CMS Manual System

Pub. 100-20 One-Time Notification

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

Transmittal 95 **Date: JULY 30, 2004**

CHANGE REQUEST 3400

SUBJECT: Modification to Post-payment Adjustment Process for Home Health Prospective Payment System Claims Failing to Report Prior Inpatient Discharges

I. SUMMARY OF CHANGES: This transmittal modifies the requirements for post-payment adjustments outlined in Transmittal 13, Change Request 2928 to require identification and payment of underpayments for Federal fiscal years 2001, 2002 and 2003.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Service dates beginning October 1, 2001 and ending September 30, 2003.

IMPLEMENTATION DATE: January 3, 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
N/A	

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

IV. ATTACHMENTS:

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

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 95	Date: July 30, 2004	Change Request 3400

SUBJECT: Modification to Post-payment Adjustment Process for Home Health Prospective Payment System Claims Failing to Report Prior Inpatient Discharges

I. GENERAL INFORMATION

A. Background:

Payments for home health prospective payment system (HH PPS) claims are based on payment groups derived from beneficiary assessment data reported by home health agencies (HHAs) on the Outcomes and Assessment Information Set (OASIS). Each of the HH PPS payment groups, known as home health resource groups (HHRGs) has an associated weight value that increases or decreases Medicare's payment for an episode of care relative to a national standard per episode amount. The HHRGs are reported to Medicare on HH PPS claims using the health insurance PPS (HIPPS) code set.

In 2003 and early 2004, reports to Medicare's four Regional Home Health Intermediaries (RHHIs) by the Office of Inspector General (OIG) showed that the Medicare program was vulnerable to make excess payments on HH PPS claims when certain OASIS assessment information is reported in error. When HHAs report in OASIS item M0175 that a beneficiary has not been discharged from a hospital within 14 days of the start of home health care, the claim for that beneficiary may in some cases be submitted using a HIPPS code for a higher weighted payment group. The OIG has found that Medicare has paid many claims with HIPPS codes representing no hospital discharge in cases where Medicare claims history shows that an inpatient stay occurred during the 14 days prior to the start of care. On October 24, 2003 the CMS issued Transmittal 13 (Change Request 2928), which implemented pre-payment and post-payment safeguards to address this vulnerability.

The post-payment process outlined by Transmittal 13 was intended to identify and recover overpayments only. The CMS now annually analyzes its National Claims History (NCH) to identify HH PPS claims with HIPPS codes representing no hospital discharge for which an inpatient hospital claim was received for dates of service within 14 days of the start of care. These are inpatient hospital claims that were received after the HH PPS claim had already been paid. This post-payment identification is necessary because under Medicare timely filing guidelines, hospital claims may not be received for 15-27 months from the end of the hospital stay. The CMS has developed a file of the claims identified in this process and will distribute the file to each RHHI for adjustment.

Since the publication of Transmittal 13, HHAs have requested that Medicare systems should also look for the presence of skilled nursing facility (SNF) or inpatient rehabilitation facility (rehab) stays that the provider did not report and adjust claims where such stays were found. In situations where no SNF or rehab stay was reported, but such a claim is found in Medicare claims history, the claim was underpaid. HHAs may not have reported SNF or rehab stays because of misunderstanding how to report OASIS item M0175 or not utilizing all sources of information about prior inpatient stays during the early years of the transition to HH PPS.

B. Policy:

Medicare will modify the post-payment review process outlined in Transmittal 13 to identify both overpayments and underpayments that resulted from inaccurate reporting of prior inpatient discharges for Federal fiscal years 2001, 2002 and 2003. For claims with dates of service in Federal fiscal year 2004 and for future years, Medicare will maintain the process of identifying overpayments only. Medicare believes that HHAs now understand the OASIS assessment item and the importance of reporting of prior inpatient discharges accurately. HHAs have the information needed to submit claims accurately available to them through patients and their caregivers, inpatient discharge sources and Medicare systems in a great majority of cases. In cases where errors are discovered, HHAs have the full Medicare timely filing period to submit adjustments to correct claims they believe were underpaid.

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 one 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 (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3400.1	For fiscal years 2001 and after, RHHIs shall receive from CMS an annual file ("M0175 downcode file") of claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim is found on NCH history for dates of service within 14 days of the start of care.		X							

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3400.2	For fiscal years 2001, 2002 and 2003, RHHIs shall receive from CMS an annual file ("M0175 upcode file") of claims with HIPPS codes with a fourth position of "J" or "L" for which an inpatient rehabilitation facility or skilled nursing facility claim is found on NCH history for dates of service within 14 days of the start of care and an inpatient hospital claims is not found on NCH history within the same period.		X							
3400.3	FISS shall create and distribute to RHHIs a program to create adjustments from the M0175 downcode file, ensuring all HH PPS claims received in the file are processed as if the claim were identified for adjustment during initial processing.					X				
3400.4	FISS shall create and distribute to RHHIs a program to create adjustments from the M0175 upcode file, adjusting HIPPS codes on the claims and ensuring the claims are repriced before resubmission to CWF.					X				
3400.4.1	The FISS program shall change a HIPPS code with a fourth position of "L" to a HIPPS code with a fourth position of "M."					X				
3400.4.2	The FISS program shall change a HIPPS code with a fourth position of "J" to a HIPPS code with a fourth position of "K."					X				
3400.4.3	The FISS program shall not change any HIPPS code that is the result of a medical review determination.					X				
3400.4.4	The FISS program shall create a report of claims in the file that were identified to be upcoded but that were not changed due to a medical review determination.					X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3400.5	RHHIs shall employ the FISS program to process all HH PPS claims received in the M0175 downcode file and the M0175 upcode file (for applicable years) simultaneously, so that payment adjustments net out on HHA's remittance advices.		X							
3400.6	RHHIs shall employ the FISS program to complete all adjustments associated with the M0175 downcode file and the M0175 upcode file (for applicable years) within one calendar quarter of receipt, unless otherwise instructed by CMS.		X							
3400.7	RHHIs shall annually give HHAs five weeks notice informing them of the dates claim adjustments associated with the M0175 downcode file and the M0175 upcode file (for applicable years) will begin and describing how these adjustments can be identified on remittance advices.		X							
3400.8	RHHIs shall suspend all adjustments associated with the M0175 downcode file and the M0175 upcode file in an on-line location for provider inspection during the 5-week notice period.		X							

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3400.1	RHHIs will receive a 2001 M0175 downcode file from CMS to be used in place of files received from the OIG.
3400.1 and 3400.2	RHHIs will receive separate files for each fiscal year. Multiple fiscal years will not be processed simultaneously.
3400.7	To assist providers in recognizing post-payment adjustments by the RHHIs, adjustments may be identified on the remittance advice by type of bill 3xI and remark code N180.

B. Design Considerations: N/A

C. Interfaces: N/A

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

E. Dependencies: The RHHI's timeline for initiating adjustments after January 3, 2005 may be dependent on timely receipt of files and on other specific direction from CMS.

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Beginning October 1, 2000 and ending September 30, 2003. **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Wil Gehne, 410-768-1648, WGehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Offices	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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