

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11341	Date: April 7, 2022
	Change Request 12657

SUBJECT: Corrections to Home Health Billing for Denial Notices and Calculation of 60-Day Gaps in Services

I. SUMMARY OF CHANGES: This change request removes the requirement to submit a Notice of Admission before billing for home health denial notices. It also revises home health edit criteria to ensure Medicare systems calculate 60-day gaps in service consistently.

EFFECTIVE DATE: October 1, 2022 - Claims processed on or after this date.

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

IMPLEMENTATION DATE: October 3, 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
R	10/60/No Payment Billing

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:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. **Background:** Correction to Home Health (HH) Billing for Denial Notices

Before the implementation of the one-time home health Notice of Admission (NOA) in calendar year 2022, every claim for a home health period of care first required the submission of a Request for Anticipated Payment (RAP). Billings for denial notice (Type of Bill (TOB) 320 reporting condition code 21) were excluded from this requirement for a prior RAP because no payment was requested on the claim. Claims with TOB 320 and condition code 21 also did not create or update period of care records in original Medicare's Common Working File (CWF) system. Due to an oversight in the NOA implementation, billings for denial were not excluded from the requirement for all claims to be preceded by an NOA that creates an election period in CWF. The requirements below correct this, ensuring claims with TOB 320 and condition code 21 are accepted when an election period is not present and that these claims trigger no updates to HH periods of care.

Correction to the Calculation of 60-Day Gaps in Home Health Services

A sequence of related home health periods of care is defined beginning with an admission to home health services and ending when there is a 60-day gap in home health services. This 60-day gap is used by Medicare systems for two purposes. It is used to validate whether a home health period of care is correctly coded as an early or later period. It is also used to identify early periods that should pay a Low Utilization Payment Adjustment (LUPA) add-on amount. Medicare administrative contractors recently identified a minor variance between the way the 60-day gap is counted and used for these two purposes. The requirements below revise the counting method used for identifying LUPA add-ons, in order to create consistency.

B. Policy: This change request contains no new policy. It corrects the implementation of existing home health payment policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F M V C	I C M W	S S S F			
12657.1	The contractor shall allow HH claims to process without an election period on file, if the following conditions are present: <ul style="list-style-type: none"> • TOB is 0320 • Condition code 21 is present AND • Claim From date is on or after January 1, 2022. 										X
12657.1.1	The contractor shall not update HH election period information, if present, based on claims with these conditions.									X	
12657.2	The contractor shall not apply the edit that ensures an HH claim with a LUPA add-on amount (Pricer return code 14) is the first or only period of care, if the period of care within 60 days has a cancel indicator present.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E	C M I	D E I	
		A	B	H H H				
12657.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			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:
.2	This is CWF edit 539H.
.1	This requirement revises prior requirement 12227.3.12.1.

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):

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

60 - No Payment Billing

(Rev.11341; Issued:04-07-22 ; Effective: 10-01-22 ; Implementation: 10-03-22)

Home health agencies may seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment bills or billings for denial notice.

A. Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 0320, and condition code 21. Claims with condition code 21 and any other TOB will be returned to the provider for correction. *A Notice of Admission (TOB 032A) is not required before the submission of a claim with TOB 0320 and condition code 21.*

The statement dates on the claim should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also submit the charge for each line item on the claim as a non-covered charge.

In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line on the claim. If no OASIS assessment was done or if the HHA chooses not to perform payment grouping before submitting the claim, report any valid HIPPS code.

The claim must meet other minimum Medicare requirements. If an OASIS assessment was done and the HHA chooses to perform payment grouping for their internal accounting purposes, the HHA may report the resulting HIPPS code.

B. Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS period of care. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate NOA and claim for the HH PPS period of care. The period billed under the HH PPS claim and the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on one claim are non-covered.

C. Custodial Care under HH PPS, or Termination of the Benefit during a Period

In certain cases, Medicare allows the use of no payment claims in association with an ABN involving custodial care and termination of a benefit during a period of care. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of a period of care; there an ABN must be used assuming a triggering event occurs (i.e., the initiation of completely noncovered care). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a previous period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The ABN for notification of the beneficiary, and,
2. A condition code 21 no-payment claim to bill all subsequent services.