CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1079	**Date: OCTOBER 20, 2006**
	Change Request 5085

Subject: Changes to the Process for Recovering Medicare Payments for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Hospitalizations

I. SUMMARY OF CHANGES: This transmittal ensures the overpayment recovery process for HH PPS claims failing to report prior hospitalizations is compliant with the requirements of section 935 of the Medicare Modernization Act.

New / Revised Material
Effective Date: January 18, 2007
Implementation Date: January 18, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.19.2/Adjustments of Episode Payment--Hospitalization Within 14 Days of Start of Care

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1079	Date: October 20, 2006	Change Request 5085

SUBJECT: Changes to the Process for Recovering Medicare Payments for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Hospitalizations

I. GENERAL INFORMATION

A. Background: In 2003 and 2004, the Office of the Inspector General (OIG) issued reports to Medicare's four Regional Home Health Intermediaries (RHHIs) demonstrating that the Medicare program is vulnerable to making excess payments on HH PPS claims when certain Outcomes and Assessment Information Set (OASIS) information is reported in error. When HHAs report in OASIS item M0175 that a beneficiary has not been discharged from a hospital within 14 days of the start of home health care, the claim for that beneficiary may in some cases be submitted using a Health Insurance Prospective Payment System (HIPPS) code for a higher paying payment group.

The OIG found that Medicare has paid many claims with HIPPS codes representing no hospital discharge in cases where Medicare claims history shows that an inpatient stay did, in fact, occur. The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) and the RHHIs take action to recover these excessive payments.

In July 2004, CMS issued Transmittal 95, Change Request 3400, which provided instructions to the RHHIs on how to make adjustments to HH PPS claims and make the recommended recoveries using files supplied by CMS. These files were known as the "M0175 downcode files" (which identify adjustments to recover excessive payments) and the "M0175 upcode files" (which identify claims that have been underpaid). The RHHIs were scheduled to make the adjustments associated with these two files in late 2005. In November 2005, the adjustment process was put on hold pending new instructions to ensure that the recoveries were compliant with section 1893(f)(2) of the Social Security Act, which was added by section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).

B. Policy: Section 1893(f)(2) – the limitation on recoupment --requires CMS to change the way Medicare recoups certain overpayments. Before the MMA was enacted, if a provider or supplier elected to appeal an overpayment determination, there was no effect on Medicare's ability to recover the debt. This MMA provision requires that if a provider of services or a supplier seeks a reconsideration by a Qualified Independent Contractor (QIC) on an overpayment determination, CMS and its Medicare contractors may not recoup the overpayment until the date the decision on the reconsideration has been rendered. The QIC is the second level of appeal in the Medicare claims appeal process; the contractor redetermination is the first level of appeal.

CMS has determined that the limitation on recoupment under section 1893(f)(2) applies to the recovery of funds relating to the M0175 downcode files and that demand letters must be issued for the overpayment amounts. The requirements below describe how the previously planned claims adjustment process will be revised to include issuing demand letters. This process will be used for M0175 adjustments for fiscal year 2001. Also, for purposes of this recovery, receipt of a timely and valid request for appeal (the contractor redetermination) triggers the limitation on recoupment. Contractors can recoup until then and retain the

amount recouped unless and until the overpayment determination is reversed through the administrative appeal or judicial review process. If the contractor redetermination results in a full or partial affirmation of the overpayment, contractors can begin or resume recoupment starting 30 days after giving notice unless the provider appeals to the QIC in the interim. The contractor should cease or not begin recoupment if the QIC notifies the contractor that a valid and timely request for a reconsideration (second level appeal) has been received. Following final action by the QIC, the contractor can initiate or resume recoupment whether or not the provider subsequently appeals to the Administrative Law Judge (ALJ), the third level of appeal. For financial reporting purposes, the status of the debt during the redetermination and reconsideration processes will be "appeal"; however, when recoupment begins or resumes, the status shall be changed to reflect the status "eligible for internal offset" for financial reporting purposes. Once the demand letter process resumes, normal status codes used for debt collection activities will resume.

This CR does not change the rebuttal process for this recovery. It does not alter the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, nor the decision making time frames. The normal debt collection and referral process is unchanged unless specifically varied by this CR. In the event of a conflict between this CR and Chapter 3 (Overpayments) or Chapter 4 (Debt Collection) of Pub. 100-06, Medicare Financial Management Manual, this CR should be followed for this recovery effort. Pub. 100-06 will be revised subsequently to address the provisions of 1893(f)(2).

M0175 adjustments for fiscal year 2002 and later years will be identified and recovered using the process similar to the one described below, however system changes to automate portions of this process will be made in the future. Separate instructions will describe these system changes and set the schedule for additional years of adjustments, including adjustments recommended by any recent and future OIG reports on this matter.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	**Requirements**	**Responsibility ("X" indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5085.1	Medicare contractors shall process all adjustments associated with the 2001 M0175 upcode and downcode files but prevent any monies from being paid or recovered.		X							
5085.1.1	Medicare contractors shall process all adjustments associated with the 2001 M0175 upcode and downcode files within 75 days of the issuance of this instruction.		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5085.1.2	Medicare contractors shall bypass timely filing edits when processing associated with the 2001 M0175 upcode and downcode files.		X							
5085.2	Medicare contractors shall have their data centers develop a report to aggregate by HHA provider number the net payment effect of the M0175 adjustments after all adjustments are processed.		X							Data Centers
5085.3	If the net payment effect of the M0175 adjustments is a refund due the HHA, Medicare contractors shall follow existing underpayment policies to refund or apply the amount payable to other debts.		X							
5085.4	Medicare contractors shall issue demand letters for all net overpayments due resulting from the M0175 adjustments, by the implementation date shown below.		X							
5085.4.1	Medicare contractors shall include the report of the claim adjustments that comprise the overpayment along with the demand letter to each HHA.		X							
5085.4.2	Medicare contractors shall send the demand letter by first class mail.		X							
5085.4.3	Medicare contractors shall change the language in the demand letter to notify the HHA about the effect of an appeal on recoupment.		X							
5085.4.4	Medicare contractors shall ensure the language in the demand letter makes clear that the provider may appeal the entire overpayment or only some claim adjustments.		X							
5085.5	Medicare contractors shall set up withholdings against each HHA's current claims payments for the overpayment amounts on the 16th day from the date of the demand letter if payment in full, an acceptable request for an extended repayment schedule, or a valid request for a contractor redetermination is not received from the HHA.		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5085.6	Medicare contractors shall cease recoupment upon receipt of a timely and valid request for a redetermination. If the recoupment has not yet gone into effect when the request is received, the Medicare contractor shall not initiate recoupment. The debt shall be reported in Appeal status and shall continue to be aged. Interest accruals shall not be reported on the financial statements during the time the debt is reported in the appeal status.		X							
5085.6.1	The Medicare contractor shall determine what constitutes a valid and timely request for a redetermination in accordance with appeals regulations and instructions.		X							
5085.6.2	If the Medicare contractor recouped funds before a timely and valid request for a redetermination was received, the amount recouped shall be retained and applied first to interest and then to principal.		X							
5085.6.3	If an overpayment is appealed and recoupment stopped, the Medicare contractor should continue to collect other debts owed by the HHA, but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.		X							
5085.7	If the redetermination decision is a full reversal of the overpayment determination, Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged.		X							
5085.8	If the redetermination results in a full affirmation, the Medicare contractor shall start or resume recoupment no earlier than the 30th calendar day and no later than the 45th calendar day after the date of the notice of redetermination. The debt shall remain in appeal status until recoupment begins or is reinstated. At that time, the status of the debt		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	shall be changed to reflect "eligible for internal offset."									
5085.8.1	The Medicare contractor shall start or resume recoupment only if the debt (remaining unpaid principal balance and interest) has not been satisfied in full and if the HHA has been given opportunity for rebuttal in accordance with existing collection policies and requirements.		X							
5085.8.2	The Medicare contractor shall not start or resume recoupment following notification from the Qualified Independent Contractor (QIC) that a timely and valid request for a reconsideration has been received by the QIC. The debt status shall be appeal.		X							
5085.9	If the redetermination results in a partial affirmation which reduces the overpayment amount, the Medicare contractor shall start or resume recoupment no earlier than the 30th calendar day and no later than the 45th calendar day after notice to the HHA. The status of the debt shall be changed from appeal to "eligible for internal offset" once the recoupment begins or resumes.		X							
5085.9.1	The Medicare contractor shall effectuate the redetermination decision and issue a notice to the provider of the revised overpayment amount.		X							
5085.9.2	The Medicare contractor shall start or resume recoupment only if the revised debt (recalculated unpaid principal balance and interest) has not been statisfied in full and if the HHA has been given opportunity for rebuttal in accordance with existing collection policies and requirements.		X							
5085.9.3	The Medicare contractor shall not start nor resume recoupment following notification from the QIC that a timely and valid request for a reconsideration has been received by the QIC.		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	The debt shall be in appeal status.									
5085.10	During the period in which recoupment is stopped following a redetermination that results in a full or partial affirmation, Medicare contractors shall not issue a second demand letter, the intent to refer letter nor proceed with referral to the Department of Treasury.		X							
5085.11	If recoupment is started or resumed following the redetermination, the status of the debt shall be changed to "eligible for internal offset," the Medicare contractor shall cease recoupment following notification from the QIC that a timely and valid request for a reconsideration has been received by the QIC and the status of the debt shall be appeal.		X							
5085.12	If the QIC reconsideration results in a full reversal of the overpayment as modified by the redetermination, Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged.		X							
5085.13	The Medicare contractor shall initiate or resume recoupment within 10 days following notification from the QIC of final action on the reconsideration if the debt has not been satisfied in full. At this time, the debt status shall be changed to "eligible for internal offset."		X							
5085.14	Final action by the QIC is the earliest to occur of the following: (i) The QIC receives a timely and valid request to withdraw the reconsideration request; (ii) the QIC mails or otherwise transmits a written notice of the dismissal of the reconsideration request; (iii) the QIC notifies the parties that the reconsideration is being escalated to an ALJ; or (iv) the QIC transmits written notice of the reconsideration decision.									QICs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5085.15	The Medicare contractor shall continue to recoup until the debt is satisfied in full or the overpayment is reversed whether or not the HHA subsequently appeals to the third level (Administrative Law Judge) or above.		X							
5085.16	For a period of up to 60 days following final action by the QIC and resumption of recoupment, Medicare contractors should not issue a second demand letter, the intent to refer letter nor proceed with referral to the Department of Treasury. However, once the demand letter process resumes, the standard and currently used status codes shall be resumed indicating a second demand letter or intent to refer letter and the debt shall remain in the "eligible for internal offset" status until it has been paid in full or referred to Treasury through cross-servicing.		X							
5085.17	The Medicare contractor shall track and report on M0175 overpayments where an appeal has been requested by the HHA. Tracking shall include the following data elements: Claim Number, AR Number, RHHI Number, Receipt Date of Appeal, Level of Appeal, Appeal decision, Appeal Decision Date, and the dollar amount of an appeal reversal.		X							
5085.17.1	Medicare contractors should develop their own internal report format or may complete the attached spreadsheet template.		X							
5085.17.2	Medicare contractors shall submit the report to Nancy Braymer on the 15th day following the end of the calendar year quarter (April 15, July 15, October 15, January 15.) with the first report to be due on April 15, 2007.		X							
5085.18	If the overpayment determination is affirmed on appeal, the Medicare contractor shall calculate interest under current policies. If the overpayment determination is reversed in favor		X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	of the HHA at the redetermination or reconsideration level, the Medicare contractor shall calculate interest under current policies. If the overpayment determination is reversed in whole or in part at the third level of administrative appeal (ALJ) or above, the Medicare contractor shall contact the post – implementation contact for further instructions.									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5085.19	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5085.1	RHHIs may use tape-to-tape flag ‘W’ to ensure that claims are transmitted to the Common Working File, are included on the Provider Statistical and Reimbursement report and are included in workload, but are not reflected on a provider’s remittance advice.
5085.1.1	Adjustments which encounter edits due to changes in the system since the original claim was processed will be worked as appropriate for the edit condition.
5085.17	The reporting described in this requirement is in lieu of entering these overpayments into the Provider Overpayment Reporting (POR) system which otherwise would be required by JSM-06233.
5085.17	The Administrative Qualified Independent Contractor (AdQIC) will be tracking overpayment appeals at levels of appeal above the QIC, including the Administrative Law Judge and the Department Appeals Board. The Medicare Contractor is not required to affirmatively track these but should include data on the outcome of appeal decisions at these levels following effectuation where known.

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: New workloads associated with demand letters, withholding and appeals are created by these requirements, but estimates have shown the overpayment recovery amount associated with this project significantly exceeds the costs.

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 18, 2007 **Implementation Date:** January 18, 2007 **Pre-Implementation Contact(s):** Wil Gehne (410) 786-6148, wilfried.gehne@cms.hhs.gov (claims processing), Nancy Braymer (410) 786-4323 nancy.braymer@cms.hhs.gov (overpayment procedures) **Post-Implementation Contact(s):** Wil Gehne (410) 786-6148 (claims processing), Nancy Braymer (410) 786-4323 (overpayment procedures)	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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

Attachment – appeal report template.xls

QUARTERLY M0175 APPEAL REPORT (KEY)

Contractor Number ____

Contractor Name ____

Month/Year of Report ____

Claim Number	**Provider Number**	**A/R Number**	**Receipt Date of Appeal**	**Level of Appeal**	**Appeal Decision**	**Appeal Decision Date**	**Adjustment Date**	**Dollar amt of reversal** (after adjustment)	**Reason for reversal** (only required for redeterminations)
Numeric	Alpha/Numeric	Numeric	Date	R- Redetermination Q- QIC J- ALJ B- DAB JR- Judicial Review	A- Affirm most recent decision P- Partially favorable F- Full Reversal W- Withdrawal D- Dismissal	Date	Date	Currency	

QUARTERLY M0175 APPEAL REPORT

Contractor Number ____

Contractor Name ____

Month/Year of Report ____

Claim Number	Provider Number	A/R Number	Receipt Date of Appeal	Level of Appeal	Appeal Decision	Appeal Decision Date	Adjustment Date	Dollar amt of reversal	Reason for reversal

10.1.19.2 - Adjustments of Episode Payment - Hospitalization Within 14 Days of Start of Care

(Rev. 1079, Issued: 10-20-06; Effective/Implementation Date: 01-18-07)

Whether a beneficiary was a hospital inpatient during the 14 days before the start of an HH PPS episode will be confirmed by searching Medicare claims history for a processed inpatient hospital claim during that period. Under the HH PPS case-mix system, if a beneficiary was in a nursing facility or rehabilitation facility during the 14 days before the start of an episode but was not also a hospital inpatient during that period, the episode will receive a higher case-mix score than if a hospitalization was also present.

Certain HIPPS codes, which represent the HH PPS case-mix group, indicate the presence of a nursing facility or rehabilitation facility discharge within 14 days but no hospitalization during that period. Only when both these conditions are met do HIPPS codes result with "K" or "M" in their fourth position.

Medicare systems will compare incoming RAPs and claims with these HIPPS codes to Medicare claims history for the beneficiary and determine during processing whether an inpatient hospital claim has been received for dates of service within 14 days of the start of care. If an inpatient hospital claim is found, Medicare systems will take action on the RAP or claim. The RAPs will be returned to the provider to alert them to the hospital stay and allow them to correct the HIPPS code. The claims will be automatically adjusted to correct the HIPPS code and will be paid at the correct payment level.

When a Home Health Agency (HHA) submits an HH PPS claim on the basis of a Significant Change In Condition (SCIC), Medicare systems will bypass downcoding revenue code 0023 lines other than the earliest dated line on the HH PPS claim identified as having an inpatient claim within 14 days of the home health admission.

When this payment adjustment is made on a pre-payment basis, the electronic remittance advice (ERA) will be coded so the adjustment can be clearly identified. The ERA will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment. A distinct remark code will also be applied to the ERA and standard paper remittance for these claims.

Under Medicare timely filing guidelines, hospital claims may be received for 15-27 months from the end of the hospital stay. As a result of this lengthy timely filing period, there may also be cases where the HH PPS claim has been processed before the inpatient hospital claim is received. In these cases, absence of the inpatient claim in Medicare claims history could mean either no hospital stay occurred or the hospital claim has not yet been submitted. As a result, Medicare systems are unable to confirm the lack of hospitalization before the HH PPS claim is paid. To account for these cases, CMS will annually analyze its claims history to identify HH PPS claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim with dates of services within 14 days was received after the HH PPS claim had already been paid. Such claims will be subject to post-payment *recovery*.

When the payment adjustment is made on a post-payment basis, standard demand letter overpayment procedures, compliant with §1893 of the Social Security Act, will be used to collect the overpayment.