national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Hospice Top Claim Errors

3/26/2025

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Today's Presenter

NGS PROVIDER EXPERIENCE
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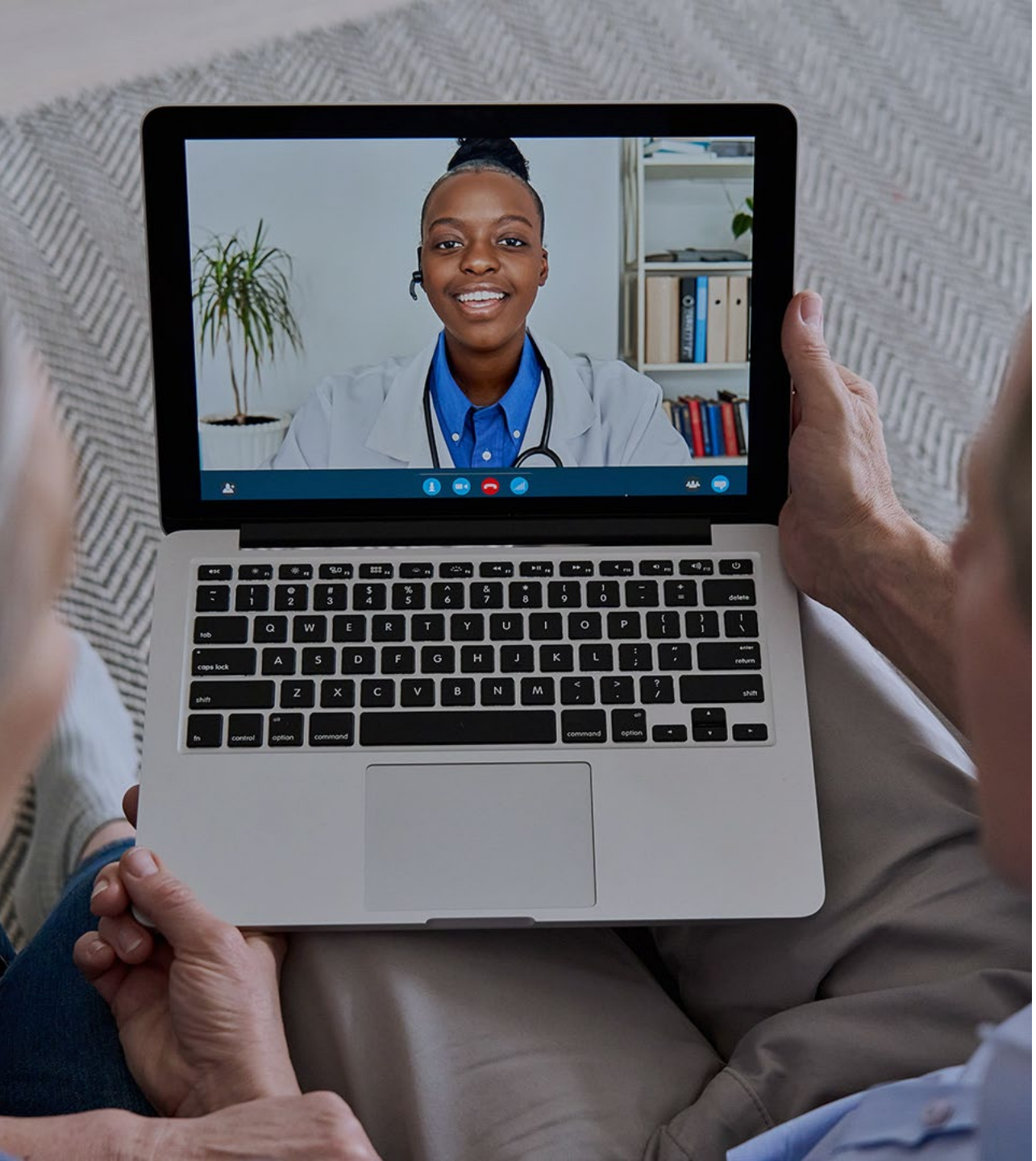

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Objectives

- Review the top rejection and return to provider (RTP) reason codes recently assigned to hospice claims.
- Discuss how to correct the reason code errors and review billing guidelines behind the Notice of Election and hospice claims.

Agenda

- Billing Reminders
- Top Rejection Reason Codes
- Top Return to Provider (RTP) Reason Codes
- Resources
- Q&A

Billing Reminders

Notice of Election

- Purpose: open hospice election period in Common Working File (CWF) so other providers will see beneficiary has elected hospice to prevent inappropriate Medicare payment to nonhospice providers for services related to terminal diagnosis
- Once initial election processed, CWF maintains beneficiary in hospice status until death or until election termination received
- Considered timely-filed if received and accepted by MAC within five calendar days after hospice admission date
  - Has receipt date within five calendar days after hospice admission date
  - NOE is processed and has status/location of P B9997
  - NOE is not returned to hospice for corrections
- Medicare will not cover and pay for days of hospice care from hospice admission date to date NOE is submitted and accepted by MAC
  - These non covered days are provider liable

Some Things to Keep in Mind

- Claims can only be submitted after the NOE has processed
- All services provided to the patient by the hospice related to the terminal condition must be submitted on the hospice claim
  - 81X, 82X TOB
- Claims must be billed monthly and sequentially
- Claims not submitted in order (sequentially) will be returned
  - There can be no gaps in days billed for sequential claims
- All hospice claims must be billed to Medicare, including patients in a VBID MA plan, and those who have Medicare as a secondary payer
- Hospice claims are subject to one-year timely filing

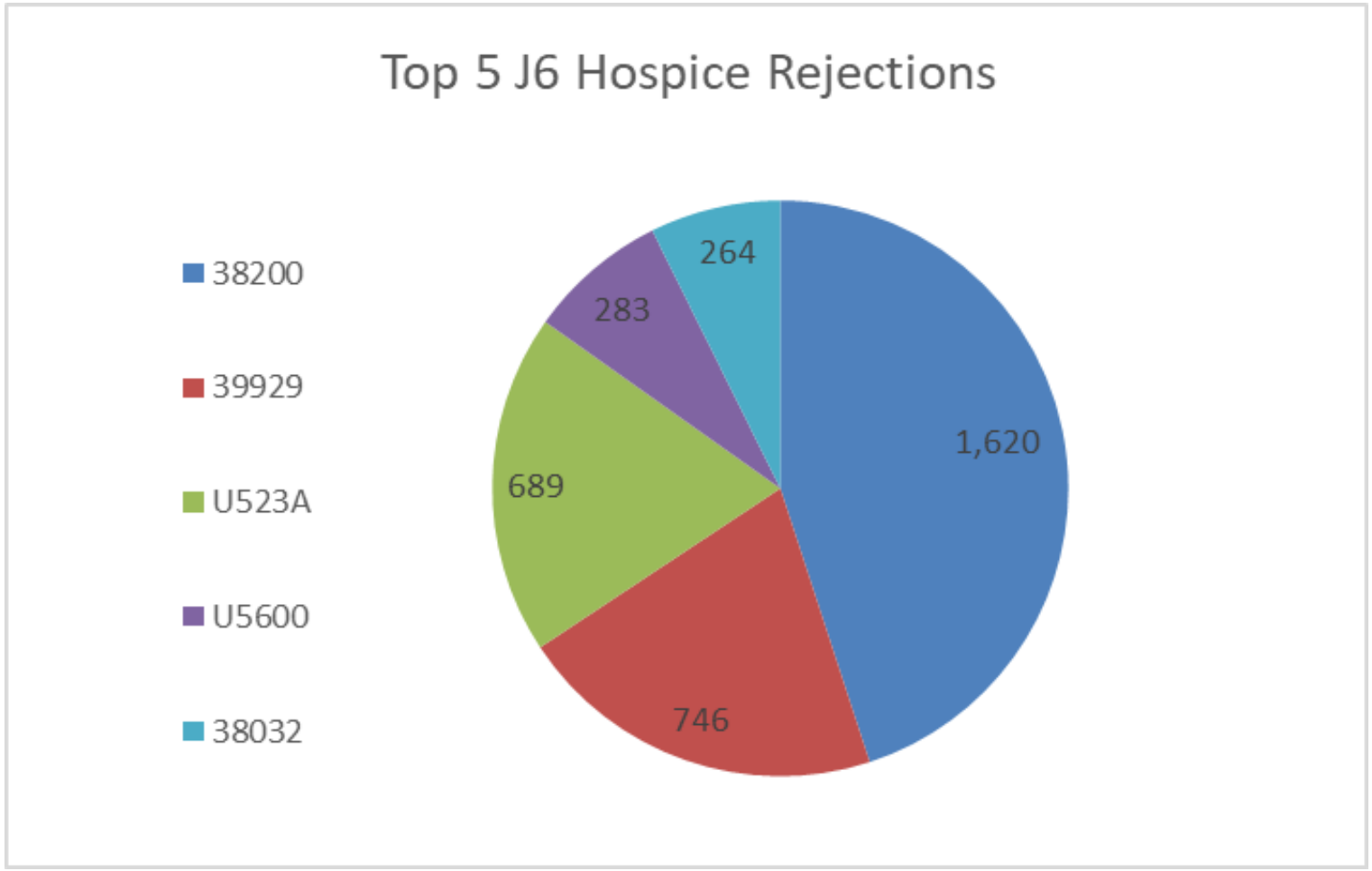
Claim Status/Locations

- Rejections (R B9997)
  - Claims need to be resubmitted
  - In limited situations, claims need to be adjusted

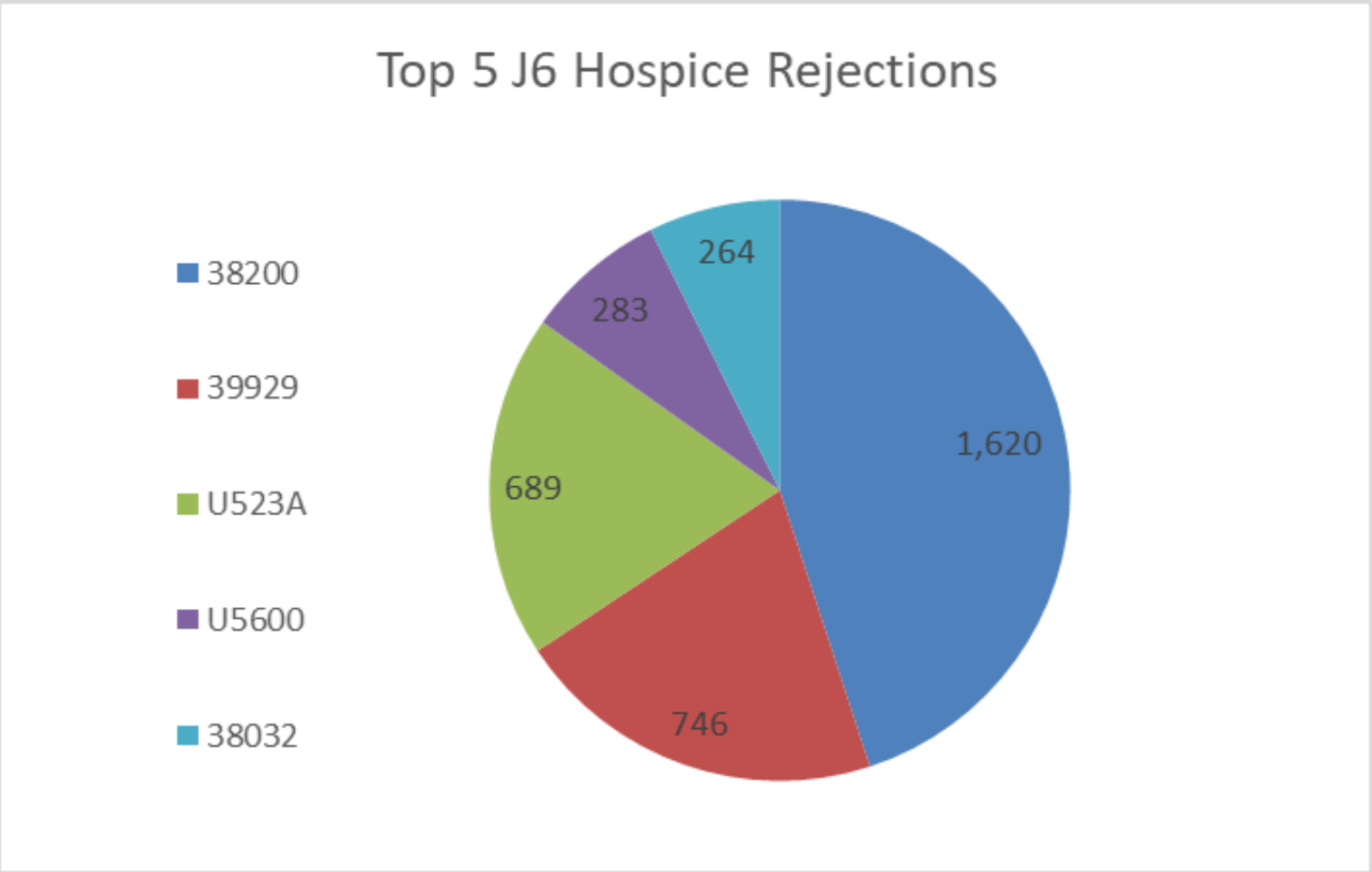
- Returned to Provider (T B9997)
  - Claims need to be corrected and resubmitted

Top Rejection Reason Codes

Top 5 J6 Hospice Rejections



Top 5 JK Hospice Rejections



Rejection Reason Code 38200

RC Narrative: This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same

- HIC Number
- TOB (all three positions of any TOB)
- Provider number
- Statement from date of service
- Statement through date of service
- Total charges (0001 revenue line)
- Revenue code
- HCPCS and modifiers (if required by revenue code file)

Background/Correcting Reason Code 38200

- FISS will only accept one original billing for the statement dates being billed
- This code is assigned when a processed claim is in the FISS history file
  - Any claim billed with the same information will reject as a duplicate
- Verify billing already submitted
  - Check remit, NGSConnex or FISS/DDE

Rejection Reason Code 39929

RC Narrative: Each line of charges on this claim has rejected and/or rejected and denied

- Background/correction
  - When line items are assigned different reasons for rejection, the line level reason code will assign 39929, and the line information is found within the claim
  - Review line level rejection information to determine the rejection for each line of the claim
  - Access MAP171D for line-item detail information
    - Hit F2 once or F11 twice from page two of the claim to access MAP171D in DDE
    - Hover over reason code in the line details in NGSConnex

Rejection Reason Code U5600

RC Narrative: The dates of service reported on this claim are a duplicate to a claim with the same dates of service that has previously processed. Therefore, no Medicare payment can be made.

Correcting Reason Code U5600

- Providers should develop and implement a process to ensure that duplicate claims are not being submitted
- If the claim is truly a duplicate, no action is necessary
- If this is not a duplicate and the provider is trying to add information to the original claim, submit an adjustment to the processed claim
  - Note: Hospice room and board denials must be submitted with revenue code 0659, HCPCS code A9270 and a 'GY' modifier

Rejection Reason Code U523A

RC Narrative: The dates of service are during both a hospice election period and a Medicare Advantage (MA) Plan's period that is in the Value-Based Insurance Design (VBID) model.

Background/Understanding Reason Code U523A

- The VBID Model allowed for a hospice benefit component until CMS terminated the hospice benefit component as of 11:59 PM, 12/31/2024
- Hospice providers must continue to send all notices and claims to both the participating MAO and the relevant MAC on a timely basis for dates of service that fall under the VBID Model
  - MAO will process the claim for payment
  - Original Medicare claim will process for informational and operational purposes and reject with RC U523A

Rejection Reason Code U5211

RC Narrative: The statement from/thru date is greater than the date of death on beneficiary master record

- The claim through date cannot go beyond a patient's date of death

Correcting Reason Code U5211

- Review the beneficiary's eligibility record to determine the date of death on file
  - If date of death is correct, submit an adjustment (type of bill XX7) to your claim, ensuring claim ‘To’ date and line-item dates of service do not overlap date of death on file
  - If date of death is incorrect, contact the Social Security Administration to advise of incorrect date of death
    - Monitor beneficiary's eligibility file for date of death correction
    - Once corrected, submit claim adjustment (type of bill XX7)
    - Do NOT adjust claim until incorrect date of death has been corrected or removed

Rejection Reason Code 38032

RC Narrative: This outpatient claim is a duplicate of a previously processed outpatient claim. The following situations exist

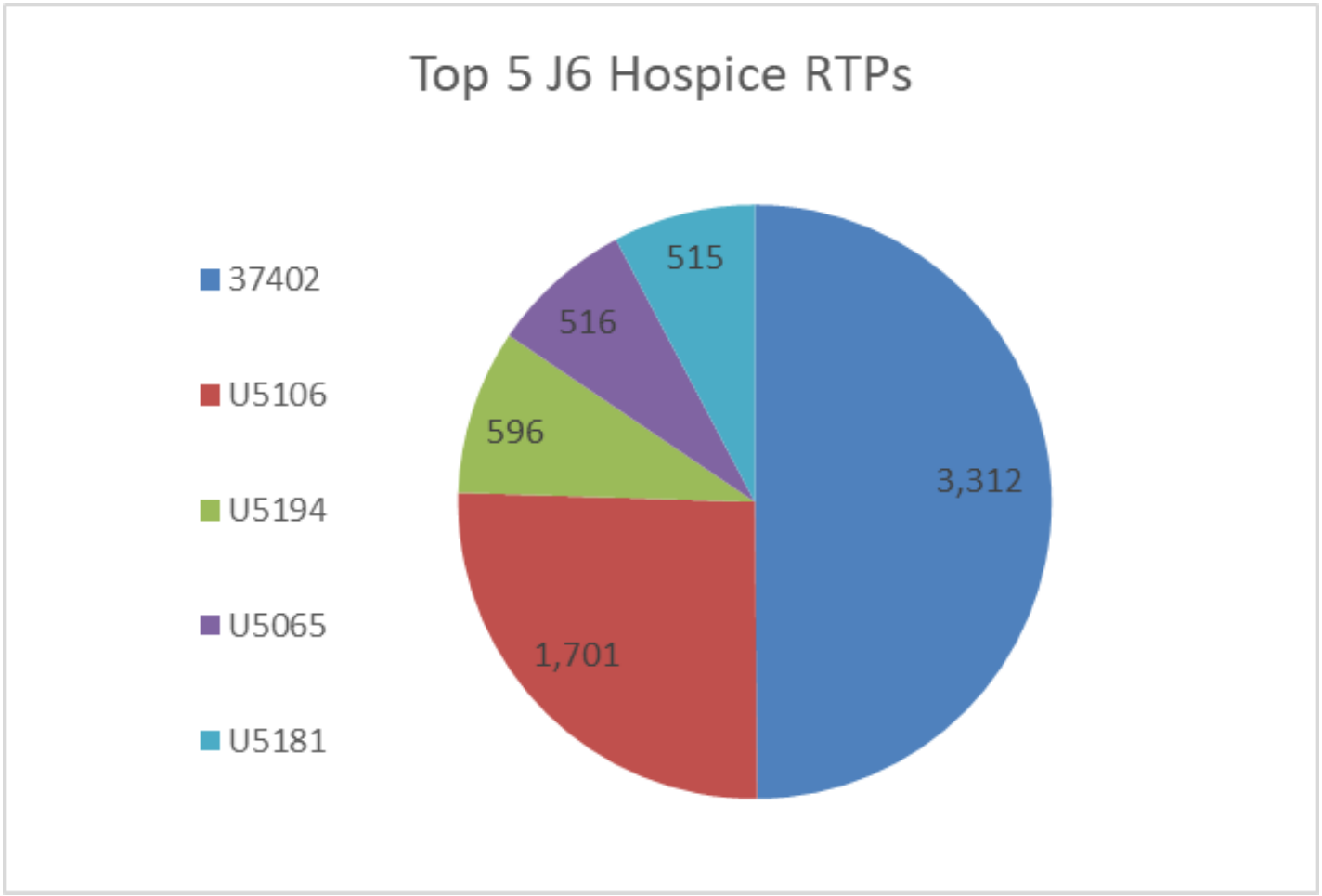
- The ‘statement covers period’ is the same on both bills
- Provider numbers are the same
- At least one revenue code or one HCPCS doe is the same on both bills
- At least one diagnosis code matches on both claims

Correcting Reason Code 38032

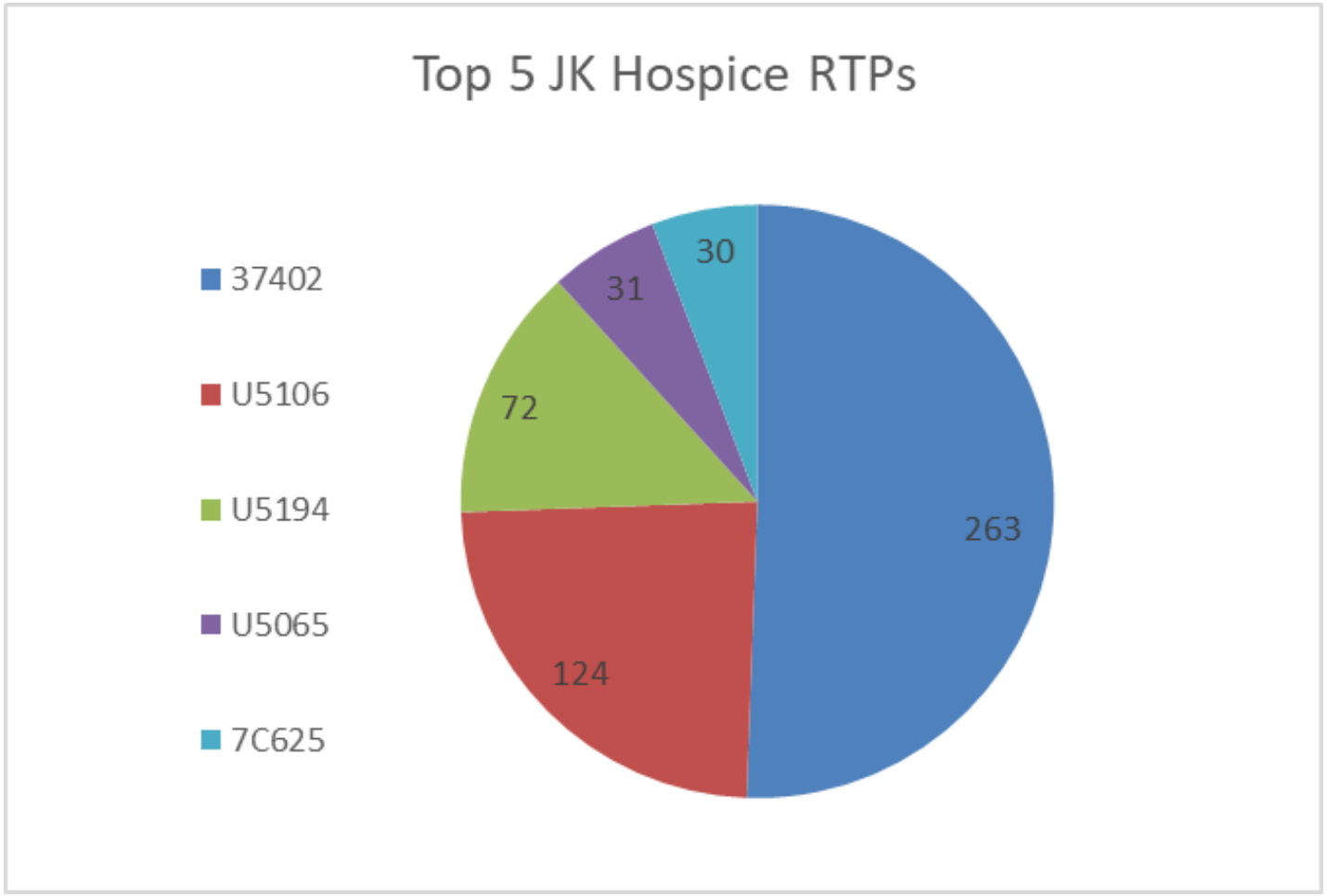
- Develop and implement process to ensure duplicate claims are not being submitted
- If claim is truly a duplicate, no action is necessary
- If this is not a duplicate and you are trying to add information to the original claim, submit an adjustment to the processed claim

Top RTP Reason Codes

Top 5 J6 Hospice RTPs



Top 5 JK Hospice RTPs



RTP Reason Code 37402

RC Narrative: Hospice claim (81X or 82X) with from date greater than 04/01/98 and there is no claim with TOB 81X or 82X whose thru date is exactly one day less than this claim's from date.

Background/Correcting Reason Code 37402

- Hospice claims must be submitted sequentially per calendar month billing (not a thirty-day billing period)
  - Previous month's claim must process and finalize before following month's claim will process
    - FISS will search claim history for prior claim; there cannot be any skipped dates between 'To' date and following month's claim 'From' date
  - When sequential billing requirements are not followed, claim will RTP
    - If prior claim is RTP'd and needs correcting, that claim must be corrected and finalized before subsequent claim can be submitted
- Verify previous month's claim submitted and in finalized location prior to billing subsequent claim
- Verify dates billed are correct and there isn't a gap in dates billed

RTP Reason Code U5106

RC Narrative: Hospice NOE received to add a new election period with a start date which falls within a previously established hospice election period.

Background/Correcting Reason Code U5106

- NOE and/or claims post hospice elections and benefit periods to CWF
- There cannot be another NOE submitted that overlaps an already established election/benefit period
- Ensure NOE is not a duplicate of a previously submitted or processed NOE
- Before submitting NOE, review hospice benefit periods prior to billing to ensure ‘Admit’ date on NOE being submitted is not within ‘Start Date’ and ‘Term Date’ of benefit period in CWF

RTP Reason Code U5194

RC Narrative: A hospice NOE with an admission date on or after 10/1/2014 must be received within five calendar days after the effective date of the hospice election. An initial hospice claim (where the from date matches the admit date) has been received where the NOE was not received timely and OSC 77 is either missing or contains invalid dates.

Background/Correcting Reason Code U5194

- NOE must be received within five calendar days after effective date of the hospice election
- When NOE is not received timely, Medicare will not cover/pay for days of care from admission date to the date NOE was submitted/accepted
- Ensure OSC 77 is reported to identify span of dates from date of admission to date before the NOE received
  - All services/charges related to noncovered days need to be reported as noncovered

- **Note:** In order to calculate the five calendar days, day one is the day after the admission date – count five days from that date. E.g., Admission date is 03/10/YY; Day 1 is 03/11/YY, which means Day 5 (NOE due date) is 03/15/YY.

RTP Reason Code U5065

RC Narrative: The claim from date is prior to the MBI effective date on CWF Xwalk file and the MBI is the oldest occurrence in the HICXWALK file for the beneficiary at CWF.

- Hospices may only bill services provided to the patient after the effective date of their Medicare coverage

Correcting Reason Code U5065

- Verify effective date(s) for the MBI of beneficiary prior to billing
- If new MBI has been issued, all claims after effective date of new MBI must be submitted with new MBI
  - Dates of service before the MBI change date – use old or new MBI
  - Span-date claims with a “From Date” before the MBI change date – use old or new MBI
  - Dates of service entirely on or after effective date of MBI change – use new MBI

RTP Reason Code U5181

RC Narrative: Per the CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11, Section 30.3, occurrence code 27 is reported on the claim for the billing period in which the certification or recertification was obtained. Therefore

- If the certification/recertification was done prior to the service dates on the claim, an occurrence code 27 is not appropriate – or
- When the claim dates of service are spanning a current election period, the occurrence code 27 date must equal the start date of the next election period. (Note that the occurrence code 27 date will create the next election period if one is not currently present.) – or
- If billing an occurrence code 27 date for a late recertification, an occurrence span code 77 must also be present for the days that are prior to the late recertification date.

Background/Correcting Reason Code U5181

- Hospices use occurrence code (OC) 27 and date of election on all NOEs and initial claims following a hospice election
- OC 27 and date are also required on all subsequent claims when claim's dates of service overlap the first day of the next benefit period
- When OC 27 is required, but not reported, or does not include the correct date, NOE or claim will receive RC U5181
- Ensure OC 27 is submitted on NOE; OC 27 date **must match** 'From' date and 'Admit' date on NOE

RTP Reason Code 7C625

RC Narrative: Clarify reason for discharge.

Please review the articles on our website to determine the appropriate coding and Remarks to include on your discharge claim:

- Avoiding Reason Code 7C625: Appropriate Use of Remarks on Final Hospice Claims
- Reporting Hospice Discharges, Revocations and Transfers

Resources

National Government Services Web Resources

- NGS website
- Events
  - Upcoming education sessions
  - Past events material
- Education
  - Medicare Topics
    - Hospice Billing (job aids)
- Top Claim Errors

CMS Resources

CMS website

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* (cms.gov)
  - Chapter 9 (Coverage of Hospice Services Under Hospital Insurance)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual* (cms.gov)
  - Chapter 11 (Processing Hospice Claims)
- Medicare Learning Network (MLN home page | CMS)
  - Resource Materials
  - Training
  - MLN Matters Articles
- Hospice Center | CMS

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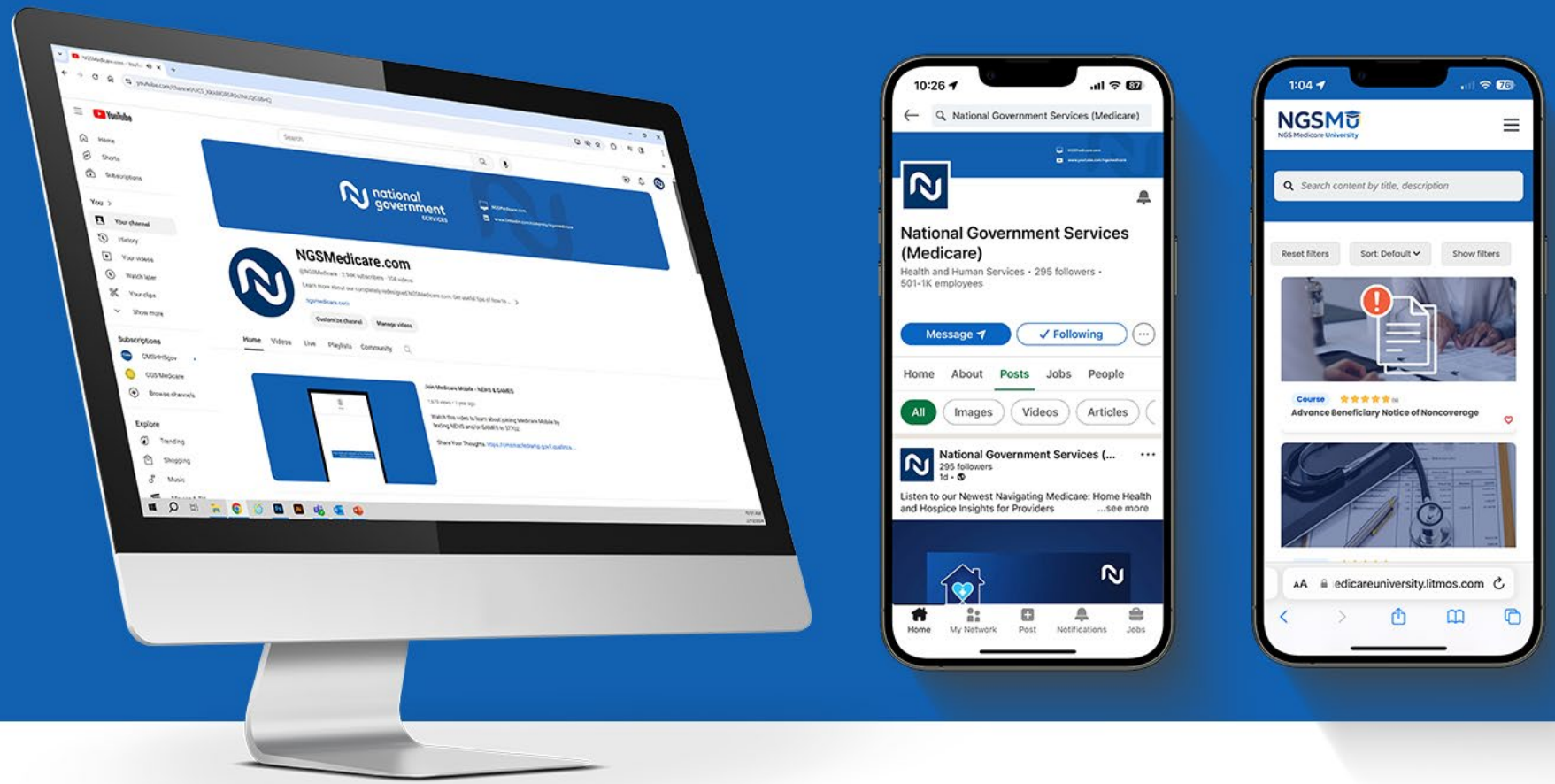

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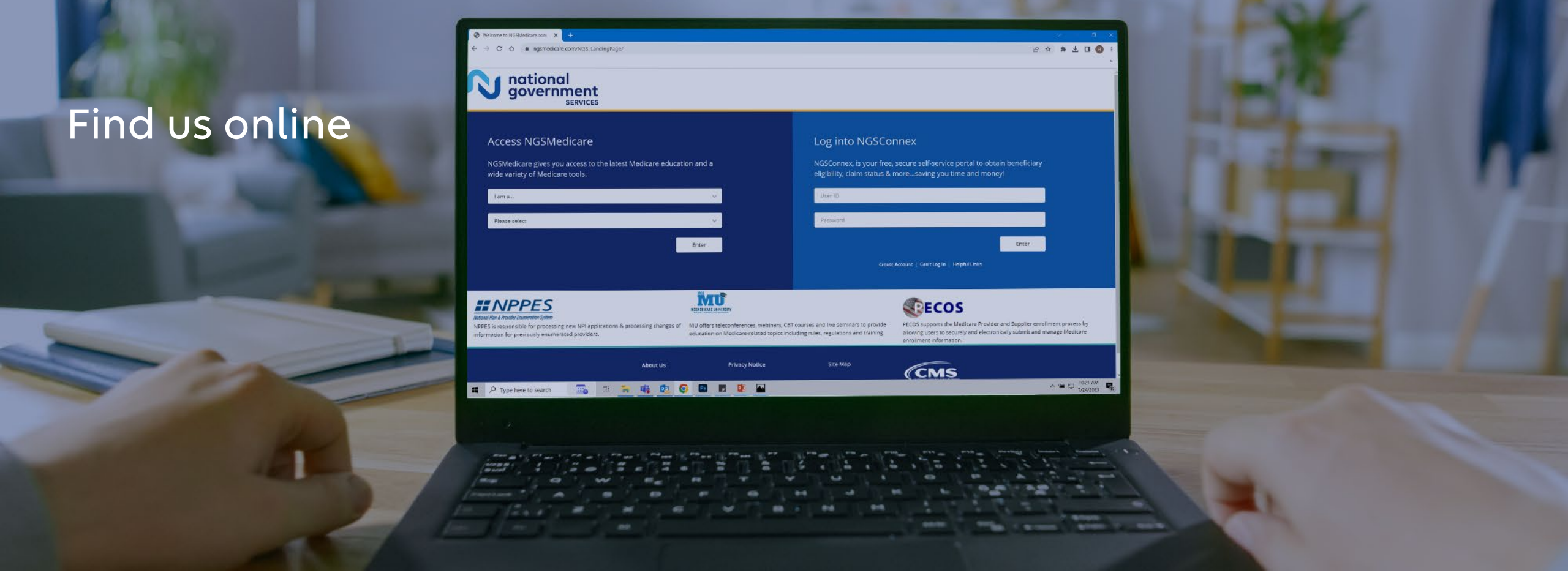

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