CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2642	**Date: January 31, 2013**
	Change Request 8142

SUBJECT: Hospice Monthly Billing Requirement

I. SUMMARY OF CHANGES: This instruction implements system edits to return hospice claims to the provider when submitting more than one claim per month per beneficiary or when submitting claims spanning more than one calendar month.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/ 90 / Frequency of Billing and Same Day Billing

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	**Transmittal: 2642**	**Date: January 31, 2013**	**Change Request: 8142**

SUBJECT: Hospice Monthly Billing Requirement

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: Hospices are subject to the repetitive billing requirements as provided in the Centers for Medicare & Medicaid Services (CMS) Publication 100-04, Chapter 1, Section 50.2.2. This requirement was further clarified in the CMS Publication 100-04, Chapter 11, Section 90 requiring that hospice providers conform to calendar month billing. This instruction enforces the calendar month billing requirement and establishes standard system edits to return claims to hospice providers when more than one claim per beneficiary is received in a single month. The only exception to this processing requirement is if the beneficiary was discharged or revoked from the hospice election and later re-elected the benefit during the same month.

B. Policy: No change in existing policy.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8142.1	Medicare contractors shall return to provider (RTP) hospice claims, type of bill 81x or 82x (excluding frequency codes A-E) with dates of service on or after July 1, 2013, when there is a patient status code 30 and the thru date on the claim does not equal the last day of the billing period month.	X					X	X				
8142.2	Medicare contractors shall return to provider (RTP) hospice claims, type of bill 81x or 82x (excluding frequency codes A-E) with dates of service on or after July 1, 2013, when the claim from and thru dates span multiple months.	X					X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8142.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X					X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Tucker, wendy.tucker@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

90 - Frequency of Billing and Same Day Billing

(Rev.2642, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing *must* conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months. *Hospices submitting more than one claim in a calendar month for the same beneficiary will have claims returned beginning on dates of service July 1, 2013. The only exception to this requirement is in the case of the beneficiary being discharged or revoking the benefit and then later re-electing the benefit during the same month. The monthly billing requirement applies even if the patient is discharged, revokes, or expires on the first of the next calendar month. For example, if a patient is admitted to hospice on August 8th and revokes the benefit on September 1st, the hospice must submit two claims. A claim is submitted for dates of service August 8 to August 31and a separate claim is submitted with dates of service September 1 to September 1.*

Hospice claims should not span multiple months. Any hospice claim spanning multiple months will be returned to the provider for correction.

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