CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3015	**Date: August 7, 2014**
	Change Request 8648

Transmittal 2929, dated April 10, 2014, is being rescinded and replaced by Transmittal 3015, dated August 7, 2014, to change the effective and implementation dates for ICD-10 and ASC X12, and to delete from this CR section 30.3 which has been updated by Transmittal 2973 (CR 8777). All other information remains the same.

SUBJECT: Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Medicare Claims Processing Manual, Chapter 11. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications. Also, the title for section 110 was changed to delete the letter "N" after the X12. This is the only change to the title for section 110.

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: September 8, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/Table of Contents
R	11/20.1.2/Completing the Uniform (Institutional Provider) Bill (Form CMS 1450) for Hospice Election
R	11/110/Medicare Summary Notice (MSN) Messages/ASC X12 Remittance Advice Adjustment Reason and Remark Codes

III. FUNDING:
For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3015	Date: August 7, 2014	Change Request: 8648

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SUBJECT: Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE:
ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012
IMPLEMENTATION DATE:
ICD-10: Upon Implementation of ICD-10
ASC X12: 30 Days from issuance

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Medicare Claims Processing Manual, Chapter 11.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8648.1	A/B MACs that process hospice claims shall be aware of the changes in Pub. 100-04, Medicare Claims Processing Manual, Chapter 11.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev.3015, Issued: 08-07-14)

20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election

(Rev. 3015, Issued: 08-07-14, Effective: ICD- Upon Implementation of ICD-10, ASC-X12:01-01-12, Implementation: ICD- Upon Implementation of ICD-10, ASC-X12:09-08-14)

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election.

NOTE: Information regarding the form locator numbers that correspond to these data element names can be found in chapter 25.

Provider Name, Address, and Telephone Number

The minimum entry for this item 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 9-digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Enter the 3-digit numeric type of bill code: 81A, B, C, D, E 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

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

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

3rd Digit - Frequency

A - Hospice benefit period initial election notice
B - Termination/revocation notice for previously posted hospice election
C - Change of provider
D - Void/cancel hospice election
E - Hospice Change of Ownership

Patient's Name

The patient's name is shown with the surname first, first name, and middle initial, if any.

Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

(If available.) Show the month, day, and year of birth numerically as MM-DD-YYYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission Date

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.

Provider Number

This is the 6-digit number assigned by Medicare (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI).

Insured's Name

Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name exactly as it appears 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.

Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's HICN. For example, if Medicare is the primary payer, enter this information. 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.

Principal Diagnosis Code

CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service.

- *The official ICD-9-CM codes, and annual updates, are posted at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html*

- *The official annual updates to ICD-10-CM and ICD-10-PCS codes are posted at http://www.cms.gov/Medicare/Coding/ICD10/index.html .*

Use full diagnosis codes including all applicable digits, up to five digits for ICD-9-CM and up to seven digits for ICD-10-CM or ICD-10-PCS.

Attending Physician I.D.

For notice of elections effective prior to January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

The reporting requirement optional for notice of elections effective on or after January 1, 2010, and required reporting on or after April 1, 2010, establishes that the hospice enters the NPI and name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.

Other Physician I.D.

For notice of elections effective prior to January 1, 2010, if the attending physician is a nurse practitioner, enter the NPI and name of the nurse practitioner.

For notice of elections with dates of service on or after January 1, 2010, the hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying the terminal illness. When the attending physician is also the physician certifying the terminal illness, only the attending physician is required to be reported.

NOTE: for electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

Provider Representative Signature and Date

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

110 - Medicare Summary Notice (MSN) Messages/ASC X12 Remittance Advice Adjustment Reason and Remark Codes

(Rev. 3015, Issued: 08-07-14, Effective: ICD- Upon Implementation of ICD-10, ASC-X12:01-01-12, Implementation: ICD- Upon Implementation of ICD-10, ASC-X12:09-08-14)

The following messages apply specifically to Hospice beneficiaries. See Chapter 21 for a list of all *MSN* messages. *See Chapter 22 sections 60§§ and 80§§ for instructions about selection of CARC, RARC, and CAGC codes, and application of CAQH CORE operating requirements in selection of these codes.*

Also see http://www.caqh.org/CORECodeCombinations.php for the latest version of criteria for selecting CARC, RARC, and CAGC codes.

Note that administrative appeals processes are available to beneficiaries, physicians/ suppliers, or providers dissatisfied with these determinations, see Chapter 29 for more information.

MSN Code	**Message**	**ASC *X12 835 Adjustment* Codes**	**Message**
27.1	This service is not covered because you are enrolled in a hospice.	B9	Services are not covered because the patient is enrolled in a hospice.
27.2	Medicare will not pay for inpatient respite care when it exceeds 5 consecutive days at a time.	119	Benefit maximum for this time period has been reached.
27.3	The physician certification	B17 with MA54	Claim/service denied

MSN Code	Message	ASC *X12 835 Adjustment* Codes	Message
	requesting hospice services was not received timely.		because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Physician certification or election consent for hospice care not received timely.
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate. (This would be shown on the RA to the hospice by payment for that date as billed by the hospice.)	No separate message would be needed. The payment rate would be shown as the allowed amount.	
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate. (The level of care being paid would be indicated by the allowed amount.)	57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	106 with MA54	Patient payment option/election not in effect. Physician certification or election consent for hospice care not received timely.
27.8	The documentation submitted does not support that your illness is terminal.	57 with zero payment for hospice.	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or

MSN Code	Message	ASC *X12 835 Adjustment* Codes	Message
			this dosage.
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.11	The provider has billed in error for the routine home care items or services received.	97	Payment is included in allowance for the basic service/procedure.
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.	NA	
27.13	According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.	NA	