



## Ensure Required Patient Assessment Information for Home Health Claims

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### PROVIDER TYPES AFFECTED

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This MLN Matters Article is for Home Health Agencies (HHAs) who bill Medicare Administrative Contractors (MACs) for Home Health services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

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Special Edition (SE) article SE20010 reminds Home Health Agency (HHA) providers what steps need to be taken to make sure claims match the corresponding Outcome and Assessment Information Set (OASIS) assessment successfully. Be sure your billing staff is aware of this information.

### BACKGROUND

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For several years, Medicare systems have checked for a corresponding OASIS assessment upon receipt of a final home health claim. This was to ensure the claim met the requirement of Code of Federal Regulations (CFR) [42 CFR 484.210\(e\)](#) that submission of an OASIS assessment is a condition of payment. This check also validated whether the Health Insurance Prospective Payment System (HIPPS) code on claims was consistent with HIPPS codes calculated in the assessment system.

Home health claims with statement covers “From” dates on or after January 1, 2020, are paid under the Patient-Driven Groupings Model (PDGM). Under the PDGM, matching a claim to the OASIS assessment is more important than ever. HIPPS codes are no longer calculated in the assessment system, known as the Internet Quality Improvement and Evaluation System (iQIES). Instead, iQIES provides the claims system (the Fiscal Intermediary Shared 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.

There are steps an HHA can take to make sure claims match to the OASIS assessment successfully.

## **Refer to OASIS Validation Reports**

Before submitting an HH claim to your MAC, 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). Additional information concerning OASIS submission and the FVR is available at <https://qtso.cms.gov/reference-and-manuals/quick-reference-guide-oasis-submissions-and-final-validation-reports>.

If a claim is submitted and Medicare systems do not find the matching assessment, the claim is Returned to the Provider (RTP) with FISS reason code 37253. Typically, there is no need to call the iQIES help desk for assistance in resolving this reason code.

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 PDGM payments. The Reason for Assessment (RFA) (OASIS Item M0100) must be equal to 01, 03, 04, or 05. Note that RFA 05 is new to the matching process with PDGM.
  - 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 PDGM claims, reporting the assessment completion date (item M0090) as the associated date. This code is new with the PDGM.
  - 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 with reason code 37253. 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

This information will enable Medicare to research the issue.

## ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

## DOCUMENT HISTORY

Date of Change	Description
March 9, 2020	Initial article released.

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