CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1708	**Date: APRIL 3, 2009**
	Change Request 6400

Subject: Hospice Cap Calculations Letters and Administrative Appeals

I. SUMMARY OF CHANGES: Add subsection 80.3, which describes the hospice administrative appeals process.

NEW / REVISED MATERIAL
EFFECTIVE DATE: July 1, 2009
IMPLEMENTATION DATE: July 6, 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	11/80.3 / Administrative Appeals

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:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1708	Date: April 3, 2009	Change Request: 6400

SUBJECT: Hospice Cap Calculations Letters and Administrative Appeals

Effective Date: July 1, 2009

Implementation Date: July 6, 2009

I. GENERAL INFORMATION

A. Background: The law governing payment for hospice care subjects hospice payments to two statutory caps: a cap on payments for inpatient days, described in §1861(dd)(2)(A)(iii) of the Social Security Act, and an aggregate cap on total payments, described in §1814(i)(2)(A)-(C). Total hospice payments during a cap year are limited by these statutory caps. Payments in excess of either cap must be refunded by the hospice. 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. The contractor then issues a demand letter for the overpayments.

B. Policy: In accordance with CMS regulations, the contractor must notify each hospice provider in writing of the cap determinations for the cap year, regardless of whether or not the hospice has exceeded either cap. The contractor shall issue a letter to notify hospice providers of the results of the contractor's cap calculations and to serve as the provider's determination of program reimbursement. If there is a cap overpayment, there shall be an accompanying demand for repayment. Each determination of program reimbursement shall include language describing the provider's appeal rights. Pursuant to 42 CFR §418.311 and 42 CFR part 405 subpart R, if a hospice believes that either of its cap amounts has not been properly determined, or that its payments have not been properly determined, or if the hospice is otherwise dissatisfied with the determination of program reimbursement, the hospice may file for review by the contractor or by the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. If the amount in controversy is $1,000 or more, but less than $10,000, the provider may request a review from the applicable contractor. If the amount in controversy is $10,000 or more, the provider may request a review from the Provider Reimbursement Review Board (PRRB). Appeal requests must be in writing and be filed within 180 days of the date of the determination of program reimbursement. See 42 CFR §418.311 and 42 CFR part 405 subpart R.

The above described letter, serving as the provider's determination of program reimbursement, shall include the following language:

> "This notice is the contractor's final determination for purposes of appeals rights. If you disagree with this determination, you may file an appeal, in accordance with 42 CFR § 418.311 and 42 CFR part 405, subpart R. The appeal should be filed with either the applicable contractor (FI, RHHI, or A/B MAC) or the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Appeal requests must be in writing and be filed within 180 days from the date of this determination."

The Medicare policy related to the caps on hospice payments is currently available in the Internet Only Manuals (IOM), Medicare Claims Processing Manual, Pub. 100-04, Chapter 11, section 80. This manual is available on-line at http://www.cms.hhs.gov/center/hospice.asp, under the "CMS Manuals and Transmittals" section.

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	
6400.1	Medicare contractors shall send each of their providers a determination of program reimbursement showing the results of that provider's inpatient and aggregate cap calculations, regardless of whether or not the provider exceeded the inpatient or the aggregate cap.	**X**		**X**		**X**					
6400.2	Medicare contractors shall include appeals language in every determination of program reimbursement.	**X**		**X**		**X**					
6400.3	For each provider who has exceeded either cap, Medicare contractors shall include a demand for repayment in the determination of program reimbursement.	**X**		**X**		**X**					
6400.4	The contractor shall include the following appeals language in every determination of program reimbursement: "This notice is the contractor's final determination for purposes of appeals rights. If you disagree with this determination, you may file an appeal, in accordance with 42 CFR § 418.311 and 42 CFR part 405, subpart R. The appeal should be filed with either the applicable contractor (FI, RHHI, or A/B MAC) or the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Appeal requests must be in writing and be filed within 180 days from the date of this determination."	**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	
6400.5	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**		**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: None

V. CONTACTS

Pre-Implementation Contact(s): Payment Policy: Katie Lucas, katherine.lucas@cms.hhs.gov; or Office of Financial Management: Lisa Williams, lisa.williams@cms.hhs.gov.

Post-Implementation Contact(s): Payment Policy: Katie Lucas, katherine.lucas@cms.hhs.gov; or Office of Financial Management: Lisa Williams, lisa.williams@cms.hhs.gov.

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)*:

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.

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

Table of Contents

(Rev. 1708, 04-03-09)

80.3 – Administrative Appeals

(Rev.1708; Issued: 04-03-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

The applicable contractor (RHHI, FI, or AB MAC) shall issue a letter to notify hospice providers of the results of the contractor's cap calculations and to serve as the provider's determination of program reimbursement. If there is a cap overpayment, there shall be an accompanying demand for repayment. As indicated in section 418.311 of 42 CFR, a hospice that believes that its payments have not been properly determined may request a review from the applicable contractor or the Provider Reimbursement Review Board (PRRB). Each determination of program reimbursement shall include language describing the provider's appeal rights.

> *The above described letter, serving as the provider's determination of program reimbursement, shall include the following language:*
>
> *"This notice is the contractor's final determination for purposes of appeals rights. If you disagree with this determination, you may file an appeal, in accordance with 42 CFR 418.311 and 42 CFR, part 405, subpart R. The appeal should be filed with either the applicable contractor (FI, RHHI, or A/B MAC) or the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Appeal requests must be in writing and be filed within 180 days from the date of this determination."*