CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2014	**Date: January 26, 2018**
	Change Request 10180

SUBJECT: Identifying Prior Hospice Days When Calculating Hospice Routine Home Care Payments After a Transfer

I. SUMMARY OF CHANGES: This Change Request (CR) corrects the number of days used to determine the 60 days of high Routine Home Care payments on hospice claims. It ensures the count include the days provided by another hospice when there is a transfer during a benefit period.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018

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

Pub. 100-20	Transmittal: 2014	Date: January 26, 2018	Change Request: 10180

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EFFECTIVE DATE: January 1, 2016
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I. GENERAL INFORMATION

A. Background: Medicare pays a higher rate for hospice services at the routine home care (RHC) level of care for the first 60 days of service. These 60 days are counted on a beneficiary level across any hospice benefit periods that are not separated by a 60 day gap. The number of prior service days cannot be identified in all cases by the Fiscal Intermediary Shared System (FISS) from the face of the claim. The Common Working File (CWF) must read data from services provided at other hospices and return additional days that apply to the payment calculation to FISS.

To date, Medicare has instructed CWF to identify prior service days based on prior benefit periods. This overlooks the possibility that service days may have occurred at another provider prior to a transfer within the same benefit period. When a transfer occurs during a benefit period, the admitting (second) hospice submits a transfer notice (TOB 08xC) which establishes the second hospice's start date (START DATE 2) on the benefit period record in CWF. When the second hospice bills for services, the days between the original start date of the current benefit period (START DATE 1) and the second hospice's start date (START DATE 2) should be included in the prior service days used in RHC payment calculations.

Currently, Medicare has instructed hospices to account for this by reporting the benefit period start date as the admission date on their claim in the case of transfers. While this workaround results in correct payments, it requires the hospice to submit misleading information and cannot serve as a permanent solution. The requirements below instruct CWF to identify prior days correctly in transfer situations, so hospices no longer need to use this workaround.

B. Policy: This CR contains no new policy. It corrects the implementation of existing hospice payment policy.

II. 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	
10180.1	When Pricer return code 75 or 77 indicates a high RHC rate was applicable to the claim, the contractor shall reject the claim if a transfer has occurred during the current benefit period (START DATE 2 is present and not the result of a change of ownership) and no prior hospice benefit periods are within 60 days.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The contractor shall use the same overrideable edit used when prior benefit period days are identified.									
10180.1.1	When rejecting the claim, the contractor shall return the original start date (START DATE 1).								X	
10180.1.2	When rejecting the claim, the contractor shall return the number of days between the current benefit period's original start date (START DATE 1) and the date of the transfer (START DATE 2).								X	
10180.2	When rejecting a hospice claim because Pricer return code 75 or 77 is present and a prior benefit period is identified within 60 days, the contractor shall identify whether a transfer has occurred during the current benefit period.								X	
10180.2.1	If a transfer is identified, the contractor shall add the number of days between the current benefit period's original start date (START DATE 1) and the date of the transfer (START DATE 2 that is not the result of a change of ownership) to the days found in prior benefit periods when rejecting the claim. **NOTE**: The prior benefit period start date that is returned should not change. If 100 or more days are accumulated, the total number of days returned shall continue to be 99.								X	
10180.3	The contractor shall notify hospices to no longer report the benefit period start date as their admission date in transfer situations on or after the implementation date.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10180.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	availability of the article. In addition, the provider education article shall be included in the contractor's 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.					

IV. 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:
10180.1, 10180.2	The CWF edit is 5196.

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

V. CONTACTS

Pre-Implementation Contact(s): Charles Nixon, charles.nixon@cms.hhs.gov, Wil Gehne, wilfried.gehne@cms.hhs.gov.

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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