Program Memorandum Intermediaries

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

Transmittal A-02-107

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CHANGE REQUEST 2315

SUBJECT: Revisions to Common Working File Editing to Accommodate Home Health Partial Episode Payment Claims and Rescheduling of Payment Adjustment Utility

I. GENERAL INFORMATION

A. Background:

Program Memorandum (PM) A-02-008 provided instructions for the processing of claims adjustments to correct the failure of Medicare systems to properly initiate partial episode payment (PEP) adjustments on some home health prospective payment system (HH PPS) claims.

By law, payments for 60-day episodes of home health care under HH PPS must be prorated in the case that a beneficiary transfers between home health agencies (HHAs) during the course of the 60-day episode. This proration is also required in the case that 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 the transfer and discharge with readmission 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 either transfer or discharge with readmission) 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). Initially, the HHA was required to change the patient status code of this claim and resubmit the claim in order to be paid. Currently, this code is changed by Medicare systems. 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, to initiate an automatic process to apply the PEP adjustment, and to recover any difference in payment from other claims payments. This mechanism did not function properly when HH PPS was implemented.

Medicare systems corrections to ensure that this automatic process (known as the PEP unsolicited response process) functioned as designed were implemented throughout 2001 and 2002. Many corrections led to the identification of further problems in Medicare systems software and the unfolding need for further corrections led in July 2002 to the postponement of the adjustment and recovery process that PM A-02-008 described.

In addition, effective April 1, 2002, Medicare systems began transmitting non-covered lines on outpatient claims between the FI standard systems and CWF for the first time. During testing of corrections to the PEP unsolicited response process after April 1, 2002 it was determined the CWF was not prepared to accept PEP claims generated by the process. On these PEP claims, the FI standard systems often change lines on the claims from covered to non-covered and adjust the claim's statement "Through" date so that the non-covered lines fall outside the "Through" date. CWF is currently unable to accept these non-covered lines which fall outside the adjusted episode. The requirements that follow instruct CWF to make the changes necessary to accept these unsolicited response PEP claims.

Once these CWF changes and all additional standard system software corrections are completed and tested, adjustments to all unidentified PEP claims must be performed. This will be accomplished through the processing of the utility in CWF created by PM A-02-008, which identifies all the claims to be adjusted for reprocessing by the Regional Home Health Intermediaries (RHHIs).

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

Req. #	Requirements	Resp.
2315.1	CWF must revise all consistency edits which do not allow line item dates to exceed the claim "Through" date. These edits must be revised to bypass any line with non-covered charges equal to total charges on HH PPS final claims or adjustments.	CWF
2315.2	CWF must revise all HH PPS episode edits which do not allow line item dates to exceed the episode end date to bypass any line with non-covered charges equal to total charges.	CWF
2315.3	CWF must continue to use only covered service lines for purposes of triggering HH consolidated billing edits.	CWF

2315.4	CWF must continue to use only covered service lines for purposes of updating HH episode records or HH benefit period records.	CWF
2315.5	CWF will revise the utility created in PM A-02-008, as necessary, to reflect any claim record format changes that have been implemented since the July 2002 release.	CWF
2315.6	Following the implementation of requirements 2315.1 through 2315.4, each CWF host site must run the utility, and must generate separate output files of unsolicited responses for each RHHI.	CWF
2315.7	RHHIs must analyze the size of the unsolicited response file and determine, in consultation with CMS, the size of response batches to release for processing. To the greatest extent practical, batch sizes will be limited to reduce the impact on payments to individual providers.	RHHIs
2315.8	Intermediary standard systems must process the unsolicited responses in these files identically to unsolicited responses received in the regular production claims environment.	SS
2315.9	RHHIs must process batches of adjustments and create withholdings from each HHA's next remittance advice(s).	RHHIs
2315.10	RHHIs must notify providers in advance of the dates when adjustments will commence, using regular provider bulletins and website postings.	RHHIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A – Other Instructions: N/A

B – Design Considerations: N/A

C - Interfaces: 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 - 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.

E - Dependencies: This Change Request is not dependent on any other current Change Request or on any pending regulation/instruction. It is dependent on the successful resolution of all production claims processing issues in the Standard Systems relating to PEP unsolicited responses.

F - Testing Considerations: There are no special testing considerations regarding the revisions to CWF edits. 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 failures must be moved into a test region to test the utility.

IV - ATTACHMENT(S) N/A

Version: Final, 9/20/2002 Implementation Date: April 1, 2003 Discard Date: April 1, 2004 Post-Implementation Contact: Regional Offices	Effective Date: April 1, 2003 Funding: Within Current Operating Budget Pre-Implementation Contact: Wil Gehne, (410) 786-6184, wgehne@cms.hhs.gov