CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 165 **Date: April 30, 2004**

CHANGE REQUEST 3186

I. SUMMARY OF CHANGES: This revision includes business requirements and modifies the Home Health Prospective Payment System Consolidated Billing and Primary Home Health Agency section of the manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2000
***IMPLEMENTATION DATE: October 4, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.25/HH PPS Consolidated Billing and Primary HHAs

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Enhancement to Home Health Consolidated Billing Edits

I. GENERAL INFORMATION

A. Background: Under the consolidated billing policy of the home health prospective payment system (HH PPS), payment for all therapy services provided during a 60-day episode of care is bundled in the HH PPS payment to the HHA. The Common Working File (CWF) ensures that separate payment is not made in error for therapy services on institutional claims processed by fiscal intermediaries. To do so, CWF rejects all institutional claims reporting a physical therapy, occupational therapy or speech/language pathology revenue code when CWF's HH episode history indicates the beneficiary was receiving services under a HH plan of care for the dates of services in question. Other, more complex editing occurs on professional claims processed by Medicare carriers to enforce HH consolidated billing. Medicare carrier processing is not affected by this instruction.

In recent testing of HH consolidated billing, Medicare's Regional Home Health Intermediaries (RHHIs) discovered a previously undetected vulnerability. If a HH episode of care is denied, the therapy services for that episode can be resubmitted by the same home health agency (HHA) on a different type of bill and the claim can be paid. CWF editing is not currently rejecting a claim for home health services not under a plan of care (type of bill 34x) if it falls within a denied HH episode with the same provider number. The requirements below correct this vulnerability.

B. Policy: Medicare systems must ensure that HH services subject to consolidated billing which are provided under a HH plan of care and denied cannot be subsequently paid to the same HHA as services not under a HH plan of care.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3186.1	Medicare systems shall reject a claim for HH services not under a HH plan of care which contains services subject to consolidated billing when: • a denied HH episode is present and • the provider number on the incoming HH claim and on the HH episode match.	CWF
3186.1.1	Medicare systems shall recognize claims for HH services not under a HH plan of care using	CWF

	type of bill 34x.	
3186.1.2	When the date of earliest billing activity (DOEBA) and date of latest billing activity (DOLBA) on a HH episode are blank, Medicare systems shall reject a 34x claim which contains services subject to consolidated billing when: • the provider number on the 34x claims matches the HH episode, and • if the service dates on the 34x claim fall within the HH episode start and end dates.	CWF

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3186.1.2	Episode records with blank DOEBA/DOLBA dates may represent episodes for which only a RAP has been processed in addition to denied episodes. Rejecting 34x claims for the same provider number is appropriate in the both cases.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2000 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Wil Gehne, 410-786-6148, wgehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office(s)	**These instructions shall be implemented within your current operating budget**

Attachment

10.1.25 - HH PPS Consolidated Billing and Primary HHAs

(Rev. 165, 04-30-04)

HH-467.35, A3-3639.35, PM-AB-00-112

The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services is to be made to a single home health agency (HHA) overseeing that plan, and this HHA is known as the primary agency or HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise." Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home**.**

Medicare periodically publishes instructions containing a list of nonroutine supply codes and therapy codes that must be included in consolidated billing. The list changes from year to year as a result of changes in HCPCS codes, which Medicare also publishes annually.

The HHA that submits the first RAP or No-RAP LUPA claim successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given

episode in the CWF based HIQH inquiry system for HH PPS. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Contractors will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within an episode, from the first day of that episode until day 60 or last billable service date, if discharged. This applies to provider types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers). *Contractors will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under a HH plan of care when the primary HHA has already billed other services under a HH plan of care for the beneficiary.* Providers and suppliers may access information on existing episodes through the ANSI X12N 270/71 inquiry process system. See §30.1.

DME is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DMERC or billed by an HHA (including HHAs other than the primary HHA) to a RHHI. Refer to §90.1. Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the FI and the carrier at the same time for the same beneficiary. In the event of duplicate billing to both the RHHI and the DMERC, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent the simultaneous payment for the purchase and the rental of the same item.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis, in addition to episodes payments, and are billed on a claim with a bill-type that is not specific to HH PPS (TOB 34X). When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them. For more detailed information, refer to §90.1.