CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13446	**Date: November 20, 2025**
	Change Request 14219

SUBJECT: Editing for Hospital Services Provided to Hospice Enrollees

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prevent duplicate payments for services provided by acute-care hospitals to hospice enrollees. Office of Inspector General (OIG) Audit: A-09-23-03024, reports that Medicare improperly paid acute-care hospitals an estimated $190 million over 5 years for outpatient services provided to hospice enrollees.

EFFECTIVE DATE: April 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2026

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	N/A

III. FUNDING:
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

Attachment - One-Time Notification

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II. GENERAL INFORMATION

A. Background: The OIG conducted an audit of Medicare Part B claims for outpatient services that acute-care hospitals provided to hospice enrollees and found that Medicare improperly paid an estimated $190 million over 5 years for outpatient services to these hospitals for services that were related to the hospice enrollee's terminal illness and related conditions. These services were already covered as part of the hospice per diem payments and should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals. The acute-care hospitals improperly billed Medicare using condition code 07 on their outpatient claims, indicating that the outpatient services were not related to the enrollees' terminal illnesses and related conditions.

CMS will enhance the current systems' edits to help reduce improper payments for services provided by acute-care hospitals to hospice enrollees. This CR will create a new edit to automatically compare the primary diagnosis codes on hospital inpatient and hospital outpatient claims with the hospice claim's primary diagnosis codes, by doing an exact match of diagnoses. The edit will deny hospital inpatient claims and hospital outpatient claims when there is a hospice claim for the same Medicare beneficiary within the same covered period with condition code 07 with same primary diagnosis.

B. Policy: N/A

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14219.1	The contractor shall reject hospital inpatient claims when there is a hospice claim for the same Medicare beneficiary within the same covered period, when the following conditions exist: • There is a current hospital inpatient claim,	X							X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Type of Bill (TOB) 11x with Dates of Service (DOS) on or after the implementation date of this CR; • AND the hospital inpatient claim does not contain a no-pay code; • AND there is a hospice claim, TOB 81x OR 82x in history; • AND the Medicare Beneficiary Number (MBI) is the same for both claims; • AND the covered period from and through dates of the hospital inpatient claim overlaps the covered period from and through dates of the hospice claim; • AND the hospital inpatient claim has a condition code "07"; • AND the primary diagnosis code on the hospital inpatient claim is an exact match as the primary diagnosis code on hospice claim If the TOB 11x Admit date equals the Through date of the hospice claim (TOB 81x or 82x) or if the Discharge date of TOB 11x equals the From date of the hospice claim (TOB 81x or 82x), then bypass the edit.									
14219.2	The contractor shall reject hospital outpatient claims when there is a hospice claim for the same Medicare beneficiary within the same covered period, when the following conditions exist: • There is a current hospital outpatient claim, TOB 12x or 13x	X							X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	with DOS on or after the implementation date of this CR; • AND the hospital outpatient claim does not contain a no-pay code; • AND there is a hospice claim, TOB 81x OR 82x in history; • AND the MBI is the same for both claims; • AND the covered period from and through dates of the hospital outpatient claim overlaps the covered period from and through dates of the hospice claim; • AND the hospital outpatient claim has condition code "07"; • AND the primary diagnosis code on the hospital outpatient claim is an exact match as the primary diagnosis code on hospice claim If the TOB 12x or 13x Admit date equals the Through date of the hospice claim (TOB 81x or 82x) or if the Discharge date of TOB 12x or 13x equals the From date of the hospice claim (TOB 81x or 82x), then bypass the edit.									
14219.3	The contractor shall generate an Informational Unsolicited Response (IUR) for the hospital inpatient claims in history, when there is a hospice claim for the same Medicare beneficiary within the same covered period, when the following conditions exist: • There is a current hospice claim, TOB 81x								X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	OR TOB 82x with DOS on or after the implementation date of this CR; • AND there is a hospital inpatient claim, TOB 11x, in history; • AND the hospital inpatient claim does not contain a no-pay code; • AND the MBI is the same for both claims; • AND the covered period from and through dates of the hospital inpatient claim overlaps the covered period from and through dates of the hospice claim; • AND the hospital inpatient claim has a condition code "07"; • AND the primary diagnosis code on the hospital inpatient claim is an exact match as the primary diagnosis code on hospice claim. If the TOB 11x Admit date equals the Through date of the hospice claim (TOB 81x or 82x) or if the Discharge date of TOB 11x equals the From date of the hospice claim (TOB 81x or 82x), then bypass the edit.									
14219.4	The contractor shall generate an IUR for the hospital outpatient claims in history, when there is a hospice claim for the same Medicare beneficiary within the same covered period, when the following conditions exist: • There is a current hospice claim, TOB 81x OR TOB 82x with DOS on or after the implementation date of this CR;								X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• AND there is a hospital outpatient claim, TOB 12x OR 13x, in history; • AND the hospital outpatient claim does not contain a no-pay code; • AND the MBI is the same for both claims; • AND the covered period from and through dates of the hospital outpatient claim overlaps the covered period from and through dates of the hospice claim; • AND the hospital outpatient claim has condition code "07"; • AND the primary diagnosis code on the hospital outpatient claim is an exact match as the primary diagnosis code on hospice claim If the TOB 12x OR 13x Admit date equals the Through date of the hospice claim (TOB 81x or 82x) or if the Discharge date of TOB 12x OR 13x equals the From date of the hospice claim (TOB 81x or 82x), then bypass the edit.									
14219.5	Upon receipt of the IUR, the contractor shall adjust the claim to non-covered and use N as no-pay code.					X				
14219.6	In the limited instances (e.g., as the result of an appeal or reopening) where payment is appropriate, the Part A MAC shall have the capability to override the edit.	X				X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14219.7	The contractor shall process the rejected claims with the following messages: Claim Adjustment Reason Code (CARC) B9 - Patient is enrolled in a Hospice Group Code – Contractual Obligation (CO) Medicare Summary Notice Message - 16.29 English - Payment is included in another service you have received. Spanish -El pago fue incluido en otro servicio que usted recibió.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B, A/B MAC Part HHH

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0