Medicare Learning Network
MLN Matters
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - "Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu. Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website."

MLN Matters Number: MM5776 Revised

Related Change Request (CR) #: 5776

Related CR Release Date: November 2, 2007

Effective Date: For episodes beginning on or after January 1, 2008

Related CR Transmittal #: R1371CP

Implementation Date: April 7, 2008

Validation of Non-Routine Supply Reporting on Home Health Prospective Payment System (HH PPS) Claims

Note: This article was revised on November 21, 2007, to correct the effective date. The effective date should be "For HH episodes beginning on or after January 1, 2008." It incorrectly had stated January 1, 2007. All other information is unchanged.

Provider Types Affected

All Home Health Agencies (HHAs) billing Medicare Regional Home Health Intermediaries (RHHIs) for supplies provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

Effective for claims for HH PPS episodes beginning on or after January 1, 2008, which are received on or after April 7, 2008, Medicare systems require that all HH PPS claims report non-routine supply charges unless the HHA explicitly reports on the claim that such supplies were not reported.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) wants to make certain that claims from Home Health Agencies indicate the use of non-routine supplies and that the revenue codes supporting those supplies provided are listed appropriately.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes and review the *KEY POINTS* section of this article.

Background

Since the advent of the HH PPS Medicare billing instructions have required providers to report units and charges associated with all non-routine supplies associated with each episode of care. Supplies are reported on HH PPS claims using revenue code 027x. Additionally, special instructions have allowed for the optional separate reporting of wound care supplies. Wound care supplies may be identified on HH PPS claims using revenue code 0623.

Public comments on the proposed regulation for the recent refinements to the HH PPS asserted that, despite these longstanding instructions, non-routine supplies have been underreported since the implementation of HH PPS in October 2000. Medicare systems under the original HH PPS were unable to enforce the requirement for reporting supply charges. Not all HH episodes involve non-routine supplies and no other indicator on the HH PPS claim showed whether such supplies were called for in a particular case.

With the advent of the refined HH PPS, a separate case-mix adjustment for non-routine supplies is now part of the payment system. Effective for HH PPS episodes beginning on or after January 1, 2008, non-routine supply severity levels will be indicated on HH PPS claims through a code value in the 5th position of the HIPPS code. This new code value enables Medicare systems to identify episodes that require non-routine supplies and ensure that supply charges are present on claims for those episodes.

Key Points of CR5776

Medicare systems **will pay** HH PPS claims or adjustments and append remark codes M50* and N59* to the remittance advice if the following criteria are met:

- The type of bill is 32x or 33x excluding 322 and 332;
- The claim "From" date is on or after January 1, 2008;
- The claim receipt date is on or after April 7, 2008 and before October 1, 2008;
- The 5th position of the HIPPS code is a alphabetic value in the range S through X; and
- Revenue codes 27x (excluding 274) or 623 are not present on the claim.

*Remittance advice remark code M50 is defined as "Missing/incomplete/invalid revenue code(s)."

*Remittance advice remark code N59 is defined as: "**Alert:** Please refer to your provider manual for additional program and provider information." The temporary use of the combination of these messages is intended to serve as an important alert to the HHA and to direct the attention of HHAs to the supply reporting requirements in the *Medicare Claims Processing Manual*, chapter 10, section 40.2 before the Medicare implements full enforcement of supply reporting on October 1, 2008. This section of the manual is attached to CR5776 and the Web address for accessing CR5776 is available in the "Additional Information" section of this article.

As of October 1, 2008, Medicare systems **will return** to the provider HH PPS claims or adjustments if the following criteria are met:

- The type of bill is 32x or 33x excluding 322 and 332;
- The claim "From" date is on or after January 1, 2008;
- The claim receipt date is on or after October 1, 2008;

- The 5th position of the HIPPS code is a alphabetic value in the range S through X; and
- Revenue codes 27x (excluding 274) or 623 are not present on the claim.

Medicare contractors will return these HH PPS claims to the provider with a message instructing the HHA to review their records regarding the supplies provided to the beneficiary. The message should provide the following instructions:

- If supplies were provided, the charges must be added to the claim using the appropriate supply revenue code.
- If supplies were not provided, the HHA must indicate that on the claim by changing the 5th position of the HIPPS code to the appropriate numeric value in the range 1 through 6.

Additional Information

For complete details regarding this change, please see the official instruction (CR5776) issued to your Medicare RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1371CP.pdf* on the CMS website.

If you have questions, please contact your Medicare RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.