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Ensuring Correct Processing of Home Health Disaster Related Claims and Claims for Denial

MLN Matters Number: MM10372 Revised
Related Change Request (CR) Number: CR10372
Related CR Release Date: January 5, 2018
Effective Date: July 1, 2017
Related CR Transmittal Number: R3948CP
Implementation Date: July 2, 2018

Note: This article was revised on January 30, 2018, to correct the effective date, which is July 1, 2017. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for Home Health Agencies submitting claims to Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10372 informs MACs about revisions to the edit that matches claims and assessments, creating a bypass when condition code DR is reported on the claim. CR 10372 also identifies a newly added edit to ensure the correct Type of Bill code is submitted with condition code 21 when the HHA is billing for denial. Make sure that your billing staffs are aware of these changes.

BACKGROUND

In April 2017, CMS implemented CR 9585, which denied claims for Home Health (HH) episodes when the corresponding Outcomes and Assessment Information Set (OASIS) was due but not found by Medicare systems. This enforced Medicare's policy of requiring the OASIS data as a condition of payment. When an assessment is not found, the claim is “returned to provider”.

In response to hurricane and wildfire events in 2017, the Secretary of the Department of Health & Human Services declared that public health emergencies existed in various States and authorized waivers and modifications under §1135 of the Social Security Act. Under one of these waivers, the OASIS transmission requirements at 42 CFR 484.20 are suspended for those Medicare approved HHAs serving qualified home health patients/evacuees in the affected areas. When submitting claims for episodes to which this waiver applies, HHAs use the DR condition code to indicate Medicare payment is conditioned on the presence of a "formal waiver," in accordance with CR 6451.

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Currently, Medicare systems logic does not include a bypass for condition code DR. As a result, HH claims suspended to determine the appropriateness of condition code DR and then released for processing would be returned to provider in error unless the MAC takes additional manual actions. The Centers for Medicare & Medicaid Services (CMS) has added a bypass for condition code DR to this reason code, so a manual workaround will no longer be necessary.

Additionally, during research of other problems related to the claims-OASIS match, MACs reported HH claims with condition code 21 (billing for denial) that were sent to the matching process unnecessarily. This occurred because the HHA submitted condition code 21 claims using the wrong Type of Bill (TOB). To prevent this, CMS created a new edit in Medicare systems to ensure that condition code 21 may only be reported on HH claims with TOB 0320, consistent with longstanding instructions in the Medicare Claims Processing Manual.

ADDITIONAL INFORMATION

The official instruction, CR10372, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3948CP.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 10, 2021	We replaced article links with a related CR links.
January 30, 2018	The article was revised to correct the effective date, which is July 1, 2017. All other information is the same.
January 5, 2018	Initial article released.

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