CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3948	**Date: January 5, 2018**
	Change Request 10372

SUBJECT: Ensuring Correct Processing of Home Health Disaster Related Claims and Claims for Denial

I. SUMMARY OF CHANGES: This Change Request revises the edit that matches claims and assessments, creating a bypass when condition code DR is repored on the claim. It also adds a new edit to ensure the correct Type of Bill code is submitted with condition code 21 when the home health agency is billing for denial.

EFFECTIVE DATE: July 1, 2017
**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
R	10/60/No Payment Billing

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

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I. GENERAL INFORMATION

A. Background: In April 2017, original Medicare implemented Change Request (CR) 9585, which denied claims for Home Health (HH) episodes when the corresponding Outcomes and Assessment Information Set (OASIS) was due but not found by Medicare systems. This enforced Medicare's policy of OASIS as a condition of payment. When an assessment is not found, the claim was denied with reason code 37253. Subsequent instructions changed the disposition of reason code 37253 to return to provider.

In response to hurricane and wildfire events in 2017, the Secretary of the Department of Health & Human Services declared that public health emergencies existed in various States and authorized waivers and modifications under §1135 of the Social Security Act. Under one of these waivers, the OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved Home Health Agencies (HHAs) serving qualified home health patients/evacuees in the affected areas. When submitting claims for episodes to which this waiver applies, HHAs use the DR condition code to indicate Medicare payment is conditioned on the presence of a "formal waiver," in accordance with CR 6451.

Currently, the logic for reason code 37253 does not include a bypass for condition code DR. As a result, HH claims suspended to determine the appropriateness of condition code DR and then released for processing would be returned to provider in error unless the contractor takes additional manual actions. The requirements below add a bypass for condition code DR to this reason code, so the manual workload will no longer be necessary.

Another of the waivers allows contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies. Earlier this year, contractors were provided with a utility to extend these dates. The requirements below ensure this utility is reusable and available for any future emergencies, so system maintainer action is not needed on an ad hoc basis and contractors can implement extensions based on future Technical Direction Letters.

Additionally, during research of other problems related to the claims-OASIS match, contractors reported HH claims with condition code 21 (billing for denial) that were sent to the matching process unnecessarily. This occurred because the condition code 21 claims were submitted with the wrong Type of Bill (TOB). To prevent this, the requirements below create a new edit in Medicare systems to ensure that condition code 21 may only be reported on HH claims with TOB 0320, consistent with longstanding instructions in the Medicare Claims Processing Manual.

B. Policy: This CR contains no new policy. It improves the implementation of existing policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility

		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10372.1	The contractor shall allow home health claims (TOB 032x) to continue to process when no corresponding OASIS assessment is found if condition code DR is present on the claim.					X				
10372.2	The contractor shall provide a reusable process to extend the auto-cancel date on the HRAP file for Home Health RAPs (TOB 322), when requested by providers, in the event of a state of an emergency and/or natural disaster.					X				
10372.2.1	The contractor shall ensure the reusable process contains the following features: • ability to specify the number of days the auto-cancellation date is to be extended • ability to apply extensions to up to 20 State codes • ability to perform the process as frequently as daily or at any other frequency needed, without involvement of the system maintainer • ability to bypass RAPs that have already received extensions.					X				
10372.3	The contractor shall return to the provider home health claims (TOB 032x) if condition code 21 is present on the claim and the last digit of the TOB is other than '0.'			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10372.4	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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10372.1	This requirement adds a bypass condition to FISS reason code 37253.
10372.2	Since a utility for this purpose has already been created, the intent of this requirement is to ensure the existing utility is reusable by the MACs in future emergencies without FISS maintainer action.

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

V. CONTACTS

Pre-Implementation Contact(s): 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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ATTACHMENTS: 0

60 - No Payment Billing

(Rev. 3948: Issue: 01-05-18; Effective: 07-01-17; Implementation: 07-02-18)

Under HH PPS, home health agencies may seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment bills or *billings for denial notice*.

A. Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 0320, and condition code 21. *Claims with condition code 21 and any other TOB will be returned to the provider for correction.*

The statement dates on the claim should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also *submit* the charge for each line item on the claim as a non-covered charge.

In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (1AFK1) as a proxy and the following placeholder value for the OASIS Matching Key, "11AA11AA11AAAAAAAA.":

The claim must meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems also ensure that a matching RAP has not been paid for that billing period.

B. Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on the claim are non-covered.

C. Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period

In certain cases, Medicare allows the use of no payment claims in association with an ABN involving custodial care and termination of a benefit during an episode period. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there an ABN must be used assuming a triggering event occurs (i.e., the initiation of completely noncovered care). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a previous episode period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The ABN for notification of the beneficiary, and,

2. A condition code 21 no-payment claim to bill all subsequent services.