2024 Jurisdiction M (JM) Medicare Hospice Workshop Series

Back with More in 2024

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

MAHC MISSISSIPPI ASSOCIATION FOR HOME CARE

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Agenda

- 2024 Final Rule Summary
  - **Fiscal Year 2024 Hospice Payment Rate Update Final Rule**
  - **Hospice Enrollment Provisions of the 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F)**
    - Fiscal Year 2025 Hospice Payment Rate Update Proposed Rule (CMS-1810-P)
- Hospice Updates/Reminders
  - **Implement Edits on Hospice Claims**
  - **Addition of Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs) to the Hospice Interdisciplinary Team**
  - **Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, & Texas**
  - **Billing Manual Updates**
    - Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

Agenda

- Hospice Benefit Component, Value-Based Insurance Design (VBID) Model
- Palmetto GBA's eServices Portal
  - **How to Use the eServices' Eligibility Tabs**
  - **Medicare Beneficiary Identifier (MBI) Lookup**
- Overview of the Targeted Probe and Educate (TPE) Process
- Comprehensive Error Rate Testing (CERT)
- Resources for Providers

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Fiscal Year 2024 Hospice Payment Rate Update Final Rule

Hospice Enrollment Provisions 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F)

Fiscal Year 2024 Hospice Payment Rate Update Final Rule

- Fact sheet for the Fiscal Year 2024 Hospice Payment Rate Update Final Rule (CMS-1787-F) | CMS
  - Published July 28, 2023
- FY 2024 Routine Annual Rate Setting Changes
  - The FY 2024 hospice payment update percentage is 3.1 percent (an estimated increase of $780 million in payments from FY 2023)
    - 2.8 percent was proposed
  - **The hospice cap amount for FY 2024 is $33,494.01, which is equal to the FY 2023 cap amount ($32,486.92), updated by the FY 2024 hospice payment update percentage of 3.1 percent**

Fiscal Year 2024 Hospice Payment Rate Update Final Rule

Hospice Certifying Physician Enrollment

- CMS is finalizing our proposal that these two categories of physicians must be enrolled in or opted out of Medicare for hospice services to be paid. Requiring enrollment or opt-out will allow us to screen the physician to ensure they are qualified (e.g., licensed) to certify the terminal condition
  - **In response to concerns raised by commenters, we will not implement or enforce this requirement until May 1, 2024, to give unenrolled and non-opted-out physicians more time to enroll in or opt-out of the Medicare program**

Fiscal Year 2024 Hospice Payment Rate Update Final Rule

- Hospice Quality Reporting Program
  - **CMS codified the HQRP data completion threshold policy at §418.312 and provided several updates relative to the development of a patient assessment instrument, titled HOPE, and future quality measures**
  - **CMS also provided updates on health equity related to HQRP and future efforts to develop health equity measures**

Hospice Enrollment Provisions of the 2024 Home Health Final Rule

- Fact sheet for the Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F) | CMS
- CMS believes these provider enrollment provisions related to hospice ownership and management will strengthen protections against hospice fraud schemes and improve transparency.
- Change Request 13333
  - **Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08, Home Health Prospective Payment System (HH PPS) Final Rule**

Hospice Enrollment Provisions of the 2024 Home Health Final Rule

The hospice enrollment-related regulatory changes in this final rule include:

- Subjecting hospices to the highest level of provider enrollment application screening, which includes fingerprinting all 5 percent or greater owners of hospices;
- Expanding the HHA change in majority ownership provisions in 42 CFR § 424.550(b) to include hospice changes in majority ownership; and
- Clarifying that the definition of "Managing Employee" in 42 CFR § 424.502 includes the administrator and medical director of a hospice

Majority Ownership Provisions

If there is a change in majority ownership of a home health or hospice agency by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the HHA's or hospice's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner.

Majority Ownership Provisions

- The prospective provider/owner of the HHA or hospice must instead:
  - **Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510 of this subpart**
  - **Obtain a state survey or an accreditation from an approved accreditation organization**
- Exceptions:
  - **An HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation**
  - **The owners of an existing HHA or hospice are changing the HHA's existing business structure**
  - **An individual owner of an HHA or hospice dies**

Hospice Enrollment Provisions of the 2024 Home Health Final Rule

To further protect the Trust Funds and Medicare beneficiaries, we are also finalizing additional provider enrollment provisions, which include, but are not limited to, the following:

- **Reducing the period of Medicare non-billing for which a provider or supplier can be deactivated under § 424.540(a)(1) from 12 months to six months**
- **Strengthening the program integrity safeguards associated with a provisional period of enhanced oversight under section 1866(j)(3) of the Social Security Act**

Fiscal Year (FY) 2025 Hospice Payment Rate Update Proposed Rule (CMS-1810-P)

- Fiscal Year (FY) 2025 Hospice Payment Rate Update Proposed Rule (CMS-1810-P) | CMS
- Issued on March 28, 2024
  - **Medicare Hospice Payment Policies**
  - **The FY 2025 hospice payment update percentage is 2.6 percent**
  - **Hospice Quality Reporting Program (HQRP)**
  - **Hospice Conditions of Participation Technical Update**

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Hospice Updates/Reminders

Implement Edits on Hospice Claims

- Change Request 13342
  - r12330otn.pdf (cms.gov)
- Subject: Implement Edits on Hospice Claims
- Implementation Date: April 1, 2024
- Effective Date: May 1, 2024
  - **Claim "From" dates on or after this date**

Implement Edits on Hospice Claims

Summary of Changes

- **Any hospice claim with an attending or rendering National Provider Identifier (NPI), they have to be enrolled in Medicare as part of a new rule that is coming as of May 1, 2024**
- **The hospice physician and attending physician need to be enrolled/opted-out at the time they make the certification or recertification of hospice care for a patient**

Occurrence Code 27/Date Present

When Occurrence Code 27 and its associated date are present on the claim, Medicare will allow payment when

- **Occurrence Code 27 date falls on or after the physician's effective date but before the termination date, if present, on the PECOS Hospice O/R — Attending Physician File**

Occurrence Code 27/Date Not Present

Should Occurrence Code 27 and its associated date not be present on the claim, Medicare will allow payment when:

- **The claim Statement "From" Date falls on or after the physician's effective date but before the termination date, if present, on the PECOS Hospice O/R – Attending Physician file**

Claim Edit

- FISS shall create a reason code (awaiting creation) to assign on hospice claims, Type of Bill (TOB) 81X or 82X
  - **Hospice notice TOBs 8XA, 8XB, 8XC, 8XD and 8XE are excluded from this edit**
- If the NPI and first four (4) letters of the physician's last name submitted on the claim in the Attending field do not match the physician's NPI and first 4 letters of the physician's last name on the PECOS file, the claim will deny

Claim Reason Code Updates

- Effective May 1, 2024
  - **New Reason Code 17729**
    - Narrative: TOB 81X and 82X (excluding 8XA, 8XB, 8XC, 8XD and 8XE) with a Statement From Date on or after May 1, 2024, when the ATT PHYS NPI data does not match the new PECOS Hospice O/R - Referring Physician file.
  - **Reason Code 34963**
    - No longer will assign on Hospice Type of Bill (TOB) 81X or 82X (excluding 8XA, 8XB, 8XC, 8XD and 8XE)
    - This code is/was bypassed since April 2023 for hospice claims

Adjustment Requirements

An adjustment should be submitted when an input error (i.e., incorrect NPI, incorrect name spelling) is being corrected or the physician's PECOS record has been updated.

- **Adjustment of non-medical claim denials is allowed**
- **Providers shall initiate an adjusted claim through their electronic billing software (Direct Data Entry cannot be used)**

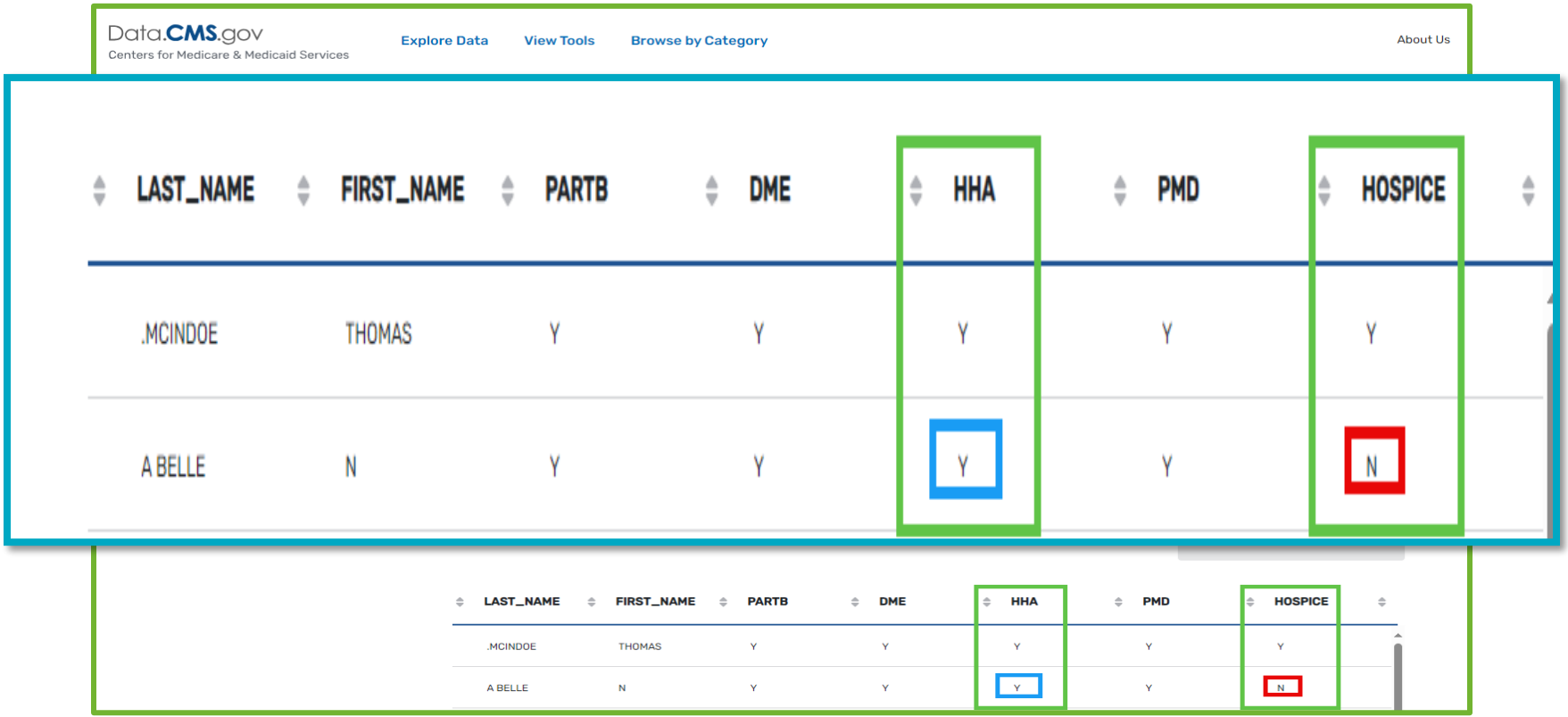
Adjustment Requirements

- Enter bill type XX7
- Condition code "D9" (FL 18–28)
- Ensure the claim number of the denied final claim is entered in the cross-reference (X-Ref) Document Control Number field
- Correct attending physician's NPI and name, if applicable
- Enter remarks (FL80) indicating the reason for the adjustment
  - **Correction to attending physician's NPI and/or name or the physician's PECOS record has been updated**

Access the Ordering & Certifying Files

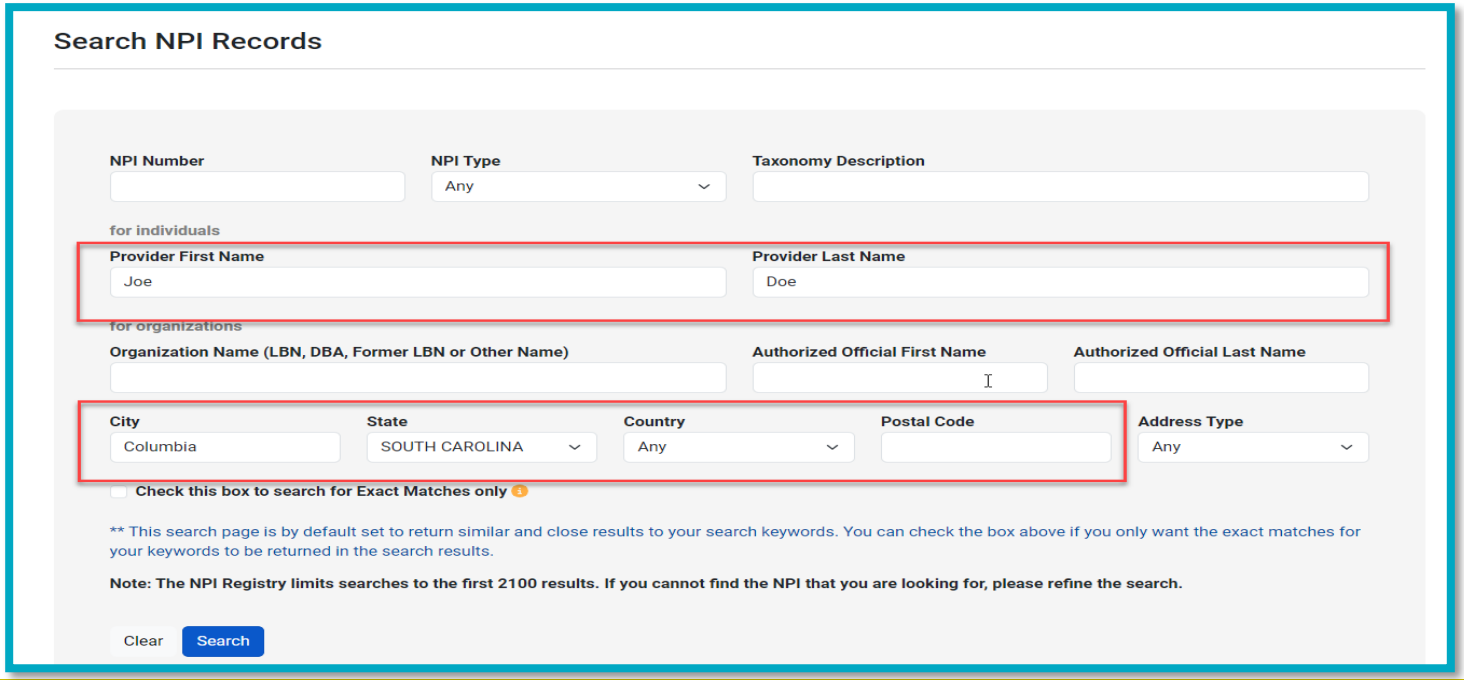
- The Ordering & Certifying Files contain a list all providers who are currently eligible to order and certify
  - **These files are only available on the CMS Data website**
- CMS has updated the existing ordering and referring file on Data.CMS.Gov with an additional column for hospice ordering and referring eligibility
  - Order and Referring — Centers for Medicare & Medicaid Services Data (cms.gov)
  - Different Medicare Benefits listed on this file have different requirements for certifications, as non-physician practitioners may certify for home health, but not for hospice

Access the Ordering & Certifying Files



NPI Lookup

Find the physician/practitioner's NPI at the National Plan & Provider Enumeration System (NPPES) website.



Claim Attending Provider Name and Identifiers

Medicare Claims Processing Manual (cms.gov), Section 30.3 — Data Required on the Institutional Claim to A/B MAC (HHH)

- Attending Provider Name and Identifiers
  - **The hospice enters the 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 hospice shall enter the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care**
    - If there is no attending physician listed, then the hospice shall report the certifying MD.
    - Do not enter a nurse practitioner (NP) or physician assistant (PA) as the "Attending"

Claim Other Provider Name and Identifiers

- Other Provider Name and Identifiers
  - **If the attending physician is a NP or PA, the hospice enters the NPI and name of the NP or PA in a field on the claim other than the Attending Provider field**
    - For electronic claims, this information is reported in Loop ID 2310F – Referring Provider Name
    - 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.

Physician Enrollments

- CMS-855I for Physicians and Non-Physician Practitioners (NPPS)
  - **Complete this application if you are an individual practitioner or eligible professional who plans to bill Medicare**
- CMS-855O for Ordering and Certifying Physicians and Non-Physician Practitioners
  - **Complete this application if you are an individual practitioner or eligible professional and enrolling sole purpose of ordering or certifying items and/or services to beneficiaries in the Medicare program**
- Opt-Out Affidavit for Eligible Physicians/Practitioners
  - **Opt-Out Affidavit for Eligible Physicians/Practitioners (palmettogba.com)**

Physician Enrollments

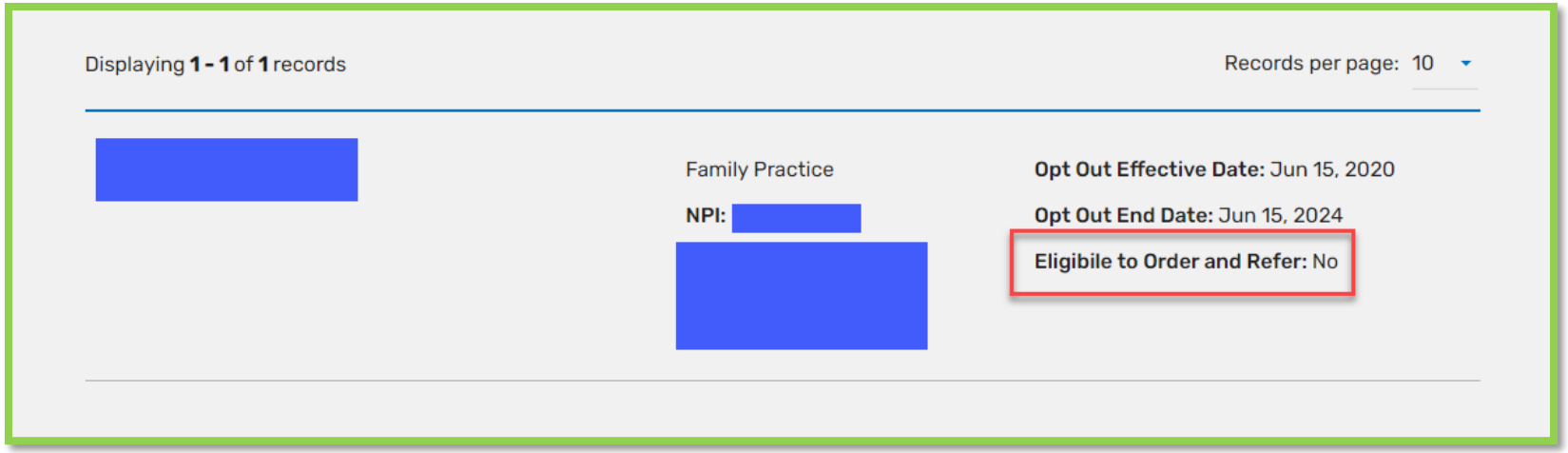
- If a hospice intends on billing Medicare for medically necessary physician services provided by a physician, Nurse Practitioner (NP), or Physician Assistant (PA) employed or receiving compensation from the hospice, that physician, NP, or PA is required to have a CMS-855I enrollment with Medicare billing rights.
- A hospice cannot bill services for a physician, NP, or PA that the physician, NP, or PA does not have the right to bill Medicare for in a non-hospice setting.
  - **Physician services billing, when applicable, is separate from other hospice billing, such as the level of care, skilled nursing, medical social services, drugs, etc.**
  - **Hospices' use revenue code 0657 on claim lines to identify hospice services furnished to patients by physicians, NPs, or PAs employed by or receiving compensation from the hospice.**
  - **Payment for physicians' administrative and general supervisory activities are included in the hospice payment rates and are not separately billable.**

Provider Opt-Out Affidavits Lookup Tool

- This look-up tool is a searchable database that allows you to look up providers who do not wish to enroll in the Medicare program and have “opted out” of Medicare, by their National Provider Identifier (NPI), or by first name and last name
  - **Provider Opt-Out Affidavits Look-up Tool — Centers for Medicare & Medicaid Services Data (cms.gov)**

Provider Opt-Out Affidavits Lookup Tool

- Not all opt-out providers are set up in PECOS to be eligible to certify, order and refer
  - **Providers who did not provide all information for opting-out or have Medicare billing privileges revoked cannot certify**



Edit Resources

- Change Request 13342
- Reason Code 17729
- New Hospice Certifying Physician Claim Edit Effective May 1, 2024
- Hospice Certifying Physician Medicare Enrollment Information
- MLN Matters Article MM13531
- MLN6922507 — Medicare Payment Systems
  - (see **Certification Requirements** under the **Hospice Payment System & Coverage** topic)

Addition of Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs) to the Hospice Interdisciplinary Team

- Change Request 13437
  - r12400bp.pdf (cms.gov)
- Subject: Hospice Benefit Policy Manual Updates Related to the Addition of Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs) to the Hospice Interdisciplinary Team
- Implementation Date: January 2, 2024
- Effective Date: January 1, 2024

Addition of Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs) to the Hospice Interdisciplinary Team

- Effective for hospice elections beginning on or after January 1, 2024, MFTs or MHCs are permitted to serve as members of the hospice IDG
- The Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been updated to include changes to the hospice IDG
- There are no billing provisions for MFT and MHC services under the Hospice Benefit and an MFT or MHC cannot independently bill Medicare for services rendered to a hospice patient
  - **CMS MFT and MHC FAQs**

Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas

- MLN7867599 - Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, & Texas (cms.gov)
  - **The goal of enhanced oversight is to reduce hospice fraud, waste, and abuse**
  - **The provisional period of enhanced oversight will include medical review such as prepayment review**
  - **The period of enhanced oversight can be 30 days – 1 year**

Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas

- For the period of enhanced oversight, new hospices include those:
  - **Newly enrolling in the Medicare Program (starting July 13, 2023)**
  - **Submitting a change of ownership (CHOW) that meets all the regulatory requirements under 42 CFR 489.18**
  - **Undergoing a 100 percent ownership change that doesn't fall under 42 CFR 489.18**

Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas

- If we're placing you in a period of enhanced oversight, we'll mail a letter to the correspondence address on file in PECOS. It will include:
  - **Effective date of the enhanced oversight period**
  - **Duration of the enhanced oversight period**
  - **Notice that we may do a medical review of all your claims. If you don't respond to our requests, we may deny claims or revoke your Medicare enrollment.**

Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

- Change Request 13238
  - **Effective date: May 15, 2023**
  - **Implementation date: July 17, 2023**

Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

- 20.1.1 — Notice of Election (NOE)
  - **Hospices can reduce the number of errors and exception requests related changes to the beneficiary identifier by performing an eligibility check immediately before admission**
  - **A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the hospice more than two weeks prior to the admission date**

Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

- 30.2.1 — Payments to Hospice Agencies That Do Not Submit Required Quality Data
  - **Beginning with the FY 2024 and for each subsequent year, failure to submit required quality data shall result in a four-percentage point reduction to the market basket percentage for any hospice that does not comply with the quality data submission requirements for that FY**

Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

- 042x Physical Therapy
  - **Added HCPCS G0157**
    - Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
- 043x Occupational Therapy
  - **Added HCPCS G0158**
    - Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes

Internet Only Manual Update, Pub. 100-04, Chapter 11 (Processing Hospice Claims)

- Occurrence Span Code and Dates
  - **M2**
    - Dates of Inpatient Respite Care
    - Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each
    - M2 is used when respite care is provided more than once during a billing period

Reminder ➦ Report Live Discharges Timely

- A timely-filed Notice of Termination/Revocation (NOTR) is submitted and accepted by the A/B MAC (HHH) within five calendar days after the effective date of discharge or revocation.
  - **While a timely-filed NOTR is one that is submitted to and accepted by the A/B MAC (HHH) within five calendar days after the hospice election, posting to the CWF may not occur within that same timeframe**
  - **The date of posting to the CWF is not a reflection of whether the NOTR is considered timely-filed**

Report Live Discharges Timely

Failure to report a live discharge timely may occur a late NOE penalty for a reelection with the same hospice.

- For example:
  - **Patient discharges alive 6/1/XX**
  - **No discharge submission is received until 6/14/XX**
  - **Patient reelects 6/10/XX**
  - **NOE for 6/10/XX reelection received 6/13/XX, but is returned for the open earlier election**
  - **The late discharge submission will cause a late NOE penalty to be applied**

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Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model

Background

- Beginning on January 1, 2021, CMS is testing the inclusion of the Part A Hospice Benefit within the Medicare Advantage (MA) benefits package through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model
- This test allows CMS to assess the impact on care delivery and quality of care, especially for palliative and hospice care, when participating MA plans are financially responsible for all Parts A and B benefits

Top Three Things Hospice Providers Need to Know

1. You must send all notices and claims to both the participating Medicare Advantage Organization (MAO) and your Medicare Administrative Contractor (MAC). The MAO will process payment, and the MAC will process the claims for informational and operational purposes and for CMS to monitor the model.
2. If you contract to provide hospice services with the plan, be sure to confirm billing and processing steps before the calendar year begins, as they may be different

   Note: While CMS encourages you to reach out to participating MAOs about contracting opportunities, you are not required to contract. If you choose not to contract, the participating MAO must continue to pay you at least equivalent to Original Medicare rates for Medicare-covered hospice care.
3. The Model does not permit prior authorization requirements around hospice elections or transitions between different levels of hospice care

How the MAC Will Process the Submissions

- NOE approves like normal (PB9997 location)
  - **A hospice would not know a patient is in a VBID MAO with the processing of the NOE**
  - **The NOE will open the election in eligibility systems, as how Original Medicare would**
- Claims will reject w/ Reason Code (RC) U523A
  - **RC Narrative: The Dates of Service are during both a Hospice Election Period and a MA Plan's Period that is in a VBID Model**
  - **All institutional claims, hospital, SNF, HH, etc., will reject with RC U523A**
- The claims will open/close benefit periods in eligibility systems

CY 2024 Participating MAOs

- There are 13 participating MAOs with a total 78 PBPs that cover 690 counties across 23 states and Puerto Rico
- For reference, in 2023, there are 15 participating MAOs with 119 PBPs that cover 806 counties across 23 states and Puerto Rico
- CMS published a spreadsheet listing all PBPs participating in the Model: vbid-cy2024-hospice-contact-info-geo.xlsx (live.com)

CY 2024 Participating MAOs

- Cambia Health Solutions with plans in select counties in OR, UT, and WA
- CVS with plans in select counties in OH and PA
- First Sacramento Capital Funding dba ProCare Advantage Plan with plans in select counties in TX
- Guidewell Mutual Holding Corporation with plans in select counties in PR
- Hawaii Medical Service Association with plans in select counties in HI
- Highmark Health with plans in select counties in PA
- Humana Inc. with plans in select counties in CO, FL, GA, IN, KY, OH, VA, and WI
- Kaiser Foundation Health Plan, Inc. with plans in select counties in CA
- Louisiana Health Services and Indemnity Company with plans in select counties in AR, LA, and MS
- Marquis Advantage, Inc. dba AgeRight Advantage Health Plan H1372-001 in select counties in OR
- SCAN Group with SCAN Health Plan in select counties in CA
- Sentara Health Care (dba AvMed Inc.) with plans in select counties in FL (new for 2024)
- Visiting Nurse Service of New York (VNSNY) with plans in select counties in NY

MAOs that Participated in CY 2021, CY 2022, and/or CY 2023, But Not in CY 2024

- Catholic Health Care System (CHCS) with plans in select counties in NY*
- Commonwealth Care Alliance, Inc. with plans in select counties in MA
- Elevance Health, Inc. (MMM Healthcare, LLC) with plans in select counties in PR*
- Intermountain Health Care, Inc. with plans in select counties in ID and UT
- Presbyterian Healthcare Services (PHS) with plans in select counties in NM*
- UnitedHealth Group with plans in select counties in AL, IL, OK, and TX*

* Participated in 2023

PBP Discontinued Participation in VBID-Hospice in 2024

Date of Member Enrollment in Model Participating PBP	Hospice Election Date	Date of Revocation or Live Discharge	Date of Hospice Re-election	Original Medicare is Responsible for Hospice	Date FFS Medicare is responsible for claims during a hospice stay	Model-Participating MAO is Responsible for Hospice	Date MAO is responsible for claims during a hospice stay
1/1/23 (and continues enrollment in plan in 2024)	6/15/23	2/2/24	5/2/24	Yes (Second hospice election only)	5/2/24 – discharge	Yes (First hospice stay only)	6/15/23 – 2/2/24 (MAO responsible for non-hospice claims, post-live discharge)

Payment Coverage Scenarios

Date of Member Enrollment in Model Participating PBP	Hospice Election Date	Date of Revocation or Live Discharge	Date of Hospice Re-election	Original Medicare is Responsible for Hospice	Date FFS Medicare is responsible for claims during a hospice stay	Date FFS Medicare is responsible for non-hospice claims during post live-discharge	Model-Participating MAO is Responsible for Hospice[4]	Date MAO is responsible for claims during a hospice stay
PBP Effective in 2022 (i.e., PBP is participating newly in VBID-Hospice in 2022)								
1/1/22	3/6/22	N/A	N/A	No	N/A	N/A	Yes	3/6/22 – discharge
1/1/22	11/1/21	N/A	N/A	Yes	11/1/21 - discharge	N/A	No	N/A
1/1/22	10/21/21	3/2/22	N/A	Yes (First hospice stay only-discharge)	10/21/21 – 3/2/22	Month of discharge (3/2/22 - 3/31/22)	No (Beginning 4/1/22 for non-hospice)	N/A (no reelection)
1/1/22	12/11/21	1/15/22	2/8/22	Yes (First hospice stay only-discharge)	12/11/21 – 1/15/22	Month of discharge (1/15/22 - 1/31/22)	Yes (Beginning 2/1/22 for non-hospice and second hospice stay))	2/8/22 – discharge
1/1/2022	6/15/21	2/2/22	2/25/22	Yes (First hospice stay only-discharge)	6/15/21 – 2/2/22	2/2/22 – 2/24/22	Yes (Second hospice stay only)	2/25/22 – discharge
PBP Effective in 2022 Only (i.e., PBP is participating newly in VBID-Hospice in 2022 and discontinued participation in VBID-Hospice in 2023)								
1/1/22 (and continues enrollment in plan in 2023)	6/15/22	2/2/23	5/2/23	Yes (Second hospice stay only)	5/2/23 – discharge	N/A	Yes (First hospice stay only)	6/15/22 – 2/2/23 (MAO responsible for non-hospice claims, post-live discharge)
PBP Effective in 2022 and 2023 (i.e., PBP is participating in VBID-Hospice in 2022 and 2023)								
1/1/23	8/1/22	N/A	N/A	Yes	8/1/22 – 12/31/22	N/A	Yes	1/1/23 – discharge
PBP Effective in 2023 (i.e., PBP is participating newly in VBID-Hospice in 2023)								
1/1/23	10/21/22	3/2/23	N/A	Yes	10/21/22 – 3/2/23	Month of discharge (3/2/23 - 3/31/23)	No (Beginning 4/1/23 for non-hospice)	N/A (no reelection)

CY 2024 VBID-Hospice Supplement to Technical and Operational Guidance (cms.gov)

Customer Experience Survey

Overall, how satisfied are you with your MAC?

- ☐ Extremely satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Extremely dissatisfied

Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?

Customer Experience Survey

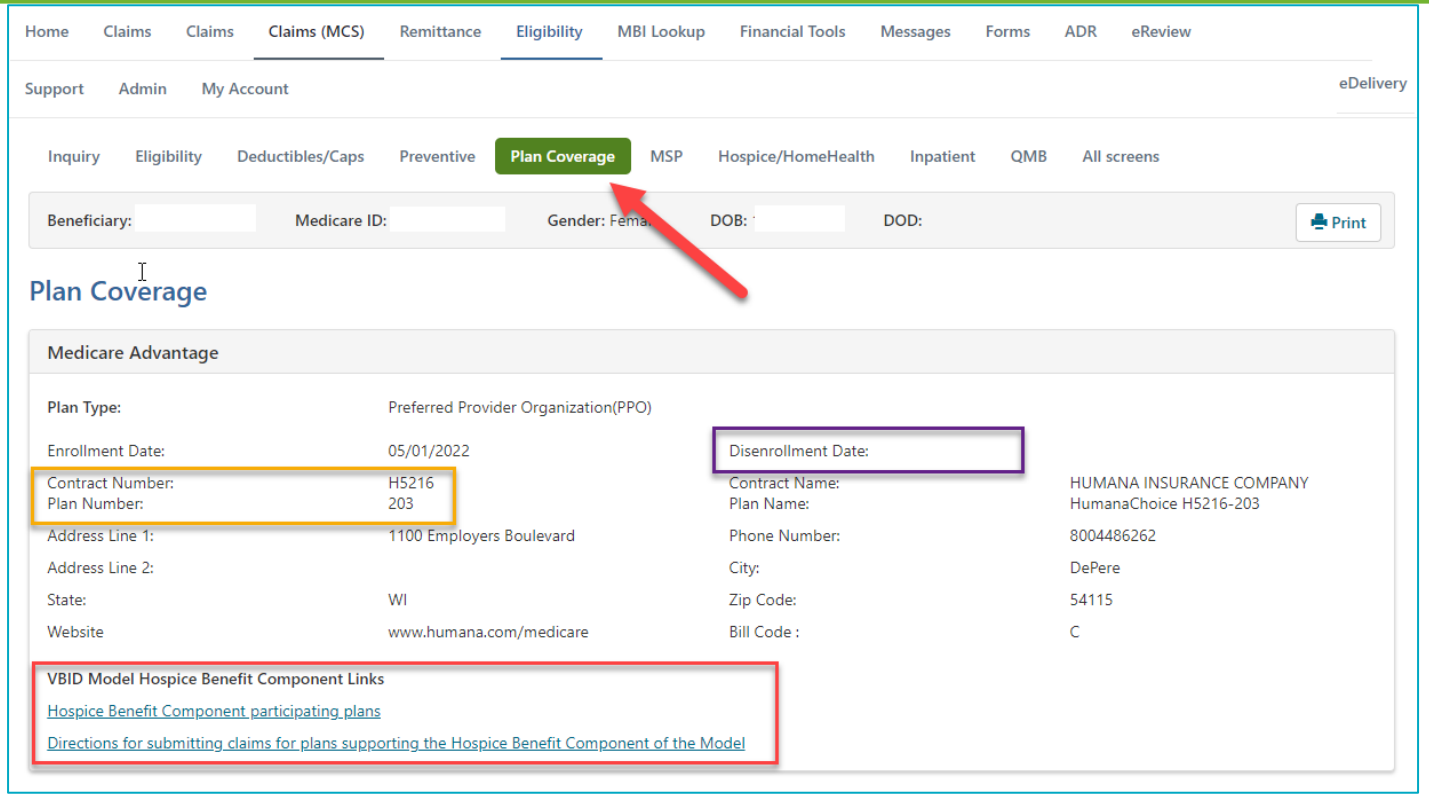
FEEDBACK

Don’t forget to complete the feedback survey!

https://tinyurl.com/3u2vasbb

Participating MAO Lookup

eServices – Plan Coverage Tab



2023 Participating MAOs

	Contract ID	Plan ID	Segment ID	Parent Organization	Plan Name	County(ies)
52	H3832	007	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Standard (PPO)	Hawaii;Kalawao;Kauai;Maui
53	H3832	008	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Standard Plus (PPO)	Hawaii;Kalawao;Kauai;Maui
54	H3832	009	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Complete (PPO)	Honolulu
55	H3832	010	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Complete Plus (PPO)	Honolulu
56	H3832	011	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Dual Care (PPO D-SN	Hawaii;Honolulu;Kalawao;Kauai;Maui
57	H3957	031	000	Highmark Health	Security Blue HMO-POS ValueRx (HMO-POS)	Allegheny;Armstrong;Beaver;Butler;Cambria;Fayette;Greene;Indiana;Lawrence;Washington;Wes
58	H0028	025	001	Humana Inc.	Humana Gold Plus H0028-025 (HMO)	Adams;Arapahoe;Denver;Douglas;Jefferson;Broomfield
59	H0028	025	002	Humana Inc.	Humana Gold Plus H0028-025 (HMO)	Boulder;Clear Creek;Elbert;El Paso;Fremont;Larimer;Pueblo;Teller;Weld
60	H0028	047	000	Humana Inc.	Humana Gold Plus H0028-047 (HMO)	Adams;Arapahoe;Boulder;Clear Creek;Denver;Douglas;Elbert;El Paso;Fremont;Jefferson;Larimer;
61	H1036	236	000	Humana Inc.	Humana Community (HMO)	Jefferson
62	H4141	015	000	Humana Inc.	Humana Gold Plus H4141-015 (HMO)	Clayton;DeKalb;Fulton;Gwinnett;Henry
63	H5216	019	000	Humana Inc.	HumanaChoice H5216-019 (PPO)	Clark;Floyd;Harrison;Anderson;Bath;Bourbon;Boyle;Bullitt;Clark;Fayette;Franklin;Hardin;Henry;Ja
64	H5216	068	000	Humana Inc.	HumanaChoice Florida H5216-068 (PPO)	Broward;Miami-Dade;Palm Beach
65	H5216	073	000	Humana Inc.	HumanaChoice H5216-073 (PPO)	Bartow;Carroll;Cherokee;Clayton;Cobb;Coweta;Dawson;DeKalb;Douglas;Fayette;Floyd;Forsyth;Fu
66	H5216	144	000	Humana Inc.	HumanaChoice H5216-144 (PPO)	Amelia;Caroline;Chesapeake City;Chesterfield;Colonial Heights City;Cumberland;Dinwiddie;Fran
67	H5216	203	001	Humana Inc.	HumanaChoice H5216-203 (PPO)	Barrow;Bartow;Butts;Carroll;Catoosa;Chattahoochee;Chattooga;Cherokee;Clarke;Clayton;Cobb;C
68	H5216	203	002	Humana Inc.	HumanaChoice H5216-203 (PPO)	Baker;Bibb;Crawford;Dougherty;Houston;Jones;Lee;Monroe;Peach;Sumter;Terrell;Twiggs;Worth
69	H5216	239	000	Humana Inc.	Humana Care Extra (PPO)	Cherokee;Cobb;DeKalb;Douglas;Fulton;Gwinnett;Paulding
70	H5216	252	000	Humana Inc.	HumanaChoice H5216-252 (PPO)	Brown;Calumet;Dodge;Door;Fond du Lac;Forest;Green Lake;Kenosha;Kewaunee;Manitowoc;Mara
71	H5216	253	000	Humana Inc.	HumanaChoice H5216-253 (PPO)	Brown;Calumet;Dodge;Door;Fond du Lac;Forest;Green Lake;Kenosha;Kewaunee;Manitowoc;Mara
72	H5619	071	000	Humana Inc.	Humana Gold Plus H5619-071 (HMO)	Clark;Floyd;Harrison;Adair;Anderson;Ballard;Bath;Bell;Bourbon;Boyle;Bracken;Breathitt;Breckinri
73	H5619	139	001	Humana Inc.	Humana Gold Plus H5619-139 (HMO)	Amelia;Charles City;Cumberland;Goochland;King and Queen;King William;Louisa;New Kent;Powh
74	H5619	139	002	Humana Inc.	Humana Gold Plus H5619-139 (HMO)	Chesterfield;Colonial Heights City;Dinwiddie;Hanover;Henrico;Hopewell City;Petersburg City;Rich
75	H5619	140	001	Humana Inc.	Humana Gold Plus H5619-140 (HMO)	Accomack;Franklin City;Gloucester;Isle of Wight;James City;Mathews;Middlesex;Northampton;Po
76	H5619	140	002	Humana Inc.	Humana Gold Plus H5619-140 (HMO)	Chesapeake City;Hampton City;Newport News City;Norfolk City;Portsmouth City;Suffolk City;Virg
77	H6622	001	000	Humana Inc.	Humana Gold Plus H6622-001 (HMO)	Brown;Calumet;Fond du Lac;Green Lake;Kewaunee;Manitowoc;Marathon;Marinette;Marquette;O
78	H6622	004	000	Humana Inc.	Humana Gold Plus H6622-004 (HMO)	Chesterfield;Colonial Heights City;Dinwiddie;Hanover;Henrico;Hopewell City;Petersburg City;Prin
79	H6622	005	000	Humana Inc.	Humana Gold Plus H6622-005 (HMO)	Chesapeake City;Hampton City;Newport News City;Norfolk City;Portsmouth City;Suffolk City;Virg
80	H6622	023	000	Humana Inc.	Humana Cleveland Clinic Preferred (HMO-POS	Cuyahoga;Lake;Lorain;Medina;Stark;Summit
81	H6622	034	000	Humana Inc.	Humana Gold Plus H6622-034 (HMO)	Dane;Kenosha;Milwaukee;Ozaukee;Racine;Ro…;Sheboygan;Walworth;Washington;Waukesha
82	H0524	034	000	Kaiser Foundation Health Plan, Inc	Kaiser Permanente Senior Advantage Ventura	Ventura
83	H0524	083	000	Kaiser Foundation Health Plan, Inc	Kaiser Permanente Senior Advantage Ventura	Ventura
84	H2722	003	000	Louisiana Health Service & Indem	Vantage DUAL PLUS (HMO-POS D-SNP)	Arkansas;Ashley;Benton;Bradley;Calhoun;Carroll;Chicot;Clark;Clay;Cleburne;Cleveland;Columbia
85	H5576	019	000	Louisiana Health Service & Indem	Vantage DUAL PLUS (HMO-POS D-SNP)	Acadia;Allen;Ascension;Assu…ption;Avoyelles;Beauregard;Bienville;Bossier;Caddo;Calcasieu;Cal
86	H7163	003	000	Louisiana Health Service & Indem	Vantage DUAL PLUS (HMO-POS D-SNP)	Adams;Amite;Attala;Boli…;Calhoun;Carroll;Choctaw;Claiborne;Clarke;Coahoma;Copiah;Covingto
87	H1372	001	000	Marquis Companies I, Inc.	AgeRight Advantage Health Plan (HMO I-SNP)	Benton;Clackamas;…son;Josephine;Klamath;Lane;Linn;Marion;Multnomah;Washington;Yamhill
88	H3204	001	000	Presbyterian Healthcare Services	Presbyterian Senior Care Plan 2 with Rx (HMO	Bernalillo;Cibola;Rio Arriba;Sandoval;Santa Fe;Socorro;Torrance;Valencia

About | CY24 VBID Hospice MAO Contacts | CY24 VBID Hospice Service Areas | Discontinued MAO Contacts | CY23 VBID Hospice Service Areas | CY22 VBID ...

2024 Participating MAOs

	Contract ID	Plan ID	Segment ID	Parent Organization	Plan Name	County(ies)
34	H5774	038	000	Guidewell Mutual Holding Corpor	Enlace Plus (HMO)	Adjuntas;Aguada;Aguadilla;Aguas Buenas;Aibonito;Anasco;Arecibo;Arroyo;Barceloneta;Barranqu
35	H5774	040	000	Guidewell Mutual Holding Corpor	Platino Selecto (HMO D-SNP)	Aguada;Aguadilla;Anasco;Arecibo;Barceloneta;Camuy;Hatillo;Isabela;Lares;Las Marias;Manati;Ma
36	H3832	007	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Standard (PPO)	Hawaii;Kalawao;Kauai;Maui
37	H3832	008	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Standard Plus (PPO)	Hawaii;Kalawao;Kauai;Maui
38	H3832	009	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Complete (PPO)	Honolulu
39	H3832	010	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Complete Plus (PPO)	Honolulu
40	H3832	011	000	Hawaii Medical Service Associatio	HMSA Akamai Advantage Dual Care (PPO D-SN	Hawaii;Honolulu;Kalawao;Kauai;Maui
41	H3957	031	000	Highmark Health	Security Blue HMO-POS ValueRx (HMO-POS)	Allegheny;Armstrong;Beaver;Butler;Cambria;Fayette;Greene;Indiana;Lawrence;Washington;Wes
42	H0028	025	001	Humana Inc.	Humana Gold Plus H0028-025 (HMO)	Adams;Arapahoe;Denver;Douglas;Jefferson;Broomfield
43	H0028	025	002	Humana Inc.	Humana Gold Plus H0028-025 (HMO)	Boulder;Clear Creek;Elbert;El Paso;Fremont;Larimer;Pueblo;Teller;Weld
44	H0028	047	000	Humana Inc.	Humana Gold Plus H0028-047 (HMO)	Adams;Arapahoe;Boulder;Clear Creek;Douglas;Elbert;El Paso;Fremont;Jefferson;Larimer;Pueblo;
45	H1036	236	000	Humana Inc.	Humana Community (HMO)	Jefferson
46	H4141	015	000	Humana Inc.	Humana Gold Plus H4141-015 (HMO)	Clayton;DeKalb;Fulton;Gwinnett;Henry
47	H4141	017	003	Humana Inc.	Humana Gold Plus H4141-017 (HMO)	Barrow;Bartow;Bryan;Bulloch;Burke;Chatham;Chattahoochee;Cherokee;Clarke;Clayton;Cobb;Col
48	H4141	017	005	Humana Inc.	Humana Gold Plus H4141-017 (HMO)	Baker;Baldwin;Bibb;Butts;Crawford;Dougherty;Glascock;Hancock;Houston;Jasper;Jefferson;Jones
49	H5216	001	000	Humana Inc.	HumanaChoice H5216-001 (PPO)	Brown;Calumet;Dodge;Door;Fond du Lac;Forest;Green Lake;Kenosha;Kewaunee;Manitowoc;Mara
50	H5216	068	000	Humana Inc.	HumanaChoice Florida H5216-068 (PPO)	Broward;Miami-Dade;Palm Beach
51	H5216	073	000	Humana Inc.	HumanaChoice H5216-073 (PPO)	Bartow;Carroll;Cherokee;Clayton;Cobb;Coweta;Dawson;DeKalb;Douglas;Fayette;Floyd;Forsyth;F
52	H5216	144	000	Humana Inc.	HumanaChoice H5216-144 (PPO)	Amelia;Caroline;Chesapeake City;Chesterfield;Colonial Heights City;Cumberland;Dinwiddie;Fran
53	H5216	203	001	Humana Inc.	HumanaChoice H5216-203 (PPO)	Barrow;Bartow;Butts;Carroll;Catoosa;Chattahoochee;Chattooga;Cherokee;Clarke;Clayton;Cobb;C
54	H5216	203	002	Humana Inc.	HumanaChoice H5216-203 (PPO)	Baker;Bibb;Crawford;Dougherty;Houston;Jones;Lee;Monroe;Peach;Sumter;Terrell;Twiggs;Worth
55	H5216	252	000	Humana Inc.	Humana USAA Honor with Rx (PPO)	Brown;Calumet;Dodge;Door;Fond du Lac;Forest;Green Lake;Kenosha;Kewaunee;Manitowoc;Mara
56	H5216	253	000	Humana Inc.	HumanaChoice H5216-253 (PPO)	Brown;Calumet;Dodge;Door;Fond du Lac;Forest;Green Lake;Kenosha;Kewaunee;Manitowoc;Mara
57	H5619	071	000	Humana Inc.	Humana Gold Plus H5619-071 (HMO)	Clark;Floyd;Harrison;Adair;Anderson;Ballard;Bath;Bell;Bourbon;Boyle;Bracken;Breathitt;Breckinr
58	H5619	157	000	Humana Inc.	Humana Gold Plus H5619-157 (HMO)	Accomack;Amelia;Charles City;Chesapeake City;Chesterfield;Colonial Heights City;Cumberland;D
59	H6622	001	000	Humana Inc.	Humana Gold Plus H6622-001 (HMO)	Brown;Calumet;Dane;Fond du Lac;Green Lake;Jefferson;Kenosha;Kewaunee;Manitowoc;Maratho
60	H6622	004	000	Humana Inc.	Humana Gold Plus H6622-004 (HMO)	Accomack;Charles City;Chesapeake City;Chesterfield;Colonial Heights City;Dinwiddie;Gloucester
61	H6622	023	000	Humana Inc.	Humana Cleveland Clinic Preferred [illegible]MO-POS	Cuyahoga;Lake;Lorain;Medina;Stark;Summit
62	H0524	034	000	Kaiser Foundation Health Plan, Inc	Kaiser Permanente Senior Advantage Ventura	Ventura
63	H0524	083	000	Kaiser Foundation Health Plan, Inc	Kaiser Permanente Senior Advantage Ventura	Ventura
64	H2722	003	000	Louisiana Health Service & Indem	Primewell Dual Plus (HMO-POS D-SNP)	Arkansas;Ashley;Benton;Bradley;Calhoun;Carroll;Chicot;Clark;Clay;Cleburne;Cleveland;Columbia
65	H6453	019	000	Louisiana Health Service & Indem	Blue adVantage Dual Plus (HMO-POS D-SNP)	Acadia;Allen;Ascension;Assumption;Avoyelles;Beauregard;Bienville;Bossier;Caddo;Calcasieu;Cal
66	H7163	003	000	Louisiana Health Service & Indem	Primewell Dual Plus (HMO-POS D-SNP)	Adams;Amite;Attala;Bolivar;Calhoun;Carroll;Choctaw;Claiborne;Clarke;Coahoma;Copiah;Covingt
67	H1372	001	000	Marquis Companies I, Inc.	AgeRight Advantage Health Plan (HMO I-SNP)	Benton;Clackamas;Jackson;Josephine;Klamath;Lane;Linn;Marion;Multnomah;Washington;Yamhil
68	H5425	086	000	SCAN Group	SCAN Embrace (HMO I-SNP)	Los Angeles;Los Angeles
69	H5425	087	000	SCAN Group	SCAN Embrace (HMO I-SNP)	Orange
70	H5425	091	000	SCAN Group	SCAN Embrace (HMO I-SNP)	San Bernardino

About | CY24 VBID Hospice MAO Contacts | CY24 VBID Hospice Service Areas | Discontinued MAO Contacts | CY23 VBID Hospice Service Areas | CY22 VBID ...

Frequently Asked Questions

Question: If a hospice is paid by a participating MA plan independently of their claims to the MAC, what will prevent hospices from only billing to the participating MA plan?

Frequently Asked Questions

Answer:

- CMS and the participating MA plans will be reconciling hospice data on a quarterly basis. If a hospice provider sends claims to a participating MA plan for payment, but does not bill their MAC, CMS systems will not appropriately pay the participating MA plan for services provided on behalf of its hospice enrollees.
- Given this concern, CMS has included in the CY2021 Technical and Operational Guidance the option for participating MA plans to implement a prepayment strategy under which hospice providers that routinely do not submit notices or claims to Medicare must submit their remittance codes from their respective MACs to the participating MA plan prior to receiving payment from the MA plan
- This would result in delays in payment to the hospice provider

Important Notes Related to MACs Payments

- Reimbursement for "Unrelated Care"
  - **Any unrelated care associated with an enrollee's hospice stay which is covered by a plan participating in the Hospice Benefit Component is now the financial responsibility of the participating plan**
  - **MACs should *not* process any claims for unrelated care for an enrollee which is covered by a plan participating in the Hospice Benefit Component**
- Calculation of the Aggregate Cap and the Inpatient Cap
  - **All billing related to care provided to an enrollee who have coverage through a plan participating in the Hospice Benefit Component should *not* be included in calculating a hospice's progress towards the aggregate and inpatient cap**

VBID Extension

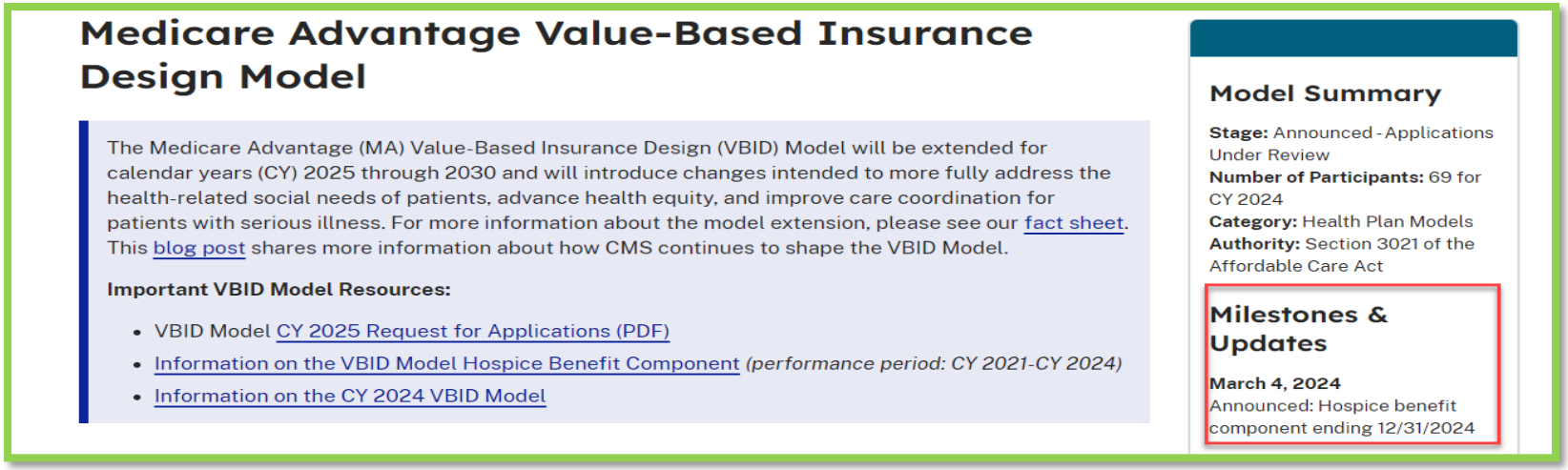
The VBID Model will be extended for calendar years 2025 through 2030 and will introduce changes intended to more fully address the health-related social needs of patients, advance health equity, and improve care coordination for patients with serious illness.

- Medicare Advantage Value-Based Insurance Design Model Extension Fact Sheet

VBID Announcement

March 4, 2024, Announcement: Hospice benefit component ending December 31, 2024

- Medicare Advantage Value-Based Insurance Design Model | CMS



Medicare Advantage Value-Based Insurance Design Model

The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model will be extended for calendar years (CY) 2025 through 2030 and will introduce changes intended to more fully address the health-related social needs of patients, advance health equity, and improve care coordination for patients with serious illness. For more information about the model extension, please see our fact sheet. This blog post shares more information about how CMS continues to shape the VBID Model.

Important VBID Model Resources:

- VBID Model CY 2025 Request for Applications (PDF)
- Information on the VBID Model Hospice Benefit Component *(performance period: CY 2021-CY 2024)*
- Information on the CY 2024 VBID Model

Model Summary

Stage: Announced - Applications Under Review
Number of Participants: 69 for CY 2024
Category: Health Plan Models
Authority: Section 3021 of the Affordable Care Act

Milestones & Updates

March 4, 2024
Announced: Hospice benefit component ending 12/31/2024

Contacting Information

- All stakeholders can reach out to the VBID Model Team with any questions, comments, or concerns about the Hospice Benefit Component at VBID@cms.hhs.gov
- For general contact information for the participating MAOs, see: https://innovation.cms.gov/innovation-models/vbid-hospice-benefit-participating-plans

Important VBID Resources

- Value-Based Insurance Design Model Hospice Benefit Component Overview
- CY 2021 VBID Hospice Benefit Component Frequently Asked Questions (PDF)
- Calendar Year 2021 Hospice Benefit Component Technical and Operational Guidance
- Calendar Year 2024 Technical and Operational Guidance Supplement

VBID Hospice Provider Letter and Checklist

- CY 2023 VBID Hospice Provider Letter and Checklist (PDF)
- CY 2024 VBID Hospice Provider Letter and Checklist (PDF) forthcoming

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eServices MBI Lookup and Hospice/Home Health Eligibility Check

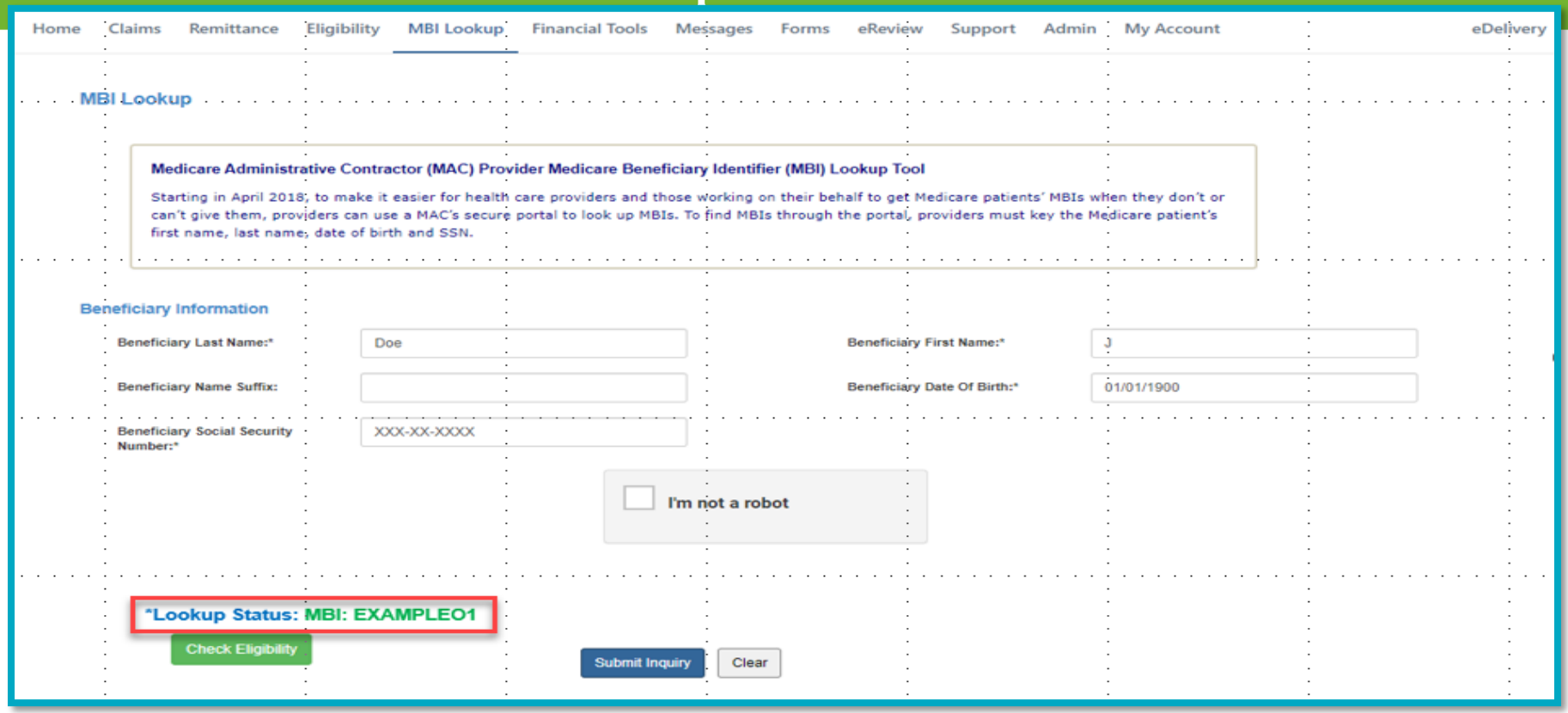
Medicare Beneficiary Identifier (MBI) Changes

- Requests to change a MBI may occur if a Medicare beneficiary, their authorized representative, requests it or CMS suspects a number is compromised
  - **If CMS reissues MBIs, it is possible your patients will seek care before receiving a new card with their new MBI**
- When an MBI changes, the beneficiary is advised to share the new MBI with their providers
  - **If you cannot obtain the new MBI from the patient, you can get it from the eServices MBI Lookup Tool**

eServices MBI Lookup

- How to successfully perform an MBI lookup?
  - **When you click on the MBI Lookup tab, you will be presented with the MBI Lookup screen**
- The following fields are required
  - **Beneficiary Last Name**
  - **Beneficiary First Name**
  - **Beneficiary Date of Birth**
  - **Beneficiary's Social Security Number (not a spouse's SSN)**
- Only the current MBI will populate

eServices MBI Lookup



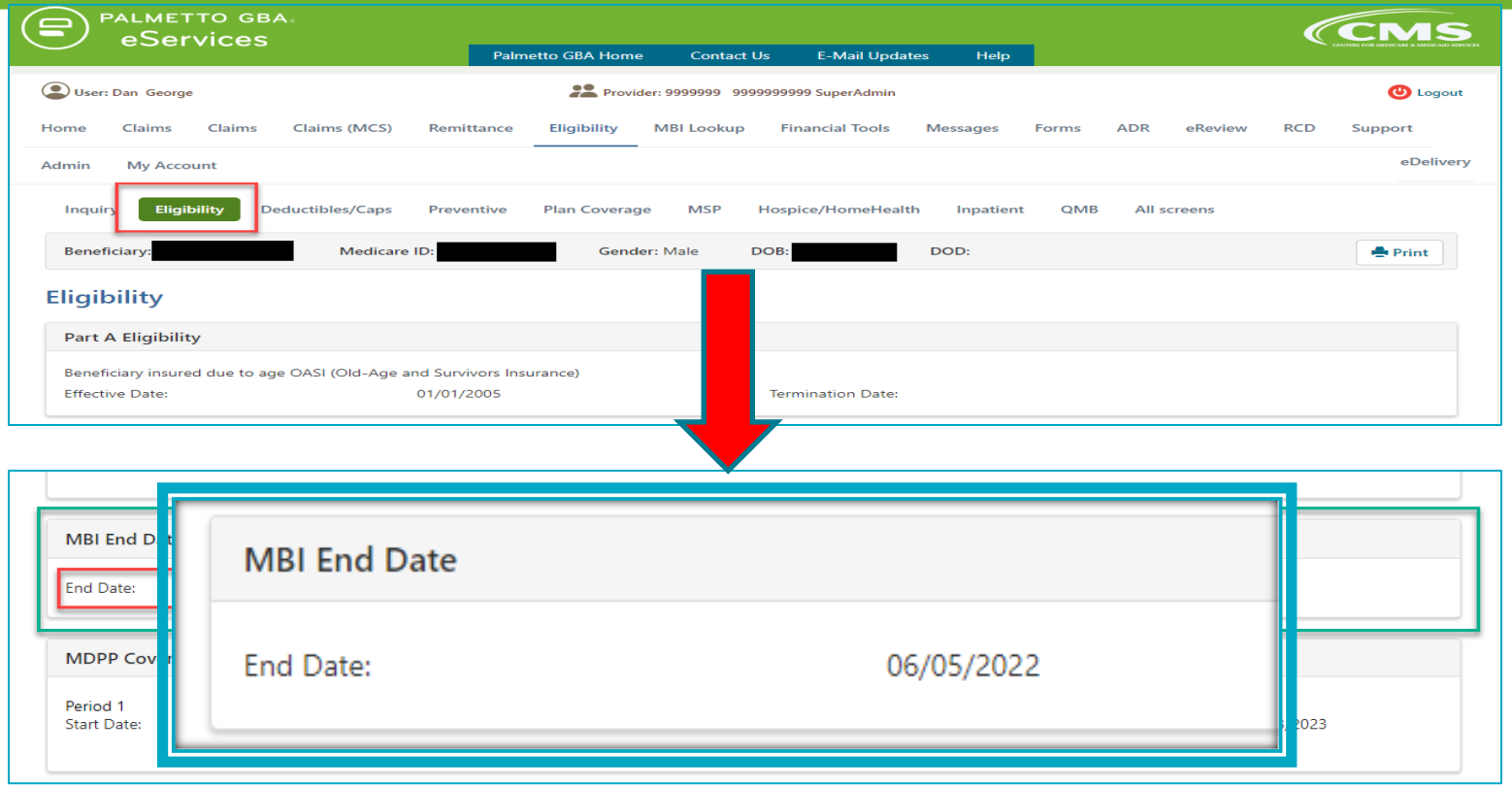
MBI Changes

You can find the termination date of the old MBI by doing a historic eligibility search in eServices. The termination date will be returned in the MBI End Date field of the Eligibility tab.

- Use a date range in the Eligibility tab search
  - **The entered date range may include a future date (up to four months in the future) to insure the MBI is not pending an upcoming change**

Jurisdiction M HHH — Home Health and Hospice Billing When a New Medicare Beneficiary Identifier Is Assigned (palmettogba.com)

MBI End Date


PALMETTO GBA
eServices
Palmetto GBA Home
Contact Us
E-Mail Updates
Help
CMS
User: Dan George
Provider: 9999999 9999999999 SuperAdmin
Logout
Home
Claims
Claims
Claims (MCS)
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
ADR
eReview
RCD
Support
Admin
My Account
eDelivery
Inquiry
Eligibility
Deductibles/Caps
Preventive
Plan Coverage
MSP
Hospice/HomeHealth
Inpatient
QMB
All screens
Beneficiary:
Medicare ID:
Gender: Male
DOB:
DOD:
Print
Eligibility
Part A Eligibility
Beneficiary insured due to age OASI (Old-Age and Survivors Insurance)
Effective Date: 01/01/2005
Termination Date:
MBI End Date
End Date:
MDPP Cov
Period 1
Start Date:
MBI End Date
End Date: 06/05/2022
2023

MBI Changes

- NOEs and claims will be returned to the provider if they are not submitted with the current MBI
  - **Highly recommended that prior to submitting the NOE, the hospice confirms the MBI is current using the eServices MBI Lookup tool**
  - **This would prevent NOEs being returned for this issue and submitting late NOE exception requests**

eServices Eligibility Inquiry

How do I successfully perform an eligibility inquiry?

- The following fields are required:
  - **Beneficiary's Last Name**
    - Only first six letters of last name needed
  - **Beneficiary's First Name**
    - Only first letter of first name needed
  - **Beneficiary's Birth Date**
  - **Beneficiary's Medicare ID**
  - **Enter a Date Range**

eServices Eligibility Inquiry

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Date ranges may not exceed **24** months at a time.

Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)

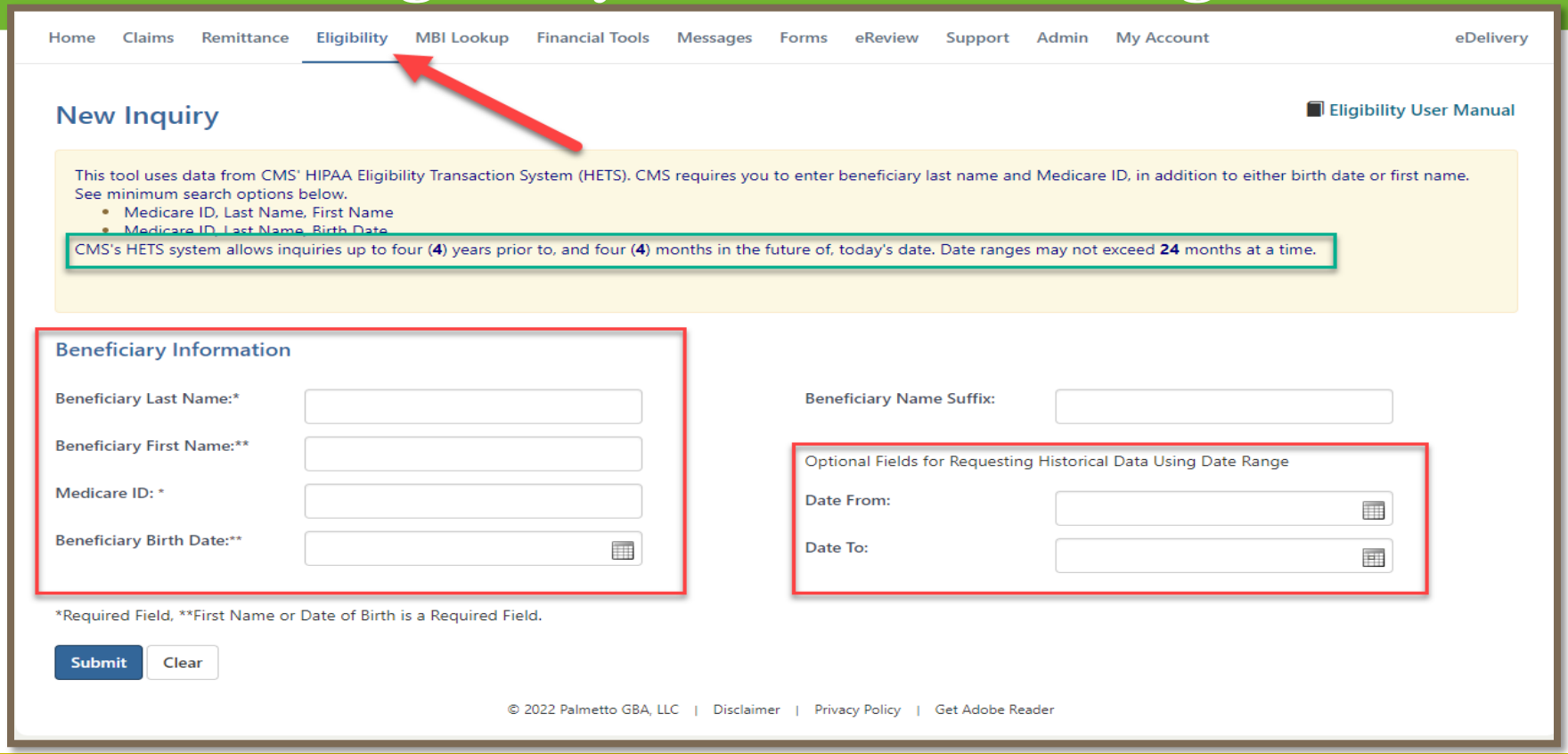
- A March 11, 2023, HETS update changed the Hospice Care Response
  - **This has updated eServices and other eligibility systems hospice responses**
- The update included:
  - **All available Hospice Election Period data will return on the HETS 271 regardless of whether an associated Hospice Benefit Period record exists**

R2023Q100_Release Summary Document

HETS

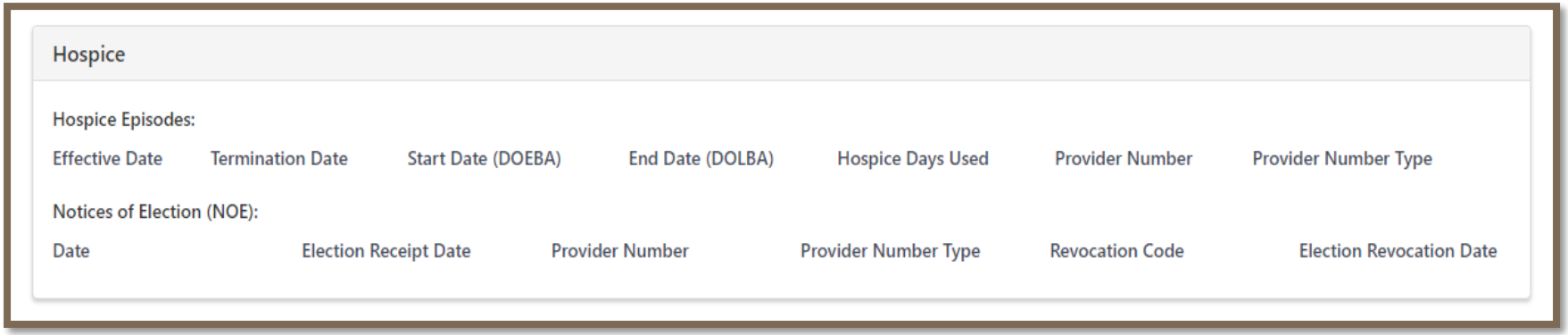
- With this update, the Hospice **Election Period** information for each election may include (new/updated components are bolded and italicized):
  - Hospice Election Date
  - ***Hospice Election Receipt Date***
  - ***Hospice Election Revocation Date***
  - ***Hospice Election Revocation Indicator***
  - Hospice Election NPI

eServices Eligibility Tab – Date Range a Must!



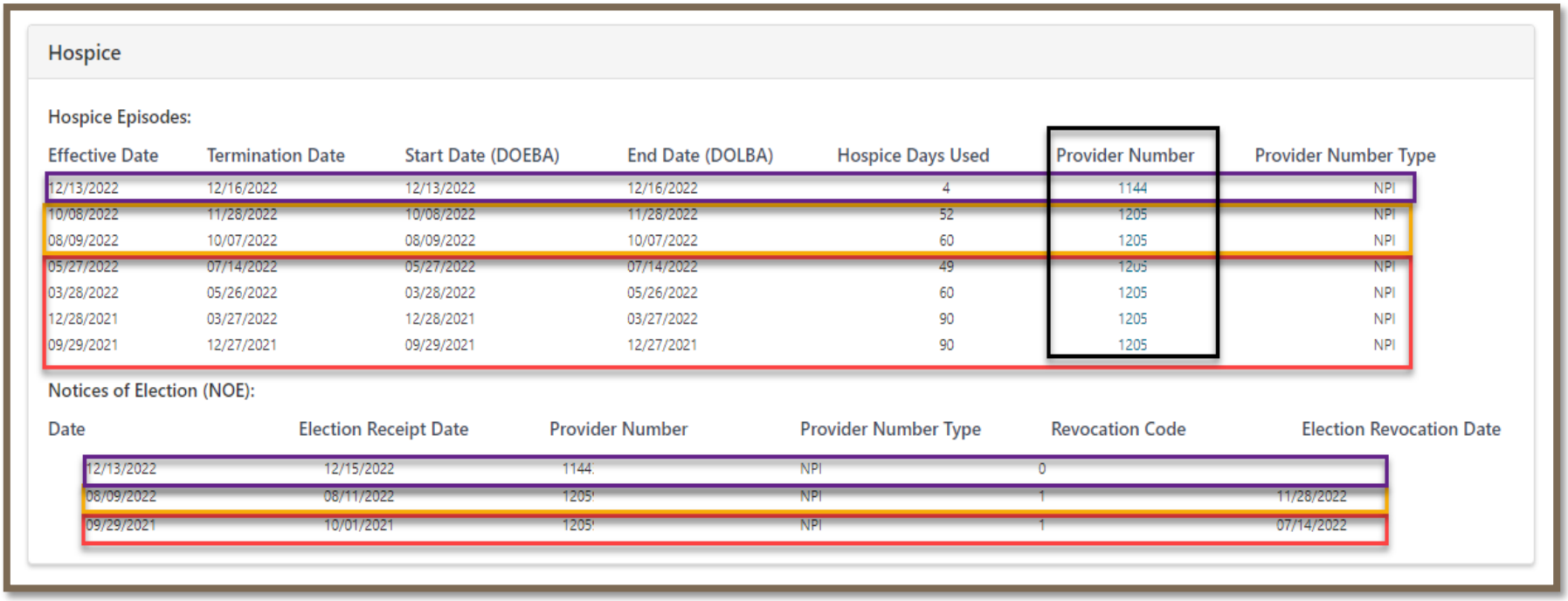
eServices – Hospice

No date range entered in the Eligibility Tab – No Response



eServices – Hospice

Date range was entered in the Eligibility Tab – Three elections returned



Hospice

Hospice Episodes:

Effective Date	Termination Date	Start Date (DOEBA)	End Date (DOLBA)	Hospice Days Used	Provider Number	Provider Number Type
12/13/2022	12/16/2022	12/13/2022	12/16/2022	4	1144	NPI
10/08/2022	11/28/2022	10/08/2022	11/28/2022	52	1205	NPI
08/09/2022	10/07/2022	08/09/2022	10/07/2022	60	1205	NPI
05/27/2022	07/14/2022	05/27/2022	07/14/2022	49	1205	NPI
03/28/2022	05/26/2022	03/28/2022	05/26/2022	60	1205	NPI
12/28/2021	03/27/2022	12/28/2021	03/27/2022	90	1205	NPI
09/29/2021	12/27/2021	09/29/2021	12/27/2021	90	1205	NPI

Notices of Election (NOE):

Date	Election Receipt Date	Provider Number	Provider Number Type	Revocation Code	Election Revocation Date
12/13/2022	12/15/2022	1144	NPI	0	
08/09/2022	08/11/2022	1205	NPI	1	11/28/2022
09/29/2021	10/01/2021	1205	NPI	1	07/14/2022

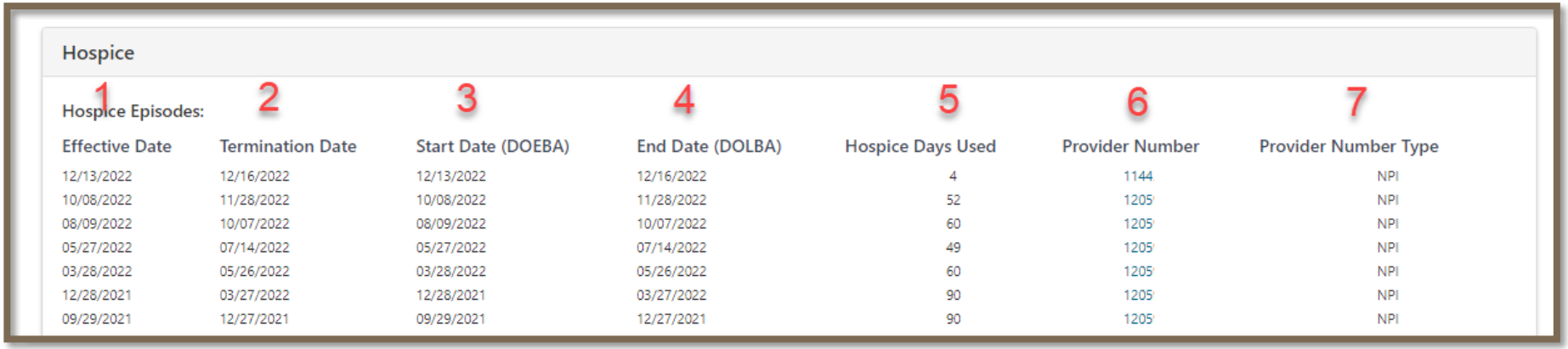
eServices – Hospice Elections Overview Fields

Notices of Election (NOE):

Date 1	Election Receipt Date 2	Provider Number 3	Provider Number Type 4	Revocation Code 5	Election Revocation Date 6
12/13/2022	12/15/2022	195	NPI	0	
08/09/2022	08/11/2022	816	NPI	1	11/28/2022
09/29/2021	10/01/2021	816	NPI	1	07/14/2022

1. Date – Election Date
2. Election Receipt Date – Date NOE was received
3. Provider Number – NPI of the hospice
4. Provider Number Type – NPI or CCN
5. Revocation Code –
   - 0 (still patient or deceased)
   - 1–3 (Discharged)
6. Election Revocation Date – Discharge date

eServices – Hospice Periods Overview Fields



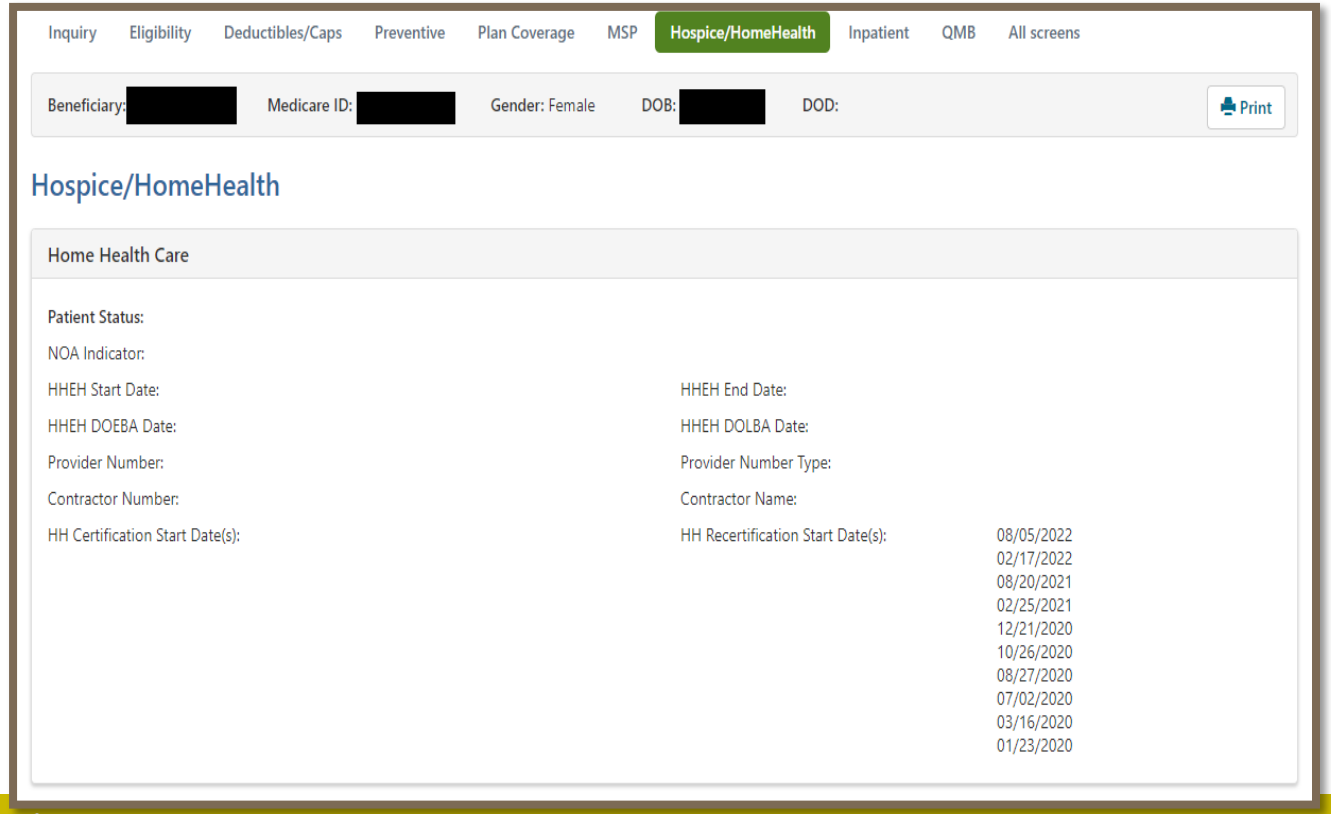
Hospice

Hospice Episodes:

1 Effective Date	2 Termination Date	3 Start Date (DOEBA)	4 End Date (DOLBA)	5 Hospice Days Used	6 Provider Number	7 Provider Number Type
12/13/2022	12/16/2022	12/13/2022	12/16/2022	4	1144	NPI
10/08/2022	11/28/2022	10/08/2022	11/28/2022	52	1205	NPI
08/09/2022	10/07/2022	08/09/2022	10/07/2022	60	1205	NPI
05/27/2022	07/14/2022	05/27/2022	07/14/2022	49	1205	NPI
03/28/2022	05/26/2022	03/28/2022	05/26/2022	60	1205	NPI
12/28/2021	03/27/2022	12/28/2021	03/27/2022	90	1205	NPI
09/29/2021	12/27/2021	09/29/2021	12/27/2021	90	1205	NPI

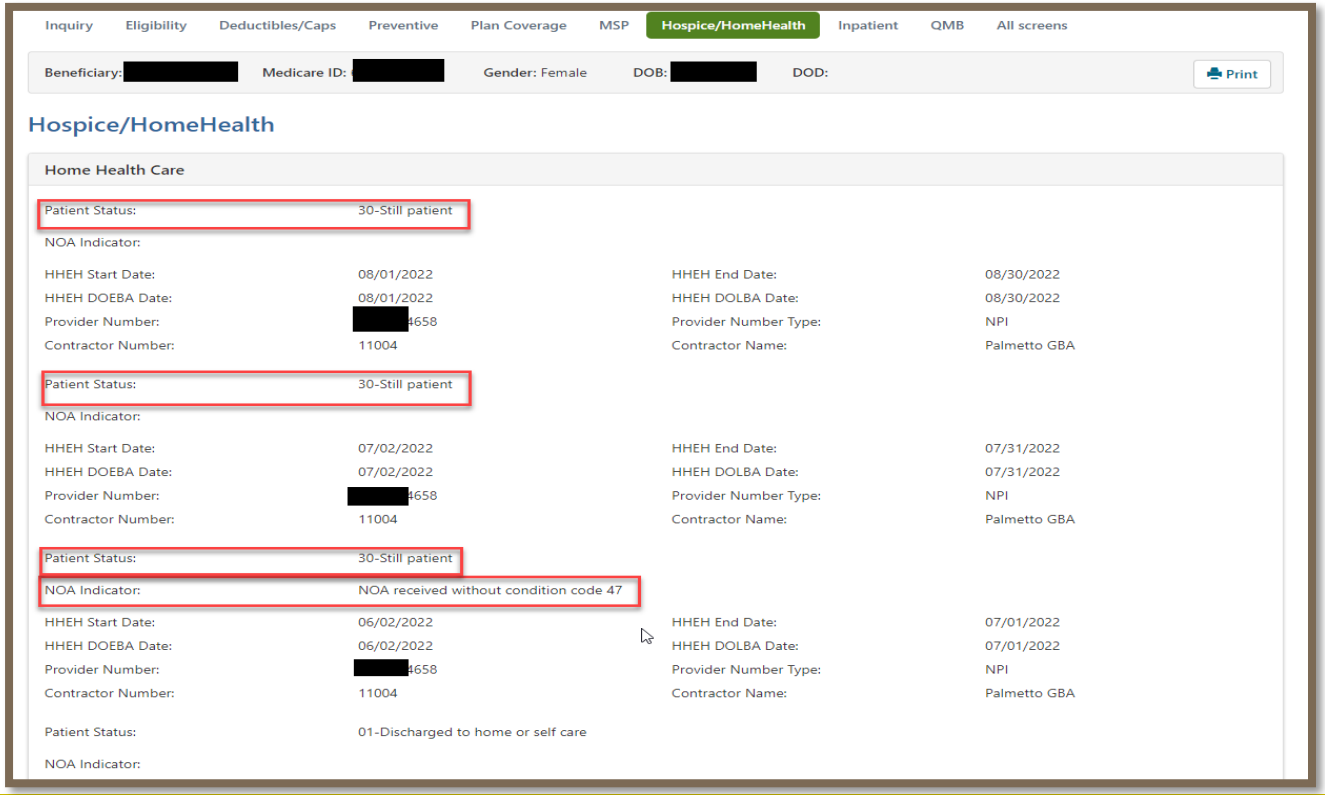
1. Effective Date – Period Start Date
2. Termination Date – Period End Date
3. Start Date – Date of Earliest Billing Activity (DOEBA)
4. End Date – Date of Latest Billing Activity (DOLBA)
5. Hospice Days Used – Days used in period
6. Provider Number – The NPI of the hospice – **New hyperlink to NPPES!**
7. Provider Number Type – NPI or CCN

Example of Home Health Response with **No** Date Range Entered on Inquiry Page



Example of patient admitted to home health (HH) on 6/2/22 with 30-day claims submitted and processed for June, July and August 2022. Without date range, only HH recert dates populated.

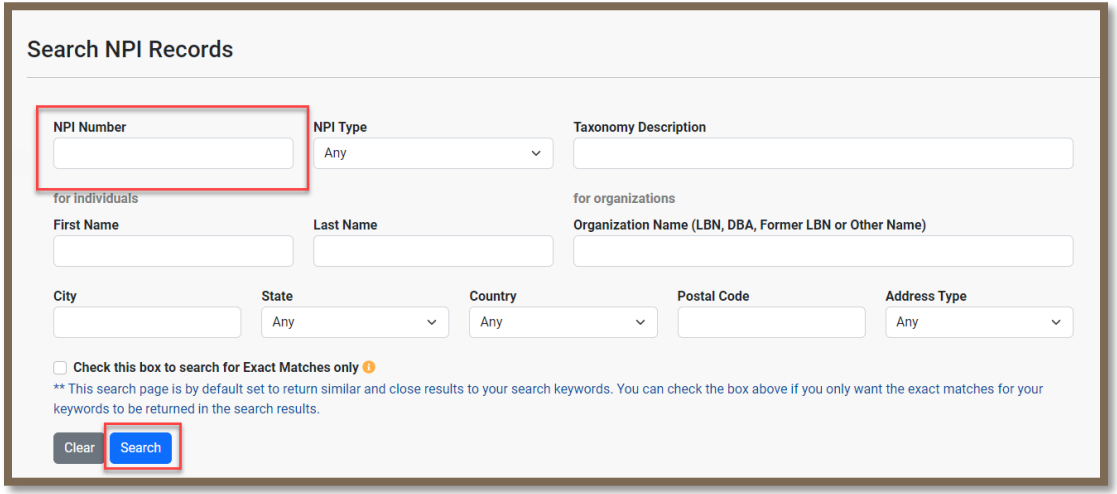
Example of Home Health Response with Date Range Entered on Inquiry Page



Same patient entered with a date range in the inquiry screen of 1/1/22 to 9/30/22. HH periods and patient status information populated.

NPI Lookup

The NPI listed under the Hospice Episodes is now hyperlinked to the National Plan & Provider Enumeration System (NPPES) website. Click on the NPI and a new webpage will open. Just enter the NPI and search.



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Overview of the Targeted Probe and Educate (TPE) Process

TPE Purpose

CMS designed the program to:

- **Reduce claim denials and appeals**
- **Decrease provider burden**
- **Improve the medical review and education process**

The goal is to help you quickly improve.

Active Medical Reviews

Code Type	Specific Code	Edit Topic	Edit Description
Rev Code	General Inpatient Care (GIP)	GIP	Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 656 and place of service codes Q5004–Q5009
Rev Code	New Hospice Providers	New Hospice Providers	Review of new hospice provider claims
DX Codes	Non-Cancer Length of Stay (NCLOS)	NCLOS	Review of hospice claims for NCLOS
Rev Code	Routine Home Care (RHC-Rev Code 651)	Routine Home Care (RHC-Rev Code 651)	Routine Home Care (RHC-Rev Code 651)

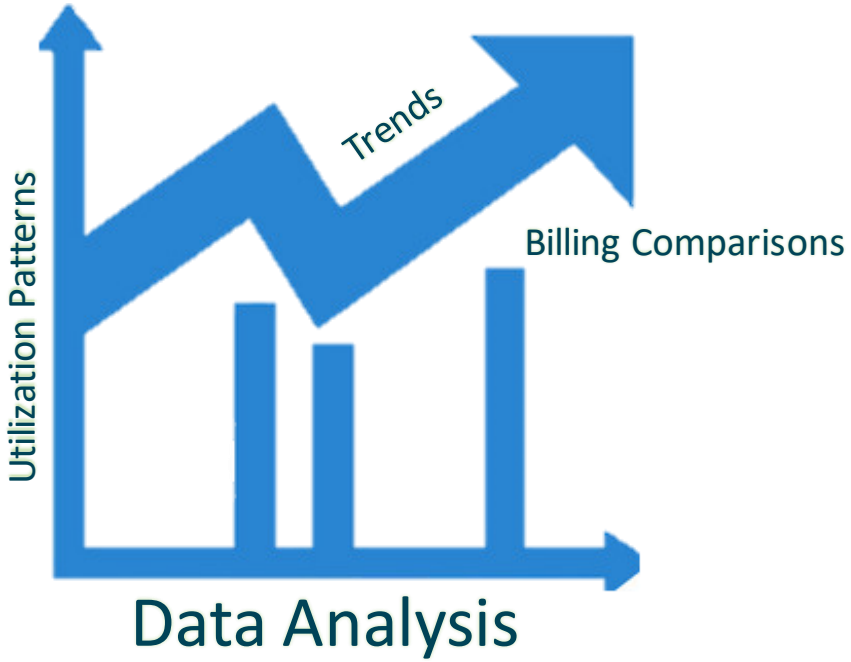
JM Parts A, B and Home Health and Hospice Targeted Probe and Educate Active Medical Review List

Active Medical Reviews

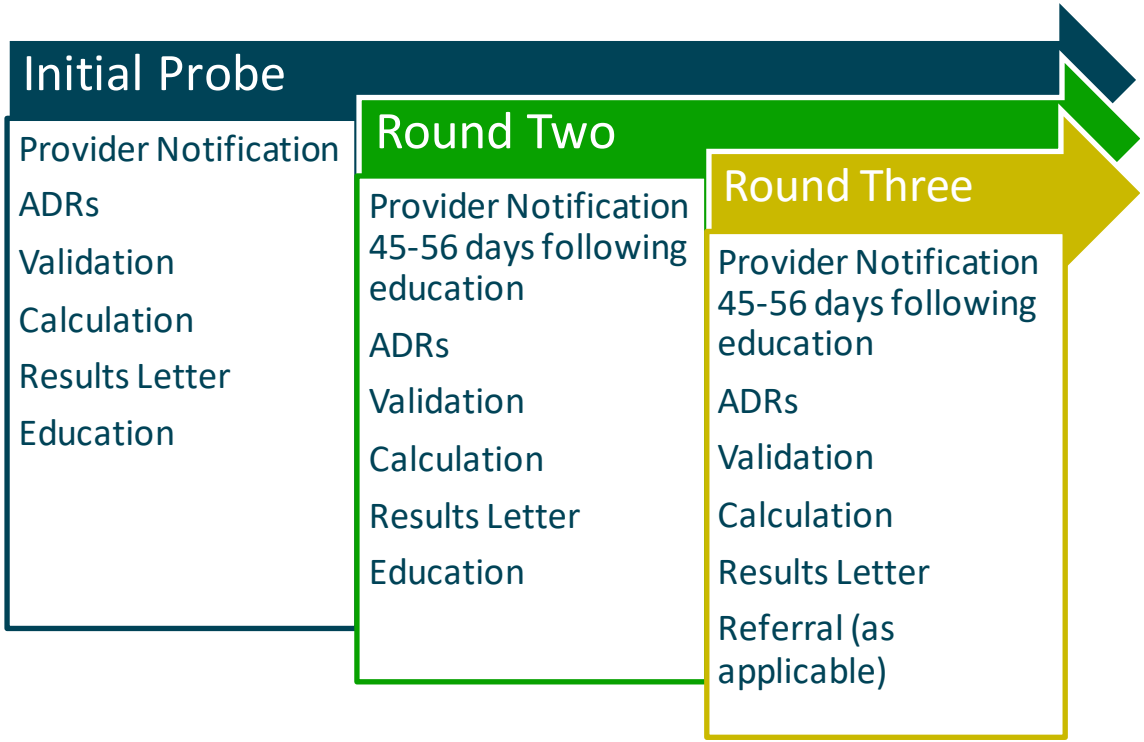
Code Type	Specific Code	Edit Topic	Edit Description
Rev Code	0651, 0652, 0655, 0656	Hospice-Length of Stay (LOS) Greater than 365 Days	Review of claims submitted for Hospice-Length of Stay (LOS) Greater than 365 Days
Revenue Code	0652	Hospice Services Continuous Home Care	Review of claims submitted for hospice services continuous home care
Bene Sharing	All	Hospice Services Bene Sharing	Review of claims submitted for hospice services bene sharing

JM Parts A, B and Home Health and Hospice Targeted Probe and Educate Active Medical Review List

TPE Starts with Data Analysis



Targeted Probe and Educate Process



Corrective Action Referral:
Extrapolation
Referral to UPIC
Referral to RA
100% Pre-Pay Review

Is There a Documented Threshold to Determine if the Provider Should Move to the Next Round?

Each MAC evaluates the TPE probe claim denial or charge denial rate against an established threshold at the conclusion of each probe round

Providers with error rates that exceed the established threshold may be progressed to the next round*

Prior to the start of the next TPE probe round, all completed appeals and reopens are considered prior to transitioning a provider to the next probe

If the new claim and charge denial rates are 20% or less, a new TPE results letter will be issued, and the provider will be removed from progressing to the next probe

**This information is communicated to the provider via the probe results information that all providers are issued at the conclusion of the 20 – 40 claim review for each probe.*

Point of Contact

- When submitting the requested medical record documentation in response to the ADR, submit the following information:
  - **Point of contact for the agency**
  - **Name and phone number**
- This allows for follow up during the review if missing documentation is identified

Point of Contact

Please use the table below as a guide for submitting point of contact Information.

NPI			
PTAN			
Group/Practice Name			
Provider Name			
Contact Name			
Title			
Contact Number			
Hours of Availability		Time Zone	☐ Pacific ☐ Mountain ☐ Central ☐ Eastern

Results and Education – Hospice

Some examples of missing documentation most frequently requiring contact, may include (but not limited to):

- No Hospice Election Statement
- No or incorrect certification for DOS billed
- Missing face-to-face
- Missing point of contact
- No physician's narrative
- No POC/Interdisciplinary doc for DOS billed
- Missing documentation to support the level of care billed:
  - Rev code 0656 — General Inpatient Care

Claim Remarks

Check Page 4 of DDE for specific remarks related to the denial:

- THE DOCUMENTATION SUBMITTED DOES NOT SUPPORT MEDICAL PROGNOSIS OF SIX MONTHS OR LESS. REFER TO CMS MANUAL SYSTEM, PUB 100- 04, MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 11, SECTION 10 (5CF36)DX. SENILE DEGENERATION OF BRAIN. ALZ. LCD L34567/A56639 USED. DOCUMENTATION DOES NOT SUPPORT DECLINE TOWARDS TERMINALITY. ABLE TO ANSWER QUESTIONS APPROPRIATELY. TALKS ABOUT HER HUSBAND WHO HAS PASSED A COUPLE YEARS AGO. STATES FEELING GOOD - TAKEN MEDS, PAIN AND NAUSEA UNDER CONTROL. ABLE TO WORK WORD PUZZLE. ABLE TO FEED SELF. INCONTINENT OF BOWEL AND BLADDER BUT ABLE TO USE BSC IF GOTTEN UP IN TIME. WAS IN HOSPITAL FOR SEVERE CONSTIPATION/IMPACTION. PROVIDER DID SUBMIT LETTER STATING THAT GIP LEVEL OF CARE BILLED IN ERROR, DOS 3/1-3/31/23 SHOULD HAVE BEEN BILLED AS RHC.

What Is the Process to Appeal a TPE Denial?

The appeals process has not changed due to TPE

If you have a review determination during TPE that results in a claim denial, we encourage you to review the medical records you submitted. If you disagree with that determination, you should follow the established appeal's process.

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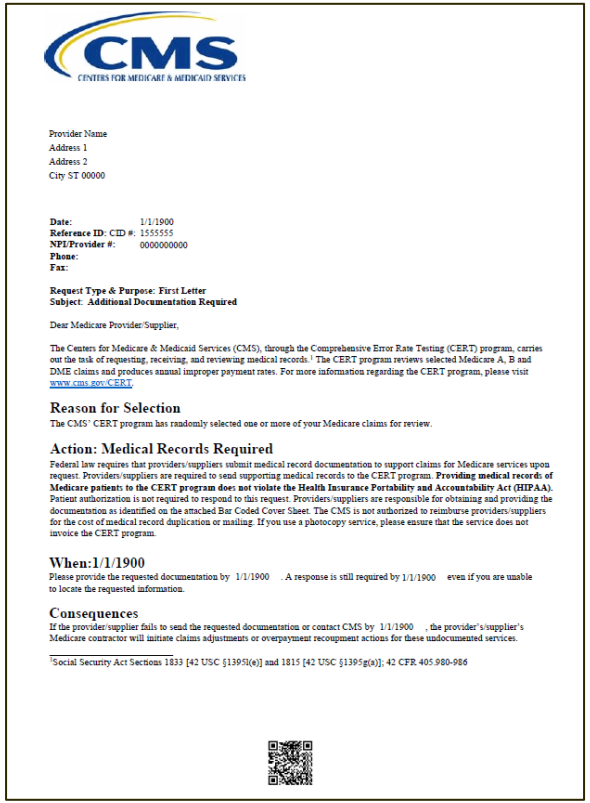
Comprehensive Error Rate Testing (CERT) Reminders

Responding to CERT Requests



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Name
Address 1
Address 2
City ST 00000

Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #: 0000000000
Phone:
Fax:

Request Type & Purpose: First Letter
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection
The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When:1/1/1900
Please provide the requested documentation by 1/1/1900 . A response is still required by 1/1/1900 even if you are unable to locate the requested information.

Consequences
If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

[1]Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986

- Responding to a CERT request is not optional
- A reply is still required if records can not be located
- This is not a HIPPA violation
- Contact the CERT Documentation Center at 888–779–7477, if you have questions regarding requested documentation

CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
1510 E. Parham Road
Henrico, VA 23228

Important Dated Information Enclosed

Immediate Response Required
Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

Responding to CERT Requests

Avoid general payment errors by ensuring that:

- You are aware of CERT requests
- Updates are made to your contact information when necessary
- The original barcoded cover sheet is used when responding to request

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor
GS-00F-263CA CERT

CID: 1555555

Due Date: 1/1/1900 Medicare Part B Provider
Patient Name: Patient Name
Date of Birth: 1/1/1900 **Date of Service: 1/1/1900 - 1/1/1900**
Claim Control Number: CCN0000000000
Universe Date: 1/1/1900 Request Date: 1/1/1900
Contractor Number: 99999 Contractor Type: B
Billing Provider NPI: 0000000000
Letter Sequence: ADR to Billing Provider (First Request)

Please send documentation to:
Fax #: 804-261-8100 or
Mail: CERT Documentation Office - Attn: CID # 1555555, 1510 East Parham Road, Henrico, VA 23228
Phone #: 888-779-7477 or 443-663-2699

The documents listed below may be required in support of a medical claim review. Please provide all of the **pertinent** medical records/ documentation listed **below and any additional documentation** to support the above listed claim for the specified date(s) of service. Please copy both sides of each page and please DO NOT cut off page edges when copying.

Note: If the medical record documentation is not signed or if the signature is illegible, submit an attestation statement or a signature log for those medical record entries. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. An attestation statement cannot be used when an order is not signed.

CERT Documentation Submission

Methods of Submission	
Postal Mail	CERT Documentation Center 1510 East Parham Road Henrico, Virginia 23228
Fax	Send a separate fax for each individual claim to (804) 261-8100
Electronic Submission of Medical Documentation (esMD)	Include a CID# or Claim Number
Compact Disc (CD)	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via email to: CERTMail@nciinc.com or via fax to (804) 264-9764 • Only images in TIFF or PDF are acceptable
Email Attachment	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via email to: CERTMail@nciinc.com or via fax to (804) 264-9764 • Only images in TIFF or PDF are acceptable

Avoiding CERT Errors

Avoid Documentation errors by ensuring:

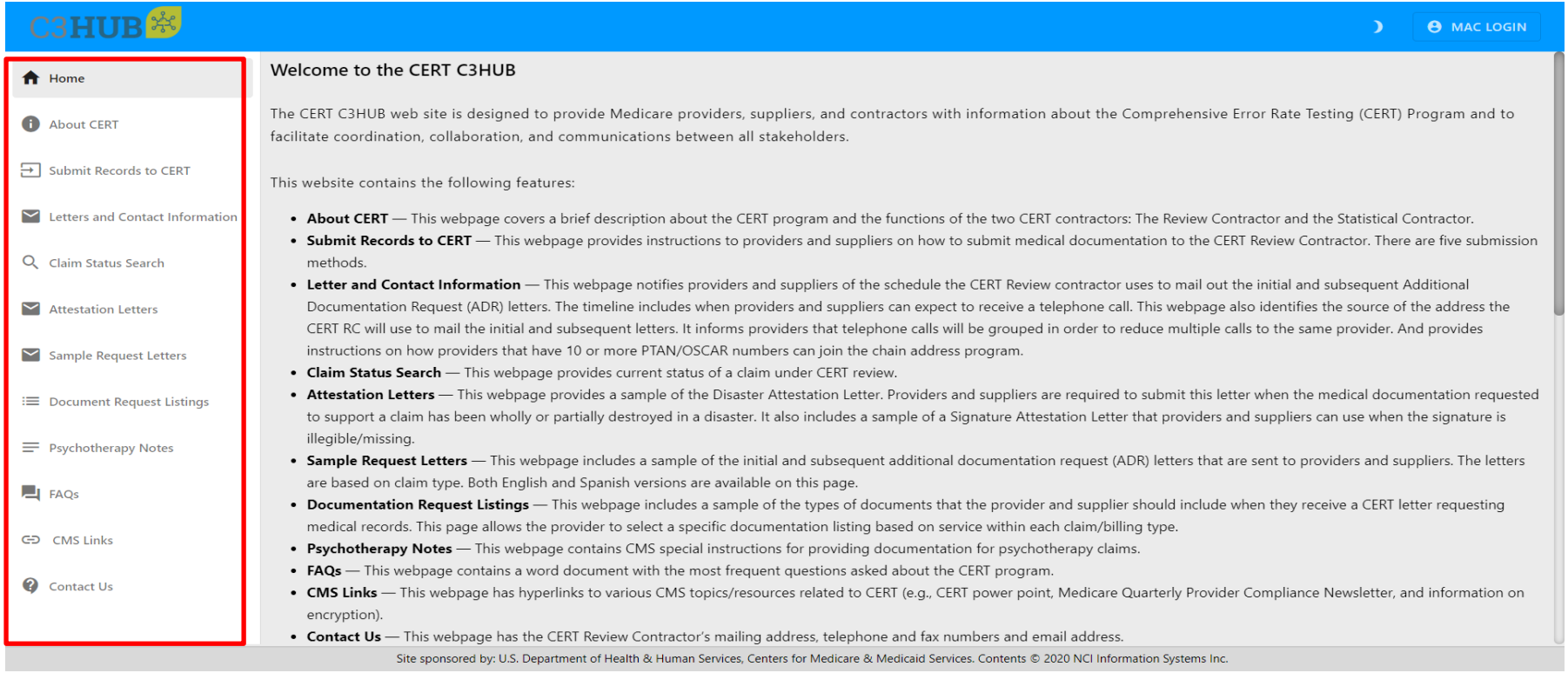
- Comprehensive documentation is submitted timely
- The code billed best reflects rendered services
- An order or an intent to order is obtained when necessary
- Documentation and signatures that are legible (signature logs and attestation statements should be used when necessary)

CERT Website – C3HUB

CERT website C3Hub

- The CERT C3HUB web site is designed to provide Medicare providers, suppliers, and contractors with information about the CERT Program and to facilitate coordination, collaboration, and communications between all stakeholders

CERT Website – C3HUB



CERT Resources

- Palmetto GBA Comprehensive Error Rate Testing (CERT) web page
- Responding to CERT Documentation Request
- CERT website C3Hub

References and Resources

Medicare Program Integrity Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
Hospice Documentation Audit Tool	https://www.palmettogba.com/Palmetto/Providers.Nsf/files/Hospice_Documentation_Audit_Tool.pdf/$File/Hospice_Documentation_Audit_Tool.pdf
Notice of Election	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6KPD3187
Certification	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/9CWSWZ3714
GIP Reduction	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6K632367
CERT	https://www.cms.gov/files/document/2020-medicare-fee-service-supplemental-improper-payment-data.pdf

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Resources for Hospice Providers

CMS Hospice Resources

- Medicare Contractor Beneficiary and Provider Communications Manual
- Medicare Benefit Policy Manual-Hospice
- Medicare Claims Processing Manual-Hospice
- Hospice Code of Federal Regulations
- Model Hospice Election Statement Example
- Model Hospice Election Statement Addendum Example

Palmetto GBA Hospice Resources

- Palmetto GBA Jurisdiction M Home Health and Hospice MAC home page
- Hospice Certification of Terminal Illness
- Palmetto GBA Medical Review Home Page
  - Responding to a Hospice Additional Documentation Request
- Hospice Beneficiary Election Statement Addendum Frequently Asked Questions (FAQ)
- Value-Based Insurance Design Model Hospice Benefit Component Overview
- Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services (Related to Terminal Diagnosis) Job Aid
- Hospices are to Report Post-Mortem Visits with the Modifier PM

Hospice Notice Job Aids

- Notice of Election (NOE — TOB 8XA) Billing Job Aid
- Notice of Termination/Revocation of Election (TOB 8XB) Job Aid
- Notice of Transfer (TOB 8XC) Billing Job Aid
- Notice of Cancellation (TOB 8XD) Billing Job Aid
- Hospice Notice of Change of Ownership (TOB 8XE) Billing Job Aid
- Hospice Transfer Requirements
- Hospice Change of Ownership

Connect With Us

FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on Twitter for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!

https://tinyurl.com/3u2vasbb