Program Memorandum Intermediaries

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

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CHANGE REQUEST 1973

SUBJECT: Processing of Home Health Prospective Payment System (HH PPS) Mass Adjustments -- Regional Home Health Intermediaries (RHHIs) Only

I - GENERAL INFORMATION

A - Background: This Program Memorandum (PM) provides instructions for the processing of mass claims adjustments to correct for the failure of Medicare claims systems to properly initiate partial episode payment adjustments on some HH PPS claims.

By law, payments for 60-day episodes of home health care under HH PPS must be prorated in the event that a beneficiary transfers between home health agencies (HHAs) during the course of the 60-day episode. This proration is also required in cases in which a beneficiary is discharged from an HHA with their treatment goals met, but the beneficiary is later readmitted to the same HHA within the original 60-day period. In both these cases, the proration takes the form of a partial episode payment (PEP) adjustment, in which the claim payment for the services prior to the transfer or discharge is multiplied by the number of days between the first and last billable visits divided by 60.

Frequently, claims for which PEP adjustments must be applied are known to the HHA and the adjustment is triggered in Medicare systems by the HHA reporting a patient status code of 06 (indicating transfer or discharge/readmit) on their final claim for the period prior to the transfer or discharge. If the HHA is not aware that a PEP adjustment applies, Medicare systems should ensure that the PEP adjustment is made. Two mechanisms were developed as part of the initial HH PPS implementation to ensure this.

If the claim for the services subsequent to the transfer or discharge has been paid, a claim for an episode that overlaps those services but which does not have a patient status of 06 will be rejected by the Common Working File (CWF). The HHA must change the patient status code of this claim and resubmit the claim in order to be paid. This mechanism has functioned properly since HH PPS was implemented.

If the claim for the services subsequent to the transfer or discharge has not been paid, Medicare systems have no way to recognize that a PEP adjustment should be applied when the claim for the earlier period is received. If this claim is not submitted with a patient status code of 06, Medicare systems will process the claim with the full episode payment. Later, when the claim that would cause the PEP adjustment to apply is received, Medicare systems were designed to identify the claim that received the full payment and to initiate an automatic process to apply the PEP adjustment and recover any difference in payment from other claims payments. This mechanism did not function properly when HH PPS was implemented.

Medicare systems are being corrected to ensure that this automatic process (known as the unsolicited response process) functions as designed and all future PEP adjustments are recognized and applied in a timely fashion. System changes to ensure this were implemented in Fiscal Intermediary Standard System (FISS) and CWF in July and October

2001. Similar changes will be implemented in the Arkansas Part A Standard System (APASS) as soon as possible. Then adjustments to all unidentified PEP claims must be performed through the creation of a utility in CWF to identify all the claims to be adjusted and the reprocessing by the RHHIs of the claims from the utility.

B - Policy: Section 1895(b)(6) of the Social Security Act provides for the proration of prospective payment amounts as described above. The supporting regulation for this proration is found at 42 CFR 484.205(a)(2) and 485.235.

II - BUSINESS REQUIREMENTS

Claims Processing Requirements:

Req. #	Resp.	Requirements
1973.1	CWF	CWF shall develop a one-time utility program to identify for adjustment all HH PPS episodes (10/01/2000 to the present) for which the episode end date overlaps the episode start date of a subsequent episode.
1973.1.1	CWF	For the final claim (type of bill 329, 339 or subsequent adjustment type of bill) for each episode identified, CWF will determine if the patient status on the claim is 06. If it is not, CWF will generate an unsolicited response to initiate a PEP adjustment on the claim, using the existing process for these responses (the trailers 20/23/23 process).
1973.1.2	CWF	Each CWF host site shall run this utility, and shall generate separate output files of unsolicited responses for each RHHI.
1973.1.3	CWF	CWF shall construct the output file of the utility to allow the RHHI's data center to release the responses in batches of a size to be determined by the RHHI.
1973.2	SS	Intermediary standard systems will process the unsolicited responses in these files identically to unsolicited responses received in the regular production claims environment.
1973.3	RHHIs	RHHIs shall analyze the size of the unsolicited response file and determine, in consultation with CMS, the size of batches of responses to release for processing. To the greatest extent practical, batch sizes will be limited to reduce the impact on payments to individual providers.
1973.4	RHHIs	RHHIs shall process batches of mass adjustments and create withholdings from each HHA's next remittance advice(s).
1973.5	RHHIs	RHHIs shall notify providers in advance of the dates when adjustments will commence, using regular provider bulletins and website postings.
1973.5.1	RHHIs	RHHIs shall include in their provider notification instructions to providers who may be aware of claims that should have received PEP adjustments or who may wish to research whether PEP adjustments should be applied. RHHIs shall encourage these providers to submit adjustment to their own claims with patient status 06 prior to the implementation of the mass adjustments outlined in this PM.

III - Possible Design Considerations and Supporting Information

A - Inputs:

X-Ref Req. #	Input Description
N/A	No new claims inputs are required since existing paid claims history will be used in this process.

B - Outputs:

X-Ref Req. #	Output Description
N/A	Current outputs for the unsolicited PEP adjustment process are unchanged by this instruction.

C - Interfaces:

X-Ref Req. #	Interface Description
N/A	No interfaces with CMS software modules are affected by this instruction. The PEP adjustments initiated by this instruction will flow through the HH PPS Pricer normally.

D - Provider Impact:

X-Ref Req. #	Provider Impact (Specify Contractor Requirements for the Impacts Below)
.4	Providers will see withholdings on their remittance advices resulting from adjustment processing in the same manner in which such adjustments appear on remittances as part of regular claims processing.

E - Contractor Financial Reporting /Workload Impact: This instruction will result in an increase of adjustment claims processed at the RHHIs. Audit and reimbursement as well as customer service/provider education workloads may be increased as a result of provider inquiries in response to the mass adjustments.

F - Dependencies: This Change Request is not dependent on any other current Change Request or on any pending regulation/instruction.

G - Testing Considerations: Since the utility to identify claims will be created and run after the existing failures in the PEP adjustment mechanisms are corrected, new test cases to re-create the scenario will not be possible. Claims from existing paid claim history for the period from October 1, 2000 to the date of each Standard System's correction of the problem must be moved into a test region to test the utility.

IV - Attachment(s) N/A

The *effective date* for this PM is July 1, 2002.

The *implementation date* for this PM is July 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2003.

If you have any questions, contact your Regional Office.