Program Memorandum Intermediaries

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

Transmittal A-03-046 **Date: MAY 30, 2003**

CHANGE REQUEST 2710

SUBJECT: Demonstration--Settlement of Payments for Home Health Services to Beneficiaries Eligible for both Medicare and Medicaid in Connecticut, and Massachusetts. Regional Home Health Intermediaries (RHHIs) Only.

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) and the States of Connecticut and Massachusetts have developed a demonstration program that will utilize a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each State may have paid in error. This process will eliminate the need for the home health agencies to assemble, copy, and submit large numbers of medical records. The process will also eliminate the need for the RHHI to perform a full medical review of every case.

The demonstration project will initially be limited to the States of Connecticut and Massachusetts. The project will apply for a period of 5 years and will cover the Federal fiscal years (FFY) 2000 through 2004 for Massachusetts and FFY 2001 to 2005 for Connecticut. The requirements below outline processes for FFY 2001 and after claims only. Separate instructions will follow regarding FFY 2000 claims.

The demonstration will consist of two components: (1) an educational initiative to improve the ability of all parties to make appropriate coverage recommendations for dual eligible claims and (2) a statistically valid sampling methodology to be applied in settlement of claims paid by Medicaid that each State believes may have a potential to also be covered by Medicare. The educational initiative will be described in future instructions. This Program Memorandum (PM) provides instructions for defining the universe for the sample, and reviewing the sample cases.

On an annual basis, the demonstration States will develop a universe of candidate claims paid by Medicaid for a FFY for which each State believes payment may be due from Medicare. A new universe will be created by each State for each succeeding FFY. Each State will create the universe of candidate cases on a Medicare patient basis, i.e., a candidate case will consist of all claims for a particular Medicare beneficiary. Each State will provide this universe in a listing similar to a Statement of Intent to file claims. The listing will include the data elements described in requirement 2710.2 below and will be submitted to the RHHI that would normally process claims for the providers on the listing. This RHHI is referred to below as the "servicing RHHI."

Upon receipt of the listing of candidate cases and claims from each State, the servicing RHHI will review the listing to determine whether all candidate claims for their service area will be accepted into the universe. The servicing RHHI will verify Medicare eligibility for all persons in the claims universe and determine if Medicare has previously adjudicated any claims. All claims for persons not eligible for Medicare and claims that Medicare has already paid in full, partially paid or denied will be excluded from the claims universe. This process of "cleaning" the universe is described in requirements 2710.3 and 2710.4 below. The cleaned listing will be forwarded from the servicing RHHI to the demonstration RHHI, providing a copy to each State.

Each year, a statistically valid sample of cases will be selected by the demonstration RHHI from each State's claims universe, as described above. The demonstration RHHI will review claims for all sample cases to determine Medicare coverage and level of payment. An additional 15 cases will be drawn as an over-sample to be used as needed if the claims in the main sample could not be completed or the supporting records could not be provided. The demonstration RHHI may request any documentation necessary as part of the claims review. Where such information is not forthcoming, the demonstration RHHI will replace the sampled claim with one of the additional cases drawn as an over-sample (subject to the 15-case limit for the over-sample). In those cases where the demonstration RHHI determines that not all the care is covered, it will provide a written specific, detailed explanation as to why it believes Medicare does not cover the care. The demonstration RHHI will also provide a written explanation when the claim was not submitted or insufficient documentation was provided by the HHA. CMS or each State may exclude a home health agency from participation in future years of the demonstration if the HHA does not cooperate in submitting the required paperwork for the sample.

Once all sampled cases have been reviewed by the demonstration RHHI, the demonstration RHHI will determine the total allowable Medicare amount for the sample and the total amount of Medicaid payments for the sample. The demonstration RHHI will determine the ratio of allowable Medicare amounts for the sample to the total dollars paid by Medicaid for the entire sample. This ratio, expressed as a percentage, will then be applied to the total Medicaid payments for the claims universe to determine the settlement amount to be paid to each State. CMS will then make initial settlement with each State.

Each State will have an opportunity to review all denials along with all pertinent documentation. If the State disagrees with the demonstration RHHI's findings, it can file a written request for reconsideration. In addition, a discussion/face to face meeting may occur. The demonstration RHHI will then perform an independent and thorough reconsideration of the case, fully taking into account the rationale of the State as expressed in the face-to-face meeting. The demonstration RHHI's processes are described in requirements 2710.7 through 2710.15 below.

If the State remains dissatisfied with a reconsideration determination, a State official will submit the sample claim(s) in question and a written rationale to a CMS official for review. If the CMS official continues to believe Medicare does not cover the services, the CMS official will provide a written explanation to the State. Cases that remain unsettled will be submitted to an outside arbitrator. Subsequent settlement may be made based on the outcome of these processes.

Nothing in the demonstration project would supersede the rights of an individual to pursue Medicare coverage in accordance with the existing regulations, including an appeal to an ALJ. These cases would be excluded from the sample and processed normally. The demonstration project would also not supersede the rights of States to pursue through the existing demand bill process claims removed from the universe due to previous Medicare payment. Such demand bills would be due from the provider by no later than the end of the 6th month from the month in which the notice of exclusion from the demonstration was received by each State.

Additionally, CMS or each State may exclude an HHA from participation in the demonstration if it does not: (a) cooperate in submitting the required paperwork for the sample, (b) participate in the educational component of the demonstration, or (c) demonstrate improvement in filing its initial claims with the appropriate payer. Either each State or CMS will be able to opt out of the demonstration in future years.

B - Policy: CMS and the States have committed to this demonstration project through the signing of Memoranda of Understanding.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
2710.1	A case for purposes of this project shall be defined as all claims for a specific beneficiary during an FFY	
2710.2	Servicing RHHIs shall receive from each State a listing of cases and claims to be considered for the sample universe, which includes the following data elements. For each case: • Individual's Name • Individual's Medicaid Identification Number • Individual's Medicare Health Insurance Claim (HIC) Number • Unique Client Case Identification Number (or blank) • Individual's Date of Birth • Home Health Agency Name • Home Health Agency Medicaid Provider Number • Home Health Agency Medicare Provider Number For each Medicaid claim: • Medicaid Selected Review Period From Date of Service • Medicaid Selected Review Period Through Date of Service • Medicaid Procedure Code – "HCPC State Only Code" • Medicaid Procedure Code From Date of Service For Period At Issue • Medicaid Procedure Code Through Date of Service For Period At Issue • Medicaid Procedure Code Quantity of Service • Total Medicaid Procedure Code(s) Quantity Of Service • Total Medicaid Procedure Code(s) Medicaid Dollars At Issue • Total Medicaid Dollars • Header Record Indicator (or blank)	Servicing RHHIs
2710.2.1	If multiple providers in a single case have different servicing RHHIs, servicing RHHIs shall receive from each State a listing that includes cases submitted to both servicing RHHIs, including only the claim specific information for the servicing RHHI's provider.	Servicing RHHIs
2710.2.2	Except for the duplication of cases described in requirement 2710.2.1, servicing RHHIs shall receive from each State discrete files of cases.	Servicing RHHIs
2710.3	Servicing RHHIs shall review the cases and claims submitted by each State, to determine which to retain in the universe.	Servicing RHHIs
2710.3.1	Servicing RHHIs shall duplicate each State's submitted	Servicing

	listing or reproduce an abbreviated listing that identifies all records in the original, retaining a clean copy of the original and creating a listing to be annotated with the results of their review.	RHHIs
2710.3.2	Servicing RHHIs shall search paid claims history for the beneficiary HIC and identify all claims within the review period "From" and "Through" dates for each case submitted by each State.	Servicing RHHIs
2710.3.2.1	Servicing RHHIs shall determine whether any dates within the review period fall outside the timeliness requirement as stated in 42 CFR §§ 424.44 and 424.45, and annotate the listing with the message "Not timely for Medicare payment" if the requirement is not met.	Servicing RHHIs
2710.3.2.2	If servicing RHHIs identify any paid or denied claims within the review period "From" and "Through" dates for each case, the RHHI shall annotate the listing with summary information about the claim. Summary information shall include: • Paid/denied indicator • If denied, the associated denial reason code • Claim "From/Through" dates • Summary by revenue code of services billed If a claim contains both paid and denied services, the RHHI shall provide two summaries of services for the claim, one for paid services and a second for denied services.	Servicing RHHIs
2710.3.2.3	Servicing RHHIs shall indicate a claim as paid whether Medicare paid the claim as a primary or as a secondary payer.	Servicing RHHIs
2710.3.2.4	Servicing RHHIs shall review claims history only for the presence of home health PPS claims (types of bill 32x and 33x, other than 322 and 332).	Servicing RHHIs
2710.4	If no portion of a claim is found to be paid or denied, the servicing RHHI shall query eligibility records on the Common Working File (CWF) to ensure the beneficiary was eligible for Medicare during the review period.	Servicing RHHIs
2710.4.1	If no Medicare eligibility is on record for the review period "From" and "Through" dates for each case, the servicing RHHI shall contact the State to determine whether additional HIC numbers should be researched for the case.	Servicing RHHIs
2710.4.2	If no Medicare eligibility is on record for the full review period "From" and "Through" dates for each case, the servicing RHHI shall annotate the listing with the message "Not eligible for Medicare during this period" or an equivalent code.	Servicing RHHIs
2710.4.3	If Medicare fee-for-service eligibility is on record for part of the review period "From" and "Through" dates for each case, the servicing RHHI shall annotate the listing with the message "Partial Medicare fee-for-service eligibility on	Servicing RHHIs

	record" or an equivalent code and the beneficiary's dates of eligibility.	
2710.4.3.1	The servicing RHHI shall annotate the listing with this message or code if any fee-for-service eligibility exists (Part A and/or Part B).	Servicing RHHIs
2710.4.3.2	The servicing RHHI shall report the beneficiary's dates of eligibility without regard to whether Part A and/or Part B applied.	Servicing RHHIs
2710.4.4	If Medicare managed care eligibility is on record for the review period "From" and "Through" dates for each case, the servicing RHHI shall annotate the listing with the message "Medicare managed care enrollment on record" or an equivalent code and the beneficiary's dates of enrollment.	Servicing RHHIs
2710.5	Upon completing the review described in requirements 2710.3 and 2710.4, servicing RHHIs shall return a copy of the original and annotated listings to each State.	Servicing RHHIs
2710.6	Upon completing the review described in requirements 2710.3 and 2710.4, servicing RHHIs shall forward a copy of the original and annotated listings to the demonstration RHHI.	Servicing RHHIs
2710.6.1	Servicing RHHIs shall forward to the demonstration RHHI any necessary provider file information associated with the claims in the listings.	Servicing RHHIs
2710.7	The demonstration RHHI shall be Associated Hospital Service of Maine.	Demo RHHI
2710.8	The demonstration RHHI shall create from the annotated listings of each servicing RHHI a combined listing of the universe for each State.	Demo RHHI
2710.8.1	The demonstration RHHI shall remove from the annotated listings of each servicing RHHI those claims for which no Medicare eligibility was on record for the full review period "From" and "Through" dates for each case, i.e. those noted as "Not eligible for Medicare during this period"	Demo RHHI
2710.8.2	The demonstration RHHI shall merge services from different providers for the same beneficiary into combined cases.	Demo RHHI
2710.8.3	The demonstration RHHI shall remove from the universe all services falling within or overlapping the "From/Through" dates of paid or denied Medicare claims.	Demo RHHI
2710.8.4	The demonstration RHHI shall remove from the universe all services falling within partial periods during which the beneficiary was not eligible for Medicare or within partial periods during which the beneficiary was enrolled in Medicare managed care.	Demo RHHI
2710.8.5	The demonstration RHHI shall sum the total Medicaid dollars associated with all remaining services in the universe and provide each State with a final listing.	Demo RHHI

2710.9	The demonstration RHHI shall select a sample of cases and an oversample according to the sampling methodology described in the attachment.	Demo RHHI
2710.9.1	The demonstration RHHI shall create a listing of the claims for the sample cases and their associated payment amounts, summing the total Medicaid payment amount for the sample. This listing and total may be later revised based on the substitution of oversample cases.	Demo RHHI
2710.9.2	The demonstration RHHI shall inform each State of the claims selected for the sample, the HHAs to be contacted to request records and the date the requests will be made.	Demo RHHI
2710.10	The demonstration RHHI shall request the submission of Medicare claims and full medical records in support of all claims for all cases in the sample and the oversample from the HHAs that provided the services.	Demo RHHI
2710.10.1	The demonstration RHHI shall request that providers submit Medicare claims in paper form, bundled with the associated medical records.	Demo RHHI
2710.10.2	The demonstration RHHI shall require that Medicare claims for FFY 2001 and after be submitted in accordance with all HH prospective payment system billing instructions.	Demo RHHI
2710.10.3	Since the record requests are not triggered by submission of claims to the Medicare Shared System, the demonstration RHHI shall issue request letters and track receipt of records outside the Shared System.	Demo RHHI
2710.11	The demonstration RHHI shall perform medical review of all claims in the sample	Demo RHHI
2710.11.1	The demonstration RHHI shall require the requested records to be submitted within 25 business days of the receipt of the initial request	Demo RHHI
2710.11.2	If the requested records are not received within 15 business days of the request, the demonstration RHHI shall make a 2nd request to the HHA, with a copy of the request to each State.	Demo RHHI
2710.11.3	If the requested records are not received within 25 business days of the receipt of the initial request, the demonstration RHHI shall strike the associated case from the sample, replacing it with a case from the oversample for which timely records have already been received.	Demo RHHI
2710.11.4	The demonstration RHHI shall perform medical review of sample or oversample claims in accordance with all current home health prospective payment system medical review policies. The 60-day timeframe for completion of medical reviews (Program Integrity Manual) does not apply to this demonstration.	Demo RHHI
2710.11.4.1	For all selected claims, the demonstration RHHI shall review medical documentation and determine whether the services provided were covered, correctly coded, and are	Demo RHHI

	reasonable and necessary.	
2710.11.4.2	The demonstration RHHI should conduct Medical review to the extent necessary to ensure all qualifying criteria are met and that the medical documentation supports payment at the HIPPS code billed.	Demo RHHI
2710.12	The demonstration RHHI shall document the results of their medical review	Demo RHHI
2710.12.1	The demonstration RHHI shall calculate Medicare HH PPS payment amounts due for each claim after medical review of the claim has been completed and annotate the claim sample listing with the resulting Medicare payment amount	Demo RHHI
2710.12.2	The demonstration RHHI shall not enter claim records for demonstration cases into Medicare Shared Systems.	Demo RHHI
2710.12.3	The demonstration RHHI shall provide a written specific, detailed explanation of the reason for any denials and provide this information, along with a copy of the medical records and documentation submitted by the providers, to each State.	Demo RHHI
2710.13	The demonstration RHHI shall determine the payment amount due to each State under the demonstration.	Demo RHHI
2710.13.1	The demonstration RHHI shall multiply the total Medicaid payments for universe (calculated in requirement 2710.8.5) by the ratio of Medicare payments to Medicaid payments for the sample.	Demo RHHI
2710.13.2	The demonstration RHHI shall report the resulting dollar amount for a given FFY to CMS, for CMS' use in the interagency funds transfer process.	Demo RHHI
2710.14	The demonstration RHHI shall conduct reconsiderations of cases at the request of each State.	Demo RHHI
2710.15	The demonstration RHHI shall research and report to CMS regarding home health consolidated billing and the claims reviewed in the sample.	Demo RHHI
2710.15.1	The demonstration RHHI shall research CWF paid claims history for the service periods of all claims reviewed in the sample	Demo RHHI
2710.15.2	The demonstration RHHI shall record any paid claims for outpatient therapies or non-routine medical supplies subject to home health consolidated billing, noting the claim dates, payment amount and services paid.	Demo RHHI
2710.15.3	The demonstration RHHI shall not initiate any payment action against the claims identified in their research.	Demo RHHI
2710.15.4	The demonstration RHHI shall submit to CMS a report of all claims identified in their research.	Demo RHHI

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2710.2 - 2710.4, including sub-requirements	To the greatest extent practicable, the receipt, annotation and forwarding of each State's submitted listing should be performed using electronic files.
2710.3 - 2710.4 including sub-requirements	To the greatest extent practicable, the review and cleaning of each State's submitted listing should be automated by the servicing RHHIs. As new Medicare system functionality becomes available in out years of the demonstration (e.g. the 270/271 eligibility transaction), processes should become automated that were manual in year one.
2710.3.2.2	Submissions that have been returned to the provider (RTP) are not viewed as claims under Medicare regulations and so are not annotated on the listing.
2710.3.2	CMS has determined that servicing RHHIs are not required to search RHHI history or CWF for claims that may be subject to home health consolidated billing policies as part of this demonstration.
2710.4 including sub-requirements	Sub-requirement numbers may provide a convenient coding system to replace listing full text messages. Claims for beneficiaries identified as not Medicare eligible in requirement 2710.4.2 could be reported on the listing with the code '4.2.'
2710.12.1	Since sample claims will be adjudicated outside the Medicare Shared System, the demonstration RHHI should use CMS supplied PC Pricer software to calculate the Medicare payment amount.

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact:

No additional Financial Reporting will be required at this time. Financial reporting requirements for costs associated with the Demonstration, as well as costs for home health agency third party liability costs overall, may follow in a separate instruction. Reporting requirements, if instituted, would require reporting from the effective date of the Demonstration.

The Demonstration should reduce for each RHHI the current workload of processing home health third party liability demand bills from the participating States. The nature of the statistical analysis removes the need to fully process and adjudicate the entire universe of claims; thus, resulting in a substantial reduction in the overall claims which, absent the Demonstration, would be required to be processed. Servicing RHHIs will only be required to perform initial review and cleaning of cases submitted by States. Servicing RHHIs will not be required to fully process and adjudicate any claim within the Demonstration. While the Demonstration RHHI will be required to process and adjudicate claims, adjudication will only be required for 200 cases per State per FFY, or rather a limited sample of the larger universe of cases and claims.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. ATTACHMENT: SAMPLING METHODOLOGY

Implementation Date: June 13, 2003 Discard Date: June 13, 2008 Pre-Implementation Contact: Wil Gehne, (410) 786-6148	Effective Date: June 13, 2003 Funding: Provided through the regular budget process Post-Implementation Contact: Appropriate regional office

Attachment

SAMPLING METHODOLOGY

Universe: Dually-eligible beneficiaries and any services provided by Home Health Agencies which were paid by the State Medicaid Agency for which the State now seeks Medicare payment. Not included in the universe: ineligible Medicare beneficiaries; duplicate beneficiaries, claims or services; services previously adjudicated by Medicare (paid or denied); and services to beneficiaries who opt out; services by excluded providers.

Sample Unit: *Medicare HICN (Health Insurance Claim Number) designating a dually eligible Medicare beneficiary*

Time Frames: – *Separate sample for each State and each fiscal year for each for the five demonstration years.*

Sample Size: 200 for each year *plus 15 additional over-sampled cases per year.*

Sampling Technique: Systematic sampling (Interval sampling using random start.) The universe will be arranged in ascending order according to the amount paid for each case. If it becomes necessary to use the 15 over-sampled cases, each time a case is needed it will be randomly drawn from the remaining over-sampled cases.

Review Criteria*: Based on its review of Medicare claims and related medical records and other information submitted by providers, Associated Hospital Service will make a determination for each of 200 sampled (or oversampled) cases of the dollar amount Medicare would have paid ("Approved Medicare reimbursement amount') compared to what Medicaid paid.*

Estimation Technique: A statistical estimator will be used to project the sample results *(average Medicare payment compared to the average Medicaid payment)* for the entire universe of claims, i.e., to determine a total amount that Medicare would have paid for the entire universe.

Cases Lacking Proper Documentation: For sampled cases where the *provider* is unable to provide coding information and/or medical record documentation sufficient for AHS to make a payment determination, a substitute case must be picked from a 15 case "pool" which has been randomly selected in addition to (and separately from) the original sample of 200. The substitute cases must be randomly selected from the pool each time a substitute case is needed. If all 15 cases in the pool become exhausted, no further substitutions are allowed. *Once an original case has been replaced by a substitute case, it is eliminated from the sample and cannot be re-submitted at a later time.*