CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 82 **Date: JULY 23, 2004**

CHANGE REQUEST 3266

I. SUMMARY OF CHANGES: Requires intermediaries to perform complex medical review on 100 percent of home health demand bills.

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 23, 2004
***IMPLEMENTATION DATE: August 23, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to 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	6/TOC
N	6/6/6.2/Home Health
R	6/6/6.2.1/Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home"
N	6/6/6.2.2/Medical Review of Home Health Demand Bills

***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: Home Health Demand Bills

I. GENERAL INFORMATION

A. Background:

As a result of litigation settlement, FIs must perform complex medical review on 100 percent of home health demand bills.

B. Policy: None

C. Provider Education: None

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3266.1	Intermediaries shall review 100% of home health demand bills.	Intermediaries

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: August 23, 2004 **Implementation Date: August 23, 2004** **Pre-Implementation Contact(s):** Debbie Skinner, Dskinner2@cms.hhs.gov, (410) 786-7480 **Post-Implementation Contact(s):** Debbie Skinner, Dskinner2@cms.hhs.gov, (410) 786-7480	These instructions should be implemented within your current operating budget.

Medicare Program Integrity Manual

Chapter 6 - Intermediary MR Guidelines for Specific Services

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6.2 - Home Health

(Rev. 82, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

6.2.1 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home"

(Rev. 82, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

A. General Information--RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.

NOTE: For the purposes of this manual section a favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the RO has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

Promptly pay the claim that was the subject of the favorable final appellate decision. Promptly pay or review based on the review criteria below: All claims that have been denied that are properly pending in any stage of the appeals process.

All claims that have been denied where the time to appeal has not lapsed. All future claims submitted for this beneficiary.

For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.

Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.

Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.

Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received

the favorable final appellate decision and the date of this decision. This information should be made available to CMS upon request.

B. Review Criteria--Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision unless there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for home health care. If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review.

EXAMPLE 1

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical review determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary's ability to leave the home.

6.2.2 - Medical Review of Home Health Demand Bills

(Rev. 82, Issued 07-23-04, Effective: August 23, 2004, Implementation: August 23, 2004)

As a result of litigation settlements, intermediaries must perform complex medical review on 100% of the home health demand bills.