CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2203	**Date: April 29, 2011**
	Change Request 7396

SUBJECT: Home Health Requests for Anticipated Payment and Timely Claims Filing

I. SUMMARY OF CHANGES: This change request revises the enforcement of timely claims filing in Medicare systems by excluding most home health requests for anticipated payment.

EFFECTIVE DATE: January 1, 2010
IMPLEMENTATION DATE: October 3, 2011

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 receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/70.5/Application to Special Claim Types

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2203	Date: April 29, 2011	Change Request: 7396

SUBJECT: Home Health Requests for Anticipated Payment and Timely Claims Filing

Effective Date: **January 1, 2010**

Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background:

Section 6404 of the Affordable Care Act of 2010 amended the claims timely filing requirements to reduce the maximum time period for submission of all Medicare Fee-for-Service claims to 1 calendar year after the date of service (DOS). These amendments apply to services furnished on or after January 1, 2010. CMS implemented the amendments via change requests (CRs) 6960, 7080 and 7270.

CR 7080 established the policy that for institutional claims that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim shall be used to determine the date of service for claims filing timeliness. This policy had an unintended impact on billing home health prospective payment system (HH PPS) episodes of care. Under the HH PPS, each 60-day episode of care is billed in two parts. At the beginning of the episode, after the delivery of the first billable service, the home health agency (HHA) submits a Request for Anticipated Payment (RAP) to receive a percentage of the payment anticipated for the episode. After the 60-day episode has ended, the HHA submits a final claim for the episode to receive the remainder of the payment due for all the covered services in the episode.

The "From" and "Through" dates on the final HH PPS final claim reflect the actual dates of the start and end of the HH episode. Timely filing edits which determine whether or not an episode is timely by comparing the final claim's receipt date to the final claim's "Through" date are appropriate. A final claim receipt date over 1 calendar year from the final claim "Through" date is considered not to be timely. Medicare instructions require the "From" and "Through" dates on the RAP, however, to be the same date. The date the episode begins (the "From" date) is known when the RAP is submitted, but the date the episode ends may not yet be known because the patient may be discharged at any point during the 60 days. Rather than submitting an artificial "Through" date or a future date that cannot be processed by Medicare systems, HHAs submit a "Through" date that matches the "From" date.

This means the RAP will have an earlier "Through" date than its associated final claim. When Medicare systems have enforced timely filing based on the "Through" date, RAPs have been rejected as untimely when the associated final claim was still timely. CMS has determined that this is an error. The requirements in this CR correct the error.

B. Policy: Since by regulation under 42 CFR 409.43(c)(2), RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated HH PPS final claim could still be timely under Section 6404 of the Affordable Care Act of 2010. RAPs for which the associated HH PPS final claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7396.1	Medicare systems shall bypass the timely filing edit on institutional claims when: • The type of bill is 322 or 332 • The Statement Covers Period "From" date is on or after January 1, 2010, and • The Statement Covers Period "From" date plus 59 days is less than or equal to one calendar year from the claim receipt date.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7396.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					X					HH & H MACs

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7396.1	**FOR EXAMPLE:** A RAP with a "From" date of 01/01/2011 would use a calculated date of 03/01/2011 to determine whether the bypass would apply. If this RAP is received on 02/28/2012, the RAP will bypass timely filing. If the same RAP is received on 03/02/2012, the RAP will continue to be rejected as untimely, since a final claim of any length for this episode would also be untimely.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

70.5 - Application to Special Claim Types

(Rev. 2203, Issued: 04-29-11, Effective: 01-01-2010, Implementation: 10-03-11)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

  However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 29 on Reopenings).

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any intermediary within the time limit.

- *Home health Requests for Anticipated Payment (RAPs) - Since by regulation RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated home health prospective payment system (HH PPS) claim could still be timely. RAPs for which the associated HH PPS claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.*