CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3629	**Date: October 27, 2016**
	Change Request 9585

SUBJECT: Denial of Home Health Payments When Required Patient Assessment Is Not Received

I. SUMMARY OF CHANGES: This Change Request automates the denial of home health prospective payment system (HH PPS) claims when the condition of payment for submitting patient assessment data has not been met.

EFFECTIVE DATE: April 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/10.1.10.3/Submission of Request for Anticipated Payment (RAP)
N	10/10.19.3/Adjustments of Episode Payment – Validation of HIPPS Codes

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: 3629	Date: October 27, 2016	Change Request: 9585

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EFFECTIVE DATE: April 1, 2017
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I. GENERAL INFORMATION

A. Background: Per the Code of Federal Regulations (CFR) at 42 CFR 484.210(e), submission of an OASIS assessment for all home health (HH) episodes of care is a condition of payment. If the OASIS is not found during medical review of an HH claim, the claim is denied. Original Medicare systems validate the Health Insurance Prospective Payment System (HIPPS) code submitted on an HH claim against the HIPPS code calculated by when the OASIS assessment is received in the Quality Improvement Evaluation System (QIES). If the codes do not match, the HIPPS code calculated from the OASIS assessment is used for payment. Currently, Medicare systems take no action on claims when the OASIS assessment is not found.

The Office of Inspector General (OIG) has recommended that Medicare strengthen its enforcement of OASIS as a condition of payment. In Medicare's response to OIG report OEI-01-10-00460, CMS stated its intention to use the claims-OASIS interface to do this. The response said, in part, "Initially, the interface will validate whether the payment group codes submitted on claims match the codes calculated from OASIS assessments. Once the initial stage is complete, the process can be expanded to include denying all claims if an OASIS assessment has not been submitted."

The initial stage was implemented in April 2015. CMS informed providers through MLN Matters Special Edition article SE1504. In that article, CMS also notified home health agencies of our next step for the process: "CMS plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release. At that time, Medicare will deny claims when a corresponding assessment is past due in the QIES but is not found in that system." This Change Request provides Medicare contractors with requirements to implement this next step.

B. Policy: Submission of an OASIS assessment is a condition of payment for HH episodes of care. OASIS reporting regulations at 42 CFR 484.20(a) require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30 day period will have elapsed by the time a 60 day episode of HH services is completed and the final claim for that episode is submitted to Medicare. If the OASIS assessment is not found in the QIES system upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9585.1	If the HIPPS code in the response information received from QIES on a home health claim is ZZZZZ, the contractor shall deny the claim if the claim receipt date is more than 40 days after OASIS assessment completion date returned from QIES.			X		X				
9585.1.1	The contractor shall bypass the edit to deny the claim if no OASIS assessment is returned from QIES when the date of birth on the claim indicates the beneficiary is 18 years old or less.					X				
9585.1.2	When denying claims due to requirement 9585.1, contractors shall use the following messages: Group Code: CO CARC: 272 RARC: N/A MSN: 41.17			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9585.2	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			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the 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:
9585.1	The assessment completion date is returned from QIES in the ASSES-DATE-CONV field and copied to the claim per CR 7760.
9585.1	While the regulation requires the assessment to be submitted within 30 days, the initial implementation of this edit will allow 40 days. This is to allow tolerance for circumstances in which the beneficiary is discharged early in the episode and the claim is submitted close to the same date as the OASIS is transmitted. The timing of processing in these cases may prevent the systems from identifying the OASIS assessment. A future CR may reduce this tolerance period based on experience with the process.
9585.1.1	New MSN message 41.17 is defined "This claim was denied because the home health agency didn't submit the required patient assessment information." The Spanish translation is "Este reclamo fue rechazado porque la agencia no presentó la información requerida para la evaluación del paciente."

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):

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

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents

(Rev. 3629 Issued: 10-27-16)

10.1.19.3 - Adjustments of Episode Payment – Validation of HIPPS Codes

10.1.10.3 - Submission of Request for Anticipated Payment (RAP)

(Rev. 3629, Issued: 10-27-16, Effective: 04-01-17, Implementation: 04-03-17)

The HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met.

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the *national assessment system*;
- Once a physician's verbal orders for home care have been received and documented;
- A plan of care has been established and sent to the physician; and
- The first service visit under that plan has been delivered.

An episode will be opened on CWF with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

RAPs are submitted using TOB 0322. RAPs must include the information output by Grouper for HH PPS in addition to other claim elements. While Medicare requires very limited information on RAPs, HHAs have the option of reporting service lines in addition to the Medicare requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected payment amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine payment or for later data collection.

The HH Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

10.1.19.3 - Adjustments of Episode Payment – Validation of HIPPS Codes

(Rev. 3629, Issued: 10-27-16, Effective: 04-01-17, Implementation: 04-03-17)

Recoding Based on OASIS-calculated HIPPS Codes

The HIPPS code calculated based on the OASIS assessment for an episode is reported on the HH RAP and claim. HHAs may calculate the HIPPS code using CMS-provided Grouper software or with their own software that recreates CMS grouping logic. When the OASIS assessment is submitted to the Medicare quality system, the HIPPS code is independently calculated using the CMS-provided Grouper program.

When processing the claim for an episode, Medicare systems compare the provider-submitted HIPPS code with the HIPPS code calculated based on the assessment information in the quality system. If the codes do not match, the OASIS-calculated HIPPS code is used for payment.

Medicare systems display the OASIS-calculated HIPPS code in Direct Data Entry (DDE) in a field named "RETURN-HIPPS1." When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice. In other cases, the HIPPS code in this field will match what the HHA submitted on their claim.

The OASIS-calculated HIPPS code may be re-coded further by Medicare systems. The OASIS-calculated HIPPS code will be sent to the HH PPS Pricer program which may change the code based on changes in therapy services (see section 10.1.19.1) or whether the claim is for an early or later episode (see section 10.1.19.2). In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice. HHAs will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE:

Field in DDE	***DDE Map***	***Represents***
HCPC	*MAP171E*	*HHA-submitted HIPPS code*
RETURN-HIPPS1	*MAP171E*	*OASIS-calculated HIPPS code*
APC-HIPPS	*MAP171A*	*Pricer re-coded HIPPS code*

The OASIS-calculated HIPPS code may also be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the HIPPS code determined by medical review will be used for payment and will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

When an OASIS Assessment Has Not Been Submitted

Submission of an OASIS assessment is a condition of payment for HH episodes of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30 day period will have elapsed by the time a 60 day episode of HH services is completed and the final claim for that episode is submitted to Medicare. If the OASIS assessment is not found in the quality system upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N/A
MSN: 41.17