CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11280	**Date: February 25, 2022**
	Change Request 12619

Transmittal 11258, dated February 10, 2022, is being rescinded and replaced by Transmittal 11280, dated, February 25, 2022 to revise section 20.1.3 of the manual instruction to change the use of "sub-unit" to "another location". All other information remains the same.

SUBJECT: Gap Billing Between Hospice Transfers

I. SUMMARY OF CHANGES: This change request is creating system edits to prevent gap billing between hospice transfers. Currently, there is no mechanism in place to prevent gap billing. Since hospice transfers must occur on the same day, there cannot be a break in hospice care or a gap in billing.

EFFECTIVE DATE: July 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2022

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
R	11/20.1.3/Change of Provider/Transfer Notice

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11280	Date: February 25, 2022	Change Request: 12619

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SUBJECT: Gap Billing Between Hospice Transfers

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I. GENERAL INFORMATION

A. Background: The hospice regulations at 42 Code of Federal Regulations (CFR) 418.24(d) define the duration of a hospice election to mean an election that continues through the initial election period and through the subsequent election periods without a break in care as long as the individual: (1) Remains in the care of a hospice; (2) Does not revoke the election; and (3) Is not discharged from the hospice under the provisions of §418.26. Additionally, the regulations at §418.30 allow an individual or representative to change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not considered a revocation of the election, but is a transfer. Section 418.30(c) requires that, when changing the designation of hospice programs, such as in a transfer situation, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

(1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

(2) The date the change is to be effective.

Therefore, in order for the election to remain enforced during a transfer, as required under §418.24(d), there cannot be a break in care. This means that there is always a hospice billing for hospice days during the duration of a hospice election, even in a transfer situation. As such, there cannot be a gap in the number of billing days between the original hospice and the hospice to which a beneficiary is transferring. The regulations at §418.26(a)(1) state that an individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice -

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under § 418.24(e); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

If a patient enters another hospice after any break in care, CMS deems the patient to have been discharged and the patient would have to re-elect the benefit with the new hospice. In this scenario, discharge and re-election would trigger the start of a new election period.

Currently, transfers are being allowed to process through the Common Working File (CWF) where the "from date" from the receiving hospice does not match the "to date" from the transferring hospice, resulting in a gap in billing and indicating a gap in care. When one hospice transfers a patient to another hospice with any gap following the date of transfer as indicated on the signed statement in accordance with 418.30(c)(2), this is deemed a gap in care and therefore, would not be considered a continuous hospice election. We consider any gap, even of one day, to be a discharge and readmission rather than a transfer, and the

beneficiary would have to re-elect hospice care with the new hospice. Section 418.30(b) states that the change of the designated hospice is not a revocation of the election for the period in which it is made. A break in hospice care without an immediate transfer to another hospice alerts CMS to the possibility that the transferring hospice may have violated 42 CFR § 418.26(a), which limits the circumstances under which a hospice may discharge a live hospice patient. As noted above, pursuant to section 418.26(c)(2), a discharge without an immediate transfer also triggers resumption of Medicare benefits waived under section 418.24(d).

In an effort to prevent gap billing from occurring during a hospice transfer, this Change Request (CR) creates a new CWF edit that no longer allows gaps of care to occur during a transfer. The CWF edit will reject the hospice transfer if the transfer does not occur immediately and there is a gap in the number of billing days between one hospice and the next. If the receiving hospice's claim "from date" is not the same as the transferring hospice's "through date" with "patient status" indicating a transfer (codes 50 or 51), the transfer will be rejected. The edit will not apply to a subsequent claim, if a transfer is posted and the hospice's claim "from date" is the same as the "transfer date".

This CR will also update Pub 100-04, Chapter 11, Section 20.1.3 - Change of Provider/Transfer Notice to include additional instructions about hospice transfers.

B. Policy: This CR contains no new policy. It revises Medicare systems to administer existing hospice benefit policy more efficiently.

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	
12619.1	The contractor shall create an edit to reject hospice transfer notices (8xC) when the From Date is not equal to the posted history hospice claim's Through Date with Patient Status '50' or '51' during the same Benefit Period.								X	
12619.1.1	The contractor shall accept the new edit outlined in BR 12619.1.					X				
12619.1.2	The contractor shall Return to Provider (RTP) the hospice transfer (8xC) with the new reject for the gap involving the transfer.			X						
12619.2	The contractor shall create an edit to reject the first hospice claim following a transfer if submitted with a From Date that does not match the Start 2 date on the hospice benefit period.								X	
12619.2.1	The contractor shall accept the new edit outlined in BR 12619.2.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12619.2.2	The contractor shall RTP the incoming hospice claim following the transfer with the new reject if submitted with a From Date that does not match the Start 2 date on the hospice benefit period.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12619.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			X		

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Carla Douglas, 410-786-4799 or carla.douglas@cms.hhs.gov , Wilfried Gehne, 410-786-6148 or 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):
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.

ATTACHMENTS: 0

20.1.3 - Change of Provider/Transfer Notice

(Rev. 11280, Issued: 02-25-22, Effective: 07-01-22 , Implementation: 07-05-22)

If the beneficiary is transferred to another hospice (discharge status codes 50 or 51) the claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer notice after the transfer has occurred and the beneficiary's hospice benefit is not affected. The 8XC does not get submitted until after the other provider has finalized their billing.

NOTE: *Transfers are not allowed from the same provider. Hospices must not submit an 8XC if the CMS Certification Number (CCN) is the same. In this scenario the beneficiary is not transferred to another hospice, they are transferred to another location of the same hospice.*

A beneficiary can change hospices only once per benefit period (90-day or 60-day). When the beneficiary transfers to a different hospice, he/she continues in the same benefit period. To transfer hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

(1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

(2) The date the change is to be effective.

Given that hospices bill for the date of discharge or transfer, for claims purposes, the "From" date for the receiving hospice must be the same as the "Through" date for the transferring hospice, otherwise this would constitute a gap in care and a gap in billing and would not be considered a transfer. For example, if a beneficiary designates that a transfer is to be effective on January 10th, the transferring hospice's "Through" date must be January 10th and the receiving hospice's "From" date must be January 10th in order to be a continuous hospice election without a gap in care or billing. That is, the transferring hospice is responsible for the beneficiary up until, and including the transfer date.

If the beneficiary is transferring from outside the service area and the transferring hospice cannot arrange care until the beneficiary reaches the new hospice, the hospice may discharge the beneficiary. This way, if the beneficiary requires medical treatment while in the process of transferring, he/she can access it under his/her traditional Medicare coverage. This would terminate the beneficiary's current benefit period and require the beneficiary to re-elect hospice coverage at the new hospice and begin a new benefit period.

The hospice transfer will be rejected if the transfer does not occur immediately. If the receiving hospice's claim "from date" is not the same as the "through date" with "patient status" indicating a transfer (codes 50 or 51), the transfer will be rejected. The edit will not apply to a subsequent claim, if a transfer is posted and the hospice's claim "from date" is the same as the "transfer date".

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

81C - Hospice (Nonhospital-Based) Change of provider
82C - Hospice (Hospital-Based) Change of provider

Statement Covers Period (From-Through)

The "From" date would be the date the change is effective. No through date is required.

Patient's Name

The patient's name is shown with the surname first, first name, and middle initial, if any.

Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

Show the month, day, and year of birth numerically as MM-DD-YYYY.

Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission Date

The hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the receiving hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the new admission date cannot be the same as the revocation or discharge date of the previous benefit period.

Show the month, day, and year numerically as MM-DD-YY.

Condition Codes

Condition codes are not required on an original transfer notice. If the hospice is correcting a date of transfer using occurrence code 56, the hospice reports condition code D0. If the two codes are not reported together, the transfer notice will be returned to the hospice.

Occurrence Codes and Dates

An occurrence code 27 is not required on a transfer notice, unless the date of transfer is also the first day of the next benefit period.

Hospices may submit a transfer notice that corrects a date of transfer previously submitted in error. In this case, the hospice reports the correct effective date of the transfer in the From Date field and reports the original, incorrect effective date using occurrence code 56. Medicare systems use the original, incorrect date to find the benefit period to be corrected, then replaces that date of transfer with the corrected information.

Release of Information

Valid values are:

I-Informed consent to release medical information for condition or diagnoses regulated by Federal Statutes

Y-Yes, provider has a signed statement permitting release of information.

Provider Number

The hospice enters their NPI.

Insured's Name

Send all NOEs with Medicare as the primary payer. Enter the beneficiary's name on line A. Show the name exactly as it appears on the beneficiary's HI card.

Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's HICN. For example, if Medicare is the primary payer, enter this information. To ensure accuracy and prevent a delay in posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Principal Diagnosis Code

CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes, which were updated annually through October 1, 2013, are posted at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

The official annual updates to ICD-10-CM and ICD-10-PCS codes are posted at http://www.cms.gov/Medicare/Coding/ICD10/index.html .

Use full diagnosis codes including all applicable digits, up to five digits for ICD-9-CM and up to seven digits for ICD-10-CM.

Attending Physician I.D.

For notice of elections effective prior to January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

The reporting requirement, optional for notice of elections effective on or after January 1, 2010, and required reporting on or after April 1, 2010, establishes that the hospice enters the NPI and name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.

Other Physician I.D.

The hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying the terminal illness. When the attending physician is also the physician certifying the terminal illness, only the attending physician is required to be reported.

NOTE: for electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

Provider Representative Signature and Date

A hospice representative must make sure the required physician's certification, and a signed hospice election statement are in the records before signing the Form CMS-1450. A stamped signature is acceptable.