiary's name, HICN, and effective date of entitlement to hospital insurance and/or medical insurance. (Section 399, Exhibit 1A, displays the HI card, and §301.4 explains the numbering system as an aid in recognizing valid numbers.)

A HI card is acceptable without a signature, however, ask the patient to sign it.

301.2 Temporary Notice of Medicare Eligibility.--The SSO may issue a temporary HI eligibility notice pending the issuance of a HI card when the beneficiary is in need of medical services. (See §399, Exhibit 1C.) Enter the patient's name and claim number on the admission notice. The intermediary will use that information to check HCFA's records, and respond to you about the patient's eligibility.

301.3 Social Security Award Certificate.--HI Beneficiaries receive a Social Security Award Certificate, (see §399, Exhibit 1B) showing the HICN, dates of entitlement to Part A and/or Part B, and the following statement:

"This notice may be used if Medicare services are needed before you receive your health insurance card."

301.4 Identifying HICNs.--Most HICNs are 9-digit numbers with letter suffixes, e.g., 000-00-0000-A. However, it may also be a 6 or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix/suffix of the claim number, **or even the claim number itself**, to change.

A. HICNs Assigned by SSA.--The potentially valid HICN assigned by SSA **to entitled beneficiaries is a 9-digit number followed by one of the following** suffixes:

000-00-0000-A

000-00-0000-B, B1-B9, BA, BD, BG, BH, **BJ**, BK, BL, BN, BP, BQ, BR, BT,
BW, BY

000-00-0000-C1-C9, CA-CK, D1-D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN,
DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ

000-00-0000-E, E1-E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM

000-00-0000-F1, F2, F3, F4, F5, F6, F7, F8

000-00-0000-J1, J2, J3, J4

000-00-0000-K1-K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM

000-00-0000-W, W1-W9, WB, WC, WF, WG, WJ, WR, **WT**

B. Numbers Assigned by the RRB.--The RRB began using the social security number in its numbering system in 1964. The numbers assigned prior to that time are 6-digit numbers assigned in numerical sequence, and have no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers, when used as claim numbers by the RRB, always have letter prefixes. (In rare cases, when a qualified railroad retirement beneficiary has a claim number with less than 6 digits; add sufficient zeros between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

All-Inclusive List of Potentially Valid RRB HICNs.--

| | |
|-----------------------------------|---------------------------------|
| A-000000, or A-000-00-0000 | PA-000000, or PA-000-00-0000 |
| MA-000000, or MA-000-00-0000 | PD-000000, or PD-000-00-0000 |
| WA-000000, or WA-000-00-0000 | H-000000 |
| WD-000000, or WD-000-00-0000 | MH-000000 |
| CA-000000, or CA-000-00-0000 | WH-000000 |
| WCA-000000, or WCA-000-00-0000 | WCH-000000 |
| | PH-000000 |
| | JA-000000 |
| WCD-000000, or WCD-000-00-0000 | |

C. Special Health Insurance Only Claim Numbers.--Some individuals who are not entitled to Social Security retirement, survivors, or disability insurance benefits, nor qualified for railroad retirement, are entitled to HI benefits.

They use Social Security numbers with these suffixes:

000-00-0000-T, TA, TB, TC, TD, TE, TF, TG, TH,
TJ, TK, TL, TM, TN, TP, TQ, TR,
TS, TT, TU, TV, TW, TX, TY, TZ, and
000-00-0000M
000-00-0000MI

| Suffix T indicates the individual is entitled to **free hospital or free** hospital and medical insurance, and is not entitled to monthly benefits.

| Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage **and is paying a premium**.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits, and has refused hospital insurance benefits.

301.5 Changes in HICNs.--Changes in an individual's entitlement to social security or railroad retirement benefits may result in a completely different HICN being assigned; e.g., an individual not entitled to monthly benefits (000-00-0000) marries and becomes entitled to wife's benefits on her husband's account (III-II-IIIIB).

301.6. Notice of Hospital (or Medical) Insurance Utilization or Explanation of Benefits.—If the patient cannot furnish his HI card or one of the notices described in §301 when admitted, he/she may use a utilization form which shows his/her claim number. Form HCFA-1533, Medicare Hospital, Skilled Nursing Facility, and Home Health Benefits Records (see § 399, Exhibit 2) is mailed to a beneficiary shortly after Part A inpatient hospital, or SNF benefits have been paid on his behalf. An Explanation of Medicare Benefits (EOMB) is sent to a beneficiary by the carrier after payment of a SMI claim. An EOMB is also sent to the beneficiary by the intermediary after the beneficiary receives Part B outpatient services. The beneficiary receives a utilization notice after payment on his or her behalf for Part B inpatient and outpatient hospital and SNF services.

301.7. Contacts With the SSO to Obtain HICNs.--When a beneficiary cannot furnish an HI claim number, request it from the SSO. Establish a working procedure for obtaining HICNs.

NOTE: The SSO also helps a beneficiary replace a lost or destroyed HI card.

A. Information Required by the SSO.--If the patient's social security number is available, the SSO usually requires no additional information to locate the HICN, or to determine that the patient has not established HI entitlement.

If the social security number is not available, furnish the following information:

- o The patient's name and a statement as to whether or not he/she ever applied for Social Security monthly benefits, railroad retirement benefits, or Medicare benefits;
- o If the patient says he/she applied, the name of the person whose social security number the application was based, e.g., his/her own or the spouse's number;
- o The full name of the patient's father, the maiden name of the patient's mother, and the patient's date and place of birth; and
- o The patient's address.

If you cannot furnish all the identifying information, furnish as much as possible.

B. The SSO's Reply.--The SSO furnishes the HICN as soon as possible. If it is not readily available, the SSO informs you of the action it is taking, i.e., that a claim number has been requested from SSA records, it is developing an application, or an application is pending.

If an application for hospital insurance benefits is taken as a result of the request for a claim number, or is pending when you request a claim number, the SSO gives you the claim number when processing is completed. You may then send the notice of admission to the intermediary.

302. NOTICE OF ELECTION (NOE)

When a Medicare beneficiary elects hospice services, complete Form Locators (FLs) 1, 4, 12, 13, 14, 15, 17, 32, 51, 58, 60, 67, 82, 83, and 85 of the Uniform (Institutional Provider) Bill (Form HCFA-1450) which is an election notice. Also, complete Form HCFA-1450 when the election is for a patient who has changed an election from one hospice to another.

Send the HCFA-1450 to the intermediary. Forward the HCFA-1450 by mail, or by messenger or telephone depending upon your arrangements with the intermediary. Also, send a copy to the carrier servicing your area. Annotate the copy with a reference to the Medicare Carriers Manual, §4175.2.

If a patient enters the hospice before the month, he/she becomes entitled to Medicare benefits, e.g., before age 65, do not send the election notice before the first day of the month in which he/she becomes 65.

302.1 Completing the Uniform (Institutional Provider) Bill (Form HCFA-1450) Notice of Election.--This form, also known as the UB-92, was developed to be suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for your notice of election. Items not listed need not be completed, although you may complete them when billing multiple payers.

FL 1. (Untitled) - Provider Name, Address, and Telephone Number

Required.--The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Required.--Enter the three-digit numeric type of bill code: 81A, B, C, D, or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit - Type of Facility

- 8 - Special facility or hospital ASC surgery (requires special information in second digit below).
- 9 - Reserved for National Assignment.

2nd Digit - Classification (Special Facility Only)

- 1 - Hospice (Nonhospital based)
- 2 - Hospice (Hospital based)

| <u>3rd Digit - Frequency</u> | <u>Definition</u> |
|---|---|
| A - Hospice Admission Notice | Use when the hospice is submitting Form HCFA-1450 as an Admission Notice. |
| B - Hospice Termination/Revocation Notice | Use when the hospice is submitting Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election. |
| C - Hospice Change of Provider Notice | Use when Form HCFA-1450 is used as a Notice of Change to the hospice provider. |
| D - Hospice Election Void/Cancel | Use when Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election. |
| E - Hospice Change of Ownership | Use when Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice. |

FL 12. Patient's Name

Required.--Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required.--Enter the patient's full mailing address, including street number and name, post office number or RFD, city, State, and Zip code.

FL 14. Patient's Birthdate

Required.--Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

FL 15. Patient's Sex

Required.--Enter an "M" for male or an "F" for female. This item is used in conjunction with FLs 67- 81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Required.--Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FL 32. Occurrence Code and Date

Required.-- Enter a code and associated date to indicate the physician's signed certification of the new hospice period. Code structure:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|---|---|
| 27 | Date of Hospice Certification or Re-Certification | Code indicates the date of certification or re-certification of the hospice benefit |

period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.

FLs 51A, B, and C. Provider Number

Required.--Enter the six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, and C. Insured's Name

Required.--Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, and C. Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67. Principal Diagnosis Code

Required.--Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. HCFA only accepts ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260, or HCFA approved errata and supplements to this publication. HCFA approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

FL 82. Attending Physician I.D.

Required.--Enter the UPIN and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians;
- SLF000 for providers to report that the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted unless the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 IDs may be audited.

FL 83. Other Physician I.D.

Required.--Enter the word "employee" or "nonemployee" here to describe the relationship the patient's attending physician has with you. "Employee" also refers to a volunteer under your jurisdiction.

FL 85-6. Provider Representative Signature and Date

Required.--A hospice representative makes sure the required physician's certification, and a signed hospice election statement are in the records before signing Form HCFA-1450. A stamped signature is acceptable.

302.2 Intermediary Reply to Notice of Election.--The reply to the notice of election is furnished according to your arrangements. Whether the reply is given by telephone, mail or wire, it is based upon the intermediary's query to HCFA master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

303. BILLING PROCEDURES

Use the Uniform (Institutional Provider) Bill (Form HCFA-1450) to bill for all covered hospice services.

303.1 Completion of the Uniform (Institutional Provider) Bill (Form HCFA-1450) for Hospice Bills.--This form, also known as the UB-92, is suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. Items not listed need not be completed although you may complete them when billing multiple payers.

FL 1. (Untitled) - Provider Name, Address, and Telephone Number

Required.--The minimum entry is the provider's name, City, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Required.--This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (Only Codes used to bill Medicare are shown.)

1st Digit - Type of Facility

- 8 - Special facility or hospital ASC surgery (requires special information in second digit below).
- 9 - Reserved for National Assignment

2nd Digit - Classification (Special Facility Only)

- 1 - Hospice (Nonhospital based)
- 2 - Hospice (Hospital based)

3rd Digit - Frequency

Definition

0 - Nonpayment/zero claims

Use this code when you do not anticipate payment from the payer for the bill, but are informing the payer about a period of nonpayable confinement or termination of

care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you.

- | | |
|-----------------------------------|--|
| 1 - Admit Through Discharge Claim | Use this code for a bill encompassing an entire course of hospice treatment for which you expect payment, i.e., no further bills will be submitted for this patient. |
| 2 - Interim - First Claim | Use this code for the first of an expected series of payment bills for a hospice course of treatment. |
| 3 - Interim - Continuing Claim | Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted. |
| 4 - Interim - Last Claim | Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (FL 6) is the discharge date or date of death. |
| 5 - Late Charge Only | Use for outpatient claims only. Late charges are not accepted for Medicare inpatient or ASC claims. |
| 7 - Replacement of Prior Claim | Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill. |
| 8 - Void/Cancel of a Prior Claim | This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information. |

FL 6. Statement Covers Period (From-Through)

Required.--Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient's entitlement began. The "From" date is used to determine timely filing. Since the 12-month hospice "cap period" (see §§405 and 407) ends each year on October 31, hospice services for October and November cannot be submitted on the same bill. Use October 31 as a cutoff date. Submit separate bills for October and November.

FL 12. Patient's Name

Required.--Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required.--Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

FL 14. Patient's Birthdate

Required.--Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, zero fill the field.

FL 15. Patient's Sex

Required.--Enter an "M" for male or an "F" for female. This item is used in conjunction with FLs 67- 81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Required.--Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FL 22. Patient Status

Required.--This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code Structure

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to another short-term general hospital
- 03 Discharged/transferred to SNF
- 04 Discharged/transferred to an ICF
- 05 Discharged/transferred to another type of institution (including distinct part) or referred for outpatient services to another institution
- 06 Discharged/transferred to home under care of organized home health service organization
- 07 Left against medical advice or discontinued care
- *09 Admitted as an inpatient to this hospital
- 20 Expired (or did not recover - Christian Science patient)
- 30 Still patient or expected to return for outpatient services
- 40 Expired at home (Hospice claims only)
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
- 42 Expired - place unknown (Hospice claims only)
- 50 Hospice - home
- 51 Hospice - medical facility

*If a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began more than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

Required.--Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) or FL 84 (remarks) to record additional occurrences and dates.

3-12

04-00

ADMISSION AND BILLING PROCEDURES

Rev. 55

303.1 (Cont.)

Use the following codes where appropriate:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|--|---|
| 24 | Date Insurance Denied | Enter the date of receipt of a denial of coverage by a higher priority payer. |
| 23 | Cancellation of Hospice Election Period (INTERMEDIARY USE ONLY) | Code indicates date on which a hospice period of election is cancelled by an intermediary as opposed to revocation by the beneficiary. |
| 27 | Date of Hospice Certification or Re-Certification | Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods. |
| 42 | Date of Discharge | Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (Hospice claims only.) |
| C4-C9 | | Reserved for National Assignment. |
| D0-D9 | | Reserved for National Assignment. |

FL 36. Occurrence Span Code and Dates

Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|---------------------------------|---|
| M2 | Dates of Inpatient Respite Care | Code indicates From/Through dates of a period of inpatient respite care for hospice patients. |

FLs 39, 40, and 41. Value Codes and Amounts

Required.--The only value codes that apply to hospice benefits are those that indicate Medicare payment is secondary to another payer. Enter the appropriate code(s) and related dollar amount(s) where the primary payer is other than Medicare, and where the primary payer has made payment at the time of billing Medicare. If the primary payer has denied payment, indicate this with zeros in the value amount. Enter the date of the denial and occurrence code 24 in the appropriate occurrence field. The value codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). If more than one value code is shown for a billing period, show codes in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used up before the second line is used). The amount of payment shown in the value field is deducted from the intermediary's payment to the hospice.

| <u>Code</u> | <u>Title</u> | <u>Definition</u> |
|-------------|--|--|
| 12 | Working Aged Beneficiary/Spouse With an EGHP | Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a |

- conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 13 ESRD Beneficiary in a Medicare Coordination Period With an EGHP Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 14 No-Fault, Including Auto/Other Insurance Enter this code to indicate the amount shown is that portion of a higher priority no-fault insurance payment including auto/other insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 15 Workers' Compensation (WC) Enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
- 16 Public Health Service (PHS), Other Federal Agency Enter this code to indicate the amount shown is that portion of a higher priority PHS or other Federal agency's payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment.

61 Location Where Service is Delivered (HHA and Hospice) MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator, right justified to the left of the dollars/cents delimiter. Value code 61 is required to accompany only revenue codes 651 and 652.

FL 42. Revenue Code

Required.--Assign a revenue code for each payment rate. Enter the appropriate three-digit numeric revenue code on the adjacent line in FL 43 to explain each charge in FL 47.

NOTE: Use revenue code 657 to identify your charges for services furnished to patients by physicians employed by you, or receiving compensation from you. In conjunction with revenue code 657, enter a physician procedure code in the right hand margin of FL 43 (to the right of the dotted line adjacent to the revenue code in FL 42). Appropriate procedure codes are available to you from your intermediary. Procedure codes are required in order for the intermediary to make reasonable charge determinations when paying you for physician services.

Use these revenue codes to bill Medicare.

| <u>Code</u> | <u>Description</u> | <u>Standard Abbreviation</u> |
|-------------|------------------------|--|
| 651* | Routine Home Care | RTN Home |
| 652* | Continuous Home Care | CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour.) |
| 655 | Inpatient Respite Care | IP Respite |
| 656 | General Inpatient Care | GNL IP |
| 657 | Physician Services | PHY Ser (must be accompanied by a physician procedure code) |

* Reporting of value code 61 is required with these revenue codes.

FL 43.--Revenue Description

Not Required.--Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown under FL 42.

FL 46.--Units of Service

Required.--Enter the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

FL 47.--Total Charges

Required.--Enter the total charges for the billing period by revenue code (FL 42) on the adjacent line in FL 47. The last revenue code entered in FL 42 ("000I") represents the grand total of all charges billed. The total is in FL 47 on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

FLs 50A, B, and C.--Payer Identification

Required.--If Medicare is the primary payer, enter "Medicare" on line A. If Medicare is not the primary payer, identify the primary payer on line A and enter Medicare on line B or C, if appropriate.

FL 51A, B, and C.--Provider Number

Required.--Enter your six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, and C.--Insured's Name

Required.--Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name as on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, and C.--Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67.--Principal Diagnosis Code

Required.--Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study that's chiefly responsible for the patient's admission.

FL 82.--Attending Physician I.D.

Required.--Enter the UPIN and name of the physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians that are assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Services' physicians, including the Indian Health Services;
- VAD000 for Department of Veterans' physicians;
- RET000 for retired physicians;
- SLF000 for providers to report that the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted unless the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 IDs may be audited.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

If more than one referring physician is indicated, enter the UPIN of the physician requesting the service with the highest charge.

FL 83. Other Physician I.D.

Required.--Enter the word "employee" or "nonemployee" to describe the relationship the patient's attending physician has with you.

FL 84. Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill, but are necessary for proper payment.

FL 85-6. Provider Representative Signature and Date

Required.--A hospice representative makes sure that the required physician's certification, and a signed hospice election statement are in the records before signing Form HCFA-1450. A stamped signature is acceptable.

303.2 Billing for Covered Medicare Services Unrelated to Hospice Care.--Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and are furnished during a hospice election period, are billed to the intermediary or carrier for non-hospice Medicare payment. These services are billed by the provider, in accordance with existing procedures, as a new admission with appropriate query and billing actions.

303.5 Frequency of Billing.--Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--Inpatient billing under PPS is normally done after discharge. However PPS hospitals not receiving periodic interim payments (PIP) may bill 60 days after an admission, and every 60 days thereafter.

Each PPS interim bill must include all diagnoses, procedures and services from admission to the through date. Repeat charges included on the prior bill on the subsequent interim adjustment bill.

Your initial PPS interim claims must have a patient status of 30 (still patient). Submit all interim PPS bills with the following designation:

-- 112 - for interim bill (first claim);

When you submit a bill subsequent to the first, submit it in the adjustment format as one of the following:

- o A 117 bill with a patient status of 30 (still patient); or
- o A 117 discharge bill with a patient status of:
 - 01 - Discharged to home or self-care;
 - 02 - Discharged/transferred to another short-term general hospital;
 - 03 - Discharged/transferred to SNF;
 - 04 - Discharged/transferred to ICF;
 - 05 - Discharged/transferred to another type of institution (including distinct parts), or referred for outpatient services to another institution;
 - 06 - Discharged/transferred to home under care of organized home health service organization;
 - 08 - Discharged to home under care of a home IV therapy provider; or
 - 20 - Expired (or did not recover - Christian Science Patient).

SNFs and non-PPS hospitals (i.e., excluded units or hospitals) bill upon discharge or after 30 days (and if necessary, every 30 days thereafter). You may bill more frequently if you bill electronically. Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed earlier. The from date must be the day after the through date on the earlier bill. If you receive PIP, you do not submit interim bills.

For hospice short-term inpatient care, submit the monthly bill designating the inpatient services with revenue code 655 or 656, as appropriate. Submit the bill in your normal manner if the inpatient hospice care is provided under your auspices. If the inpatient care is furnished by another entity, and they are billing Medicare directly, use occurrence span code 74 to show the period of inpatient care, as described under outpatient billing.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). These instructions also apply to Home Health Agency and hospice services under Part A. This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

| <u>Service</u> | <u>Revenue Code</u> |
|-----------------------------------|-------------------------------------|
| - DME Rental | 290-299 |
| - Therapeutic Radiology | 330-339 |
| - Therapeutic Nuclear Medicine | 342 |
| - Respiratory Therapy | 410-419 |
| - Physical Therapy | 420-429 |
| - Occupational Therapy | 430-439 |
| - Speech Pathology | 440-449 |
| - Home Health Visits | 550-599 |
| - Hospice Services | 650-659 |
| - Kidney Dialysis Treatments | 820-859 |
| - Cardiac Rehabilitation Services | 482, 943 |
| - Psychological Services | 910-919 (in a psychiatric facility) |

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Bill other one-time Part B services upon completion of the service.

Bills for outpatient surgery must contain, on a single bill, all services provided on the day of surgery except for kidney dialysis services, which are billed on a 72X bill type. These services normally include:

- o Nursing services, services of technical personnel, and other related services;
- o The patient's use of the hospital's facilities;
- o Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- o Diagnostic or therapeutic items and services (except lab services);
- o Blood, blood plasma, platelets, etc.; and
- o Materials for anesthesia.

303.6 Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines.--

A. General.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B. Coverage Requirements.--Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and its administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

C. Billing Requirements.--Provide the influenza virus, pneumococcal pneumonia and hepatitis B vaccines to those beneficiaries who request them including those who elected the hospice benefit. These services are coverable when furnished by you. Bill services for the vaccines to your local carrier on the HCFA-1500. Payment is made using the same methodology as if you were a supplier. If you do not have a supplier number, contact your local carrier to obtain one. If you have any other specific billing questions, contact your carrier to obtain assistance.

D. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

- 90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
- 90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
- 90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
- 90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
- 90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
- 90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

These codes are for reporting of the vaccines only. The provider bills for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

NOTE: Hospices should contact their local carrier for instructions on simplified billing for influenza virus vaccine and pneumococcal pneumonia vaccine.

303.7 Clarification of Reimbursement for Transfers that Result in Same Day Hospice Discharge and Admission.--In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for the day of discharge and admission.

304. MEDICAL REVIEW OF HOSPICE CLAIMS

To assure that appropriate payments are made for services provided to individuals electing hospice care, the intermediary is required to request and review medical records (including the written plans of care) from you.

The purpose of the MR is to assure that the services provided were:

- o Covered hospice services;
- o Stipulated in the plan(s) of care;
- o Necessary for the palliation or management of the beneficiary's terminal illness; and
- o Appropriately classified for payment purposes as specified in Chapter 4.

Submit all medical records and documentation to your intermediary within 30 days of the date your intermediary requests them. If you do not, the claim is denied, and you are liable for the costs of the noncovered services.

In addition, your intermediary may, at times, find it necessary to access information at your site. Any records related to a beneficiary must be made available. The intermediary may also find it necessary to visit the beneficiary and/or their relatives at home to verify that Medicare payment is appropriate. At the time the beneficiary elects hospice benefits, they are asked to sign a separate form consenting to Medicare home visits. However, if the patient refuses to sign the consent form, hospice benefits are not affected. The consent form (see Exhibit 4) makes both you and the patient aware of the possibility of such visits and the fact that they are necessary to determine the quality of delivered health care services. The consent form makes it clear that the patient and/or the family member has the right to refuse entry at any given time.

As a result of MR, an intermediary may reclassify care from one rate category to another. For example, if continuous home care was provided to a patient whose condition did not require the level of care described in §230.2 (or did not receive it), the intermediary makes payment for the services at the routine home care rate.

305. CLAIMS PROCESSING TIMELINESS

A. Claims Processing Timeliness Requirements.--"Clean" claims must be paid or denied within the applicable number of days from the date of their receipt as follows:

| <u>Time Period for Claims Received</u> | <u>Applicable Number of Days</u> |
|--|----------------------------------|
| 01-01-93 through 09-30-93 | 24 for EMC & 27 for paper claims |
| 10-01-93 and later | |

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| 10-01-93 and later | |

See subsection D for the definition of a clean claim. All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMCs are subject to the above requirements.

The count starts on the day after the receipt date and ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if the span is 30 days or less, the requirement is met.

B. Payment Floor Standards.--Your intermediary does not pay, issue, mail, or otherwise pay for any claim it receives from you within the waiting period as indicated below. The length of the waiting period is determined by the date a claim is received. Your intermediary starts its count on the day after the day of receipt. For example, a paper claim received October 1, 1993, can be paid on or after October 28, 1993. An electronic claim received November 1, 1993, can be paid on or after November 15, 1993.

| <u>Claims Receipt Date</u> | <u>Waiting Period (Calendar Days)</u> |
|----------------------------|---------------------------------------|
| 01-01-93 through 09-30-93 | 14 for EMC & 26 for paper claims |
| 10-30-93 and later | 13 for EMC & 26 for paper claims |

NOTE: No payment claims are not subject to the payment floor standards.

C. Interest Payment on Clean Non-PIP Claims Not Paid Timely.--Interest must be paid on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- o Claims requiring external investigation or development by your intermediary;
- o Claims on which no payment is due; or
- o Full denials.

Interest is paid on a per bill basis at the time of payment.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6 month basis effective every January 1st and July 1st. Effective January 1, 2000, you may access the Treasury Department's new web page--www.publicdebt.treas.gov/opd/opdprmt2.htm semi annually for the new rate. Your intermediary notifies you of any changes to this rate.

Interest is calculated using the following formula:

$$\text{Payment amount} \times \text{rate} \times \text{days} \div 365 \text{ (366 in a leap year)} = \text{interest payment.}$$

The interest period begins on the day after payment is due and ends on the day of payment.

| EXAMPLES: | <u>Clean Paper Claim</u> | <u>Clean Electronic Claim</u> |
|-----------------------------|--------------------------|-------------------------------|
| Date Received | November 1, 1993 | November 1, 1993 |
| Payment Due | November 28, 1993 | November 15, 1993 |
| Payment Made | December 3, 1993 | December 2, 1993 |
| Interest Begins | December 2, 1993 | December 2, 1993 |
| Days for Which Interest Due | 2 | 1 |
| Amount of Payment | \$100 | \$100 |
| Interest Rate | 5.625% | 5.625% |

Use the following formula:

o For the clean paper claim-- $\$100 \times .05625 \times 2$ divided by 365 = \$.0308 or \$.03 when rounded to the nearest penny.

o For the clean electronic claim-- $\$100 \times .05625 \times 1$ divided by 365 = \$.0154 or \$.02 when rounded to the nearest penny.

When interest payments are applicable, your intermediary indicates for the individual claim the amount of interest on their remittance record to you.

D. Definition of "Clean Claim"--A "clean" claim is one that does not require your intermediary to investigate or develop external to their Medicare operation on a prepayment basis.

Examples of clean claims are those that:

o Pass all edits (intermediary and Common Working File (CWF)) and are processed electronically;

o Do not require external development by your intermediary and are not approved for payment by CWF within 7 days of your intermediary's original claim submittal for reasons beyond your intermediary's or your control;

o Are investigated within your intermediary's claims, Medicare review, or payment office without the need to contact you, the beneficiary, or other outside source;

o Are subject to medical review but complete medical evidence is attached by you or forwarded simultaneously with EMC records in accordance with your intermediary's instructions. If your intermediary requests medical evidence see first item under subsection E; or

o Are developed on a postpayment basis.

E. Other Claims--Claims that do not meet the definition of "clean" claims are "other" claims. Other claims require investigation or development external to your intermediary's Medicare operation on a prepayment basis. Other claims are those that are not approved by CWF for which your intermediary identifies as requiring outside development. Examples are claims on which your intermediary:

- o Requests additional information from you or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;
- o Requests information or assistance from another contractor. This includes requests for charge data from the carrier or any other requests for information from the carrier;
- o Develops MSP information;
- o Requests information necessary for a coverage determination;
- o Performs sequential processing when an earlier claim is in development; and
- o Performs outside development as a result of a CWF edit.

306. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

A. Background.--CLIA of 1988 changes clinical laboratories' certification. Effective September 1, 1992, clinical laboratory services are covered only if the entity furnishing laboratory services has been issued a CLIA number. However, laboratories may be paid for a limited number of laboratory services if they have a CLIA certificate of waiver or a certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

B. General.--Do not bill for laboratory tests. The survey process is used to validate that laboratory services in a hospice are being provided in accordance with the CLIA certificate. You are responsible for verifying CLIA certification prior to ordering laboratory services under arrangements.

C. CLIA Number.--Use the following CLIA positions:

- o Positions 1 and 2 of the CLIA number are the State code (based on the laboratory's physical location at time of registration);
- o Position 3 is an alpha letter "D"; and
- o Positions 4-10 are a unique number assigned by the CLIA billing system. (No other laboratory in the country will have this number.)

D. Certificate for Physician-Performed Microscopy Procedures.--Effective January 19, 1993, a laboratory that holds a certificate for physician-performed microscopy procedures may perform only those tests specified as physician-performed microscopy procedures and waived tests, as described in §306 E. below, and no others. The following codes may be used:

HCPCS Code Test

| | |
|-------|---|
| Q0111 | Wet mounts, including preparations of vaginal, cervical or skin specimens; |
| Q0112 | All potassium hydroxide (KOH) preparations; |
| Q0113 | Pinworm examinations; |
| Q0114 | Fern test; |
| Q0115 | Post-coital direct, qualitative examinations of vaginal or cervical mucous; and |
| 81015 | Urine sediment examinations. |

E. Certificate Of Waiver.--Effective September 1, 1992, all laboratory testing sites (except as provided in 42 CFR 493.3(b)) must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States.

A grace period starting May 1, 1993, and ending on July 31, 1993, has been granted to allow providers time to adapt to the new coding system. Physicians, suppliers, and providers may submit claims for services furnished during this grace period with 1992 or 1993 lab codes.

Claims for services provided prior to the grace period (prior to May 1, 1993) must reflect 1992 codes, even if received after the end of the grace period (after July 1, 1993). Claims with dates of services prior to May 1, 1993, which reflect 1993 codes, are denied.

Services furnished on or after September 1, 1992, by laboratories that have a certificate of waiver are limited to the following eight procedures:

| <u>HCPCS Code</u> | | <u>Test</u> |
|-------------------|-------------|--|
| <u>1992</u> | <u>1993</u> | |
| Q0095 | 81025 | Urine pregnancy test; visual color comparison tests; |
| Q0096 | 84830 | Ovulation test; visual color comparison test for human luteinizing hormone; |
| Q0097 | 83026 | Hemoglobin; by copper sulfate method, non-automated; |
| Q0098 | 82962 | Glucose, blood; by glucose monitoring devices cleared by the FDA specifically for home use; |
| 82270 | 82270 | Blood, occult; feces; |
| Q0100 | 81002 | Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy; |
| Q0101 | 85013 | Microhematocrit; spun; and |
| Q0102 | 85651 | Sedimentation rate, erythrocyte; non-automated. |

Effective January 19, 1993, a ninth test was added to the waived test list:

| | |
|-------|---|
| Q0116 | Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout. |
|-------|---|

F. Certificate of Registration.--Initially, you are issued a CLIA number when you apply to the CLIA program.

306.1 Focused Medical Review (FMR).--This section has been moved to the Program Integrity Manual which can be found at the following Internet address:
www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

307. CREDIT BALANCE REPORTING REQUIREMENTS -- GENERAL

The Paperwork Burden Reduction Act of 1980 was enacted to inform you about why the Government collects information and how it uses this information. In accordance with §§1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, §1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, complete a Medicare Credit Balance Report (HCFA-838), to ensure that monies owed to Medicare re repaid in a timely manner.

The HCFA-838 is specifically used to monitor identification and recovery of "credit balances" due to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- o Paid twice for the same service either by Medicare or by Medicare and another insurer;
- o Paid for services planned but not performed, or for non-covered services;
- o Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance or amounts;
- o A hospital which bills and is paid for outpatient services included in a beneficiary's inpatient claim. Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the HCFA-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to §§300 and 301 that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

307.1 Submitting the HCFA-838.--Submit a completed HCFA-838 to your intermediary within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program.

307.2 Completing the HCFA-838.--The HCFA-838 consists of a certification page and a detail page. An officer or the Administrator of your facility must sign and date the certification page. If no Medicare credit balances are shown in your records for the reporting quarter, you must still have the officer or Administrator sign the form and submit it to attest to this fact.

The detail page requires specific information on each credit balance on a claim-by-claim basis. The detail page provides space to address 17 claims. You may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you report. Submit the detail page(s) on computer diskette, which is available from your intermediary. Submit the certification page in hard copy.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE Part B pertains only to services you provide which are billed to your intermediary. It does not pertain to physician and supplier services billed to carriers.

Complete the HCFA-838 providing the information required in the heading area of the detail page(s) as follows:

- o The full name of the facility;
- o The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- o The month, day and year of the reporting quarter, e.g., 12/31/93;
- o An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- o The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- o The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

- Column 1- The last name and first initial of the Medicare beneficiary, (e.g., Doe, J.).
- Column 2- The Medicare Health Insurance Claim Number (HICN) of the Medicare beneficiary.
- Column 3- The 1-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.
- Column 4- The 3-digit number explaining the type of bill, e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions, §303.)

- Columns 5/6 - The month, day and year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 1/1/93).
- Column 7- The month, day and year (e.g., 1/1/93) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and ICN number correspond to the most recent payment.
- Column 8- An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)
- Column 9- The amount of the Medicare credit balance that was determined from your patient/accounting records.
- Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the HCFA-838 to your intermediary.)
- Column 11 - A "C" when you submit a check with the HCFA-838 to repay the credit balance amount shown in column 9, or an "A" if you submit an adjustment request.
- Column 12 - The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if you make full payment.
- Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons".
- Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability. For code description, see §303.)
- 12 - Working Aged
 - 13 - End Stage Renal Disease
 - 14 - Auto No Fault/Liability
 - 15 - Workers' Compensation
 - 16 - Other Government Program
 - 41 - Black Lung
 - 42 - Department of Veterans Affairs (VA)
 - 43 - Disability

Column 15 - The name and address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the HCFA-838, it is not to be reported on a subsequent period report.

307.3 Payment of Amounts Owed Medicare.--Pay all amounts owed Medicare as shown in column 9 of the credit balance report at the time you submit the HCFA-838. (See §307.7.) Make payment by check or by submission of adjustment requests. Submit adjustment requests in hard copy or electronic format.

If you use a check to pay credit balances, submit adjustment requests for the individual credit balances that pertain to open cost reporting periods. Your intermediary will assure that monies are not collected twice.

If the amount owed Medicare is so large that immediate repayment would cause financial hardship, request an extended repayment schedule.

Interest is assessed on Medicare credit balances not timely repaid applying 42 CFR 405.376. In part this means:

- o Interest accrues on outstanding amounts beginning from the due date of a timely-filed Medicare credit balance report if the report is not accompanied by payment in full.

- o Interest is charged on the entire amount shown on a Medicare credit balance report beginning from the day after the report was due if the report is not timely-filed.

- o Interest is charged on outstanding amounts beginning from the date a credit balance occurred, in those instances where a credit balance(s) was omitted from a Medicare credit balance report or was not accurately reported.

- o Interest will not be charged on Medicare credit balances resulting from MSP provisions until they are past due in accordance with the 60-day repayment provision of 42 CFR 489.20. Once due, interest is assessed on outstanding Medicare credit balances resulting from MSP provisions in the same manner as any other outstanding Medicare credit balance, as discussed above.

307.4 Records Supporting HCFA-838 Data.--Develop and maintain documentation that shows that each patient record with a credit balance (transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for preparation of the HCFA-838. At a minimum, your procedures should:

- o Identify whether or not the patient is an eligible Medicare beneficiary;
- o Identify other liable insurers and the primary payer; and
- o Adhere to applicable Medicare payment rules.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the HCFA-838 or for not maintaining documentation that adequately supports the credit balance data reported to HCFA. Your intermediary will review your documentation during audits/reviews performed for cost report settlement purposes.

307.5 Provider-Based Home Health Agencies (HHAs).--Provider-based HHAs are to submit their HCFA-838 to their Regional Home Health Intermediary even though it may be different from the intermediary servicing the parent facility.

307.6 Exception for Low Utilization Providers.--Providers with extremely low Medicare utilization do not have to submit a HCFA-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-1, §2414.B, or files less than 25 Medicare claims per year.

307.7 Compliance with MSP Regulations.--MSP regulations at 42 CFR 489.20 require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a HCFA-838 and adherence to HCFA's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the HCFA-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it in the HCFA-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the HCFA-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the HCFA-838, but within the 60 days allowed.

EXHIBIT I

Medicare Credit Balance Report Certification

The Medicare Credit Balance Report is required under the authority of §§1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS, OR OMITTS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by _____ (Provider Name(s) and Number(s)) for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations, and instructions.

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Public reporting burden for this collection of information is estimated to average 6 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to:

Health Care Financing Administration,
P.O. Box 26684
Baltimore, Maryland 21207 and to:

Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, D.C. 20503.

Paperwork Reduction Project (0938-0600)

EXHIBIT II

This page is reserved for
The Medicare Credit Balance Report
(HCFA-838)

399. EXHIBITS

- Exhibit 1A. Health Insurance Cards
- Exhibit 1B. Social Security Award Certificate
- Exhibit 1C. Temporary Notice of Medicare Eligibility
- Exhibit 2. Medicare Hospital, Skilled Nursing Facility, and Home Health Benefits Record (Form HCFA-1533)
- Exhibit 3. Uniform (Institutional Provider) Bill (Form HCFA-1450)
- Exhibit 4. Hospice Home Visit Consent Form

THIS IS SPACE FOR HEALTH INSURANCE CARDS

THIS PAGES IS RESERVED FOR

Exhibit 1-B

Social Security Award Certificate

THIS IS SPACE FOR (TEMPORARY NOTICE OF MEDICARE ELIGIBILITY)

THIS IS SPACE FOR (MEDICARE HOSPITAL, SKILLED NURSING FACILITY
AND HOME HEALTH BENEFITS RECORD)
HCFA -1533

THIS IS SPACE FOR (MEDICARE HOSPITAL, SKILLED NURSING FACILITY
AND HOME HEALTH BENEFITS RECORD)
HCFA -1533

Exhibit 3

THIS IS SPACE FOR UB-82 HCFA-1450)

Exhibit 4

HOSPICE HOME VISIT CONSENT FORM

| | | | | |
|---|------------|--------------------|----------------------------------|---------------|
| 1. Patient's last name | First name | MI | 2. Health insurance claim number | |
| 3. Patient's address (Street number, City, State, Zip Code) | | | 4. Date of birth | 5. Sex M F |
| 6. Hospice name and address (City and State) | | 7. Provider number | | |
| 8. Date of Hospice Election | | | | |

This consent form permits the fiscal intermediary medical review personnel to conduct home visits with you and/or your family members in order to ensure that quality care is provided and that Medicare payments for the services received are appropriate.

You and/or your family members have the right to refuse entry into your home at any time. Refusal to sign the home visit consent form or to permit entry into your home after consent is given will not affect payment for hospice services.

I understand the explanation described above and give my permission for home visits.

Beneficiary
Signature _____ Date _____

Signature of hospice representative _____

401. GENERAL

With the exception of payment for physician services (see §406), Medicare reimbursement for hospice care is made at one of four predetermined rates for each day in which a Medicare beneficiary is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the application of the statutory "cap" on overall payments and the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary. The statutory "cap" (calculated by the Medicare intermediary) and the limitations on payment for inpatient care are described in sections that follow.

402. LEVELS OF CARE

There are four levels of care into which each day of care is classified:

- A. Routine Home Care
- B. Continuous Home Care
- C. Inpatient Respite Care
- D. General Inpatient Care

For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For levels A, C, and D only one rate is applicable for each day. For level B, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

402.1 Routine Home Care.--The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition.

402.2 Continuous Home Care.--The hospice is paid the continuous home care rate when continuous home care is provided. (See §230.2A.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

402.3 Inpatient Respite Care.--The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See §230.2B.) Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

For hospice claims on which the respite care rate is not allowed because the five consecutive day limit is exceeded, use the following messages to notify the beneficiary:

o MSN message 27.12: "The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate."

o EOMB message 16.98: "The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate."

The Spanish translation for this message is as follows:

"La documentación indica que su nivel de cuidado temporero excedió 5 días consecutivos. Por lo tanto, el pago por cada día después del quinto (5) día será ajustado a la tarifa de cuidado rutinario en el hogar."

ó=alt 162

í=alt 161

é=alt 130

402.4 **General Inpatient Care.**--Payment at the inpatient rate is made when general inpatient care is provided. (See §230.1E.) None of the other fixed payment rates (i.e., routine home care) are applicable for a day on which the patient receives hospice inpatient care except as described in §402.5.

402.5 **Date of Discharge.**--For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

403. HOSPICE PAYMENT RATES

The hospice rates, before area wage adjustments, for each of the categories of care described above, are as follows:

| | |
|-----------------------------|-------------------------------------|
| Routine Home Care Rate | \$97.11 |
| Continuous Home Care Rates | \$566.82 Full Rate-24 hours of care |
| | \$23.62 Hourly Rate |
| Inpatient Respite Care Rate | \$100.46 |
| General Inpatient Care Rate | \$432.01 |

These rates are in effect for services provided on or after October 1, 1998 through September 30, 1999.

404. LOCAL ADJUSTMENT OF PAYMENT RATES

The payment rates above are adjusted for regional differences in wages. The hospice wage index is published in the *Federal Register* each year, and is effective October 1 of that year through September 30 of the following year. Current wage index values can be obtained from the *Federal Register* Notice announcing the update or from your intermediary. To select the proper index for your area, first determine if your hospice is located in one of the Urban Areas listed in Table A of the *Federal Register* notice. If so, use the index for your area. If you are not listed as one of the Urban Areas, use the index number of the rural area for your State, listed in Table B of the *Federal Register* notice.

Once you determine the index for your area, the computation of the rates for your hospice can be made using the following tables in this section. Table I indicates the portion of each of the rates subject to the wage index. Table II is an example of the computation of wage adjusted rates for a hospice located in Baltimore, Maryland, using the index number of 1.0549. Table III is used to compute the rates applicable to your hospice. The wage adjusted continuous care rate can then be divided by 24 to determine the hourly billing rate.

TABLE I

| | National rate | Wage component subject to index | Un-weighted amount |
|------------------------|---------------|---------------------------------|--------------------|
| Routine Home Care | \$97.11 | \$66.72 | \$30.39 |
| Continuous Home Care | 566.82 | 389.46 | 177.36 |
| Inpatient Respite | 100.46 | 54.38 | 46.08 |
| General Inpatient Care | 432.01 | 276.53 | 155.48 |

TABLE II

| | National Rate | Wage Component subject to index | Index for Balto., MD | Adjusted Wage Component | Non-wage Component | Adjusted Rate |
|------------------------|---------------|---------------------------------|----------------------|-------------------------|--------------------|---------------|
| Routine Home Care | \$97.11 | \$66.72 | 1.0549 | \$ 70.38 | \$ 30.39 | \$100.77 |
| Continuous Home Care | 566.82 | 389.46 | 1.0549 | 410.84 | 177.36 | 588.20 |
| Inpatient Respite | 100.07 | 54.38 | 1.0549 | 57.37 | 46.08 | 103.45 |
| General Inpatient Care | 432.01 | 276.53 | 1.0549 | 291.71 | 155.48 | 447.18 |

TABLE III

| | National Rate | Wage component subject to index | Index for your area [±] | Adjusted wage component (col. 2 x col.3) | Non-wage Component | Wage Adjusted Rates for your area (col. 4 + col. 5) |
|------------------------|---------------|---------------------------------|----------------------------------|--|--------------------|---|
| | col. 1 | col. 2 | col. 3 | col.4 | col. 5 | col.6 |
| Routine Home Care | \$ 97.11 | \$ 66.72 | — | | \$ 30.39 | |
| Continuous Home Care | 566.82 | 389.46 | — | | 177.36 | |
| Inpatient Respite | 100.07 | 54.38 | — | | 46.08 | |
| General Inpatient Care | 432.01 | 276.53 | — | | 155.48 | |

Continuous Home Care Rate, adjusted for wages = \$ ÷24 hours = \$ ____ Hourly Rate

405. LIMITATION ON PAYMENTS FOR INPATIENT CARE

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (11/1 - 10/31). For purposes of this computation, if the intermediary determines that the inpatient rate should not be paid, any days for which you receive payment at a home care rate are not counted as inpatient days. The limitation is calculated by your intermediary as follows:

- o The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2.

- o If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.

- o If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

1. calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. multiplying excess inpatient care days by the routine home care rate.

3. adding together the amounts calculated in 1. and 2. above.

4. comparing the amount in 3. above with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement is refunded by the hospice.

406. PAYMENT FOR PHYSICIAN SERVICES

Payment for physician services provided in conjunction with the hospice benefit is made in different ways:

A. Administrative Activities.--Payment for physicians' administrative and general supervisory activities is included in the payment rates listed in §403. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group.

B. Patient Care Services.--Payment for physicians' direct patient care services furnished by hospice employees or under arrangement with the hospice is made in the following manner:

- o Formulate a charge and bill the intermediary for these services.
- o The intermediary pays you at the lesser of the actual charge or 100 percent of the Medicare reasonable charge for these services. This payment is in addition to the daily rates.
- o Payment for physicians' services is counted with the payments made at the daily payment rates to determine whether the hospice cap amount has been exceeded.
- o No payment is made for physician services furnished voluntarily. However, some physicians may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if you are obligated to reimburse the physician for the services. A physician must treat Medicare patients on the same basis as other patients in the hospice; a physician may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.

EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the intermediary and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.

C. Attending Physician Services.--Payment for patient care services rendered by a physician designated by the hospice patient as the attending physician is made in the following manner:

- o Patient care services rendered by an attending physician who volunteers services to the hospice is made in accordance with subsection B. (This is because physicians who volunteer services to the hospice are, as a result of this volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3).
- o Patient care services rendered by an independent attending physician (a physician who is not considered employed or under contract with the hospice) are not part of the hospice benefit. These physicians bill the Medicare carrier directly. Payment for services to hospice patients is made directly by the carrier to the independent attending physician at 80 percent of the reasonable charge.

Only the independent attending physician's personal professional services to the patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.

The hospice must notify the Medicare carrier of the hospice election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

This reimbursement is not counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

407. CAP ON OVERALL REIMBURSEMENT

Overall aggregate payments made to a hospice are subject to a "cap amount," calculated by the intermediary at the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicare beneficiaries during this period are compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. "Total payment made for services furnished to Medicare beneficiaries during this period" refers to payment for services rendered during the cap year beginning November 1st and ending October 31, regardless of when payment is actually made. Payments are measured in terms of all payments made to hospices on behalf of all Medicare hospice beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap. For example, payments made to a hospice for an individual electing hospice care on October 5, 1997, pertaining to services rendered in the cap year beginning November 1, 1996, and ending October 31, 1997, are counted as payments made during the first cap year (November 1, 1996 - October 31, 1997), even though that individual is not counted in the calculation of the cap for that year. (The individual is, however, to be counted in the cap calculation for the following year since the election occurred after September 27 - see below).

The hospice cap is to be calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, we require that the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1997, runs from October 1, 1997 through October 31, 1998. Similarly, the first cap period for hospice providers entering the program after November 1, 1996 but before November 1, 1997 ends October 31, 1998.

The "cap amount" is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount of \$6,500. This amount will be adjusted in future years to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers

(U.S. city average), published by the Bureau of Labor Statistics (BLS), from March 1984 to the fifth month of the accounting year. Section 407.1 explains how the statutory cap amount of \$6,500 is to be adjusted in future years. Hospices that began operations before January 1, 1975, are eligible for an exception to the application of this cap. You must apply and be approved to receive this waiver. Send applications to:

Health Care Financing Administration
Chronic Care and Purchasing Policy Group, CHPP
C5-02-23
7500 Security Boulevard
Baltimore, MD. 21244-1850

The computation and application of the "cap amount" is made by the intermediary at the end of the cap period. The material is presented here for your benefit as an aid to planning. You are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the intermediary. This must be done within 30 days after the end of the cap period.

Follow these rules in determining the number of Medicare beneficiaries who have elected hospice care during the period:

- o The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.
- o The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicare beneficiary during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of beneficiaries to be counted in each cap period.

Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)

When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary. It is inequitable to count the patient's stay in the hospices as equivalent if there were marked differences in the lengths of stay. Consequently, a calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay. The intermediary servicing the hospice program in which the beneficiary dies or exhausts the hospice benefit is responsible for determining the proportionate lengths of stay for all preceding hospices. This intermediary is also responsible for disseminating this information to any other intermediaries servicing hospices in which the beneficiary was previously enrolled. Each intermediary then adjusts the number of beneficiaries reported by these hospices based on the latest information available at the time the cap is applied.

EXAMPLE: John Doe, a Medicare beneficiary, initially elects hospice care from hospice A on September 2, 1997. Mr. Doe stays in hospice A until October 2, 1997 (30 days) at which time he changes his election and enters hospice B. Mr. Doe stays in hospice B for 70 days until his death on December 11, 1997. The intermediary servicing hospice B is responsible for determining the proportionate number of Medicare beneficiaries to be reported by each hospice that delivered hospice services to Mr. Doe. This intermediary determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in hospice A and 70 days in hospice B). Since Mr. Doe was in hospice A for 30 days, Hospice A counts .3 of a Medicare beneficiary for Mr. Doe in its hospice cap calculation (30 days/100 days). Hospice B counts .7 of a Medicare beneficiary in its cap calculation (70 days/100 days). The intermediary servicing hospice B makes these determinations and notifies the intermediary servicing hospice A of its determination. These intermediaries are then responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

Readjustment of the hospice cap may be required if information previously unavailable to the intermediary at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the example above, if the intermediary servicing hospice A had calculated and applied the hospice cap on November 30, 1997, information would not have been available at that time to adjust the number of beneficiaries reported by hospice A, since Mr. Doe did not die until December 11, 1997. The intermediary servicing hospice A would have to recalculate and reapply the hospice cap to hospice A based on the information it later received from the intermediary servicing hospice B. The cap for hospice A after recalculation would then reflect the proper beneficiary count of .3 for Mr. Doe.

An additional step is required when more than one Medicare certified hospice provides care to the same individual, and the care overlaps 2 cap years. In this case, each intermediary must determine in which cap year the fraction of a beneficiary is reported. If the beneficiary entered the hospice before September 28, the fractional beneficiary is included in the current cap year. If the beneficiary entered the hospice after September 27, the fractional beneficiary is included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, hospice A includes .3 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 1996, and ending October 31, 1997, since Mr. Doe entered hospice A before September 28, 1997. Hospice B includes .7 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 1997, and ending October 31, 1998, since Mr. Doe entered hospice B after September 27, 1997.

Where services are rendered by two different hospices to one Medicare patient, and one of the hospices is not certified by Medicare, no proportional application is necessary. The intermediary counts one patient and uses the total cap for the certified hospice.

We do not expect that the situation of beneficiaries changing to other hospices occurs frequently, thus we do not anticipate that the effect on hospice payments is significant.

407.1 Adjustments to Cap Amount.--The original cap amount of \$6,500 per year is to increase or decrease for accounting years that end after October 1, 1984 by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. As indicated in 42 CFR 418.309, the hospice cap is applied on the basis of a cap year beginning November 1 and ending the following October 31.

For example, for the cap amount for the period ending October 31, 1998, we calculate using the March 1998 price level in the medical care expenditures category of 239.8 and divide by the March 1984 price level of 105.4 to yield an index of 2.275 (rounded). The new hospice cap amount is the product of \$6500 (base year cap) multiplied by 2.214. Therefore, the cap amount for the period ending October 31, 1997, is \$14,788.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.

EXAMPLE:

10/01/97 - Hospice A is Medicare certified.

10/01/97 to 10/31/98 - First cap period (13 months) for hospice A.

Statutory cap for first Medicare cap year (11/01/96 - 10/31/97) = \$14,394

Statutory cap for second Medicare cap year (11/01/97 - 10/31/98) = \$14,788

Weighted average cap calculation for hospice A:

One month (10/01/97 - 10/31/97) at \$14,394 = \$ 14,394

12 months (11/01/97 - 10/31/98) at \$14,788 = \$177,456

13 month period \$191,850 divided by 13 = \$14,758 (rounded)

In this example, \$14,758 is the weighted average cap amount used in the initial cap calculation for hospice A for the period October 1, 1997 through October 31, 1998.

NOTE: If hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

408. APPEALS

A. Individual Determinations--

1. Beneficiary Appeals--A hospice beneficiary is entitled to the full range of appeal rights for cases involving a denial of benefits in accordance with the procedures in Part 405, Subpart G of the regulations (i.e., 42 C.F.R. §§405.701 et seq.). In these cases, a beneficiary may request a reconsideration regardless of the amount in controversy. If the beneficiary is dissatisfied with the reconsideration determination, he may request a hearing before an Administrative Law Judge (ALJ) if the amount in controversy is at least \$100. If dissatisfied with the ALJ's decision, he may request an Appeals Council review. If \$1,000 or more remains in controversy following the Appeals Council review or Appeals Council denial of a request for review, the beneficiary may file suit in a United States District Court.

2. Hospice Appeals--A hospice, as is the case with any Medicare Part A provider, is entitled to appeal a claim filed on behalf of an individual only if the individual does not exercise his appeal rights and if the initial determination involves: (1) An intermediary finding that the items or services are not reasonable and necessary (§1862(a)(1) determination), and (2) An intermediary finding that either they or the beneficiary provider, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage. The authority for such provider appeal is found in §1879(d) of the Act.

In the following circumstances, a hospice has the full range of appeal rights specified in Subpart G (i.e., reconsideration, ALJ hearing, Appeals Council review and judicial review), if amounts in controversy are met and the beneficiary does not exercise his appeal rights.

a. When an intermediary finds that items or services furnished to a beneficiary are not covered because they are not reasonable and necessary for the palliation or management of terminal illness and further finds that the beneficiary or the hospice, or both, should have known this. (The hospice may not combine claims from more than one beneficiary to reach the \$100 minimum for an ALJ hearing.)

b. When a hospice submits a claim requesting payment at the continuous home care rate, the intermediary is obliged to determine the medical necessity for continuous home care (i.e., an 1862(a)(1) determination).^{*} If the intermediary decides that continuous home care is not medically necessary and pays the claim at the routine care rate, the hospice may appeal the benefit reduction if the intermediary finds that either the beneficiary or the hospice, or both, knew or should have known that the services were not covered at the continuous home care level. (The hospice may not combine claims from more than one beneficiary to reach the \$100 minimum for an ALJ hearing.)

^{*}To constitute continuous home care, care must be provided for at least 8 hours. (See §230.2.) If such care is not provided for a minimum of 8 hours, a technical denial occurs (not an 1862(a)(1) determination) and the hospice has no appeal rights.

3. Beneficiary Representation by Hospice.--To be represented by a hospice, the beneficiary must execute a form SSA-1696-U4, Appointment of Representative, in addition to the appropriate reconsideration or hearing request. The SSA-1694-U4 form must contain the signed acceptance of an authorized official of the hospice being appointed.

When the appeal involves either services that constitute custodial care or are not reasonable and necessary and thus the application of the limitation of liability provisions under §1879 of the Act, the hospice representative (attorney or non-attorney) must waive in writing any right to payment from the beneficiary for these services. The intermediary must obtain the written waiver even when the claim is initially paid under the limitation of liability provision, i.e., when it finds that neither the hospice nor the beneficiary is liable. This waiver requirement is intended to insure against conflict of interest.

A hospice representative (including an attorney) cannot charge the beneficiary a fee in connection with such representation.

The costs incurred by a hospice in representing a beneficiary in an unsuccessful appeal are not allowed as reasonable costs in determining its Medicare reimbursement.

B. Provider Payment Determinations.--A hospice dissatisfied with an intermediary determination, as set out in a notice issued to the hospice at the end of the cap year may request and obtain an intermediary hearing if the amount of program reimbursement in controversy with respect to matters for which the hospice has a right to review is at least \$1,000, but less than \$10,000. Where the dispute involves \$10,000 or more, jurisdiction lies with the Provider Reimbursement Review Board (PRRB). A request for a hearing must be filed no later than the 180th calendar day following the date the hospice received notice of the intermediary's determination. The hearing is conducted consistent with the procedures in Part 405, Subpart R of the regulations (i.e., 42 C.F.R. §§405.1800 et seq.), and a decision by the PRRB is subject to review only by the Administrator of HCFA. There is no judicial review of the final administrative decision.

Examples of types of reimbursement issues for which a hospice may request a hearing are as follows:

1. Calculation and application of the hospice cap.
2. Calculation of reimbursement where the hospice is found to have exceeded the 80/20 ratio of home care to inpatient care days.

The methods and standards for the calculation of the hospice payment rates established by HCFA, as well as questions as to the validity of the applicable law, regulations, or HCFA rulings, are not subject to administrative review.

NOTE: Generally, matters involving payment to a hospice of an incorrect payment rate with respect to one or more of the categories of hospice care (this may, for example, result from the use of a money amount other than the applicable payment rate calculated by HCFA or from an incorrect adjustment of such rate to reflect local differences in wages) are expected to be resolved by the intermediary. However, if these matters are unresolved at the end of the cap year, the hospice has a right to a hearing.

409. COST REPORTING AND RECORDKEEPING REQUIREMENTS

A. Cost Reports.--HCFA is developing cost reporting forms and instructions and will distribute them to hospices upon completion so that any needed changes can be made in their recordkeeping systems. The information collected through these cost reports will be used to update reimbursement rates in the future. In no case will cost reports be required more often than annually.

B. Final Settlement.--There are no retroactive adjustments made to the reimbursement rates discussed above, other than application of the limits discussed in §§405 and 407 above. The cost reports are used strictly for data collection.

C. Accounting Requirements.--The cost data submitted must be on the accrual basis of accounting and in accordance with generally accepted accounting principles. All books and records shall be retained for 5 years. HCFA reserves the right to audit any cost or utilization data collected. Sufficient documentation must be maintained for audit purposes, and to support the allocation of costs.

410. HOSPICE COINSURANCE

The payment rates in §403 have been reduced by a coinsurance amount on outpatient drugs and biologicals and inpatient respite care as required by law. No other coinsurance or deductibles may be imposed for services furnished to beneficiaries during the period of an election, regardless of the setting of the services. You may charge beneficiaries for the applicable coinsurance amounts.

410.1 Coinsurance on Outpatient Drugs and Biologicals.--The statute specifies that you may charge the beneficiary a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than \$5, for each prescription furnished on an outpatient basis. The payment rates have been reduced by average coinsurance expected to be collected. If you intend to charge coinsurance, establish a "drug copayment schedule" that specifies each drug and the copayment to be charged. The charges included on the schedule must approximate 5 percent of the cost of the drugs or biologicals to you, up to the \$5 maximum. Additionally, the cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. Submit this schedule to the intermediary, who will review it in advance to assure that it is reasonable.

410.2 Coinsurance on Inpatient Respite Care.--You may charge the beneficiary a coinsurance amount equal to 5 percent of the amount HCFA has estimated to be the cost of respite care, after adjusting the national rate for local wage differences. The following table may be used to calculate the amount that a hospice may charge for respite coinsurance.

| | |
|---|-------------|
| Wage Adjusted Inpatient Respite Care | |
| Rate for your area (from Table III, p. 4-5) | \$ |
| | ÷95% |
| Rate for Inpatient Respite Care Including Coinsurance | |
| | <u>x 5%</u> |
| Coinsurance amount your hospice may charge | \$ |

No retroactive adjustments will be made to coinsurance amounts already collected from beneficiaries for inpatient respite care days as a result of any reimbursement adjustments made, such as application of the limitation on payments for inpatient care (see §405).

The total amount of coinsurance for inpatient respite care for any beneficiary during a hospice coinsurance period may not exceed the amount of the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. A hospice coinsurance period begins with the first day for which an election for hospice services is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on which no such election is in effect for the beneficiary.

Example: Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care under a final election period. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, the maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

The hospice is responsible for billing and collecting the coinsurance amounts from the beneficiary.

411. PROHIBITION AGAINST BILLING OTHERS FOR COVERED SERVICES

Section 1866 of the Social Security Act requires providers (including hospice providers) to file an agreement with the Secretary of Health and Human Services in order to be qualified to participate and to be eligible for payment under the Medicare program. In this agreement the hospice agrees not to charge (and accordingly may not charge) any individual or any other person for items or services for which the individual is entitled to have payment made under the hospice provision. Where items and services are not subject to the Medicare secondary payer provision, Medicare is the primary payer for all covered benefits and another insurer should not be billed for these items or services. (The secondary payer provision may be in effect if the patient or spouse is employed and has coverage under the employer's health insurance program.) For example, a hospice may not bill a third party such as an insurance company or the American Cancer Society for covered palliative drugs and biologicals for which payment is made through the Medicare rates.

If a hospice furnishes, at the request of a beneficiary, items or services in addition to those that are covered under the hospice provision, the hospice may charge the beneficiary for these items or services.