Program Memorandum Intermediaries

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

Transmittal A-02-068 **Date: JULY 24, 2002**

CHANGE REQUEST 2095

Subject: Enhancements to Home Health Prospective Payment System (HH PPS) Claims Processing

I - GENERAL INFORMATION

A – Background

This Program Memorandum (PM) provides instructions for several modifications to Medicare HH PPS claims processing systems to improve overall claims processing efficiency and accuracy as well as to strengthen existing program integrity safeguards. None of the Medicare systems modifications described in this PM require billing changes by Medicare home health agencies or other providers.

1. Revision to Common Working File (CWF) Edit for Overlapping Episodes--Currently, all HH PPS claims that overlap an HH PPS episode already on record receive the same CWF edit. Various scenarios can lead to a claim overlapping an existing episode. Differing scenarios may require differing responses to the claim on the part of the Regional Home Health Intermediary (RHHI). With this PM, three scenarios involving overlaps of episodes will be isolated from the current edit and will receive new and discrete edits from CWF. Requirements one through seven below describe this change.

2. Increased Editing to Prevent Duplicate Billing--Currently, Medicare systems rely entirely on the comparison of claims to HH PPS episode records in CWF to ensure that duplicate HH PPS claims are not paid. With this PM, additional duplicate billing checks will be installed. The intermediary Standard Systems will perform duplicate checks comparing incoming Requests for Anticipated Payment (RAPs) and claims to claims already in their paid claims history. Requirements eight and nine below describe this change.

3. Identification of Paid Claims to Receive Partial Episode Payment (PEP) Adjustments Due to Overlaps with Medicare + Choice (M+C) Enrollment--Currently, HH PPS claims are returned to the HHA for correction if they are found to overlap an M+C enrollment period. However, a HH PPS claim may be paid prior to the posting of an M+C period in CWF. When the M+C period is posted in CWF, CWF does not check whether the period overlaps a previously paid HH PPS episode. The previously paid claim should receive a Partial Episode Payment (PEP) adjustment in this case, but has received a full payment. With this PM, CWF will create a process to search for overlapping HH PPS episodes when an M+C period is posted. If an overlapping episode is found, Medicare systems will perform an automated adjustment of the claim for that episode to correct the payment amount. Requirements ten through seventeen below describe this change.

B – Policy

The modifications to Medicare systems described in this PM conform with policies and regulations governing HH PPS. The HH PPS regulations appear at 42 CFR 484 Subpart E. The preamble to the HH PPS final rule specifically addresses PEP adjustment for HMO enrollees. This information can be found at ***Federal Register*** vol. 65, no. 128, p. 41162, published on July 3, 2000.

II - BUSINESS REQUIREMENTS

Claims Processing Requirements:

Req. #	Resp.	Requirements
2095.1	CWF	CWF must revise edit 5385 to no longer set when the RAP or claim overlapping an existing episode has the same provider number, and the RAP or claim "From" date matches the episode start date of the existing episode. For purposes of all requirements in this PM, "claim" includes episode payment claims, LUPA claims and no-RAP LUPA claims.
2095.2	CWF	CWF must create a new edit which must set when a RAP or claim overlapping an existing episode has the same provider number, and the RAP or claim "From" date and the episode start date match.
2095.3	CWF	CWF must revise edit 5385 to no longer set when the RAP or claim overlapping an existing episode has the same provider number, and the RAP or claim "From" date is different from the episode start date of the existing episode.
2095.4	CWF	CWF must create a new edit which must set when a RAP or claim overlapping an existing episode has the same provider number, and the RAP or claim "From" date is different from the episode start date of the existing episode.
2095.5	CWF	CWF must revise edit 5385 to no longer set when a claim which corresponds to an episode of less than 60 days overlaps another existing episode on which source of admission code B or C is not present.
2095.6	CWF	CWF must create a new edit which must set when a claim which corresponds to an episode of less than 60 days overlaps another existing episode on which source of admission code B or C is not present.
2095.7	SS	Standard Systems must create three new reason codes to apply to RAPs or claims that are returned from CWF with the new edits described in requirements 2095.2, 2095.4 and 2095.6 above.
2095.8	SS	Standard Systems must compare incoming RAPs to paid claims history and must reject any RAP for which a paid RAP or paid, suspended or denied claim is found with a matching provider number, HIC number, and matching statement "From" date but without a cancel date.
2095.9	SS	Standard Systems must compare incoming HH PPS claims to paid claims history and must reject any claim for which a paid, suspended or denied claim is found with a matching provider number, HIC number, and a revenue code with a matching line item date of service but without a cancel date.
2095.10	CWF	When creating a new M+C enrollment period, CWF must search the HH episode file for episodes with end dates that overlap (i.e. fall on or after) the start date of the enrollment period.

Req. #	Resp.	Requirements
2095.11	CWF	If the DOEBA and DOLBA dates on the overlapping episode are blank, CWF will take no action on the corresponding paid RAP for the episode.
2095.12	CWF	If the overlapping episode shows a patient status code of 06 and the DOLBA on the episode falls before the M+C enrollment date, CWF will take no action against the corresponding paid claim for the episode.
2095.13	CWF	If the conditions in requirements 2095.11 and 2095.12 are not met, CWF must identify the corresponding paid claim for the episode in paid claims history
2095.14	CWF	For all HH PPS claims identified in requirement 2095.13, CWF must initiate an unsolicited response for the claim, with a code in the trailer mask uniquely identifying the response as caused by an M+C overlap.
2095.15	CWF	In all respects other than the unique trailer mask, CWF must model the unsolicited response on the existing PEP unsolicited response process (the trailers 20/23/23 process).
2095.16	SS	In all respects other than the outputs described below, standard systems must initiate payment adjustments against claims identified in the unsolicited responses after the model of the existing PEP unsolicited response process.
2095.17	RHHI	RHHI provider education staff must not publish information regarding these enhancements prior to their implementation in the production claims process.

III - Possible Design Considerations and Supporting Information

A - Inputs:

X-Ref Req. #	Input Description
N/A	No new provider claims inputs are required in this process.

B - Outputs:

X-Ref Req. #	Output Description
2095.9	Remittance advices for HH PPS claims rejected due to the presence of an exact duplicate claim in paid claims history must report reason code 18 (defined “duplicate claims/service”). The code must be reported at the claim level.
2095.16	Remittance advices for HH PPS claims adjusted due to unsolicited responses for M+C overlaps must report adjustment reason code 24 (defined “Payment for charges denied/reduced. Charges are covered under a capitation agreement/managed care plan”). The code must be reported at the claim level.
2095.16	Medicare Summary Notices (MSNs) for HH PPS claims adjusted due to unsolicited responses for M+C overlap must report MSN message 11.3 (defined “Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them”).

C - Interfaces:

X-Ref Req. #	Interface Description
2095.14	Recognition of the new trailer mask may affect the trailers 20/23/23 process interface.

D - Provider Impact:

X-Ref Req. #	Provider Impact (Specify Contractor Requirements for the Impacts Below)
2095.16	A different remittance advice code received on automatically adjusted claims may initially generate provider questions to the RHHI, although its longer term function is to better explain the nature of the payment adjustment providers receive.

E - Contractor Financial Reporting/Workload Impact: This instruction will not result in impacts to financial reporting or contractor workload.

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

G - Testing Considerations: Testing of requirements 2095.14 through 2095.16, will require careful coordination to set up effective test cases. CWF should identify specific beneficiaries that will be set up as M+C enrollees and provide that information to the Standard System maintainers and RHHIs. The Standard System maintainers and RHHIs will need to create their history claims prior to the beneficiary being set up in CWF as M+C in order to generate the unsolicited response. After being informed by test sites that these claims have been created, CWF should set up the M+C enrollment periods for these beneficiaries so that testing can begin.

IV - Attachment(s): N/A

The *effective date* for this PM is January 1, 2003.

The *implementation date* for this PM is January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact your Regional Office.