CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11644	**Date: October 13, 2022**
	Change Request 12924

Transmittal 11634, dated October 6, 2022, is being rescinded and replaced by Transmittal 11644, dated, October 13, 2022, to correct manual section 80.1 to refer to April 1, 2023. All other information remains the same.

SUBJECT: Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to add new claims edits in response information returned from the Home Health (HH) Grouper, so HH claims receive clearer error messages. It also creates a new informational unsolicited response (IUR) to Medicare systems to correct partial episode payments.

EFFECTIVE DATE: April 1, 2023 - Claims processed on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 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
R	10/80/HH Grouper Program
R	10/80.1/HH Grouper Input/Output Record Layout
R	10/80.2/HH Grouper Decision Logic and Updates

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: New Grouper Return Code Edits

The Home Health (HH) Grouper program contains various data validity edits that ensure consistent and accurate data is used when calculating payment groups on HH claims. Of these edits, currently only Grouper return code 05 (principal diagnosis not assigned to a clinical group) causes HH claims to be returned to the provider. Grouper return code 03 (other principal diagnosis code error) is not returned to the provider. In some cases, this causes processing problems. Additionally, the edit identifies various error conditions that may be helpful to providers in improving claims accuracy. The requirements below revise Original Medicare systems to return claims with these errors, using a combination of Grouper return code 03 and Grouper validity flag information that identifies specific error conditions, to create new Fiscal Intermediary Shared System (FISS) reason codes that describe the errors to providers.

New HH Informational Unsolicited Response (IUR)

When a Notice of Admission (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. Change Request 12790 corrected a problem that occurred if a transfer NOA is submitted in error and subsequently canceled. It ensured that Medicare systems restore the previous period's End date when a transfer NOA is canceled. It did not address the possibility that a claim corresponding to the previous period may have been paid a partial period payment adjustment in error. The requirements below create a new IUR that will be sent by the Common Working File (CWF) to identify these claims and trigger FISS to adjust those claims to restore full payment for the period of care.

B. Policy:

This Change Request 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	
12924.1	The contractor shall return HH claims (TOB 032x other than 032A, 032D or 0320) to the provider when Grouper return code 03 is received in combination with validity flag information. Note: the validity flag in the Grouper output was previously not used.					X				
12924.1.1	The contractor shall return HH claims to the provider with a message indicating "Unacceptable primary diagnosis, not reportable as primary" when Grouper return code 03 is received in combination with validity flag 1.			X		X				
12924.1.2	The contractor shall return HH claims to the provider with a message indicating "Manifestation code not reportable as primary diagnosis" when Grouper return code 03 is received in combination with validity flag 2.			X		X				
12924.1.3	The contractor shall return HH claims to the provider with a message indicating "Unspecified diagnosis code not acceptable as primary diagnosis" when Grouper return code 03 is received in combination with validity flag 3.			X		X				
12924.1.4	The contractor shall return HH claims to the provider with a message indicating "External cause of injury code not reportable as primary diagnosis" when Grouper return code 03 is received in combination with validity flag 4.			X		X				
12924.1.5	The contractor shall return HH claims to the provider with a message indicating "Primary diagnosis identified as a code first code with condition present" when Grouper return code 03 is received in combination with validity flag 5.			X		X				
12924.1.6	The contractor shall return HH claims to the provider with a message indicating "Primary diagnosis code is not valid for claim dates or is blank" when Grouper return code 03 is received in combination with validity flag 6 or 7.			X		X				
12924.2	Upon receipt of a request to cancel an NOA (TOB 032D) where the incoming 032D From date is equal to the prior HH period of care End date and the patient								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	status code on the prior HH period of care is 06, the contractor shall create an IUR identifying the claim for adjustment and containing an indicator to identify an adjustment from partial period payment to full payment.									
12924.3	The contractor shall create an adjustment claim for the period of care identified by the IUR created in requirement .2.					X				
12924.3.1	The contractor shall create the adjustment with TOB 03xG.					X				
12924.3.2	The contractor shall replace the patient status code '06' created by the earlier partial payment adjustment with patient status code '30'.					X				
12924.3.3	The contractor shall change any visit lines that were non-covered by the earlier partial payment adjustment back to covered charges.					X				
12924.3.4	The contractor shall change the claim Through date on the adjustment to the original period of care end date (day 30).					X				
12924.3.5	The contractor shall return the adjustment to the HH Pricer to restore full payment for the episode.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12924.4	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			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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.					

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): Wil Gehne, wilfried.gehne@cms.hhs.gov , Carla Douglas, carla.douglas@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

80 – HH Grouper Program

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The Home Health Resource Group (HHRG) used to pay home health services billed on TOB 032x are determined by the HH Grouper program. HHRGs are represented on claims in the form of HIPPS codes. Like the HH Pricer, the HH Grouper is a module within Medicare claims processing systems. The HHA sends a HIPPS code on the claim, using revenue code 0023. Medicare systems combine claim data and OASIS data and send the data to the HH Grouper to determine the HIPPS code used for payment. The HIPPS code from the Grouper replaces the provider-submitted HIPPS code on the claim and is then sent to the HH Pricer for payment calculations.

Medicare claims processing systems send an input record to Grouper for all claims and most adjustments. Medical review or other program integrity contractor adjustments are not sent to the Grouper. The Grouper returns an output record to the shared systems whenever an input record is sent.

No part of the Grouper logic is required to be incorporated into an HHA's billing system in order to bill Medicare, unless the HHA chooses to do so to assist their accounts receivable functions. The following is presented for A/B MACs (HHH) and as information for the HHAs, in order to help HHAs understand how their HH claims are processed.

80.1 – HH Grouper Input/Output Record Layout

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The required data and format for the HH Grouper input/output record for periods of care beginning on or after January 1, 2020 are shown below:

File Position	Format	Title	Description
1 - 24	X(24)	Claim ID	Input item: Document control number of the claim record.
25-32	X(8)	From Date	Input item: The Statement Covers "From" date from the claim, in format CCYYMMDD
33	9	Period Timing	Input item: Set to 1 when claim From date matches Admission date or when a CWF sequence edit is received. Otherwise, set to 2.
34 - 35	9(2)	Referral Source	Input item: If occurrence code 61 or 62 are present on the claim, the code value is moved to this field. The occurrence date is not moved.
36 - 42	X(8)	Principal Diagnosis	Input item: The principal diagnosis code from the claim.
43 - 50	X(8)	Secondary Diagnosis	Input item: The first secondary diagnosis code from the claim.
51 - 235	Defined above	Additional Secondary Diagnosis data	Input items: 23 additional occurrences of secondary diagnoses from the claim.
236-275	X(40)	Filler	For future use.
276	9	M1033-HOSP-RISK-HSTRY-FALLS	Input item: Moved from the M1033-HSTRY-FALL field on the QIES/OASIS screen in FISS. Valid values: 0,1

File Position	Format	Title	Description
277	9	M1033-HOSP-RISK-WEIGHT-LOSS	Input item: Moved from the M1033-WEIGHT-LOSS field on the QIES/OASIS screen in FISS. Valid values: 0,1
278	9	M1033-HOSP-RISK-MLTPL-HOSPZTN	Input item: Moved from the M1033-MLTPL-HOSPZTN field on the QIES/OASIS screen in FISS. Valid values: 0,1
279	9	M1033-HOSP-RISK-MLTPL-ED-VISIT	Input item: Moved from the M1033-MLTPL-ED-VISIT field on the QIES/OASIS screen in FISS. Valid values: 0,1
280	9	M1033-HOSP-RISK-MNTL-BHV-DCLN	Input item: Moved from the M1033-MNTL-BHV-DCLN on the QIES/OASIS screen in FISS. Valid values: 0,1
281	9	M1033-HOSP-RISK-COMPLIANCE	Input item: Moved from the M1033-COMPLIANCE on the QIES/OASIS screen in FISS. Valid values: 0,1
282	9	M1033-HOSP-RISK-5PLUS-MDCTN	Input item: Moved from the M1033-5PLUS-MDCTN on the QIES/OASIS screen in FISS. Valid values: 0,1
283	9	M1033-HOSP-RISK-CRNT-EXHSTN	Input item: Moved from the M1033-CRNT-EXHSTN on the QIES/OASIS screen in FISS. Valid values: 0,1
284	9	M1033-HOSP-RISK-OTHR-RISK	Input item: Moved from the M1033-OTHER-RISK on the QIES/OASIS screen in FISS. Valid values: 0,1
285	9	M1033-HOSP-RISK-NONE-ABOVE	Input item: Moved from the M1033-NONE-ABOVE on the QIES/OASIS screen in FISS. Valid values: 0,1
286-287	9(2)	M1800-CRNT-GROOMING	Input item: Moved from the M1800-CRNT-GROOMING on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
288-289	9(2)	M1810-CRNT-DRESS-UPPER	Input item: Moved from the M1810-DRESS-UPPER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
290-291	9(2)	M1820-CRNT-DRESS-LOWER	Input item: Moved from the M1820-DRESS-LOWER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
292-293	9(2)	M1830-CRNT-BATHG	Input item: Moved from the M1830-CRNT-BATHG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06

File Position	Format	Title	Description
294-295	9(2)	M1840-CRNT-TOILTG	Input item: Moved from the M1840-CRNT-TOILTG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04
296-297	9(2)	M1850-CRNT-TRNSFRNG	Input item: Moved from the M1850-CRNT-TRNSFRNG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05
298-299	9(2)	M1860-CRNT-AMBLTN	Input item: Moved from the M1860-CRNT-AMBLTN on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06
300-599	X(301)	Filler	For future use.
601-607	X(7)	Version Used	Output item: The version of the HH Grouper which grouped the current claim. Informational only.
608-612	X(5)	HIPPS Code	Output item: The HIPPS code determined by grouping the input items above. Moved to the HCPCS code field of revenue code 0023 line of the claim.
613-614	9(2)	Validity Flag	Output item: Beginning April 1, *2023*, the specific diagnosis coding issue that requires a claim to be returned to the provider.
615-616	9(2)	Grouper Return Code	Output item: Identified technical issues that may cause no HIPPS code to be assigned.
617-700	X(84)	Filler	For future use.

If the return code is 05, the claim will be returned to the provider for correction because the principal diagnosis is not assigned to a clinical group.

If the return code is 03, the claim will be returned to the provider for correction because of a diagnosis coding issue that is indicated by the validity flag.

80.2 – HH Grouper Decision Logic and Updates

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The HH Grouper decision logic, in the form of Java computer software, and related documentation are available to the public on the CMS website at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.

The major release of the Home Health Grouper is January 1st each year with changes made as a result of the rulemaking process. There are two other off-cycle updates during the year for new and deleted ICD10-CM diagnosis codes. These are April 1st and October 1st each year. Whenever the HH Grouper is updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes.