Related Change Request (CR) #: 3400 **Medlearn Matters Number:** MM3400
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 95
Effective Date: Service dates beginning October 1, 2000 and ending September 30, 2003
Implementation Date: January 3, 2005

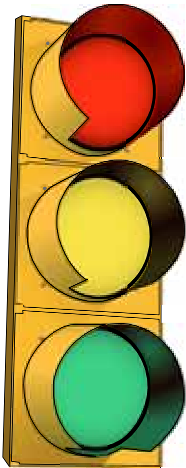
Modification to Post-Payment Adjustment Process for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Inpatient Discharges

Provider Types Affected

All Home Health Agencies (HHAs)

Provider Action Needed

HHAs should be aware of modifications to Change Request (CR) 2928, which was issued by the Centers for Medicare & Medicaid Services (CMS) on October 24, 2003.



STOP – Impact to You

The post-payment review process implemented in CR2928 has been modified to identify and pay underpayments associated with reporting errors for Federal fiscal years (FY) 2001, 2002, and 2003. This does not apply to claims with dates of service in Federal fiscal year 2004 and for future years.

CAUTION – What You Need to Know

Please note that this applies to situations where the presence of skilled nursing facility (SNF) or inpatient rehabilitation facility (rehab) stays were not reported and claims were underpaid.

GO – What You Need to Do

In cases where claims errors are discovered for the current fiscal year and future years, HHAs can have the full Medicare timely filing period to submit correct claims that are believed to be underpaid.

Background

Payments for HH PPS claims are based on the payment groups derived from beneficiary assessment data reported by HHAs on the Outcome Assessment Information Set (OASIS). Information about inpatient discharges prior to a home health episode of care is captured in OASIS item MO175. This item and other assessment data determine the HH PPS payment groups, known as home health resource groups

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(HHRGs), which have an associated weight value for an episode of care based on a national standard per episode amount. The HHRGs are represented on a claim to Medicare as a Health Insurance Prospective Payment System (HIPPS) code.

Studies by the Office of Inspector General (OIG) found that Medicare has paid claims with HIPPS codes representing no hospital discharge in cases where Medicare claims history shows that an inpatient stay occurred the 14 days prior to the start of care. When HHAs report in OASIS item M0175 that a beneficiary has not been discharged from a hospital within 14 days of the start of home health care, the claim for that beneficiary may in some cases be submitted using a HIPPS code for a higher weighted payment group. These errors in Medicare claims led the CMS to issue Transmittal 13 (CR 2928) to implement pre-payment and post-payment safeguards to address the payment vulnerability identified.

Since the publication of Transmittal 13, HHAs have requested that Medicare systems also look for the presence of SNF or rehabilitation facility stays that the provider did not report and to adjust the claims where such stays were found. In instances where no SNF or rehab stay was reported, but such a claim is found in Medicare claims history, the claim was underpaid. HHAs may not have reported SNF or rehab stays because they misunderstood how to report OASIS item M0175, or because they did not use all the sources of information about prior inpatient stays during the early years of the transition to the HH PPS.

Medicare is now modifying the post-payment review process outlined in Transmittal 13 to identify underpayments as well as overpayments that may have resulted from inaccurate reporting of prior inpatient discharges for Federal FY 2001, 2002, and 2003. For claims with dates of service in FY 2004 or beyond, Medicare will maintain the process of identifying overpayments only as outlined in Transmittal 13. Medicare believes that HHAs now understand the OASIS assessment item M0175 and the importance of reporting prior inpatient discharges accurately.

HHAs have the information available to them to submit claims accurately through patients and their caregivers, inpatient discharge sources, and Medicare systems in a great majority of cases. However, in cases where errors are discovered, the HHAs have the full timely filing period to submit adjustments to correct claims they believe were underpaid.

Implementation

The implementation date for the change is January 3, 2005 and applies to services furnished on or after October 1, 2000 and ending September 30, 2003.

Additional Information

Although this article provides details on the modifications to the post-payment process, CMS has also provided additional articles on the HHA payment system, to include:

- The Medlearn Matters article on Payment Safeguards for Home Health Prospective Payment System Claims Failing to Report Prior Hospitalization Correctly may be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2928.pdf

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- An article on Medicare Resources for Researching Inpatient Discharges within 14 Days of a Home Health Admission may be found at:: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0410.pdf
- The related Transmittal 13, Change Request 2928, guidance outlining the original home health prospective and post-payment process related to these claims can be found at: http://www.cms.hhs.gov/manuals/pm_trans/R13CP.pdf
- The Comprehensive information on Home Health billing can be found in Chapter 10 of Medicare's Claims Processing Manual. That publication can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf

If you have additional questions, please contact your regional home health intermediary at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

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