# CMS Medicare Manual System
# Pub. 100-8 Program Integrity

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

**Transmittal 42** **Date: JUNE 20, 2003**

**CHANGE REQUEST 2720**

| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
|---|---|---|---|
| 6 | Table of Contents | | 2, 2.1, 2.2, 3, 3.1, 3.2, |
| 6 | 3.7 | | 3.3, 3.4, 3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.4.5, 3.4.6, 3.4.7, 3.4.8, 3.4.9, 3.5, 3.6, 3.8, 4, 4.1, 4.2, 4.3, 4.4, 5, 5.1, 5.2, 5.3, 5.3.1, 5.3.2, 5.3.3, 5.3.4, 5.3.5, 5.3.6, 5.3.7, 5.4, 5.4.1, 6, 6.1, 6.2, 6.3, 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.3.5, 6.3.6, 6.3.7, 6.4, 6.5, 6.5.1, 6.5.2, 6.5.3, 6.5.4, 6.5.5, 6.5.6, 6.6, 7, 7.1, 7.2, 7.3,7.3.1, 7.3.2, 7.3.3., 7.3.4, 7.3.4.1, 7.3.4.2, 7.3.5, 7.3.6, 7.4, 7.4.1 7.5, 7.6, 8, 8.1, 8.1.1, 8.1.2, 9, 9.1, 9.1.1, 10, 11, 11.1, 11.1.1, 11.1.2, 11.1.3, 11.1.4, 11.1.5, 11.1.6, 11.1.7, 11.1.8, 11.1.9, 11.2, 11.2.1, 11.2.2, 11.2.3, 11.2.4, 11.2.5, 12, 13, 14, 15, 15.1, 15.2, 15.4 |

*Red italicized font identifies new material.*

**NEW/REVISED MATERIAL EFFECTIVE DATE: July 1, 2003**
**IMPLEMENTATION DATE: July 1, 2003**

**Medicare contractors only: these instructions should be implemented within your current operating budget.**

The instructions included within this chapter contain medical review (MR) guidelines for intermediaries. Many of these instructions are outdated and are being deleted to allow intermediaries to develop their own MR guidelines. In addition to being outdated, this chapter also contains lists of coverage criteria for therapy services that are being deleted. These lists include the number of therapy visits that may be covered for a specific duration for a specific diagnosis. These instructions represent coverage policies and should not be in the PIM. For medical review purposes, the PIM provides instructions to the contractors on the medical review process and the evidence each contractor should use in determining whether a service is reasonable and necessary. This chapter also contains instructions for the completion of CMS form 485 that are being deleted. This form is not required and for the most part the information can be found on the OASIS or other parts of the medical record. The form is optional and the regulation requires only that certain elements be included in the medical record. We anticipate in the near future deleting the remaining instructions found in this chapter.

**Section 2 – MR of Hospice Claims --** has been deleted.

**Section 2.1 – Review of Routine Home Care, Inpatient Respite, General Inpatient, and Continuous Care Claims --** has been deleted.

**Section 2.2 – Review of Hospital Claims for Hospital Admissions of Beneficiaries who Have Elected Hospice Care --** has been deleted.

**Section 3 – Medical Review of Home Health Services --** has been deleted.

**Section 3.1 – form CMS-485 -- Home Health Certification and Plan of Care Data --** has been deleted. However, HHAs may submit any document that is signed and dated by the physician that contains all of the required data elements in a readily identifiable location within the medical record and in accordance with the current rules governing the home health plan of care.

**Section 3.2 – Addendum to Form CMS-485 Plan of Care --** has been deleted. Exhibit 29 has the description of items contained on form 485.

**Section 3.3 – Medical Review of Home Health Claims --** has been deleted.

**Section 3.4 – Medical Review of Home Health Prospective Payment System (HHPPS) Claims (Date of Service on or After 10/1/2000) --** has been deleted.

**Section 3.4.1 – General --** has been deleted.

**Section 3.4.2 – Types of Review --** has been deleted.

**Section 3.4.3 – MR Process --** has been deleted.

**Section 3.4.4 – Claim Selection --** has been deleted.

**Section 3.4.5 – Record Request --** has been deleted.

**Section 3.4.6 – Record Review --** has been deleted.

**Section 3.4.7 – Outcome of Review --** has been deleted.

**Section 3.4.8 – Data Analysis --** has been deleted.

**Section 3.4.9 – Medicare Integrity Program-Provider Education and Training (MIPPET) --** has been deleted.

**Section 3.5 – Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care --** has been deleted.

**Section 3.6 – Treatment Codes for Home Health Services --** has been deleted.

**Section 3.7 – Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home" --** has been moved to Chapter 6, Section 2.

**Section 3.8 – Reporting --** has been deleted.

**Section 4 – MR of CORF Claims --** has been deleted.

**Section 4.1 – Review of CORF Claims --** has been deleted.

**Section 4.2 – Purpose of the MR --** has been deleted.

**Section 4.3 – Documentation Requirements --** has been deleted.

**Section 4.4 – Mental Health Services Limitation --** has been deleted.

**Section 5 – MR of Part B Intermediary Outpatient Physical Therapy (OPT) Bills --** has been deleted.

**Section 5.1 – Level I Review --** has been deleted.

**Section 5.2 – Level II Review Process --** has been deleted.

**Section 5.3 – MR Documentation for OPT Bills --** has been deleted.

**Section 5.3.1 – Medical History --** has been deleted.

**Section 5.3.2 – Evaluation --** has been deleted.

**Section 5.3.3 – Plan of Treatment --** has been deleted.

**Section 5.3.4 – Progress Reports --** has been deleted.

**Section 5.3.5 – Certification and Re-certification --** has been deleted.

**Section 5.3.6 – PT Forms --** has been deleted.

**Section 5.3.7 – Post-Pay Sample – Denial Rate --** has been deleted.

**Section 5.4 – Evaluation of PT Edits --** has been deleted.

**Section 5.4.1 – OPT Edits --** has been deleted.

**Section 6 – MR of Part B Intermediary Outpatient Speech-Language Pathology (SLP) Bills --** has been deleted.

**Section 6.1 – Level I Review --** has been deleted.

**Section 6.2 – Level II Review --** has been deleted.

**Section 6.3 – MR Documentation --** has been deleted.

**Section 6.3.1 – Medical History --** has been deleted.

**Section 6.3.2 – Assessment --** has been deleted.

**Section 6.3.3 – Plan of Treatment --** has been deleted.

**Section 6.3.4 – Progress Reports --** has been deleted.

**Section 6.3.5 – Level of Complexity of Treatment --** has been deleted.

**Section 6.3.6 – Reporting of New Episode or Condition --** has been deleted.

**Section 6.3.7 – Certification and Re-certification --** has been deleted.

**Section 6.4 – Qualified Speech Language pathologist --** has been deleted.

**Section 6.5 – Skilled and Unskilled Procedures --** has been deleted.

**Section 6.5.1 – Statements Supporting and Not Supporting Coverage --** has been deleted.

**Section 6.5.2 – MR Considerations --** has been deleted.

**Section 6.5.3 – FMR Evaluation --** has been deleted.

**Section 6.5.4 – SLP Terms --** has been deleted.

**Section 6.5.5 – Acronyms and Abbreviations --** has been deleted.

**Section 6.5.6 – SLP Tests --** has been deleted.

**Section 6.6 – Outpatient SLP Edits --** has been deleted.

**Section 7 – MR of Part B Intermediary Outpatient OT Bills --** has been deleted.

**Section 7.1 – Level I Review --** has been deleted.

**Section 7.2 – Level II Review Process --** has been deleted.

**Section 7.3 – MR Documentation --** has been deleted.

**Section 7.3.1 – Medical History --** has been deleted.

**Section 7.3.2 – Evaluation --** has been deleted.

**Section 7.3.3 – Plan of Treatment --** has been deleted.

**Section 7.3.4 – Progress Reports --** has been deleted.

**Section 7.3.4.1 – Change in Level of Assistance --** has been deleted.

**Section 7.3.4.2 – Change in Response to Treatment Within Each Level of Assistance --** has been deleted.

**Section 7.3.5 – Level of Complexity of Treatment --** has been deleted.

**Section 7.3.6 – Reporting on New Episode or Condition --** has been deleted.

**Section 7.4 – Other MR Considerations --** has been deleted.

**Section 7.4.1 – OT Availability --** has been deleted.

**Section 7.5 – Focused MR Analysis --** has been deleted.

**Section 7.6 – Outpatient OT Edits --** has been deleted.

**Section 8 – Forms HCFA-700/701, Outpatient Rehabilitation Services Forms --** has been deleted.

**Section 8.1 – Electronic Attachments --** has been deleted.

**Section 8.1.1 – Instructions for Completion of Form HCFA-700, Plan of Treatment for Outpatient Rehabilitation --** has been deleted.

**Section 8.1.2 – Instructions for Completion of Form HCFA-701, Updated Plan Progress for Outpatient Rehabilitation --** has been deleted.

**Section 9 – MR of ESRD Claims --** has been deleted.

**Section 9.1 – Review of ESRD Claims --** has been deleted.

**Section 9.1.1 – Guidelines for Review of Claims for Epoetin (EPO) --** has been deleted.

**Section 10 – Special Instructions for MR of Dysphagia Claims --** has been deleted.

**Section 11 – MR of Hospital Outpatient Claims --** has been deleted.

**Section 11.1 - Guidelines for Hospital Outpatient Services --** has been deleted.

**Section 11.1.1 – Diagnostic Services --** has been deleted.

**Section 11.1.2 – Therapeutic Services --** has been deleted.

**Section 11.1.3 – Drugs and Biologicals --** has been deleted.

**Section 11.1.4 – Supplies --** has been deleted.

**Section 11.1.5 – Narcolepsy, Sleep Apnea, Impotence Clinics --** has been deleted.

**Section 11.1.6 – Education Programs --** has been deleted.

**Section 11.1.7 – Observation Room Services --** has been deleted.

**Section 11.1.8 – Outpatient Surgical Services and Ancillaries --** has been deleted.

**Section 11.1.9 – Review of Outpatient Hospital Psychiatric Services --** has been deleted.

**Section 11.2 - Hospital Outpatient MR Selection Criteria --** has been deleted.

**Section 11.2.1 - Required Review --** has been deleted.

**Section 11.2.2 - Review Guides --** has been deleted.

**Section 11.2.3 - Revenue Code MR --** has been deleted.

**Section 11.2.4 - MR of Questionable Diagnoses and Procedures --** has been deleted.

**Section 11.2.5 - Diagnosis and Procedure Codes That May Be Automatically Denied --** has been deleted.

**Section 12 - MR of Ambulance Services --** has been deleted.

**Section 13 - MR of EPO therapy for HIV-Infected Patients --** has been deleted.

**Section 14 - Intermediary Review of CWF Alerts --** has been deleted.

**Section 15 - MR of Partial Hospitalization Claims --** has been deleted.

**Section 15.1 – General --** has been deleted.

**Section 15.2 - Bill Review Requirements --** has been deleted.

**Section 15.4 - Reason for Denial --** has been deleted.

# Medicare Program Integrity Manual

## Chapter 6 - Intermediary MR Guidelines for Specific Services

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***(Rev. 42, 06-20-03)***



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## *2* - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home" - (Rev. 42, 06-20-03)

A. General Information--RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.

NOTE: For the purposes of this manual section a favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the RO has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

- Promptly pay the claim that was the subject of the favorable final appellate decision.
- Promptly pay or review based on the review criteria below:
- All claims that have been denied that are properly pending in any stage of the appeals process.
- All claims that have been denied where the time to appeal has not lapsed.
- All future claims submitted for this beneficiary.
- For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.
- Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.
- Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.
- Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to CMS upon request.

B. Review Criteria--Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision unless there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for home health care. If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review.

EXAMPLE 1

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be

given "great weight" in future medical review determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary’s ability to leave the home.