HH PPS Case Mix Refinement

An Overview of Billing and Claims Processing Changes

Wil Gehne
CMS/CMM Provider Billing Group
Division of Institutional Claims Processing

The following are contents of slides presented at various home health association forums during September – November 2007. This information has been converted from a PowerPoint presentation into a text format to ensure that the information is accessible to all audiences, per section 508.

CMS Instructions

- CR 5746 contains revisions to a number of sections of CPM Ch. 10 to reflect the policy changes of the HH PPS case mix refinement
- Most significantly for providers:
  - Revises the field by field billing instructions for HH PPS
  - Describes the new coding required
- Of interest to IT staff:
  - Contains detailed description of new HH Pricer logic
  - Contains requirements for Medicare systems

Historical Comparison

- Original HH PPS implementation:
  - Changed unit of payment
  - Required integration of assessment and claims systems for the first time
  - Created entirely new transactions (RAPs)
  - Created new types of bill
  - Created new revenue codes and source of admission codes
  - Introduced HIPPS coding to HH claims for the first time
  - Numerous other detailed billing changes

Historical Comparison

- Case-mix Refinement:
- In terms of the data submitted on the face of a claim, only 3 changes to HH PPS billing requirements:
- Elimination of the SCIC policy

- New HIPPS coding structure and many new codes
- New format for the treatment authorization code field
  - 'claims-OASIS matching key'

Elimination of SCICs

- Effective for episodes beginning on or after 1/1/2008:
- Claims must not contain more than one revenue code 0023 line
  - Ensure your software does not create such claims
  - Ensure billers keying claims into DDE are aware not to enter more than one
- Claims will be returned to the provider

New HIPPS Coding

- Current HH PPS HIPPS codes always begin with H
- Represent the patient's scores in the clinical, functional and service domains in the 2nd thru 4th positions of the code
- Contain a 'data validity flag' in the fifth position
- Only positions 2 thru 4 are significant to payment

New HIPPS Coding

- Refined case mix system requires more information to determine payment
- Need to know the episode sequence and resulting grouping 'step'
- Five grouping steps per Table 3 of the HH PPS refinements final rule
- Need information regarding the non-routine supply severity level of the patient

New HIPPS Coding

- HIPPS codes will be the mechanism to carry this new information:
- First position will now report the grouping step
- Positions 2 - 4 continue to report the severity levels in clinical, functional and service domains

- 5th position will report the non-routine supply severity level

New HIPPS Coding – Position 1

- HIPPS codes will begin with a number
- Grouping steps will be reported exactly as shown in Table 3
- 1 = early episodes, 0-13 therapy visits
- 2 = early episodes, 14-19 therapy visits
- 3 = later episodes, 0-13 therapy visits
- 4 = later episodes, 14-19 therapy visits
- 5 = all episodes, 20+ therapy visits

New HIPPS Coding – Positions 2 - 4

- Use a coding structure very similar to the current one:
- Clinical domain levels reported with letters A, B or C
- Functional domain levels reported with letters F, G or H
- Service domain levels reported with letters K, L, M, N & P
    - Note omission of "O"

New HIPPS Coding – Position 5

- 6 non-routine supply levels

S – level 1, supplies provided	**1** – level 1, supplies NOT provided
T – level 2, supplies provided	**2** – level 2, supplies NOT provided
U – level 3, supplies provided	**3** – level 3, supplies NOT provided
V – level 4, supplies provided	**4** – level 4, supplies NOT provided
W –level 5, supplies provided	**5** – level 5, supplies NOT provided
X— level 6, supplies provided	**6**— level 6, supplies NOT provided

New HIPPS Coding

- 153 case mix groups under refined system
- 6 non-routine supply levels
  - Would result in 918 new codes minimum
- With 2 values to represent supply levels:
  - Actually results in 1836 new codes

- Complete list of HIPPS codes are shown in the master list published in CMS HIPPS code website

Treatment Authorization Code

- Current 'claims-OASIS matching key' carries info needed just to do that function – dates and reason for assessment (RFA)
- Refined HH PPS requires reporting additional information in this field
- All current info PLUS
- Information needed to recode claims as necessary

Treatment Authorization Code

- Current information fills all 18 positions
- To create room for new information:
  - collapsing the dates to use only 2 digit years and alphabetic codes for the Julian date
  - Using only one digit for the RFA
- "Possible new format" on p.35 published in the 5/25/2007 Grouper specifications was not changed – this is the final format

Treatment Authorization Code

- Last 9 positions will carry recoding information:
  - 1 number to show the episode sequence (1 = early, 2 = late)
  - 4 pairs of letters that encode the scores in the clinical and functional domains as calculated under each of the 4 equations of the refined case mix model
- Again, "possible new format" matches CR 5746

- Format will be validated by Medicare systems

Recoding claims

- Currently, HIPPS codes typically change only when the 10 visit therapy threshold is not met
  - Simple 1:1 correspondence between high and low therapy groups
- Under case-mix refinement, not as simple:
  - Combinations of episode sequence and therapy level determine which equation applies
  - Changes to one, the other or both could mean the HIPPS code must be grouped under a different equation

Recoding claims

- Changes to number of therapies have multiple impacts:
- Grouping Step:
  - Changes above or below the 14 and 20 visit thresholds change the grouping step
  - May results in complete recoding of the HIPPS code
- Service Severity:
  - Other changes in the number of visits can also change the severity level in the service domain
  - May result in a change to the 4th position of the HIPPS code

Recoding claims

- Medicare systems will validate whether the reported episode sequence is correct and whether the therapy level reported is supported by covered therapy visits
- If either the sequence or the therapy level is in error, Medicare systems will automatically adjust the HIPPS code and pay accordingly
  - From early to later and vice versa
  - Increases and decreases in therapy
- Use the pairs of values in the treatment authorization code to do it

Additional changes

- New grouping software –
  - Revised version of the pseudocode describes how it works
  - Grouper creates new HIPPS code values and treatment authorization codes I've described

- New Pricing logic
  - All routine update changes
  - New table of weights – 153 weights, one for each 1st 4 positions of the HIPPS code
  - New table of 6 supply amounts
  - New LUPA payment calculation

LUPA Add-on calculation

- Pricer will calculate the add-on when:
  - Early episode indicated in HIPPS code (1st position 1 or 2)
  - Admission date and "From" date match
  - Source of admission is not "B" or "C"
- Add on amount will be paid on the earliest dated revenue code line on the LUPA claim

- Many more changes in CMS' Pricer, but all relate to the re-coding process

Supply reporting

- In response to comments on the proposed rule that supplies have not been accurately reported on HH PPS claims, CMS is creating a validation process
- Ensure that IF the 5th position of the HIPPS code is a letter indicating supplies were reported THEN:
  - At least one revenue code 27x or 623 line must be present on the claim

Supply reporting

- Initially, if the supply lines are absent the claim will be paid and messages appended to the remittance advice alerting the HHA to the inconsistent data on their claims
- After a 'grace period' has elapsed, claims will be returned to the provider for correction

Supply Reporting

- Two reactions:
  - Report the supplies that were overlooked
  - Change the 5th position of the HIPPS code to the corresponding number that says supplies were not provided.

- Medicare systems will be revised to only use the first 4 positions of the HIPPS code to match final claims to their corresponding RAP

Supply Reporting

- Note the Grouper will ALWAYS output a code that says supplies are provided.

- If supplies are not provided in the episode, the provider must change the 5th position of the HIPPS code prior to submitting the claim

Supply reporting

- These changes will be described a separate CR and implemented in April 2008
- Grace period will begin in April 2008 and extend for a period to be announced in that CR
- The CR will outline the specific criteria for the edits and identify the remark codes that will be used on remittances to provide the alerts

M0175 Enforcement

- New case mix system does not use OASIS item M0175 in determining payment groups

- Consequently, CMS edits to check for hospital claims within 14 days prior to HH admissions will be disabled effective for episodes beginning on and after 1/1/2008

Transition Issues

- Annual update is effective for claim “Through” dates on or after 1/1/2008
- Case-mix refinements are effective for claim “From” dates on or after 1/1/2008
- Reflected in the multiple payment rate tables 11 and following
    - Be careful!

Transition Issues

- OASIS RFAs 01,03,06, 07, 08 or 09 with completion dates (M0090) of 1/1/2008 or after must use new OASIS and grouper specifications
- OASIS RFAs 04 or 05 with completion dates (M0090) of 12/27/2007 or after must use new OASIS and grouper specifications

Transition Issues

- There may be cases where an RFA 04 or 05 on 12/27/2007 or later may be needed to provide the HIPPS code for an episode prior to 1/1/2008
- In these cases and certain other cases, special actions will be needed.
- See “Question & Answers” document on the HH PPS Coding & Billing website for details

Questions?

Wil Gehne
wilfried.gehne@cms.hhs.gov