CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12106	**Date: June 29, 2023**
	Change Request 13225

SUBJECT: Corrections to Home Health Processing - Claims with Condition DR or Claims Receiving Admission Source Edits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to no longer bypass the edit requiring a matching patient assessment when a home health (HH) claim reports condition code DR. It also corrects processing of HH claims to ensure the medical review information is not lost if a reviewed claim later receives an admission source edit.

EFFECTIVE DATE: January 1, 2024 - Claims processed on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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	10/10.1.10.3/Submission of the Notice of Admission (NOA)
R	10/10.1.19/Payment Adjustments – Applying OASIS Assessment Items to Determine HIPPS Codes
R	10/40.1/Notice of Admission (NOA)

III. FUNDING:
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

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to no longer bypass the edit requiring a matching patient assessment when a home health (HH) claim reports condition code DR. It also corrects processing of HH claims to ensure the medical review information is not lost if a reviewed claim later receives an admission source edit.

CR 13020, effective July 1, 2023, revised billing instructions and Original Medicare system processes for claims identified with condition code DR as disaster-related. The billing instructions stated that condition code DR is used when submission of Outcome and Assessment Information Set (OASIS) assessments is entirely waived due to the disaster. It modified Medicare systems to allow claims with no occurrence code 50 indicating the assessment date if condition code DR is reported, processing those claims without checking for a matching assessment. However, it did not change the past process that allowed claims with condition code DR to be paid if an assessment date is reported and no matching assessment is found. This CR corrects the oversight and ensures that claims reporting condition code DR and an assessment date in occurrence code 50 are returned to the provider. This will allow the provider to remove occurrence code 50 if it was submitted in error, or correct the occurrence code 50 date and remove condition code DR.

CR 12790, effective January 1, 2023, corrected an issue with claims which have been medically reviewed and are later identified for adjustment due to an incorrect period sequence. In processing the adjustment, Medicare systems changed the User Action Code from the code applied by the medical review to "Z." This erased additional medical review coding on the claim. If the provider is still on review, this triggered an unnecessary additional record request to the provider. Medicare Administrative Contractors (MACs) have reported that this same issue is also occurring when medically reviewed claims are later identified by adjustments due to an incorrect admission source. This CR also corrects this new problem.

Finally, this CR adds instructions to manual sections regarding how to avoid delayed submission of home health Notices of Admission.

B. Policy: This CR contains no new policy. It revises Medicare systems to implement existing policies more efficiently.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility			
		A/B MAC	DME	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13225.1	The contractor shall return to the provider home health claims (TOB 032x, other than 032A or 032D) when no corresponding OASIS assessment is found and condition code DR is present on the claim.			X		X				
13225.2	The contractor shall ensure medical review information is not removed from claims or adjustments when recoding the HIPPS code due to admission source edits.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13225.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
.1	This requirement removes the DR condition code bypass in FISS reason code 37253 that was implemented by CR 10372 in July 2018.
.2	Admission source edits are CWF edits C727D and C727E.
.2	This requirement may include but not be limited to: • Ensuring User Action Codes on claim page 06 of Q, 7 and E are not overlaid with Z, and • Ensuring MR coding on claim pages 09 and 32 are not erased Additional codes and fields may also be affected to ensure the claim or adjustment

X-Ref Requirement Number	Recommendations or other supporting information:
	processes correctly.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov , Carla Douglas, carla.douglas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

10.1.10.3 - Submission of the Notice of Admission (NOA)

(Rev.12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation:01-02-24)

For each admission to home health, the HHA notifies Medicare systems via submission of a *Notice of Admission (*NOA*)*.

HHAs shall send the NOA to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE). EDI submissions require additional data not required by the NOA itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website. HHAs may voluntarily agree to adopt the companion guide and use it to submit EDI NOAs at any time.

The HHA can submit an NOA to Medicare when:

- The HHA has obtained a verbal or written order from the physician that contains the services required for the initial visit, and
- The HHA has conducted an initial visit at the start of care.

Only one NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims.

NOAs must be submitted timely. A timely-filed NOA is submitted to and accepted by the A/B MAC (HHH) within five calendar days after admission date.

In instances where an NOA is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payment, by the number of days from the home health admission date to the date the NOA is submitted to, and accepted by, the A/B MAC (HHH), divided by 30. No LUPA per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

If an HHA fails to file a timely-filed NOA, it may request an exception, which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;

2. an event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the HHA;

3. a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or,

4. other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA.

When an NOA is submitted within the five day timely filing period, but the NOA contains inadvertent errors (such as a beneficiary identifier that has recently changed), the error may not trigger the NOA to be immediately returned to the HHA for correction. In these instances, the HHA must wait until the incorrect information is fully processed by Medicare systems before the NOA is returned for correction. Such delays in Medicare systems could cause the NOA to be late. Delays due to Medicare system constraints are outside the control of the HHA and may qualify for an exception to the timely filing requirement.

HHAs can reduce the number of errors and exception requests related changes to the beneficiary identifier by performing an eligibility check immediately before admission. This can confirm that the Medicare Beneficiary Identifier (MBI) is active and accurate since the eligibility inquiry system contains an MBI End Date field. If there is a date in that field, the MBI is not valid after that date. The HHA can contact the beneficiary or use the MBI Lookup tool to determine the current MBI to use on the NOA.

Since correct beneficiary identifier information is available to the HHA, only changes that occur shortly before the admission are beyond the HHA's control. A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the HHA more than two weeks prior to the admission date.

An admission period will be opened on CWF with the receipt and processing of the NOA. NOAs are submitted using TOB 032A. After this admission period is recorded, the HHA can submit claims for HH periods of care in the admission.

See section 40.1 for detailed submission instructions and required information for the NOA.

10.1.19 - Payment Adjustments – Applying OASIS Assessment Items to Determine HIPPS Codes

(Rev.12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation: 01-02-24)

Submission of an OASIS assessment is a condition of payment for HH periods of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. Under the HH PDGM, matching a claim to the OASIS assessment *is required to process each home health claim.*

During claims processing, the quality system, known as the Internet Quality Improvement and Evaluation System (iQIES), provides the claims system (FISS), with the OASIS items used for payment grouping under the PDGM. The HIPPS code is calculated by Medicare's Grouper program with FISS. Because payment grouping cannot occur without the OASIS information, if the OASIS assessment is not found in the quality system upon receipt of a claim, Medicare systems will return the HH claim.

The only exception to this is when a disaster-related waiver of OASIS submission is in effect. In this case, the HHA reports condition code DR on the claim and does not report occurrence 50 (the assessment submission date) because no OASIS was submitted. The claim-OASIS matching process is bypassed and the provider-submitted HIPPS code is used for payment. In any other case, when occurrence code 50 is reported a matching assessment must be found in order for the claim to process.

There are steps an HHA can take to make sure a claim matches to the OASIS assessment successfully.

Ensuring the Claim Matches an OASIS Assessment

Before submitting an HH claim, HHAs should ensure the OASIS assessment has completed processing and was successfully accepted into iQIES. HHAs can verify this by reviewing their OASIS Final Validation Report (FVR).

If a claim is submitted and Medicare systems do not find the matching assessment, the claim is Returned to the Provider (RTP). Typically, there is no need to call the iQIES help desk for assistance in resolving this.

HHAs should take the following steps:

1. Double-check the FVR to confirm the receipt date shows the OASIS was accepted by iQIES before you submitted your claim. This date is shown on Page 1 of the report, in the field labeled, "Completion Date/Time." Also, ensure that the assessment has not been inactivated.
   - If the OASIS was submitted after the claim, resubmit the claim
   - If the assessment was inactivated, resubmit the assessment.

2. Ensure the assessment is one that is used for determining payments. The Reason for Assessment (RFA) (OASIS Item M0100) must be equal to 01, 03, 04, or 05.

- If the claim matches an assessment that is for another reason, update the occurrence code 50 date on the claim to correspond to the M0090 date of the applicable assessment and resubmit the claim.

3. Ensure you have submitted occurrence code 50 on any claims, reporting the assessment completion date (item M0090) as the associated date

- If the occurrence code is missing, update the claim and resubmit it.

4. Check the items Medicare systems use to match the claim and OASIS, making sure that they are the same on both submissions. These are:

- Your CMS Certification Number (OASIS item M0010)
- Beneficiary Medicare Number (OASIS item M0063)
- Assessment Completion Date (OASIS item M0090)

If any of these items do not match, correct the claim or the assessment, then resubmit.

Note: Changes to a beneficiary's Medicare Beneficiary Identifier (MBI) can affect the match. If an HHA becomes aware of a change to the MBI via the MBI look-up tool and uses the new MBI on their claim when the prior MBI was used on the OASIS, that will cause the claim to be returned. In these cases, HHAs should update item M0063 on the OASIS and then resubmit the claim.

If a claim with correct and matching information continues to RTP, the HHA should reach out to their MAC and provide:

- The claim document control number (DCN)
- The validation report's Page 1, showing the Completion Date/Time the batch of OASIS assessments was received
- The validation report's page for the OASIS assessment in question, showing the RFA, Medicare Number, and M0090 date
- Any other information requested by the MAC to confirm the matching OASIS

The MAC shall use this information to research the issue.

<u>When a Matching OASIS is Found</u>

When the OASIS assessment if found, answers to the OASIS items used in PDGM case-mix scoring are returned to the claims system and stored on the claim record. This information is displayed on a screen in the claims system, so the HHA can refer to it.
Medicare systems combine OASIS items and claims data (period timing, inpatient discharge, diagnoses) and send them to HH Grouper program (see section 80). The Grouper-produced HIPPS code replaces the provider-submitted HIPPS code on the claim and is used for payment.

The system-calculated HIPPS code may be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the medical reviewer indicates changes to the OASIS information on the claim screen where it is displayed. The original OASIS item information is in a column marked OA, the medical reviewers changes are recorded in a column marked MR. The revised OASIS information will be sent to the HH Grouper and a new HIPPS will be used for payment. This HIPPS code will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

<u>When an OASIS Assessment Has Not Been Submitted</u>

If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period, and

- Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.

Condition code 21 must not be used in these instances, since it would result in inappropriate beneficiary liability.

The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N211
MSN: 41.17

40.1 - Notice of Admission (NOA)

(Rev.12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation:01-02-24)

HHAs must send the NOA to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE). EDI submissions require additional data not required by the NOA itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website. HHAs may voluntarily agree to adopt the companion guide and use it to submit EDI NOAs at any time.

The following data elements are required to submit an NOA under HH PPS.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the CMS Certification Number to verify provider identity.

Type of Bill

Required -

032x - Home Health Services under a Plan of Treatment

4th Digit	Definition
A	Admission/Election Notice
D	Cancellation of Admission/Election Notice

Statement Covers Period (From-Through)

Required – The HHA reports the date of the first visit provided in the admission as the From date. The Through date on the NOA must always match the From date.

Patient Name/Identifier

Required - Patient's last name, first name, and middle initial.

Patient Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - Month, day, and year of birth of patient.

Left blank if the full correct date is not known.

Patient Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

Required - The Admission date on the NOA must always match the From date.

Condition Codes

Conditional. - If the NOA is for a patient transferred from another HHA, the HHA enters condition code 47.

Note: No line item service information is required by the Medicare program to complete a Notice of Admission via DDE. However, certain line information is required to meet the requirements of the 837I claim format. See the NOA Companion Guide for details on meeting these requirements.

Release of Information Certification Indicator

Required - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier

Required – *The HHA enters the beneficiary's Medicare Beneficiary Identifier (MBI). Confirm the MBI is active via an eligibility inquiry to avoid delays in the timely receipt or processing of the NOA.*

Principal Diagnosis Code

Required to meet the requirements of the 837I claim format. See the NOA Companion Guide

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.