CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3005	**Date: August 1, 2014**
	Change Request 8699

SUBJECT: Preventing Duplicate Payments When Overlapping Inpatient and Home Health Claims Are Received Out of Sequence

I. SUMMARY OF CHANGES: This Change Request improves safeguards to prevent payment of home health services when a beneficiary is an inpatient of a hospital or skilled nursing facility.

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
R	10/30.9/Coordination of HH PPS Claims Episodes With Inpatient Claim Types

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: In August 2012, the Office of Inspector General (OIG) issued report OEI-04-00240, entitled "Inappropriate and Questionable Billing by Medicare Home Health Agencies." One recommendation of this report was to improve existing edits to prevent inappropriate payments on home health claims that overlap claims for inpatient hospital stays or skilled nursing facility stays. CMS requested and received example claims from the OIG in order to research ways to improve the edits in Original Medicare claims systems that identify such overlaps.

CMS distributed examples to each of the Home Health and Hospice (HH&H) Medicare Administrative Contractors (MACs), for the MACs to review the claims in detail. This review identified two gaps in current Medicare edits:

- The edit that rejects home health claims when they have dates overlapping an inpatient stay (other than the admission date, discharge date or a date during an occurrence span code 74 period indicating a leave of absence) does not consider inpatient stays in a swing bed (Type of Bill 018x), and

- Medicare systems only identify overlaps with inpatient stays when the inpatient hospital or skilled nursing facility claim was received before the home health claim.

The requirements below revise Medicare systems to close these gaps and prevent inappropriate payments on home health claims.

B. Policy: This Change Request contains no new policy.

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	
8699.1	The contractor shall include inpatient stays on Type of Bill (TOB) 018x in editing that rejects home health claims when home health visit dates fall within the dates of an inpatient stay.								X	
8699.2	The contractor shall compare incoming inpatient								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	hospital (TOB 011x), skilled nursing facility (TOB 021x) or swing bed (TOB 018x) claims to paid home health claims (TOB 032x other than 0322 or 0320) to determine whether any line item dates of service for covered home health visits (revenue codes 042x, 043x, 044x, 055x, 056x and 057x with covered charges) fall within the dates of the inpatient claim.									
8699.2.1	The contractor shall compare home health visits dates to all dates on the inpatient claim excluding the admission date, the discharge date and any occurrence span code 74 dates.								X	
8699.2.2	If any home health visit dates are found to fall within the inpatient claim dates, the contractor shall create an informational unsolicited response (IUR) for the home health claim identifying the visit dates.								X	
8699.3	Upon receipt of an IUR identifying home health visit dates within an inpatient stay, the contractor shall create an adjustment to the home health claim and reject the line items for any visits identified by the IUR.					X				
8699.3.1	The contractor shall use the following remittance advice coding for any home health visits rejected as a result of the IUR: Group code: CO Claim Adjustment Reason Code: 96 Remittance Advice Remark Code: M80			X		X				
8699.3.2	The contractor shall re-calculate the home health prospective payment system payment amount on any adjustments created as a result of the IUR.					X				
8699.3.3	The contractor shall create a report that maintains a record of adjustments that were created and adjustments that could not be created.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8699.4	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 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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8699.3.2	The adjustments should be processed through the HH Pricer to determine whether the non-covered visits affect any payment thresholds on the claim. In many cases, the adjustment may not change the HH PPS payment amount that has already been paid to the HHA.
8699.1	This requirement will revise CWF edit 7080.
8699.3.3	This report could be modeled on the 423 report that currently records adjustments associated with PEP unsolicited responses.

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 Regional Coordinator.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 3005, Issued: 08-01-14 , Effective:01-01-15, Implementation: 01-05-15)

Beneficiaries cannot be institutionalized and receive home health care simultaneously. Therefore claims for institutional inpatient services *(inpatient hospital, skilled nursing facility (SNF) and swing bed claims),* have priority *in Medicare claims editing* over claims for home health services.

If an HH PPS claim is received, and CWF finds dates of service on the HH claim that falls within the dates of an inpatient, SNF *or swing bed* claim (not including the dates of admission and discharge *and the dates of any leave of absence*), Medicare systems will reject the HH claim. *The HHA may submit a new claim removing any dates of service within the inpatient stay that were billed in error.*

If the HH PPS claim *is* received first and the *inpatient hospital, SNF or swing bed* claim *comes* in later, but *contains* dates of service duplicating dates of service within the HH PPS episode period, *Medicare systems will adjust the previously paid HH PPS claim to non-cover the duplicated dates of service.*