CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 91 **Date: February 6, 2004**

CHANGE REQUEST 3077

I. SUMMARY OF CHANGES: Revisions to Processing of Non-covered Charges on Certain Home Health Prospective Payment System Claims.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/ 60.5/Intermediary Processing of No-Payment Bills

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-4	Transmittal: 91	Date: February 6, 2004	Change Request 3077

SUBJECT: Revisions to Processing of Non-covered Charges on Certain Home Health Prospective Payment System Claims.

The APASS maintainer and associated FIs are waived from implementing this requirement on July 6, 2004, due to their upcoming transition to the FISS system. However, they must implement this requirement upon transitioning to the FISS system.

I. GENERAL INFORMATION

A. Background: On October 31, 2003, CMS published Transmittal 25 to the Medicare Claims Processing Manual. This transmittal provided confirmation and clarification of many policies regarding the submission and processing of non-covered charges on outpatient claim types. It also provided some new requirements for Fiscal Intermediary (FI) systems regarding these claims. Among these new requirements were business requirements for the FI Shared System (FISS) to send home health prospective payment system (HH PPS) claims to the Common Working File (CWF) using non-payment code 'R' (requirements 2634.17 – 2634.19 of Transmittal 25). Non-payment code 'R' is used when the non-covered claim being transmitted to CWF must be used to update spell of illness and utilization records.

During the development of system requirements and design for the changes described in Transmittal 25, the requirement to use non-payment code 'R' were found to be far greater in scope that originally anticipated. CMS and the FISS and CWF maintainers agreed that requirements 2634.17 – 2634.19 would not be implemented in April 2004 as planned, and that these requirements would be removed from a revision to Transmittal 25 and replaced by subsequent instructions. This transmittal provides the necessary new instructions for processing HH PPS non-covered claims by Regional Home Health Intermediaries (RHHI).

B. Policy: Non-covered HH PPS claims must update HH spell of illness and utilization data in the cases defined in the Medicare Claims Processing Manual, chapter 1, section 60.5. In these cases, non-covered HH PPS claims must be transmitted to CWF with non-payment code 'R' in order to direct CWF to take these actions.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3077.1	Medicare systems shall have the ability to use non-payment code 'R' on non-covered HH PPS claims in order to ensure HH spell of illness and utilization data are updated.	FISS

3077.2	When sending non-payment code 'R' Medicare systems shall create home health value codes 62-65 on non-covered HH PPS claims, filling the values associated with the codes with zeroes.	FISS
3077.3	When sending non-payment code 'R', Medicare systems shall indicate that HH PPS claims are non-covered at the claim level, but service lines will continue to be reported as if covered.	FISS
3077.4	When non-payment code 'R' is present on HH PPS claims, Medicare systems shall update the dates of earliest and latest billing activity (DOEBA and DOLBA) of the HH spell on non-covered HH PPS claims.	CWF
3077.5	When non-payment code 'R' is present on HH PPS claims, Medicare systems should bypass consistency edits on non-covered HH PPS claims if necessary.	CWF

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3077.1 – 3077.5	For purposes of these requirements, HH PPS claims excludes requests for anticipated payment (RAPs), types of bill 322 and 332.
3077.4	CWF shall update the DOEBA and DOLBA of the home health benefit period (HHBP) file only. The DOEBA and DOLBA of the home health episode file (HHEH) shall not be changed.
3077.5	Requirement 2634.16 in Transmittal 25 is likely to create all necessary CWF bypasses. The CWF maintainer, in consultation with CMS, may exercise this optional requirement if additional bypass needs are discovered during implementation and testing of the other requirements.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements
3077.1	FISS reason codes corresponding to the non-payment code 'R' situations described in Medicare Claims Processing Manual, chapter 1, section 60.5 include, but may not be limited to, 39011 (untimely) and 56900 (provider failed to submit information).

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: The changes in this CR may be dependent on the successful implementation of Transmittal 25 (as revised) in the April 2004 quarterly release.

F. Testing Considerations: System maintainers and RHHIs should ensure testing of these requirements includes inspection of the resulting Medicare Summary Notices (MSNs). MSNs for non-covered claims with non-payment code 'R' should indicate that the beneficiary has no liability, even though service lines on the claim may continue to appear as covered.

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wgehne@cms.hhs.gov or Elizabeth Carmody, 410-786-7533, ecarmody@cms.hhs.gov** **Post-Implementation Contact(s): Regional Offices**	**These instructions shall be implemented within your current operating budget**

60.5 - Intermediary Processing of No-Payment Bills

(Rev. 91, 2-6-04)

A3-3624

A - Nonpayment Codes

Intermediaries use nonpayment codes in inpatient CWF records where payment is not made. (Inpatient bills where partial payment is made do not require nonpayment codes.) These codes alert CMS to bypass edits in CWF processing that are not appropriate in nonpayment cases. The intermediary enters the appropriate code in field 51 of the CWF record if the nonpayment situation applies to all services covered by the bill. It does not enter the nonpayment code if partial payment is made. Also, it does not enter the nonpayment code when payment is made in full by an insurer primary to Medicare. When the intermediary identifies such situations in its development or processing of the bill, it adjusts the bill data the provider submitted, and prepares an appropriate CWF record.

1 - Nonpayment Code B - Benefits Exhausted Before "From" Date on Bill.
The intermediary uses code B when benefits and/or lifetime reserve days are exhausted, or when the beneficiary elects not to use them.

2 - Nonpayment Code R
The intermediary uses code R in the following instances when there is technical liability but utilization is charged:

- It denies all SNF inpatient services for other than medical necessity or custodial care, including a provider's failure to submit medical documentation;
- Time limitation for filing expired before billing, and provider is at fault;
- Provider failed to submit needed information; and
- Patient refused to request benefits.

Regional Home Health Intermediaries also use code R in the cases listed above, if applicable.

3 - No Payment Situations Not Requiring Nonpayment Code.

- Payment cannot be made because deductible/coinsurance exceeds the payment amount.
- EGHP, LGHP, auto/medical or no-fault insurance, WC (including BL), NIH, PHS, VA, other governmental entity or liability insurance paid for all covered services.
- Services provided to HMO enrollee for which the HMO has jurisdiction for payment. This is option code B or C in R trailer.

4 - Use of Nonpayment Code N in Cases Where Provider Is Liable.
(All charges are shown as noncovered. Utilization is not charged.) Section 4096 of the Omnibus Budget Reconciliation Act (OBRA) of 1987 states that a beneficiary is not responsible for payment of the deductible, coinsurance or the remaining cost of services or items furnished by a provider who knew, or should have known, that Medicare would not pay for the Part A or Part B service or item.

5 - Use of Nonpayment Code N in Cases Where Provider Is Not Liable.
The intermediary uses code N in the following instances when neither utilization nor cost report days are reported:

- Services not covered under Part A (e.g., dental care, cosmetic surgery), excludes services determined to be medically unnecessary or custodial.
- Time limitation for filing expired before billing, and provider is not at fault.
- Limitation of liability decision finds beneficiary at fault.
- Inpatient psychiatric reduction because of days used before admission. (See Medicare Benefit Policy Manual, Chapter 4.)
- All services after active care ended in a psychiatric hospital.
- All services after the date a covered level of care ended (general hospital or SNF).

  MSP cost avoidance denials. (See Medicare Secondary Payer Manuals.)