Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-48 **Date: MARCH 27, 2001**

CHANGE REQUEST 1584

SUBJECT: Remittance Advice and Medicare Summary Notice Messages for the Home Health Prospective Payment System (HH PPS)

A. Messages for Consolidated Billing Edits Regarding Therapy and Supply Services

The instructions in section A apply to all intermediaries, carriers and durable medical equipment regional carriers (DMERCs).

In October 2000 edits were installed in the Common Working File (CWF) to enforce the consolidated billing of home health services for dates of services falling within an open HH PPS episode of care. These edits applied to outpatient therapy services and certain non-routine medical supplies that were defined in the HH PPS final rule in the ***Federal Register***. The edits are identified in CWF as 5389 (consolidated billing of supplies) and 5390 (consolidated billing of therapies). Claims returned with these codes from CWF are rejected.

When rejecting claims in association with CWF edit 5389 and 5390, apply the following reason code on the provider's remittance advice:

B15: "Claim denied/reduced because this procedure/service is not paid separately."

In order to ensure that providers understand the reason for the rejection, accompany the denial reason code with the following newly approved remark code:

N70 : "Home health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement."

These codes will be applied on the remittance advice at the claim level.

On the beneficiary's Medicare Summary Notice (MSN), apply message 16.29: "Payment is included in another service you have received." Contractors that issue Explanation of Medicare Benefits letters will apply EOMB message 9.55: "Payment is included in another service you have received."

As necessary, use the following Spanish translation for either of these messages: "El pago fue incluido en otro servicio que usted recibio."

B. Messages for Consolidated Billing Edits Regarding Primary Home Health Agencies (HHAs)

The instructions in section B apply to regional home health intermediaries (RHHIs) only.

When a claim for an HH PPS episode from one HHA has been paid, and a RAP with overlapping dates of service is received from a second HHA, coded with a source of admission indicating a beneficiary elected transfer, the second HHA assumes the status of the primary HHA for HH PPS billing purposes for that beneficiary. (HHAs must only use the transfer source of admission code

in cases where beneficiary-elected transfers have occurred.) In these cases, the previously paid claim from the first HHA must be systematically adjusted to reduce the payment with a partial episode payment adjustment. CWF currently returns an unsolicited response identifying these claims and these standard systems deny any line item dated services within the episode of the new primary HHA and adjust payment accordingly.

In reprocessing these claims to adjust the payment, apply reason code B15 and remark code N70 at the line level to the denied lines. Apply MSN message 16.29 or EOMB message 9.55, or their Spanish translation as necessary, in your notification to the beneficiary.

C. Messages for Downcoding or Upcoding of HH PPS Claims

The instructions in section C apply to RHHIs only.

The health insurance PPS (HIPPS) codes used to pay claims under HH PPS may be changed in the course of processing in two ways. Claims that fail to meet the threshold of 10 therapy visits required for payment of certain HIPPS codes may be automatically downcoded by the HH PPS Pricer software. Claims that medical review verification procedures determine to have inaccurate HIPPS codes may be manually downcoded or upcoded as appropriate by medical review staff.

In order to distinguish these two cases for providers, apply the following newly approved remark codes to providers' remittance advices:

N69: "PPS code changed by claims processing system. Insufficient visits or therapies."

N72: "PPS code changed by medical reviewers. Not supported by clinical records."

These codes will be applied at the line level, associated with the 0023 revenue code line, which has been downcoded or upcoded.

The *effective date* for the actions in this Program Memorandum (PM) that can be controlled by the contractor is March 27, 2001. The *effective date* for the actions in this PM, which require system maintainer changes, is July 1, 2001.

The *implementation date* for the actions in this PM that can be controlled by the contractor is March 27, 2001. The *implementation date* for the actions in this PM, which require system maintainer changes, is July 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2002.

If you have any questions, contact your regional office.