CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1032	**Date: January 26, 2012**
	Change Request 7675

SUBJECT: Revisions to the Hospice Medicare Summary Notice (MSN)

I. SUMMARY OF CHANGES: Revising the Medicare Summary Notice for hospice services to accurately reflect the description of services reported and correct the total charges reported for the claim.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

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:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within 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 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: 1032	Date: January 26, 2012	Change Request: 7675

SUBJECT: Revisions to the Hospice Medicare Summary Notice (MSN)

Effective Date: **July 1, 2012**

Implementation Date: July 2, 2012

I. GENERAL INFORMATION

A. Background: In recent years, the Centers for Medicare & Medicaid Services (CMS) have added new reporting requirements for visit data on hospice claims. Expanding the information on the hospice claim record was necessary to better understand the services provided under the Medicare hospice benefit. However, this new data as it appears on the MSN has caused some confusion for Medicare beneficiaries receiving the services. Since the visit charges are covered as part of the level of care per diem, itemizing the individual visit charges and including those charges in the claim total amount has incorrectly inflated the total claim charges. In addition, the current hospice MSN shows the Healthcare Common Procedure Coding System (HCPCS) line level description but does not report the units associated with the visit; this also results in confusing data on the notice.

In reviewing various MSNs, CMS has determined that a method similar to the home health MSNs would more accurately reflect the claim data. The home health MSN rolls up like visit lines to one line item and reports the number of lines (i.e. number of visits). In addition, the home health MSN shows the revenue code description instead of the HCPCS description. The revenue code description is a more concise description of the service and will better fit the space limitations of the MSN.

In an effort to make the hospice MSN more accurately reflect the claim data, CMS is implementing the following changes to the hospice MSNs (example below):

1. Use the revenue code description for the level of care lines and the visit lines.
2. Show the level of care lines with the visits associated for each level of care directly below.
3. Bold the font on the level of care line.
4. Roll up the visit lines with the same revenue code / HCPCS onto one line with the number of lines (i.e. number of visits) preceding the revenue code description for the visit.
5. Indent the visit lines under the level of care line and do not bold the font on the visit lines.
6. Suppress the visit charges because they are included in the level of care charges.
7. Display a new MSN message on visit charge lines as follows: "Payment for this hospice service is included in the payment for the hospice daily level of care; therefore, you should not be billed for this service".
8. Do not include visit charges in the total claim charges on the MSN.

Note: There is no change related to the displaying of the hospice physician services on the MSN.

Example:

20	**Routine Home Care**	**$2000.00**	
	5 Skilled Nursing Visit		b
	6 Medical Social Visit		b

1	**Continuous Home Care**	**$ 600.00**
	1 Skilled Nursing Visit	b
	1 Medical Social Visit	b
Claim Total		**$2600.00**

b. Payment for this hospice service is included in the payment for the hospice daily level of care. You shouldn't be billed for this s service.

B. Policy: No change in existing policy.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7675.1	Medicare systems shall display the revenue code description for level of care and visits lines on the hospice MSN for bill types 81X and 82X. Note: Level of care revenue codes: 0651, 0652, 0655, 0656. Visit revenue codes: 042x, 043x, 044x, 055x, 056x, 057x.						X				
7675.1.1	Medicare systems shall not display the HCPCS description for the level of care and visits, but continue to show HCPCS description for the physician services reported with revenue code 0657.						X				
7675.2	Medicare systems shall roll up the visit lines with the same revenue code / HCPCS onto one line with the number of lines (i.e. number of visits) preceding the revenue code description for the visit directly under the associated level of care. Note: For grouping on the MSN, visits with line item dates of service on or after a level of care date of service shall be considered part of that level of care until the date of service for a subsequent level of care is reported. (See visit codes above).						X				
7675.3	Medicare systems shall bold the font on the level of care line.						X				
7675.4	Medicare systems shall indent the visit lines under the level of care line and do not bold the font on the visit lines.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7675.5	Medicare systems shall suppress the visit charges from the MSN.						X				
7675.6	Medicare systems shall not include visit charges in the total claim charges on the MSN.						X				
7675.7	Medicare systems shall display the new MSN message 27.21 on visit charge lines as follows: "Payment for this hospice service is included in the payment for the hospice daily level of care. You shouldn't be billed for this service". Spanish Translation: "El pago por este servicio de cuidado paliativo está incluido en el pago de cuidado diario a nivel de hospicio. No se le debe cobrar por este servicio".						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7675.8	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					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

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

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

V. CONTACTS

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

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

VI. FUNDING

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