CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12306	**Date: October 19, 2023**
	Change Request 13402

SUBJECT: Processing Claims When the Dates of Service Are Beyond the Time Limit for the Patient Assessment

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to home health agencies, inpatient rehabilitation facilities and Medicare Administrative Contractors regarding situations when claims are payable but the corresponding patient assessment cannot be submitted.

EFFECTIVE DATE: January 24, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 24, 2024

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	3/140.3.1.1/Actions When a Claim Does Not Match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
R	10/10.1.19/Payment Adjustments – Applying OASIS Assessment Items to Determine HIPPS Codes

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

Pub. 100-04	Transmittal: 12306	Date: October 19, 2023	Change Request: 13402

SUBJECT: Processing Claims When the Dates of Service Are Beyond the Time Limit for the Patient Assessment

EFFECTIVE DATE: January 24, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 24, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide instructions to home health agencies, inpatient rehabilitation facilities and Medicare Administrative Contractors regarding situations when claims are payable but the corresponding patient assessment cannot be submitted.

A Medicare beneficiary's entitlement date may sometimes be approved or changed retroactively. Frequently, these cases result in services becoming covered for dates of service that are beyond the Medicare timely filing limit. Retroactive entitlement is an established exception to the timely filing period, so these claims may be submitted for payment (see Pub. 100-04, chapter 1, section 70.7.2).

The Internet Quality Improvement Evaluation System (iQIES) accepts assessments for up to 24 months from the assessment date. In rare cases, a retroactive entitlement decision may extend back beyond this 24 month period. When patient assessments cannot be submitted to iQIES because of the 24 month limit, the corresponding home health or inpatient rehabilitation facility claims cannot be processed without special intervention. The manual updates in this CR provide the necessary instructions for handling these situations.

B. Policy: This Change Request contains no new policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13402.1	Contractors shall apply the instructions in Pub. 100-04, ch. 3, section 140.3.1.1 when contacted by providers regarding IRF claims with corresponding IRF-PAI assessments that cannot be submitted to iQIES.	X								
13402.2	Contractors shall apply the instructions in Pub. 100-04, ch.10, section 10.1.19 when contacted by providers regarding HH claims with corresponding OASIS assessments that cannot be submitted to iQIES.			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13402.3	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		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

140.3.1.1 - Actions When a Claim Does Not Match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)

(Rev.12306; Issued: 10-19-23; Effective:01-24-24; Implementation:01-24-24)

The following outcomes are possible when the *HIPPS code on* a claim does not match the *HIPPS code calculated on the IRF-PAI found in the internet Quality Improvement Evaluation System (iQIES):*

- A matching assessment is found. The claim HIPPS code does not match the IRF-PAI HIPPS code, but the transmission date matches causing the claims processing system to use the assessment HIPPS code documented in iQIES for claims processing purposes;

- A matching assessment is found. The claim HIPPS code does not match IRF-PAI HIPPS code, and the transmission date is different causing the claims processing system to use the assessment HIPPS code and date documented in iQIES for claims processing purposes;

- A matching assessment is not found. This causes the claim to Return to Provider (RTP) with Reason Code 37096.

IRFs should be sure to have an IRF-PAI that has completed processing at iQIES before submitting an IRF claim to the Medicare Administrative Contractor. The IRF can verify this by reviewing their IRF-PAI validation report.

If an IRF has inadvertently submitted their claim prior to the corresponding IRF-PAI being accepted in iQIES and the claim has RTP'd with Reason Code 37096, simply resubmit the claim once the IRF-PAI has completed processing. This will require communication between the provider's billing office and their clinical staff that submits their IRF-PAI.

If a claim is returned because Medicare systems do not find the matching assessment, there is no need to call the QIES Technical Support Office (QTSO) help desk for such billing issues.

If a provider has submitted an IRF-PAI prior to submission of the claim with information that is different from the claim submission for any of the following information:

- Medicare Beneficiary Identifier (IRF-PAI item 2);

- Beneficiary date of birth (IRF-PAI item 6);

- Provider CCN (IRF-PAI item 1B);

- Claim statement covers through dates (IRF-PAI item 40); and

- Claim admission date (IRF-PAI item 12).

The claim or the IRF-PAI should be corrected (depending on which item had the error) and then the claim resubmitted. If the claim is resubmitted without correcting the appropriate information, the claim will be returned to the provider again.

In most cases the claim is being submitted one (1) day prior to the finalization of the IRF-PAI. IRFs may want to add an additional claim hold day(s) on their claim submission to allow IRF-PAI completing processing and to avoid claims being RTP'd with Reason Code 37096.

When IRF-PAI Assessments Cannot Be Submitted Within 24 Months

A Medicare beneficiary's entitlement date may sometimes be approved or changed retroactively. Frequently, these cases result in services becoming covered for dates of service that are beyond the Medicare timely filing limit. Retroactive entitlement is an established exception to the timely filing period, so these claims may be submitted for payment (see Pub. 100-04, chapter 1, section 70.7.2).

iQIES accepts assessments for up to 24 months from the assessment date. In rare cases, a retroactive entitlement decision may extend back beyond this 24 month period. Each assessment that cannot be submitted to iQIES because of the 24 month limit will correspond to a Medicare claim for that IRF discharge.

To process the claims for these older dates of service, IRFs should contact their MAC to alert them to the situation and request any special instructions for the timing and coding of the claims. In addition to any other special instructions, the IRF shall submit the claims with a note in the Remarks field saying "IRF-PAI over 24 months."

Upon receipt of the claims, the MAC shall take the following actions:

- *When the untimely claims are suspended to check for exception requests, confirm the dates of service are over 24 months from the occurrence code 50 date on the claim.*
- *Temporarily turn off the edit that triggers the iQIES finder file, process the affected claims without sending them to iQIES, then turn the edit back on.*
- *Process the IRF claim using the provider-submitted HIPPS code for payment calculations.*

10.1.19 - Payment Adjustments – Applying OASIS Assessment Items to Determine HIPPS Codes

(Rev.12306; Issued: 10-19-23; Effective:01-24-24; Implementation:01-24-24)

Submission of an OASIS assessment is a condition of payment for HH periods of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. Under the HH PDGM, matching a claim to the OASIS assessment is required to process each home health claim.

During claims processing, the quality system, known as the Internet Quality Improvement and Evaluation System (iQIES), provides the claims 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. Because payment grouping cannot occur without the OASIS information, if the OASIS assessment is not found in the quality system upon receipt of a claim, Medicare systems will return the HH claim.

The only exception to this is when a disaster-related waiver of OASIS submission is in effect. In this case, the HHA reports condition code DR on the claim and does not report occurrence 50 (the assessment submission date) because no OASIS was submitted. The claim-OASIS matching process is bypassed and the provider-submitted HIPPS code is used for payment. In any other case, when occurrence code 50 is reported a matching assessment must be found in order for the claim to process.

There are steps an HHA can take to make sure a claim matches to the OASIS assessment successfully.

<u>Ensuring the Claim Matches an OASIS Assessment</u>

Before submitting an HH claim, 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).

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

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 payments. The Reason for Assessment (RFA) (OASIS Item M0100) must be equal to 01, 03, 04, or 05.

- 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 claims, reporting the assessment completion date (item M0090) as the associated date

- 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. 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

The MAC shall use this information to research the issue.

<u>When a Matching OASIS is Found</u>

When the OASIS assessment if found, answers to the OASIS items used in PDGM case-mix scoring are returned to the claims system and stored on the claim record. This information is displayed on a screen in the claims system, so the HHA can refer to it.
Medicare systems combine OASIS items and claims data (period timing, inpatient discharge, diagnoses) and send them to HH Grouper program (see section 80). The Grouper-produced HIPPS code replaces the provider-submitted HIPPS code on the claim and is used for payment.

The system-calculated HIPPS code may be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the medical reviewer indicates changes to the OASIS information on the claim screen where it is displayed. The original OASIS item information is in a column marked OA, the medical reviewers changes are recorded in a column marked MR. The revised OASIS information will be sent to the HH Grouper and a new HIPPS will be used for payment. This HIPPS code will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

When an OASIS Assessment Has Not Been Submitted

If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period, and
- Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.

Condition code 21 must not be used in these instances, since it would result in inappropriate beneficiary liability.

The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N211
MSN: 41.17

When OASIS Assessments Cannot Be Submitted Within 24 Months

A Medicare beneficiary's entitlement date may sometimes be approved or changed retroactively. Frequently, these cases result in services becoming covered for dates of service that are beyond the Medicare timely filing limit. Retroactive entitlement is an established exception to the timely filing period, so these claims may be submitted for payment (see Pub. 100-04, chapter 1, section 70.7.2).

iQIES accepts assessments for up to 24 months from the assessment date. In rare cases, a retroactive entitlement decision may extend back beyond this 24 month period. Each 60-day assessment that cannot be submitted to iQIES because of the 24 month limit may correspond to up to 2 Medicare claims for 30-day periods of care.

To process the claims for these older dates of service, HHAs should contact their MAC to alert them to the situation and request any special instructions for the timing and coding of the claims. In addition to any other special instructions, the HHA shall submit the claims with a note in the Remarks field saying "OASIS over 24 months."

Upon receipt of the claims, the HH&H MAC shall take the following actions:

- *When the untimely claims are suspended to check for exception requests, confirm the dates of service are over 24 months from the occurrence code 50 date on the claim.*
- *Temporarily turn off the edit that triggers the iQIES finder file, process the affected claims without sending them to iQIES, then turn the edit back on.*

- *Use the manual recoding process to copy the provider submitted HIPPS code from the 0023 revenue code into the recoded HIPPS code field and set the payment indicator (IND) field to P so the claim bypasses the home health Grouper.*
- *Monitor the claims for any Common Working File recoding edits that may apply and update first position of the HIPPS code on the claims as necessary to resolve the edits.*