CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1268	**Date: July 26, 2013**
	Change Request 8367

SUBJECT: Update to Post Acute Transfer Edit 7272 to Extend Home Health Agency CMS Certification Number (CCN) Range and Add Bypass

I. SUMMARY OF CHANGES: This change request updates existing Common Working File (CWF) edit 7272 to correct the CCN range used to identify home health claims and to add a bypass to prevent claims from continuously looping between transfer edits 7111 and 7272.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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
N/A	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1268	Date: July 26, 2013	Change Request: 8367

SUBJECT: Update to Post Acute Transfer Edit 7272 to Extend Home Health Agency CMS Certification Number (CCN) Range and Add Bypass

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: CMS recently reexamined the post-acute transfer processing in the Common Working File (CWF) system of an Inpatient Prospective Payment System (IPPS) hospital claim with a discharge to home that did not edit when a home health claim was present in claims history and discovered a modification is necessary. The CCN range for Home Health Agency providers must be expanded to identify all Home Health Agency provider claims to properly apply the post-acute transfer payment. This Change Request (CR) instructs CWF to modify the range of Home Health Agency CCNs in A/B Crossover Edit 7272 to ensure it accurately applies the IPPS post-acute transfer policy. In addition, a bypass will be added to prevent claims from continuously looping between transfer edits.

B. Policy: This CR does not contain new policy for transfers to home for home health services. The requirements below ensure that systems editing conforms more accurately to existing policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8367.1	Medicare contractor shall modify the current edit and IUR 7272 to expand the Home Health Agency provider range from XX3100-X3199, XX7000-XX8499, or XX9000-XX9499 to XX3100-X3199, XX7000-XX8499, or XX9000 – **XX9799** to ensure it accurately reflects the IPPS post-acute transfer policy.											X	
8367.2	Medicare contractor shall develop and run a one time utility by A/B MAC/FI, beneficiary HICN and ICN to identify inpatient hospital acute care PPS claims in history processed prior to the implementation of this CR with the following elements: 1. a post acute transfer diagnostic related group (DRG) code,											X	

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	2. a patient status code other than 03, 05, 06, 62, 63, 65, 83, 85, 86, 90, 91, and 93 3. Inpatient claim discharge date equal to or after January 1, 2011, AND is equal to or within three days prior to a Home Health (HH) claim's 'from' date and the HH claim has a CCN within the range XX9500 – XX9799. NOTE: CMS does not require a report from the one time utility.												
8367.2.1	Medicare contractor shall generate an IUR based on results from utility required in 8367.2.											X	
8367.3	Medicare Contractor shall, upon receipt of the CWF-generated IUR, adjust patient status code to 06 of the inpatient hospital acute care PPS claim identified in 8367.2 and apply the post acute transfer payment rate.								X				
8367.4	Medicare Contractors may post the following notification to providers on their web site: A post-acute transfer edit in the Fiscal Intermediary Standard System (FISS) has been updated to add the home health agency CMS Certification Number (CCN) range XX9500 – XX9799. Inpatient Prospective Payment System (IPPS) acute hospital claims in history with a discharge to home that did not edit when a home health claim was present in claims history will be adjusted to change the patient status code to ensure it accurately applies the IPPS post-acute transfer policy.	X				X							
8367.5	Medicare contractors shall modify the current edit and IUR 7272 to bypass when there is an intervening stay between an acute care inpatient claim and a home health claim. The intervening stay is another inpatient PPS or CAH with a 'from' date equal to the first acute inpatient hospital claim's 'through' date. The first acute care inpatient claim has a discharge date within 3 days of a Home Health admit date.											X	

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Example: Claim 1 - Acute care hospital claim 7/17 – 7/20 Claim 2 (Intervening) - CAH claim 7/20 – 7/21 Claim 3 - HHA claim 7/21 - 9/16												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

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:
	None.

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov , Sarah Shirey-Losso, sarah.shirey-losso@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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