| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 10596** | **Date: March 16, 2021** |
| | **Change Request 12085** |

**SUBJECT: Correction to Period Sequence Edits on Home Health Claims**

**I. SUMMARY OF CHANGES:** This Change Request revises Common Working File home health period sequence edits to no longer exclude low utilization payment adjustment claims.

**EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: July 6, 2021**

***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 | |

**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:**
**One Time Notification**

# Attachment - One-Time Notification

| Pub. 100-20 | Transmittal: 10596 | Date: March 16, 2021 | Change Request: 12085 |
|---|---|---|---|

**SUBJECT: Correction to Period Sequence Edits on Home Health Claims**

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## I. GENERAL INFORMATION

**A. Background:** The Common Working File (CWF) contains edits that ensure home health (HH) claims are paid in the correct episode or period of care sequence. Currently, these edits bypass low utilization payment adjustment (LUPA) claims. Before the implementation of the Patient-Driven Groupings Model (PDGM), this bypass was correct. If the claim had 4 or fewer visits, it would correctly receive a LUPA payment regardless of whether it was an early or late episode.

Under the PDGM, the early or late Health Insurance Prospective Payment System (HIPPS) codes for a period of care can have different LUPA thresholds, ranging from 1 to 6 visits. The correct early or late HIPPS code must be assigned before Medicare systems can correctly determine whether a LUPA payment should apply. In some cases, incorrect payments result if Medicare systems bypass period of care sequence edits for LUPA claims.

MACs are manually recoding the affected claims to correct payments, when providers bring the issue to their attention. This Change Request corrects CWF editing to remove the LUPA bypass for HH claims with From dates on or after January 1, 2020. Once this correction is implemented, manual recoding will no longer be necessary.

Additionally, Medicare Administrative Contractors (MACs) have reported cases where CWF is sending unsolicited response to trigger partial period payment adjustments on claims that have no covered visits. These adjustments cannot be processed through the HH Pricer, so this Change Request also makes changes to FISS to no longer send these unsolicited responses to the Pricer.

**B. Policy:** This Change Request contains no new policy. It corrects the implementation of existing policy.

## 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 | |
| 12085.1 | The contractor shall no longer bypass home health period of care sequence edits if the incoming claim is a LUPA (claim with Pricer Return Code '06' or '14') | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | and the claim From date is on or after January 1, 2020. | | | | | | | | | |
| 12085.2 | Until period of care sequence edits are corrected, the contractor shall continue to use the Medical Review workaround to recode claims with related payment errors, if providers bring the claim to their attention. | | | X | | | | | | |
| 12085.2.1 | The contractor shall override timely filing as necessary if the claim brought to their attention has service dates between January 1, 2020 and June 30, 2020. | | | X | | | | | | |
| 12085.3 | The contractor shall not send a CWF-initiated adjustment (TOB 032G) to the HH Pricer if the claim to be adjusted has no covered visits (e.g., the original claim was processed as MSP no-pay). | | | | | X | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 12085.4 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. | | | 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 BR refers to CWF edits 524P and 524Q. |
| .3 | Currently, because the claims have no covered visits, the adjustments are sending zero PEP days to the HH Pricer. This triggers the receipt of HH Pricer return code 15 and sets reason code 37221, which the MAC cannot resolve. |

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

## V. CONTACTS

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

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

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
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**ATTACHMENTS: 0**