

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



News Flash – Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services. CMS will continue to address industry questions concerning the new requirements, and will update information at <http://www.cms.gov/center/hha.asp> and <http://www.cms.gov/center/hospice.asp> on the CMS website.

MLN Matters® Number: MM7396

Related Change Request (CR) #: 7396

Related CR Release Date: April 29, 2011

Effective Date: January 1, 2010

Related CR Transmittal #: R2203CP

Implementation Date: October 3, 2011

Home Health Requests for Anticipated Payment and Timely Claims Filing

Provider Types Affected

This article is for Home Health Agencies (HHAs) who bill Medicare Regional Home Health Intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

Provider Action Needed

Since, by regulation, Requests for Anticipated Payments (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) final claim could still be timely under Section 6404 of the Affordable Care Act. 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. Make sure your billing staff is aware of these changes and that HHA claims are filed timely.

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Background

Section 6404 of the Affordable Care Act 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. See the MLN Matters® articles MM6960, MM7080, and 7270 at

<http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf>, <http://www.cms.gov/MLN MattersArticles/downloads/MM7080.pdf>, and <http://www.cms.gov/MLN MattersArticles/downloads/MM7270.pdf>, respectively, for details on the implementation of this requirement.

MM7080, details of how this provision impacts policy regarding institutional claims that include span dates of service (i.e., a “From” and “Through” date span on the claim). The “Through” date on such claims is 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 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 CR 7396 correct the error.

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Example: If a RAP has a “From” date of January 1, 2011, Medicare will use a calculated “Through” date of March 1, 2011, to determine if the timely filing edit applies. In so doing, if a RAP with the “From” date of January 1, 2011, is received on February 28, 2012, it will be processed. If that same RAP was received on March 2, 2012, it would be rejected as untimely.

Additional Information

The official instruction, CR7396, on this issue is available at <http://www.cms.gov/Transmittals/downloads/R2203CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

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/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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