CMS Manual System	Department of Health & Human Services (DHHS)				
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)				
Transmittal 11503	Date: July 21, 2022				
	<b>Change Request 12790</b>				

# SUBJECT: Corrections to Processing of Canceled Home Health Notices of Admission and of Period Sequence Edits

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to modify Original Medicare systems to ensure prior periods are updated correctly when a Notice of Admission is canceled. It also ensures medical review information is not removed when claims are subsequently adjusted due to period sequence edits.

### EFFECTIVE DATE: January 1, 2023 - Claims processed on or after this date.

\*Unless otherwise specified, the effective date is the date of service.

**IMPLEMENTATION DATE: January 3, 2023** 

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				

### 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: 11503 | Date: July 21, 2022 | Change Request: 12790

**SUBJECT:** Corrections to Processing of Canceled Home Health Notices of Admission and of Period Sequence Edits

EFFECTIVE DATE: January 1, 2023 - Claims processed on or after this date.

\*Unless otherwise specified, the effective date is the date of service.

**IMPLEMENTATION DATE: January 3, 2023** 

#### I. GENERAL INFORMATION

**A. Background:** The Original Medicare program implemented Notices of Admission (NOAs) for home health (HH) admissions effective January 1, 2022. HH NOAs are submitted using Type of Bill (TOB) 032A and may be canceled with TOB 032D if they are submitted in error. The implementation instruction for NOAs, Change Request 12227, contained requirements for removing the HH admission period created by an NOA when TOB 032D is processed. It did not account for reversing changes to the previous admission period that may result when an NOA is received in a transfer situation.

When an NOA is submitted indicating the beneficiary transferred from another home health agency (HHA) and the NOA From date falls within the HH period of care of the previous HHA, the End date of the previous period is truncated to allow the transfer. If a transfer NOA is submitted in error and subsequently canceled, the TOB 032D will remove the transfer HHA's admission period but will not restore the original calculated 30-day End date on the period of the previous HHA. This requires the previous HHA to cancel and resubmit their NOA before any of their claims can be processed. This is an avoidable administrative burden on that HHA. The requirements below revise Medicare systems to restore the previous period's End date when a transfer NOA is canceled.

Also, Medicare Administrative Contractors (MACs) have reported an issue with claims which have been medically reviewed and are later identified for adjustment due to an incorrect period sequence. In processing the adjustment, Medicare systems changes the User Action Code from the code applied by the medical review to "Z." This erases additional medical review coding on the claim. If the provider is still on review, this will trigger an unnecessary additional record request to the provider. If the provider is no longer being reviewed, the claim continues processing without the medical review coding, which impacts medical review reporting. These requirements also correct these problems.

**B.** Policy: This Change Request contains no new policy. It corrects the implementation of existing policy.

#### II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
			A/B		D	S	Shai	red-		Other
		N	MA(	$\mathbb{C}$	M	S	Syst	tem		
					Е	Ma	int	aine	ers	
		A	В	Н		F	M	V	C	
				Н	M	I	C	M	W	
				Н	A	S	S	S	F	
					C	S				
12790.1	Upon receipt of a request to cancel an NOA (TOB								X	

Number	Requirement	Responsibility														
											red-		Other			
		N	MAC		MAC		MAC		MAC		M E	System Maintainers				
		ABH		л р п		ВН		F			C					
			ט	Н	M		C	M	W							
				Н	A C	S S	S	S	F							
	032D) where the incoming 032D From date is equal to the prior HH period of care End date, the contractor shall recalculate the prior HH period End date to 30 days from that period's Start date.  Note: This action should occur whether or not the incoming 032D reports condition code 47.															
12790.2	The contractor shall ensure medical review information is not removed from claims or adjustments when recoding the HIPPS code due to episode sequence edits.					X										

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
			A/B		D	C
		1	MAC		M	Ε
					E	D
		A	В	Н		I
				Н	M	
				Н	A	
					C	
	None					

# IV. SUPPORTING INFORMATION

# Section A: Recommendations and supporting information associated with listed requirements:

<sup>&</sup>quot;Should" denotes a recommendation.

X-Ref	Recommendations or other supporting information:
Requirement	
Number	
12790.2	This requirement may include but not be limited to:
	• Ensuring User Action Codes on claim page 06 of Q, 7 and E are not overlaid with Z, and
	Ensuring MR coding on claim pages 09 and 32 are not erased
	Additional codes and fields may also be affected to ensure the claim or adjustment processes correctly.

X-Ref	Recommendations or other supporting information:
Requirement	
Number	
12790.2	Period sequence edits are CWF edits U524P and U524Q.

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

#### V. CONTACTS

**Pre-Implementation Contact(s):** Carla Douglas, carla.douglas@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):**

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**