DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM7865

Related Change Request (CR) #: CR 7865

Related CR Release Date: November 2, 2012

Effective Date: HH PPS Episodes ending on or after January 1, 2010

Related CR Transmittal #: R2583CP

Implementation Date: April 2, 2013

Erroneous Partial Episode Payment Adjustments on Certain Home Health Dual-Eligible Claims

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) who bill Regional Home Health Intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs) for services provided to dual eligible beneficiaries.

Provider Action Needed

Change Request (CR) 7865 contains no new policy. It revises Medicare systems to ensure that payment episode adjustments for overlapping home health care episodes are not incorrectly applied.

In Third Party Liability (TPL) demand bill situations, overlapping Home Health (HH) episodes sometimes cause Medicare claims to be erroneously paid as Partial Episode Payments (PEPs). CR7865, from which this article is taken, corrects this by creating adjustments to restore full payment when the fully denied demand bill is processed.

You should ensure that your billing staffs are aware of the new requirements that CR7865 provides, the details of which are in the Background section, below.

Background

Sometimes a Medicare and Medicaid dually-eligible beneficiary, who is admitted to home health care as a Medicare patient, subsequently meets their Medicare treatment goals before the end of a 60-day episode; and, as a result, stops meeting Medicare coverage requirements. This beneficiary is then discharged from their Medicare home health episode but continues to receive home health services which are billed to Medicaid.

While states may vary in their requirements for a new Start of Care Outcome & Assessment Information Set (OASIS) assessment in these cases, a Home Health Agency (HHA) required to conduct a new OASIS assessment when the beneficiary's payer source changes is likely to bill their services to Medicaid using a claim "From" date that immediately follows the date of discharge from Medicare.

The State Medicaid program may later request that the HHA submit demand bills on the beneficiary's behalf for services which have been billed to Medicaid. In these cases, the episode period corresponding to the new OASIS assessment is likely to overlap the 60-day period associated with the last Medicare-covered home health episode.

When the Request for Anticipated Payment (RAP) for the demand billed episode is processed, it will cause a Partial Episode Payment (PEP) adjustment to apply to the prior episode because Medicare cannot presume that the demand billed episode will or will not be covered based on the RAP. When the final claim for the demand billed episode is received and reviewed, it is often found to be entirely non-covered.

Medicare has established that the PEP adjustment to the prior claim is no longer correct; however, Medicare systems do not have a mechanism to restore the full payment, and the HHA cannot submit an adjustment to correct their payment. The requirements of CR7865 create a mechanism to restore full episode payment when appropriate.

Specifically, CR7865 requires Medicare contractors to:

1. Auto-adjust any claim paid as a Partial Episode Payment (PEP) adjustment to restore full episode payment, if the final claim for the overlapping episode is a fully denied demand bill (condition code 20 [the demand billing indicator] and all charges are non-covered);
2. Replace the patient status code '06' (discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care) that was created by the earlier PEP adjustment with patient status code '01' (discharge to home or self-care);
3. Return the adjustment to the HH Pricer to restore full payment for the episode; and
4. Adjust any timely claims that received PEP adjustments in error when brought to their attention by the HHA.

What you should do in these cases

If the State requesting a demand bill for the services within the original Medicare 60-day episode does not require a new OASIS assessment, you should submit an adjustment to your previously paid Medicare claim, using Type of Bill (TOB) 3x7. In addition, you should:

- Add condition code 20 to the adjustment claim;
- Change the statement "Through" date to reflect the full 60-day period; and
- Add the services provided during the demand bill request period as non-covered line items.

If the State requesting a demand bill for the services within the original Medicare 60-day episode requires a new OASIS assessment, you should submit a RAP and submit the claim with condition code 20 as you would for any other demand bill situation. When Medicare receives the RAP for the demand billed episode it will cause a Partial Episode Payment (PEP) adjustment to apply to the prior episode. If the final claim for the demand billed episode is later reviewed and found to be entirely non-covered, Medicare systems will automatically adjust the prior episode to restore the appropriate full episode payment.

Note: HH consolidated billing edits are not affected by these changes.

Additional Information

You can find the official instruction, CR7865, issued to your RHHI or A/B MAC by visiting http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2583CP.pdf on the CMS website. You will find the updated "Medicare Claims Processing Manual," Chapter 10 (Home Health Agency Billing), Section 50 (Beneficiary-Driven Demand Billing Under HH PPS) as an attachment to that CR.

If you have any questions, please contact your RHHI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.