Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1111

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3604 (Cont.) - 3604 (Cont.)	6-41 - 6-42 (2 pp.)	6-41 - 6-42 (2 pp.)
3604 (Cont.) - 3604 (Cont.)	6-45 - 6-46 (2 pp.)	6-45 - 6-46 (2 pp.)
3648 - 3648 (Cont.)	6-289 - 6-292 (4 pp.)	6-289 - 6-290 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2000*
IMPLEMENTATION DATE: October 1, 2000

Section 3604, Review of Form HCFA-1450 for Inpatient and Outpatient Bills, is amended to add a new occurence code, 23, and occurrence span code, M2, to this section for use in hospice billing.

Section 3648, Review of Hospice Bills, adds a new occurrence code and occurrence span code for hospices.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Code	Title	Definition
01	Auto accident	Code indicates the date of an auto accident. This code is used to report an auto accident that involves liability insurance. (See §§3419ff.)
02	No-Fault Insurance Involved - Including Auto Accident/Other	Code indicates the date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicates the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Other Accident	Code indicates the date of an accident not described by the above codes. This code is used to report that the provider has developed for other casualty related payers and has determined there are none. (Additional development not needed.)
11	Onset of Symptoms/Illness	Code indicates the date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	(HHA Claims only) Code indicates the date the patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit.
17	Date Occupational Therapy Plan Established or Reviewed	Code indicates the date a plan was established or last reviewed for occupational therapy.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment	(Part A claims only.) Code indicates date on which the provider began claiming payment Began under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)

Code	Title	Definition
22	Date Active Care Ended	(SNF claims only.) Code indicates date on which a covered level of care ended in a SNF. Code is not required if code "21" is used.
23	Cancellation of Hospice Election Period	Code indicates date on which a hospice period of election is cancelled by an intermediary as (INTERMEDIARY USE ONLY) opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Code indicates the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is not longer available to the patient.
26	Date SNF Bed Available	Code indicates the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care. (See §3350.)
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT. (See §3350.)
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology. (See §3350.)
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Code indicates the date of the notice provided by the hospital stating that requested requested car (diagnostic procedures or treatments) is not considered reasonable or necessary by Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Code indicates the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.

Code	Title	Definition
74	Noncovered Level of Care	Code indicates the From/Through dates for a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span code 76, 77, or 79. Codes 76 and 77 apply to most noncovered care. Used for leave of absence. This code is also used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A.
75	SNF Level of Care	Code indicates the From/Through dates for a period of SNF level of care during an inpatient hospital stay. It also means that a PRO reviewing the stay approved the patient's remaining stay in the hospital because of the nonavailability of a SNF bed. For hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLS 24-30). It is not applicable to swing-bed hospitals which transfer patients from the hospital to a SNF level of care.
76	Patient Liability	Code indicates the From/Through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary. Code is to be used only where you or the PRO approve such charges in advance and the patient is notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability-- Utilization Charged	Code indicates the From/Through dates for a period of noncovered care for which the provider is liable (other than for lack of medical necessity or as custodial care.) The beneficiary's record is charged with Part A days, Part A or Part B deductible, and Part B coinsurance. The provider may collect Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) Code indicates the From/Through dates given by the patient for a SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and is not shown in FL 36. (See §3035.B.2.)

79	Provider Liability--No Utilization (Payer Code)	Code indicates the From/Through dates of a eriod period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M0	PRO/UR Stay Dates	If a code "C3" is in FLS 24-30, the "From" and "Through" dates of the approved billing period are here.
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. Providers enter the control number assigned to the original bill here. Utilized by all provider types on adjustment requests (Bill Type, FL4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. (For Hospice claims only, the name, address, and provider number of a transferring Hospice is shown by the new Hospice on its HCFA-l450 admission notice. (See §3648, FL 38.) For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLS 39, 40, and 41. Value Codes and Amounts
Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "A" through line "D." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used before the second line is used and so on).

04	Inpatient Professional Component Charges Which are Combined Billed	Code indicates the amount shown is the sum of the inpatient professional component charges which are combined billed. Medicare uses this information in internal processes and also in the HCFA notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)

3648. REVIEW OF HOSPICE BILLS

Form HCFA-1450 was developed by representatives of the hospital and health insurance industries to be suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. Items not listed need not be reviewed although providers may complete them when billing multiple payers. Medicare systems, including the common working file (CWF) and standard systems employed by regional home health intermediaries for hospice claims processing, are required to edit for the following information as appropriate.

FL1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may also be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit zip codes are acceptable. Use the information to reconcile provider number discrepancies.

FL 4. Type of Bill
Required. This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (only codes used to bill for hospice care are shown).

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

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

3rd Digit - Frequency	Definition
A - Admission Notice	The hospice notifies you of the beneficiary's election of hospice benefits by forwarding form HCFA-1450. For admission purposes FLS 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, 67, 82, and 83 are completed. (Also FL 34 when the admission is for a patient who has changed an election from one hospice to another.)

3rd Digit - Frequency	Definition
B - Hospice Termination/ Revocation Notice	This code is used when the hospice is submitting the HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	This code is used when the HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/Cancel	This code is used when the HCFA-1450 is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	This code is used when the HCFA-1450 is used as a Notice of Change in Ownership for the hospice.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim - First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (FL 6) is the discharge date or date of death.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also being submitted by the provider showing the corrected information.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period covered by this bill are shown in numeric fields (MM-DD-YY). Days before the patient's entitlement are not shown. The "From" date is used to determine timely filing. (See §§3307ff.) Since the l2-month hospice "CAP period" (see Hospice Manual, §§405 and 407) ends each year on October 31, hospice services for October and November cannot be submitted on the same bill.

FL l2. Patient's Name
Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

FL l3. Patient's Address
Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, city, State, and ZIP code.

FL l4. Patient's Birthdate
Required. (If available.) The month, day, and year of birth is shown numerically as MM-DD-YY. If the date of birth was not obtained after reasonable efforts by the hospice, the field will be blank.

FL l5. Patient's Sex
Required. An "M" for male or an "F" for female must be present.

FL l7. Admission Date
Required. The admission date to the hospice is used to report the effective date of the hospice election. If a patient changes the election to another hospice, the admission date to the second hospice is shown. It represents the effective date of the hospice election change. The date of admission may not precede the physician's certification by more than 2 calendar days. The month, day, and year are shown numerically as MM-DD-YY.

EXAMPLE: The hospice election (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, l993. The first hospice benefit period ends 90 days from January 8, 1993.

FL 22. Patient Status
Required. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code Structure
01 - Discharged (left care of this hospice)
30 - Still patient (remains a patient of this hospice)
40 - Died at home
41 - Died in a medical facility, such as a hospital, SNF, ICF or Free-Standing Hospice
42 - Place of death unknown

Fls 32, 33, 34, and, 35. Occurrence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two numeric digits and dates are shown as six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, FL 36 (occurrence span) or FL 84 (Remarks) is used to record additional occurrences and dates.

NOTE: There are occurrences on which other payers require reporting that are not shown below. See §§34l9, 3490, and 349l to determine when Medicare is the secondary payer.

Code	Title	Definition
23	Cancellation of Hospice Election Period (INTERMEDIARY USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an intermediary as opposed to revocation by the beneficiary.
42	Termination of Hospice Care	The date the patients hospice care ends. Hospice care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice election, or death. Show termination code 42 in FLs 32-35.

NOTE: See §3604 for additional occurrence codes and payment information where other payers are involved.

FL 36. Occurrence Span Code and Dates.
Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of respite care for hospice patients.

FL 38. Transferring Hospice I.D.
Required. Show this information when a receiving (second) hospice submits an admission notice involving a patient who changed the hospice election and moved from one hospice to another. Show the transferring hospice's complete name, address, and provider number. This information is an alert that the hospice admission continues a hospice benefit period rather than beginning a new one.

FLs 39, 40, and 41. Value Codes and Amounts
Required. The only value codes that apply to hospice benefits are those that indicate Medicare payment is secondary to another payer. Deduct the amount of payment shown in the value field from the payment to the hospice. If the primary payment is greater than the payment due the hospice, adjust against past or future payments due the hospice for the beneficiary involved. See §3604 for a complete description of codes used for reporting primary payers.

FL 42. Revenue Code
Required. For each payment rate, a revenue code is assigned. The appropriate four-digit numeric revenue code is entered on the adjacent line in FL 42 to explain each charge in FL 47.

NOTE: Revenue code 657 identifies provider charges for physician services furnished to hospice patients by physicians employed by the hospice or receiving compensation from the hospice for services furnished. In conjunction with revenue code 657, the provider enters a physician procedure code. Request the carrier to provide area prevailing charge data for physician services provided to hospice patients. Make reasonable charge determinations for revenue code 657 by paying the hospice for the lower of the area prevailing or billed charge. You are responsible for forwarding the physician procedure codes to the provider to facilitate hospice billing.