CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 427 **Date: JANUARY 14, 2005**

CHANGE REQUEST 3616

SUBJECT: Revision of Change Request 2928: Implementation of Payment Safeguards for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Hospitalizations

I. SUMMARY OF CHANGES: This instruction will provide the appropriate action to be taken when Significant Changes In Condition are reported on HH PPS claims, when there was a previously reported inpatient claim within 14 days of the original Health Insurance Prospective Payment System code.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2004
IMPLEMENTATION DATE: July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.19.2/Adjustments of Episode Payment - Hospitalization Within 14 Days of Start of Care

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 427	Date: January 14, 2005	Change Request 3616

SUBJECT: Revision of Change Request 2928: Implementation of Payment Safeguards for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Hospitalizations

I. GENERAL INFORMATION

A. Background: Currently, Medicare systems downcode HH PPS claims when the Common Working File identifies an inpatient hospital stay within 14 days of admission to a Home Health Agency (HHA). The 14 days are determined by comparing the "From" date of the HH PPS claim to the "Through" date of the inpatient hospital claim. It has been identified that when HHAs submit claims with more than one Health Insurance Prospective Payment System (HIPPS) code on the basis of a Significant Change In Condition (SCIC), that the Medicare systems are downcoding the SCIC based on the date of the original HIPPS code. Therefore, this Change Request will instruct Medicare Systems on how to correct the downcoding of SCIC claims.

B. Policy: No policy changes.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3616.1	Medicare systems shall bypass downcoding revenue code 0023 lines other than the earliest dated line on HH PPS claims identified as having an inpatient claim within 14 days of an HH admission.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3616.2	RHHIs shall adjust HH PPS claims with more than one HIPPS code present that have been downcoded inappropriately for having an inpatient claim within 14 days of an HH admission when such services are brought to the attention of the RHHI by the provider.		X							

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3616.2	Adjustments can be initiated for claims dated back to April 1, 2004 when the implementation of CR 2928 occurred.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2004 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, yyoung@cms.hhs.gov Wil Gehne, (410) 786-6148, wgehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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10.1.19.2 - Adjustments of Episode Payment – Hospitalization Within 14 Days of Start of Care

(Rev. 427, Issued: 01-14-05, Effective: 04-01-04, Implementation: 07-05-05)

Whether a beneficiary was a hospital inpatient during the 14 days before the start of an HH PPS episode will be confirmed by searching Medicare claims history for a processed inpatient hospital claim during that period. Under the HH PPS case-mix system, if a beneficiary was in a nursing facility *or rehabilitation facility* during the 14 days before the start of an episode but was not also a hospital inpatient during that period, the episode will receive a higher case-mix score than if a hospitalization was also present.

Certain HIPPS codes, which represent the HH PPS case-mix group, indicate the presence of a nursing facility *or rehabilitation facility* discharge within 14 days but no hospitalization during that period. Only when both these conditions are met do HIPPS codes result with "K" or "M" in their fourth position.

Medicare systems will compare incoming RAPs and claims with these HIPPS codes to Medicare claims history for the beneficiary and determine during processing whether an inpatient hospital claim has been received for dates of service within 14 days of the start of care. If an inpatient hospital claim is found, Medicare systems will take action on the RAP or claim. The RAPs will be returned to the provider to alert them to the hospital stay and allow them to correct the HIPPS code. The claims will be automatically adjusted to correct the HIPPS code and will be paid at the correct payment level.

When a Home Health Agency (HHA) submits an HH PPS claim on the basis of a Significant Change In Condition (SCIC), Medicare systems will bypass downcoding revenue code 0023 lines other than the earliest dated line on the HH PPS claim identified as having an inpatient claim within 14 days of the home health admission.

Under Medicare timely filing guidelines, hospital claims may be received for 15-27 months from the end of the hospital stay. As a result of this lengthy timely filing period, there may also be cases where the HH PPS claim has been processed before the inpatient hospital claim is received. In these cases, absence of the inpatient claim in Medicare claims history could mean either no hospital stay occurred or the hospital claim has not yet been submitted. As a result, Medicare systems are unable to confirm the lack of hospitalization before the HH PPS claim is paid. To account for these cases, CMS will annually analyze its claims history to identify HH PPS claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim with dates of services within 14 days was received after the HH PPS claim had already been paid. Such claims will be subject to post-payment adjustment, to correct the HIPPS code used for payment.

Whether this payment adjustment is made on a pre-payment or a post-payment basis, the electronic remittance advice (ERA) will be coded so the adjustment can be clearly identified. The ERA will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment. A distinct remark code will also be applied to the ERA for these claims.