



## Hospice Cap Calculations Letters and Administrative Appeals – JA6400

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Date Job Aid Revised: April 14, 2009

Effective Date: July 1, 2006

Implementation Date: July 6, 2009

**Key Words** MM6400, CR6400, R1708CP, Appeals, Hospice, Cap, Calculations, Letters

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Fiscal Intermediaries (FIs)
- Regional Home Health Intermediaries (RHHIs)

**Provider Types Affected** Hospice providers submitting claims to FIs, A/B MACs, and/or RHHIs for services provided to Medicare beneficiaries



Change Request (CR) 6400 requires Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap.

### Letter of Determination of Program Reimbursement

**Provider Needs to Know...**

- The letter will include the inpatient and aggregate cap calculation results.
- Additionally, it will include appeals language in every determination of program reimbursement letter.
- If a provider has exceeded the cap, the letter will include a demand for repayment.

### Important Information

- The latest hospice cap amount for the cap year ending October 31, 2008 is \$22,386.15.

- The Medicare contractor (RHHI, FI, or AB MAC) will issue a letter to providers to notify them of the results of the contractor's cap calculations and to serve as their determination of program reimbursement.
- If there is a cap overpayment, there will be an accompanying demand for repayment.

**Administrative Appeals**

- As indicated in Section 418.311 of 42 Code of Federal Regulations, if providers believe that their payments have not been properly determined, they may request a review from the applicable contractor if the amount in controversy is \$1,000 or more, but less than \$10,000, or from the Provider Reimbursement Review Board if the amount in controversy is \$10,000 or more.
- Appeal requests must be in writing and be filed within 180 days from the date of the determination.
- Appeal rights are discussed further in the *Medicare Claims Processing Manual* (Chapter 11 - Processing Hospice Claims, Section 80.3), which is attached to CR6400.

**Background**

- The law governing payment for hospice care subjects hospice payments to two statutory caps:
  - A cap on payments for inpatient days, described in Section 1861(dd)(2)(A)(iii) of the Social Security Act; and
  - An aggregate cap on total payments, described in Section 1814(i)(2)(A)-(C).
- The Centers for Medicare and Medicaid Services (CMS) is requiring Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap.

Operational Impact      N/A

**Reference Materials**

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6400.pdf> on the CMS website.

The official instruction (CR6400) issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1708CP.pdf> on the CMS website.

The hospice cap is discussed further in the *Medicare Claims Processing Manual* (Chapter 11 - Processing Hospice Claims, Section 80.2) which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the CMS website.