CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3502	**Date: April 28, 2016**
	Change Request 9575

SUBJECT: Making Principal Diagnosis Codes Mandatory for Notice of Election (NOE) to be Accepted

I. SUMMARY OF CHANGES: There is currently no edit in FISS to prevent NOEs from being accepted without a principal diagnosis. This change request will prevent NOEs from being accepted without a principal diagnosis in accordance with the Medicare Claims Processing Manual.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS 1450) for Hospice Election
R	11/30.2.2 – Service Intensity Add-on (SIA) Payments
R	11/90 - Frequency of Billing and Same Day Billing

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: Currently, Notices of Election (NOEs) are being accepted without a principal diagnosis present. Contractors report that this occurs on a high percentage of NOEs. A principal diagnosis should be required in order for that NOE to be accepted. This change request requires Medicare systems to return NOEs submitted without a principal diagnosis.

B. Policy: NA

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	
9575.1	The contractor shall create an edit to prevent Notices of Election (NOEs), type of bill 8xA, from being accepted when there is no principal diagnosis present.					X				
9575.1.1	The contractor shall return NOEs to the provider when the principal diagnosis is missing.			X						
9575.2	The contractors shall be aware of the manual updates to chapter 11 of the Medicare Claims Processing Manual.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
9575.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X		

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): Charles Nixon, Charles.Nixon@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

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

(Rev.3502, Issued: 04-28-16, Effective: 01- 01-16, Implementation: 10-03-16)

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election. Data elements that are not shown are not required.

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 appropriate 3-digit numeric type of bill code, according to the following 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

Statement Covers Period (From-Through)

On a Notice of Termination/Revocation (NOTR), the hospice enters the start date of the hospice benefit period in which the notice is effective in the "From" date field. The hospice enters the date the termination/revocation is effective in the "Through" date field.

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

The hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the *receiving* hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the *new admission* date cannot be the same as the revocation or discharge date *of the previous benefit period.*

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. On a NOTR, the hospice enters the start date of the hospice benefit period in which the discharge or revocation is effective, not the initial hospice admission date.

EXAMPLE

The hospice election date (admission) is January 1, 2014. The physician's certification is dated January 3, 2014. The hospice date for coverage and billing is January 1, 2014. The first hospice benefit period ends 90 days from January 1, 2014.

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

Provider Number

The hospice enters 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. To ensure accuracy and prevent a delay in posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice 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, which were updated annually through October 1, 2013, 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.

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.

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.

30.2.2 – Service Intensity Add-on (SIA) Payments

(Rev.3502, Issued: 04-28-16, Effective: 01- 01-16, Implementation: 10-03-16)

Effective for hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment.

The SIA payment amount is calculated by multiplying the continuous home care (CHC) rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

EXAMPLE CLAIM: End of Life (EOL) 7 day SIA:
Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40
RHC in home, discharged deceased.

Revenue Code	HCPCS	Line Item Date of Service	Units
0651	Q5001	12/01/XX	9

0551	*G0299*	12/01/XX	4
0571	G0156	12/02/XX	6
0561	G0155	12/05/XX	4
0571	G0156	12/05/XX	3
0551	G0299	12/06/XX	3
0571	G0156	12/06XX	4
0551	G0299	12/09/XX	4
0561	G0155	12/09/XX	6
0571	G0156	12/09/XX	2

*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.
Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.
Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.
Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4.
Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/06/XX UNITS 3.
Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.
Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.
Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/09/XX UNITS 4.

90 - Frequency of Billing and Same Day Billing

(Rev.3502, Issued: 04-28-16, Effective: 01- 01-16, Implementation: 10-03-16)

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing must conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months. Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned beginning on dates of service July 1, 2013. The only exception to this requirement is in the case of the beneficiary being discharged or revoking the benefit and then later re-electing the benefit during the same month. The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8 to August 31and a separate claim is submitted with dates of service September 1 to September 1. Hospice claims should not span multiple months. Any hospice claim spanning multiple months will be returned to the provider for correction.

In cases where one hospice *transfers* a beneficiary *to* another hospice *that* admits the beneficiary on the same day, each hospice is permitted to bill and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.