Program Memorandum Carriers

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

Transmittal B-02-009 **Date: FEBRUARY 8, 2002**

CHANGE REQUEST 1991

SUBJECT: Payment for Therapy Services Wrongfully Denied

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 home health (HH) Prospective Payment Systems (PPS) episode of care. The edits applied to certain outpatient therapy services and non-routine medical supplies that were defined in the HH PPS final rule (65 FR 41128), published in the **Federal Register** on July 3, 2000. An updated list of Healthcare Common Procedure Coding System (HCPCS) codes corresponding to those services was published in Program Memorandum (PM) AB-01-65, Change Request 1622, on April 26, 2001. The edits were identified in CWF as 5389 (consolidated billing of supplies) and 5390 (consolidated billing of therapies). Claims returned with those codes from CWF rejected. Before October 2001, these edits applied only if an HHA had submitted a request for anticipated payment (RAP) for the episode. These denials occurred even when the beneficiary received therapy services after he or she had ceased to be under the home health plan of care but the home health agency had not yet filed a claim to end the episode.

Under the edits that were in place October 2000 through September 2001, we improperly denied some claims for therapy services that should have been paid. These improper denials occurred when the beneficiary received therapy services prior to the end of the 60 day period that was established based on the RAP but before the home health agency filed the claim to end the episode in CWF. We revised the CWF edits to correct this problem in October 2001. Therefore, claims that are submitted for therapy services and supplies under these conditions will not be rejected by CWF as bundled into HH PPS if processed on or after October 1, 2001.

In your next available bulletin, inform therapists of the changes to these edits and that they may resubmit the denied claims where each of the following criteria are met:

Claims were submitted on or after October 1, 2000 but before October 1, 2001.

Claims were for therapy services bundled into home health consolidated billing.

The therapists got a denial with remittance advice notice:
B15: "Claim denied/reduced because this procedure/service is not paid separately."

These resubmitted claims will pay if they do not overlap with the period between the first and last service date in a home health episode, but if they do overlap with such periods, they will again be denied because they are correctly being edited for home health consolidated billing. Process these resubmitted claims according to normal claims processing rules.

The *effective date* for this PM is February 8, 2002.

The *implementation date* for this PM is May 9, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2003

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