CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2748	**Date: July 26 2013**
	Change Request 8371

SUBJECT: Demand Billing of Hospice General Inpatient Level of Care

I. SUMMARY OF CHANGES: Provides instructions for hospice demand bills when general inpatient care (GIP) is denied and the routine home care rate is applicable.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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
N	11/ 100.2 – Demand Billing for Hospice General Inpatient Care

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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: 2748	Date: July 26, 2013	Change Request: 8371

SUBJECT: Demand Billing of Hospice General Inpatient Level of Care

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by the hospice to Medicare beneficiaries in situations where Medicare payment is expected to be denied. ABN issuance is mandatory when the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C). When a Medicare hospice beneficiary has been receiving covered general inpatient care (GIP) and the hospice determines that continued hospice GIP care is not reasonable and medically necessary, the provider must issue an ABN if the beneficiary wants to continue receiving the level of hospice care that likely won't be covered by Medicare. The beneficiary may indicate on the ABN that Medicare be billed for a determination. Billing instructions for demand bills associated with ABN issuance are provided in CMS Publication 100-4 Claims Processing Manual, Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32). The occurrence code 32 is reported on the claim with the date the ABN was provided to the beneficiary. The services in question are submitted as covered services and when billing for both ABN related and non-ABN related services, the hospice appends the GA modifier to the line item(s) related to the ABN. Hospices should be aware Medicare may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN.

Medicare contractors reviewing GIP reported on a hospice claim with an ABN provided may conclude the care is not reasonable and medically necessary. When the Medicare contractor makes the non-coverage determination, they must non-cover the line item(s) on the claim. However, since hospices may be paid the routine home care (RHC) rate in lieu of the denied GIP service, the Medicare contractor must also add a line item for RHC (revenue code 0651) for each denied GIP line. The charges associated with the added RHC line should be the RHC rate the hospice reports on their claim or in the absence of hospice submitted RHC line items, the Medicare contractor shall enter the RHC base rate. Medicare systems shall allow a hospice claim with GIP and RHC reported with the same line item date of service when at least one of the line items is non-covered. Both line items may not be covered.

B. Policy: No change in policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8371.1	Medicare contractors shall allow a hospice claim (type of bill 81x, 82x) with revenue code 0656 and 0651 reported with the same line item date of			X				X	X				

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	service when at least one of the line items is non-covered.												
8371.2	Medicare contractors shall add a covered RHC line for each denied GIP line item denied when an ABN was provided: 1. RHC Revenue code 0651 2. Charges associated with the added RHC line shall be the charges associated with RHC reported by the hospice on their claim or in the absence of hospice submitted RHC line items, the contractor shall enter the RHC base rate.			X				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8371.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

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

V. CONTACTS

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

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), and/or Carriers:
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.

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims

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(Rev.2748, Issued: 07-26-13)

100 - Billing for Hospice Denials

(Rev. 2748, Issued: 07-26-13, Effective: 01-01-14, Implementation: 01-06- 14)

100.2 – Demand Billing for Hospice General Inpatient Care

The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by the hospice to Medicare beneficiaries in situations where Medicare payment is expected to be denied. ABN issuance is mandatory when the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C). When a Medicare hospice beneficiary has been receiving covered general inpatient care (GIP) and the hospice determines that continued hospice GIP care is not reasonable and medically necessary, the provider must issue an ABN. Billing instructions for demand bills associated with ABN issuance are provided in this manual in Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32).

Hospices should be aware Medicare may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN. Medicare contractors reviewing GIP reported on a hospice claim with an ABN provided may conclude the care is not reasonable and medically necessary. When the Medicare contractor makes the non-coverage determination, they must non-cover the GIP line item(s) on the claim. Hospices may be paid the routine home care (RHC) rate in lieu of the denied GIP service. The Medicare contractor adds a line item for RHC (revenue code 0651) for each denied GIP line. The charges associated with the added RHC line should be the RHC charges the hospice reports on their claim or in the absence of a hospice submitted RHC line item, the contractor shall enter the applicable RHC base rate.

These instructions are not applicable when the beneficiary is not questioning the Medicare coverage but needs a Medicare denial for a secondary payer. In those cases, the provider should submit a non-covered claim with the condition code 21.