



News Flash – Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor website and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for “listserv” or “e-mail list” to find the registration page. If you do not know the Web address of your contractor’s homepage, it is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

MLN Matters Number: MM6400

Related Change Request (CR) #: 6400

Related CR Release Date: April 3, 2009

Effective Date: July 1, 2009

Related CR Transmittal #: R1708CP

Implementation Date: July 6, 2009

Note: This article was updated on December 20, 2012, to reflect current Web addresses. All other information remains unchanged.

Hospice Cap Calculations Letters and Administrative Appeals

Provider Types Affected

Hospice providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6400 which 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. The letter you receive will include the inpatient and aggregate cap calculation results. Additionally, it will include appeals language in every determination of

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program reimbursement letter. If you have exceeded the cap, the letter will include a demand for repayment.

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).

These statutory caps limit total hospice payments during a cap year. Payments in excess of either cap must be refunded. Currently, after the end of the cap year, the applicable contractor (RHHI, FI, or A/B MAC) computes both cap amounts, and determines the amount of program reimbursement for each hospice provider they serve.

Important Information:

The latest hospice cap amount for the cap year ending October 31, 2008 is \$22,386.15. 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.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf> on the Centers for Medicare & Medicaid Services website. Your contractor (RHHI, FI, or AB MAC) will issue a letter to notify you of the results of the contractor's cap calculations and to serve as your 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 CFR, if you believe that your payments have not been properly determined, you 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 (PRRB) 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. Your appeal rights are discussed further in the Medicare Claims Processing Manual (Chapter 11 - Processing Hospice Claims, Section 80.3), which is attached to CR 6400.

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Additional Information

The official instruction, CR 6400, issued to your RHHI, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1708CP.pdf> on the CMS website.

If you have any questions, please contact your RHHI, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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