

Regulatory Roundup: String of CMS Transmittals, Medlearn Matters Articles Relevant to Home Health

A number of transmittals and Medlearn Matters articles relevant to home health and hospice providers have been posted on the Centers for Medicare & Medicaid Services (CMS) website recently. Following is a rundown of the latest.

Electronic Claim Status Inquiries (in "one standard format for all health care plans")

CMS issued a special edition of Medlearn Matters, [article SE0524](#), to inform providers of the advantages of implementing the ASC X12N version of the 276/277 claim status inquiry transaction sets ("ASC X12N 276/277"). According to the article, providers who do so "may create a more efficient follow-up process and achieve an increase in cash flow by greatly reducing the administrative costs incurred by supporting multiple formats." Also, for small providers, implementing ASC X12N 276/277 "would make electronic claim status requests and receipt of responses feasible ... and eliminate the need to maintain redundant software and send and review claim status requests and responses manually." Use of a national standard transaction format for health care claim status inquiries is one of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The article contains some links to further information, including:

- An article containing further information, "[Realizing Savings from the HIPAA Transaction Standards: How to Get There from Here](#)," prepared by Martin A. Brutscher, a partner with McBee Associates, Inc.
- [An implementation guide for ASC X12 276/277 version 4010A1](#), as well as claim status codes and category codes.

Electronic Claim Submission Exceptions

[Transmittal 541 \(Change Request 3815\)](#), an update to the Medicare Claims Processing Manual, advises Medicare contractors that they must request information from any providers submitting paper claims to ensure that these providers meet criteria for exception to mandatory electronic claims submission, as established by HIPAA. If no response to this request is received by the contractor within 45 calendar days, or if the provider fails to meet the exception criteria, the contractor will notify the provider by mail that all paper claims received more than 90 calendar days after the date of the initial information request will not be paid. With CMS's policy stating that in general all claims must be submitted electronically, the transmittal notes that "absent an applicable exception, paper claims that a provider sends to Medicare will not be paid."

Comprehensive Error Rate Testing (CERT) Notice

CMS put out another Medlearn Matters provider education piece ([article SE0526](#)) about the need to submit requested documentation when notified of medical review activities undertaken by the CMS CERT contractors. CERT contractors are charged with reviewing claims paid, as well as those denied, by Medicare fiscal intermediaries and carriers to determine claim error rates. The error rate for 2004 was 9.3 percent; however, a significant percentage of denials issued and subsequent overpayment notices were due to provider failure to respond to requests for documentation. The Medlearn Matters article instructs providers to respond to requests and advises them that they are not required to obtain additional beneficiary authorization to forward medical records to CERT contractors.

Medicare Summary Notice Revisions

[Transmittal 535 \(Change Request 3808\)](#) instructs fiscal intermediaries and carriers, including durable medical equipment regional carriers (DMERCs), of the need to modify Medicare Summary Notices to reflect new appeals language required under the Benefit Improvement and Protection Act of 2000 (BIPA). The language sets specific new timelines (120 days) for appealing Medicare claims denials. The transmittal also is an update to the Medicare Claims Processing Manual.

Statistical Sampling Instructions

The Medicare Program Integrity Manual has been updated, via [Transmittal 108 \(Change Request 3734\)](#), to reflect requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The law mandates that "before using extrapolation to determine overpayment amounts to be recovered by recoupment ... there must be a determination that educational intervention has failed to correct the payment error." These guidelines are in agreement with CMS's "Progressive Corrective Action" policy.

Clinical Laboratory Travel Rates Corrected

A Medlearn Matters article ([MM3785](#)) corrects the earlier published 2005 standard mileage rate paid for transportation to a nursing home or to homebound patients by lab personnel to perform a specimen collection from \$0.385 to \$0.405 per mile, and sets the personnel payment at \$0.45 per mile.

Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) Update

A Medlearn Matters article ([MM3843](#)) was issued informing providers that after review of the national coverage policy for CPAP therapy for OSA, CMS declared April 4 that the policy will remain unchanged. CMS will continue to deny payment for unattended home sleep testing for diagnosis of obstructive sleep apnea as "not reasonable and necessary." Instead, "Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility," the article states.

Medicare National Coverage Determination for Mobility Equipment

As a result of a new national coverage decision, CMS announced new criteria for mobility assistive equipment, including power wheelchairs and scooters. The new criteria include assessment of an individual's ability to accomplish activities of daily living (ADLs) with and without mobility equipment. CMS plans to release guidance for physicians and other practitioners in the near future to ensure proper documentation or patient evaluation information in the clinical record.