DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Hurry, time is running out! HIPAA Version 5010 and D.0 will be required to submit Medicare claims beginning Sunday, January 1, 2012! As of Sunday, January 1, 2012, Version 5010 and National Council for Prescription Drug Programs (NCPDP) D.0 will be required for all Health Insurance Portability and Accountability Act (HIPAA) standard transactions. Beginning Sunday, January 1, 2012, HIPAA Version 4010A1 will no longer be accepted by Medicare. All trading partners must operate in HIPAA Version 5010 and D.0. Providers should take advantage of the resources available on CMS' ICD-10, Versions 5010 & D.0 & 3.0, and Medicare Fee-For-Service 5010 - D0 web pages. It is essential to begin the transition now to prevent a disruption to your claims processing and cash flow.

MLN Matters® Number: MM7660 Revised

Related Change Request (CR) #: CR 7660

Related CR Release Date: December 22, 2011

Effective Date: March 22, 2012

Related CR Transmittal #: R2374CP

Implementation Date: March 22, 2012

Additional Instructions Regarding Demand Bills Under the Home Health Prospective Payment System

Note: This article was updated on August 2, 2012, to reflect current Web addresses. All other information remains the same.

Provider Types Affected

Home Health Agencies (HHAs) who, under the Home Health Prospective Payment System (HHA PPS), bill Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7660. This CR provides additional instructions and clarifies two sections of Chapter 10 in the "Medicare Claims Processing Manual." CMS recently discovered that Medicare's instruction regarding

the reporting of the Total Charges field on claims is in conflict with the requirements of the HIPAA standard 837 Institutional claim format. The 837 requires that the Total Charges field (SV203) must always be reported, and that zero is an acceptable value. Medicare's instructions since 2000 have stated that the field may be zero or blank.

A revised Chapter 10, Section 50 also provides additional billing instructions to assist providers in preparing demand bills when requests by the State Medicaid program do not correspond to dates of existing episodes of care. Please make sure that your billing staff is aware of these changes.

Background

Demand Billing

When (on a beneficiary's behalf) a State Medicaid program requests a demand bill, regarding services which have been billed to Medicaid, the dates of service for which the State requests the demand bill might not correspond exactly to the episode periods billed to Medicare. CR7660 updates the "Medicare Claims Processing Manual" to provide additional billing instructions to help you prepare demand bills when these dates do not match.

When the Request Begins During a Non-Medicare Episode

Sometime later during the course of a Medicare-Medicaid dually-eligible patient's episode of care (in which they were initially admitted to home care with the expectation that no services would be billed to Medicare), the State could request a demand bill.

A Medicare-Medicaid dually-eligible patient may be admitted to home care with the expectation that no services will be billed to Medicare. Later, the State may request demand bills beginning during the course of that episode. This may occur when requests correspond to a calendar year. For example, the patient may be admitted in December and the request for demand bills is effective January 1. In this case, the HHA should submit a demand bill to Medicare with episode dates corresponding to the OASIS assessment that began in December. All services in the episode should be submitted as non-covered line items. As with any demand bill, condition code 20 should be reported on this claim.

When the Request Applies to Services Immediately Following Medicare Discharge

A dually-eligible patient could be discharged from Medicare HH services before the end of a 60-day episode because the patient met their treatment goals or could remain under the care of the HHA receiving services billed to Medicaid.

If the State requests a demand bill for the services within the original Medicare 60-day episode, the HHA should submit an adjustment to their previously paid Medicare claim, using TOB 3x7, and the HHA should:

1) Change the statement "Through" date to reflect the full 60-day period;

2) Add the services provided during the demand bill request period as non-covered line items; and

3) Submit the claim with condition code 20 and all of the non-covered line items for any episodes of continuous care within the demand bill request period.

Total Charge Reporting

As noted above, CMS recently discovered that Medicare's instruction, regarding the reporting of the Total Charges field on claims, is in conflict with the requirements of the HIPAA standard 837 Institutional claim format.

Specifically, the 837 requires that the Total Charges field (SV203) must always be reported (and zero is an acceptable value,) while Medicare's instructions since 2000 have said the field may be zero or blank. CR7660 corrects this discrepancy by stating that HHAs must report zero charges on the 0023 revenue code line.

Additional Information

You can find CR7660, located http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2374CP.pdf on the CMS website. You will find the updated "Medicare Claims Processing Manual", Chapter 10 (Home Health Agency Billing), Sections 50 (Beneficiary-Driven Demand Billing Under HH PPS) and 40.2 (HH PPS Claims) as an attachment to that CR.

If you have any questions, please contact your RHHI 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.