Medicare
Hospice Manual

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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REFER TO CHANGE REQUEST 1123

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
304 - 305 (Cont.)	3-17 - 3-17.1 (2 pp.)	3-17 - 3-17.1 (2 pp.)

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

Section 305, Claims Processing Timeliness, is updated to inform you that the prompt payment interest rate is available on the Treasury Department's new web page address--www.publicdebt.treas.gov/opd/opdprmt2.htm.

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.

304. MEDICAL REVIEW OF HOSPICE CLAIMS

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

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

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

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

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

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

305. CLAIMS PROCESSING TIMELINESS

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

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

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

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

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

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

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

C. Interest Payment on Clean Non-PIP Claims Not Paid Timely.--Interest must be paid on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A. For example, a clean claim received on October l, l993, must have been paid before the end of business on October 31, l993. Interest is not paid on:

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

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

Interest is paid at the rate used for §3902(a) of title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

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

Interest is calculated using the following formula:

Payment amount x rate x days ÷ 365 (366 in a leap year) = interest payment.