



Denial of Home Health Payments When Required Patient Assessment Is Not Received – Additional Information

MLN Matters Number: SE17009

Related Change Request (CR) Number: 9585

Article Release Date: March 24, 2017

Effective Date: April 1, 2017

Related CR Transmittal Number: R3629CP

Implementation Date: April 3, 2017

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

In Change Request (CR) 9585, the Centers for Medicare & Medicaid Services (CMS) directed MACs to automate the denial of Home Health Prospective Payment System (HH PPS) claims when the condition of payment for submitting patient assessment data has not been met. CR9585 is effective on April 1, 2017. This article is a reminder of the upcoming change and provides further information to assist HHAs in avoiding problems with these Medicare requirements. Make sure that your billing staffs are aware of this change.

BACKGROUND

Per the Code of Federal Regulations (CFR) at [42 CFR 484.210\(e\)](#), submission of an Outcome and Assessment Information Set (OASIS) assessment for all Home Health (HH) episodes of care is a condition of payment. In MLN Matters article [MM9585](#), Medicare notified HHAs that effective for claims with dates of service on or after April 1, 2017, Medicare systems will increase enforcement of this condition of payment.

Claims Denied When an OASIS Assessment Has Not Been Submitted

OASIS reporting regulations require the OASIS to be transmitted within 30 days of completion. In most cases, this 30-day period will have elapsed by the time a 60-day episode of HH services is completed and the HHA submits the final claim for that episode to Medicare. Upon receipt of a final claim with service dates after April 1, 2017, Medicare systems will check whether the

corresponding OASIS assessment is present in the Quality Information and Evaluation System (QIES). If the OASIS assessment is not found **AND** the receipt date of the claim is more than 30 days after the assessment completion date reported on the claim, Medicare systems will deny the HH claim.

While the regulation requires the assessment to be submitted within 30 days of completion, the initial implementation of this process will allow 40 days. Medicare systems will check for assessments used to determine the HIPPS code on the claim (Start of Care, Recertification and certain Resumption of Care assessments). Again, for the claim to be denied, the assessment must be both missing **AND** past due. When denying the claim, Medicare will apply the following remittance messages:

- Group Code of CO
- Claim Adjustment Reason Code 272

Refer to OASIS Validation Reports

Before submitting an HH claim to your MAC, the HHA should ensure the OASIS assessment has completed processing and was successfully accepted into the QIES National Database. The HHA can verify this by reviewing their OASIS Agency Final Validation Report or OASIS Submitter Final Validation Report for the submission which included the assessment. This may require communication between the provider's billing office and their clinical staff that submits the OASIS to CMS.

There is no need to call the QIES Technical Support Office (QTSO) help desk for such billing issues. The OASIS Agency Final Validation Report and OASIS Submitter Final Validation Report provide all the information needed (that is, confirmation of an assessment's receipt, the date of receipt, and any fatal or warning errors encountered) in order to prevent claims denials or to understand why a denial occurred.

HHAs should ensure, prior to submission of the OASIS assessment and the claim, that the following information is correct:

- HHA CMS Certification Number (OASIS item M0010)
- Beneficiary Medicare Number (OASIS item M0063)
- Assessment Completion Date (OASIS item M0090)
- Reason for Assessment (OASIS Item M0100) equal to 01, 03 or 04

These items will be used to match claims and assessments, so accuracy of submission can help prevent claim denials.

ADDITIONAL INFORMATION

You may also want to review MLN Matters Article MM9585, which is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9585.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

DOCUMENT HISTORY

Date of Change	Description
March 24, 2017	Initial article released

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