CMS Manual System

Pub. 100-19 Demonstrations

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

Transmittal 6 **Date: August 27, 2004**

CHANGE REQUEST 3432

SUBJECT: Revision of CR 3269 for the Demonstration Project to Clarify the Definition of Homebound (Homebound Demonstration)

I. SUMMARY OF CHANGES: This CR is a revision of CR 3269, Publication 100-19, Transmittal 3, dated May 7, 2004, Business Requirement 3269.3.0. Change Request 3269.3.0 requested a report of a limited list of patient and provider identifying information. It was determined that due to the frequency of coding errors; this information would be insufficient to guarantee proper identification of the patient. Therefore, to guarantee proper patient and facility identification and avoid the necessity of future changes, it is requested that items from the entire claim record be reported to a designated CMS data center file. CR 3432 requests the entire claim be sent to a designated file address and that a report of limited items be sent to the RHHI. All other information contained in CR 3269 remains the same.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 3, 2005

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**

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

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background:

Section 702 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (also known as the Medicare Modernization Act or MMA) mandated that the Secretary conduct a "Demonstration Project to Clarify the Definition of Homebound."

In accordance with the statute, the CMS shall conduct a 2-year demonstration in 3 States (Massachusetts, Missouri, and Colorado) in which Medicare beneficiaries with chronic conditions of a specific nature are deemed to be homebound for the purpose of receiving home health services under the Medicare program. Treatment under the demonstration is limited to no more than 15,000 beneficiaries. Beneficiaries eligible for this demonstration are those with permanent, severe disability, who need permanent help with 3 of 5 Activities of Daily Living (ADLs), permanent skilled nursing care, and daily attendant visits to monitor, treat or provide ADL assistance. They must also require technological or personal assistance to leave home and not be working outside the home.

B. Policy:

Implementation of this demonstration will not require any change in payments or payment processing under the home health prospective payment system.

At implementation of the demonstration, providers will be informed that for the duration of the demonstration in their State, a Medicare patient will be eligible to be deemed homebound, without regard to the purpose, frequency, or duration of absences from the home if the Medicare patient meets all of the following conditions:

1. Certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve.

2. Dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living specified in the Act (eating, toileting, transferring, bathing, and dressing) for the rest of the beneficiary's life.

3. Requires skilled nursing services for the rest of his or her life, and the skilled nursing is more than medication management.

4. Requires an attendant to visit on a daily basis to monitor and treat a medical condition or to assist the beneficiary with activities of daily living.

5. Requires technological assistance or the assistance of another person to leave the home.

6. Does not regularly work in a paid position full-time or part-time outside the home.

If a Medicare beneficiary meets these conditions during the demonstration period, providers may refer/enroll this patient for home care whether or not the patient meets the homebound definition.

At enrollment, if the home health agency (HHA) or physician believes that the patient meets the criteria for a demonstration patient, the physician, in signing the Plan of Care (POC), will indicate in the open text remark section that he/she certifies that the patient has a severe and permanent condition and satisfies the requirements of the demonstration. The HHA and/or physician will proceed to enroll and provide services to the patient, informing the patient that he/she is being admitted under a demonstration project of limited duration, and specifying the parameters that allow more freedom to leave the home.

The HHA will inform the patient that he/she qualifies for home care by satisfying the demonstration criteria, but that he/she may only take advantage of the more liberal homebound policy during the demonstration period.

Under the demonstration, the HHA will be encouraged to keep a log of the patients who meet the criteria and were enrolled, and also those meeting the criteria that, for whatever reason, were not enrolled.

For each identified demonstration patient, the HHA will submit to the RHHI a request for anticipated payment (RAP) entering a special code (the string "HHDEMO") in the remarks section (FL84) of the claim identifying the patient as part of the demonstration. The HHA will place the same code on the end of episode claim as well.

The RHHI will receive and process the RAP and subsequent end-of-episode claims for payment in accordance with standard Medicare rules. The claim is processed through the Fiscal Intermediary Standard System (FISS), which outputs the claim to the Common Working File (CWF) adding a Special Processing Number 44 for all demonstration claims (those with the string "HHDEMO" anywhere in FL84).

On a weekly basis, the FISS will create a file containing the paid claim history in FSSCPDCP/FSSCPDCR record format for each demonstration claim processed and paid during the week, and write it to a designated file address at the CMS data center. The FISS will also create an accompanying report listing selected variables identifying the claims included in each transmission.

The demonstration Support Contractor will access the designated CMS data center file on a regular basis to access information on new demonstration patients.

The Support Contractor will notify the patient that he/she has been identified as meeting the requirements of the demonstration and advise the patient of the opportunity during the demonstration period to leave home frequently and for longer duration than normally allowed while receiving home care under Medicare. The patient will be encouraged to take advantage of this opportunity and informed that taking advantage of the opportunity will not affect his/her Medicare benefits. The patient will be asked to keep a log of absences from home for the purpose of the evaluation of the demonstration and will be told that the

evaluation contractor may contact him/her after home care has been completed. The patient will be provided with a toll-free number to answer questions about the demonstration.

The demonstration Support Contractor shall monitor enrollment of demonstration patients across the three designated states and inform CMS when the number of demonstration participants nears 15,000. At this point, CMS will inform providers and RHHIs of the cessation of the demonstration, if prior to the end of the 2-year demonstration period.

After the patient is discharged from home care, the Support Contractor will contact the HHA to request a copy of the plan of care and medical record for each patient. Depending on the evaluation design and number of patients entering the demonstration, the number of records requested may be limited to a number below the 15,000 maximum.

C. Provider Education: None.

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	
3432.1.0	The FISS shall design and create a process for creating a file of all demonstration claims paid each week, and transmit it in FSSCPDCP/FSSCPDCR record format weekly to a file address (to be designated) at the CMS data center.					X				
3432.1.1	The FISS shall make available a printable version of the report to the RHHI containing the following items for each demonstration claim included in the weekly claims file: a. home health agency provider number b. beneficiary Medicare health insurance identification number with alphanumeric suffix c. beneficiary name d. date of service e. bill type f. document control number (DCN)					X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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*: January 1, 2005 **Implementation Date: January 3, 2005** **Pre-Implementation Contact(s):** Armen Thoumaian 410-786-6672 **Post-Implementation Contact(s):** Armen Thoumaian 410-786-6672	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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