

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** - CMS is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at [http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS\\_Quarterly\\_Update.html](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html) on the CMS website. Changes are effective on the date indicated on the update.

MLN Matters® Number: MM7833

Related Change Request (CR) #: CR 7833

Related CR Release Date: May 11, 2012

Effective Date: August 13, 2012

Related CR Transmittal #: R2466CP

Implementation Date: August 13, 2012

## Calendar Year 2013 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data

### Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

### Provider Action Needed

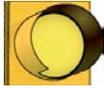


#### **STOP - Impact to You**

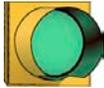
If you do not submit the required Outcomes and Assessment Information Set (OASIS) and Home Health Consumer Assessment of Health Providers and Systems (HHCAHPS) data according to the procedure described in the Background Section, below, your payment rates will be reduced by 2 percentage points.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

**CAUTION – What You Need to Know**

Change Request (CR) 7833, from which this article is taken, describes revisions to the “Medicare Claims Processing Manual,” Chapter 10 (Home Health Agency Billing), Section 120 (Payments to Home Health Agencies That Do Not Submit Required Quality Data) to reflect improvements to the payment reduction reconsideration process, and some general clarifications to the section.

**GO – What You Need to Do**

You should make sure that your billing staffs are aware of these changes in the HHA payment reduction reconsideration process.

**Background**

Section 1895(b)(3)(B)(v) of the Social Security Act requires that each home HHA submit data for the measurement of health care quality and includes a pay-for-reporting requirement to payments for Medicare home health services, effective January 1, 2007. In CY 2007 and each subsequent year, if an HHA does not submit the required data; your payment rates for the year are reduced by 2 percentage points. For payments in calendar years 2007 through 2011, this requirement was limited to the reporting of Outcomes and Assessment Information Set (OASIS) data. However, effective for payments in Calendar Year (CY) 2012 and after, the requirement also includes submission of Home Health Consumer Assessment of Health Providers and Systems (HHAHPS) data.

Specifically, Medicare considers that the following data meet this reporting requirement:

- OASIS data submitted by HHAs for all episodes beginning on or after July 1 of the previous year, and before July 1 of the current year; and
- HHAHPS monthly data collection and submission from April 1 of the prior year through March 31 of the current year.

Please note that HHAs with less than 60 patients between April 1, and March 31 of any year are exempt from HHAHPS participation for the following year; if you complete a HHAHPS Participation Exemption Request form, which you can find on the HHAHPS Website at <https://homehealthcahps.org> on the Internet. You must complete this form each year that the exemption applies.

Patient survey-eligible criteria are included in Chapter IV of the “HHAHPS Protocols and Guidelines Manual,” which is available at <https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid1> on the Internet.

The following table illustrates HHAHPS periods:

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(A) Annual Payment Update Calendar Year	(B) Did the HHA Serve 60 or more survey-eligible patients during the 12-month period specified below?	(C) If the HHA served 60 or more survey-eligible patients during the 12-month period specified in Column B, to receive the annual payment update for a specific calendar year, the HHAs must administer the survey and submit an HHCAHPS data file for each month as noted below.	(D) If the HHA served 59 or fewer survey-eligible patients during the 12-month period specified in Column B, the HHA is eligible for an exemption from participating in the HHCAHPS Survey for the 12-month period specified in Column C. To receive an exemption, the HHA must submit a Participation Exemption Request Form by the date noted below.
2013	April 1, 2010 - March 31, 2011	April 2011 – March 2012	January 21, 2012
2014	April 1, 2011 - March 31, 2012	April 2012 – March 2013	Date is announced in a HH PPS payment update rule

Each fall, RHHs and A/B MACs will receive a list of HHAs who have submitted covered claims to Medicare during these established timeframes, but have not submitted the required OASIS and/or HHCAHPS data and are potentially subject to reductions. No later than 5 business days after receiving that list (using the revised model language provided in the updated “Medicare Claims Processing Manual,” Chapter 10 (Home Health Agency Billing), Section 120 (Payments to Home Health Agencies That Do Not Submit Required Quality Data)), the contractor will send notification letters to these HHAs indicating that they are non-compliant with regard to OASIS reporting, HHCAHPS reporting, or both.

In these letters, RHHs and MACs will provide HHAs who wish to dispute their payment reduction the correct procedure to request a reconsideration. You should be aware that HHAs have 30 days from the date of the notification letter to submit a letter requesting reconsideration and documentation to support a finding of compliance.

Letters requesting reconsideration, and the accompanying documentation, should (if possible) be submitted via e-mail to [HHAPUreconsiderations@cms.hhs.gov](mailto:HHAPUreconsiderations@cms.hhs.gov).

When preparing your reconsideration request, ensure the following:

- Documents provided are relevant to the reason for your payment reduction (i.e., do not send OASIS documentation in response to a HHCAHPS related reduction);
- No Protected Health Information (PHI) is included in the request;
- All documents pertain to the same, current reporting year;
- Each request provides documents regarding a single HHA (do not combine requests or attach a list of HHA provider numbers to a request); and

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- If requesting a HHCAHPS reconsideration regarding a participation exception, provide specific information detailing why your HHA had no eligible patients.

RHHIs and MACs, receiving a reconsideration request and documentation from the HHA within the allowed timeframe, will forward the documentation electronically to the Centers for Medicare & Medicaid Services (CMS) no later than two business days from receipt. CMS will review the documentation and provide a determination to the Medicare contractor as soon as possible, but typically within a period of 6-7 weeks.

## Additional Information

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The official instruction, CR7833, issued to your RHHI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2466CP.pdf> on the CMS website. You will find the updated "Medicare Claims Processing Manual," Chapter 10 (Home Health Agency Billing), Section 120 (Payments to Home Health Agencies That Do Not Submit Required Quality Data) 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.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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