CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 471	**Date: April 24, 2009**
	Change Request 6386

SUBJECT: Revision to Processing Hospice Visit Charges on Remittance Advices and Medicare Summary Notices (MSNs)

I. SUMMARY OF CHANGES: Hospice visit charges that are covered in the hospice bundled payment are showing on the remittance advice and MSN as non-covered. To reduce confusion, improper secondary payments and unnecessary appeals by beneficiaries, CMS will process these charges as covered on the remittance advice and MSN.

EFFECTIVE DATE: **October 1, 2009**
IMPLEMENTATION DATE: **October 5, 2009**

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/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within 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 does 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.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 471	Date: April 22, 2009	Change Request: 6386

SUBJECT: Revision to Processing Hospice Visit Charges on Remittance Advices and Medicare Summary Notices (MSNs)

EFFECTIVE DATE: October 1, 2009

IMPLEMENTATION DATE: October 5, 2009

I. GENERAL INFORMATION

A. Background: Change Request 5567, Transmittal 1494 issued on April 29, 2008 entitled "Reporting of Additional Data to Describe Services on Hospice Claims" provided the requirement for hospice providers to report the number of nursing, aides, and social worker visits on the claim. The charges associated with those visits are being processed as non-covered by Medicare systems with the remittance advice code 97 "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." However, some secondary payers have made inappropriate payment for these visits.

In addition, there has also been some confusion regarding these charges appearing as non-covered on the beneficiary Medicare Summary Notice, resulting in some beneficiaries requesting an appeal of the non-covered charges. These charges are not reflected on the MSN in the "You May Be Billed" column. There is no beneficiary liability for these charges and therefore, no appeal is necessary.

Charges associated with the reported visits are covered under the hospice bundled payment, and reflected in the payment for the level of care billed on the claim. No separate or additional payment is made for the charges reported on the revenue lines reflecting visits. However, to minimize confusion for these charges Medicare will change the outcome of processing these charges to reflect as covered on the remittance advice notice and the MSN. The claim will continue to make no additional payment for these charges, and the remittance advice notice will continue to show these charges as provider liable.

B. Policy: No change in existing policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6386.1	For bill types 81x, 82x Medicare systems shall show charges and units associated with each 55X, 56X or 57X revenue code as covered.						X				
6386.2	Medicare contractors shall continue to ensure that no payment is made on 55X, 56X or 57X revenue code lines.	X				X	X				

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6386.3	Medicare contractors shall ensure that bundling of services into level of care revenue codes are reflected on the remittance advice with reason codes 97 and CO (contractual obligation).	X				X	X				
6386.4	Medicare contractors shall ensure that these charges are crossed over to trading partners with the liability assigned to the provider.	X				X	X				
6386.5	Medicare contractors shall ensure that the MSN reflects the following message: 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X				X	X				
6386.6	Medicare contractors shall ensure that the MSN does not include these visit charges in the "You May Be Billed" column.	X				X	X				

III. PROVIDER EDUCATION TABLE

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6386.7	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 site 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 your 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: For any recommendations and supporting information associated with listed requirements, use the box below:

"Should" denotes a recommendation.

X-REF REQUIREMENT NUMBER	RECOMMENDATIONS OR OTHER SUPPORTING INFORMATION:
6386.4	Medicare contractors should ensure that the remark code CO (contractual obligation) is both at the line level and claim level when crossing over the claim data to supplemental payers.

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Wendy.Tucker@cms.hhs.gov, 410-786-3004 or Wilfried.Gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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 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.