CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1405	**Date: August 1, 2014**
	Change Request 8813

SUBJECT: Diagnosis Reporting on Home Health Claims

I. SUMMARY OF CHANGES: This instruction adds editing for principal diagnoses that are not appropriate for reporting on the home health claim.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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	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 obliged 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: 1405	Date: August 1, 2014	Change Request: 8813

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EFFECTIVE DATE: January 1, 2015
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I. GENERAL INFORMATION

A. Background: Home Health Agencies (HHAs) are to report diagnosis codes on their home health claims, as required by ICD-9-CM Coding Guidelines. Adherence to ICD-9-CM coding guidelines when assigning diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The patient's primary diagnosis is defined as the diagnosis most related to the current home health plan of care. An analysis of Outcome Assessment and Information Set (OASIS) records and claims for CY 2011 revealed that some agencies were not complying with the coding guidelines when reporting the primary diagnosis, in particular with regards to certain codes that require the underlying condition be sequenced first followed by the manifestation. Given the concerns regarding compliance with coding guidelines, CMS is adopting edits to ensure greater compliance of coding guidelines for primary diagnosis codes.

B. Policy: The principal diagnosis reported on the home health claim shall be the ICD-9-CM code that is most related to the current home health plan of care. HHAs shall not submit manifestation codes as the primary diagnosis.

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	
8813.1	Contractors shall apply the edit 86 for "Manifestation code as principal diagnosis" to home health RAPs and claims (Type of Bill 032x) with dates of service on or after January 1, 2015.									IOCE
8813.2	Contractors shall return to the provider (RTP) home health claims receiving the "Manifestation code as principal diagnosis" edit.			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8813.3	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 one week of the availability of the provider education 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.			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): Joan Proctor, joan.proctor2@cms.hhs.gov (For payment policy), Wil Gehne, wilfried.gehne@cms.hhs.gov (For institutional claims processing)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0