# Program Memorandum Intermediaries/Carriers

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

**Transmittal AB-01-111** **Date: AUGUST 8, 2001**

**CHANGE REQUEST 1711**

**SUBJECT: Completion of Home Health Prospective Payment System (HH PPS) Consolidated Billing Enforcement**

Recovery of Payments Made Before the Posting of a HH PPS Episode

Effective January 1, 2002, new edits will be created to address situations in which a therapy or non-routine supply claim subject to HH PPS consolidated billing has been paid prior to the posting on the Common Working File (CWF) of a claim for a HH PPS episode. These edits will identify claims that contain line items that were paid during a home health episode that are subject to consolidated billing. The edits will use the list of HCPCS codes published in Transmittal AB-01-65, dated April 26, 2001. This list of codes will be updated annually.

Upon receipt of a HH PPS claim, CWF will search paid claims history to determine whether any services subject to consolidated billing were paid within the HH PPS episode period by any intermediary or carrier. CWF will compare the period between the HH claim from and through date (which represent the episode start date and the date of discharge) to the line item service dates of the claims on history. Consolidated services that fall within the HH claim from and through dates will be identified. CWF will generate an unsolicited response, with a trailer containing the identifying information regarding the claim subject to consolidated billing and a trailer containing line item specific information that identifies all the individual services on that claim that fall within the HH claim dates. The unsolicited response will have all necessary information to identify the claim, including document control number and health insurance claim number. CWF will electronically transmit this unsolicited response to the intermediary or carrier that originally processed the claim with consolidated services. These unsolicited responses will be included in the existing unsolicited response file. The unsolicited responses in that file which are claims to be adjusted for consolidated billing will be identified with a unique transaction identifier and disposition code. The previously paid claim will not be canceled and will remain on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response file, the intermediary standard system software will read the line item information in the new trailer for each claim and perform an automated adjustment to each claim. Carriers will perform a manual adjustment. The adjustment will line item deny the services subject to consolidated billing. The adjusted claims will then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. Intermediaries will return the claims with action code 3. Carriers and durable medical equipment regional carriers (DMERCs) will return the claims with entry code 5. Carriers must return both the covered and the denied services to CWF on the adjustment claim. Intermediaries must currently return only the covered lines to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible will be updated on the beneficiary's file and the corrected deductible information will be returned to the intermediary or carrier in trailer 11. Remittance advice and MSN messages identified in Transmittal AB-01-48, dated March 27, 2001, will be used for these line item denials. The remittance advice messages will be applied at the line level.

For intermediaries, any monies due back to Medicare resulting from these denials will be recovered using current recovery procedures.

Carriers should follow the criteria in the overpayment recovery instructions in MCM, Part 3, §§7100 - 7104 and §§7116 - 7130 for the policy guidelines for furnishing demand letters and granting appeal rights.

In the event that a denial is reversed upon appeal, based upon evidence that the home health claim information on CWF that generated the denial was inaccurate, an override procedure for the CWF denial must be available to permit payment to be made.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim will be adjusted by the intermediary or carrier standard system to line item deny all the services on the claim. Carriers must return these fully denied claims to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's National Claims History file. Carrier and DMERC systems will employ existing processes for the submission of fully denied claims. Intermediaries should hold fully denied claims resulting from these changes, which are expected to be few in number. Instructions for intermediaries to return denied lines to CWF will be provided in CR 1769, which will be implemented in a future release still to be determined.

To capture services subject to consolidated billing that were paid prior to the implementation date below, a one-time utility will be created and run against CWF paid claims history to identify therapy and supply claims with dates of service on or after October 1, 2000, which were paid prior to the posting of home health claims on CWF. The same edit criteria used for the creation of the unsolicited responses (described above) will be applied to paid claims history for all home health episodes posted prior to the implementation date. One file of unsolicited responses resulting from the utility will be sent (via network data mover or tape depending on the output file size) to each intermediary and carrier. These unsolicited responses will be processed by the intermediary or carrier standard systems like the other unsolicited responses described above and the same overpayment recovery procedures will be applied.

Modifying Consolidated Billing Edits on Institutional Claims

Concerns have been raised regarding claims for certain services being affected by HH PPS consolidated billing editing in an unintended manner. Claims for certain emergency, surgical, diagnostic, and ESRD services have been subject to consolidated billing edits based on the presence of a medical supply HCPCS code in addition to the other services provided. Because these supplies are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, we do not believe they fall within the bundling provisions of home health prospective payment.

In order to allow claims for these supplies to process unaffected by HH PPS consolidated billing edits, CWF editing of institutional claim types (HUOP transactions) will be modified. CWF edit 5389 and alert 7702 will be revised to no longer apply to institutional claim types. This edit and this alert will continue to be applied only to claims processed by DMERCs (HUDC transactions). This change will apply to claims processed on or after January 1, 2002.

**The *effective date* for this Program Memorandum (PM) is January 1, 2002.**

**The *implementation date* for this PM is January 1, 2002.**

**Funding is available through the regular budget process for costs required for implementation.**

**This PM may be discarded after January 1, 2003.**

**If you have any questions, contact your regional office.**