| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11155** | **Date: December 10, 2021** |
| | **Change Request 12461** |

**Transmittal 11047, dated October 13, 2021, is being rescinded and replaced by Transmittal 11155, dated, December 10, 2021 to change the non-payment code value in business requirement 12461.3 from R to N. All other information remains the same.**

**SUBJECT: Correct Processing of Home Health Claims if the Request for Anticipated Payment (RAP) or Notice of Admission (NOA) Was More Than 30 Days Late and Correct Identification Critical Access Hospital Sub-Unit Discharges as Institutional Periods of Care**

**I. SUMMARY OF CHANGES:** This Change Request ensures claims are systematically processed without payment if the RAP or NOA receipt date is more than 30 days after the claim From date. It also ensures discharges from Critical Access Hospital (CAH)-based inpatient rehabilitation units or inpatient psychiatric units correctly trigger institutional payment groups.

**EFFECTIVE DATE: January 1, 2021**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 4, 2022**

***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 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: 11155 | Date: December 10, 2021 | Change Request: 12461 |
|---|---|---|---|

**Transmittal 11047, dated October 13, 2021, is being rescinded and replaced by Transmittal 11155, dated, December 10, 2021 to change the non-payment code value in business requirement 12461.3 from R to N. All other information remains the same.**

**SUBJECT: Correct Processing of Home Health Claims if the Request for Anticipated Payment (RAP) or Notice of Admission (NOA) Was More Than 30 Days Late and Correct Identification Critical Access Hospital Sub-Unit Discharges as Institutional Periods of Care**

**EFFECTIVE DATE: January 1, 2021**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 4, 2022**

## I. GENERAL INFORMATION

**A. Background:** Home health (HH) claims in CY 2021 are subject to a payment penalty if the corresponding Request for Anticipated Payment (RAP) was received more than 5 days after the claim From date. In this case, no payment is made for any days falling between the claim From date and the receipt date. If the RAP was less than 30 days late, Medicare systems are calculating the penalty amount correctly and the claim processes to completion. If the RAP was 30 or more days late and no payment is due for the 30-day period of care claim, Fiscal Intermediary Shared System (FISS) sets edit 39910 in error. The requirements below correct the error, so these claims can process to completion without any payment.

Under the Patient-Driven Groupings Model (PDGM), HH claims are assigned to institutional payment groups if a discharge from acute care or post-acute care occurs within 14 days of an HH period of care. The definition of post-acute care for this policy includes discharges from inpatient rehabilitation units or inpatient psychiatric units. These units are identified on claims by CMS Certification Number (CCN) ranges. CMS has discovered an oversight in the original PDGM implementation that excluded the CCN ranges of inpatient rehabilitation units or inpatient psychiatric units that are based on Critical Access Hospitals (CAHs). The requirements below revise Medicare system edits that ensure assignment of institutional payment groups to include these CAH-based units.

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

## 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 | |
| 12461.1 | The contractor shall reject the claim when the total payment amount returned from the HH Pricer is 0, the LATE-SUB-PENALTY-AMT is greater than 0 and no fee schedule paid line items are on the claim (revenue | | | X | | X | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | codes 0274, 029x or 060x). | | | | | | | | | |
| 12461.1.1 | The contractor shall reject the claim with the following messages:<br><br>Group code: CO<br><br>CARC: 95 - Plan procedures not followed<br><br>RARC: N385 - Notification of admission was not timely according to published plan procedures<br><br>MSN: 16.34 - You should not be billed for this service. | | | X | | | | | | |
| 12461.2 | The contractor shall change the Type of Bill (TOB) on an HH claim to 320 when the total payment amount returned from the HH Pricer is 0, the LATE-SUB-PENALTY-AMT is greater than 0 and no fee schedule paid line items are on the claim (revenue codes 0274, 029x or 060x). | | | | | X | | | | |
| 12461.3 | The contractor shall apply non-payment code N to an HH claim when the total payment amount returned from the HH Pricer is 0, the LATE-SUB-PENALTY-AMT is greater than 0 and no fee schedule paid line items are on the claim (revenue codes 0274, 029x or 060x). | | | | | X | | | | |
| 12461.4 | The contractor shall move all line level charges on an HH claim to non-covered when the total payment amount returned from the HH Pricer is 0, the LATE-SUB-PENALTY-AMT is greater than 0 and no fee schedule paid line items are on the claim (revenue codes 0274, 029x or 060x). | | | | | X | | | | |
| 12461.5 | The contractor shall release any HH claims held with reason code 39910 immediately after the system changes in requirements 12461.1 - .4 are implemented.<br><br>Note: Condition code 15 may be added to these claims as needed. | | | X | | | | | | |
| 12461.6 | When an HH claim submitted as community referral/early (HIPPS code beginning with 1) is determined to be institutional/early and the associated inpatient claim has TOB 011x and the third position of | | | | | X | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | the inpatient provider number is M or R, the contractor shall:<br><br>• send the claim back to the HH Grouper with a Referral Source of 62<br>• send the resulting recoded HIPPS code to the HH Pricer<br>• record the recoded HIPPS code in the APC-HIPPS field and set the payment indicator (IND) to P, and<br>• return the recoded claim to CWF<br><br>Note: This requirement applies to HH claims with From dates on or after January 1, 2020. | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | 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: |
|---|---|
| .5 | The claim has received CWF edit 727D. This requirement adds CAH sub-units to the list of provider numbers implemented under BR 11081.6.7.2. |
| .1 - .4 | These actions are to ensure that reason code 39910 no longer sets on these claims. |

**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**