
Medicare Program Integrity Manual

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 23

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CHANGE REQUEST 1981

<u>CHAPTERS</u>	<u>REVISED SECTIONS</u>	<u>NEW SECTIONS</u>	<u>DELETED SECTIONS</u>
6	3 3.1 3.2 3.3 3.4 3.5 3.6 3.7	3.8	
Exhibits		29 30 31	

NEW/REVISED MATERIAL--EFFECTIVE DATE: May 2, 2002
IMPLEMENTATION DATE: May 2, 2002

Chapter 6, Section 3.1, Form CMS-485 - Home Health Certification and Plan of Care Data, clarifies the use of Form CMS-485 (the plan of care form) is not a CMS requirement. However, Home Health Agencies (HHAs) must have all required plan of care data elements contained in a readily identifiable location within the medical record.

Chapter 6, Section 3.2, Addendum to Form CMS-485 Plan of Care, provides HHAs the discretion to use a preprinted addendum to the plan of care when needed or any other format signed and dated by the physician.

Chapter 6, Section 3.3, Medical Review of Home Health Claims, instructs contractors to notify providers that they have 30 days to submit medical records for MR purposes but if the documentation is not received within 45 days, to make a MR determination based on available documentation. This section instructs contractors that they cannot reject the claim or return the claim to the provider when medical records are not submitted by the provider.

Chapter 6, Section 3.4.1, General, instructs contractors that once they establish that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record. It instructs contractors not to conduct MR on the request for anticipated payment (RAP).

Chapter 6, Section 3.4.2, Types of Review, defines pre-claim and post-claim review. It instructs contractors to target MR primarily on a pre-claim targeted basis.

Chapter 6, Section 3.4.3, MR Process, should be conducted after validating provider/service specific billing errors.

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Rade B. Vukmir



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