Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM6027 Revised

Related Change Request (CR) #: 6027

Related CR Release Date: May 16, 2008

Effective Date: HHPPS Episodes beginning on or after Jan. 1, 2008

Related CR Transmittal #: R1505CP

Implementation Date: October 6, 2008

Correction to Determinations of Early Episodes versus Later Episodes under the Home Health Prospective Payment System (HH PPS)

Note: This article was revised on May 27, 2008, to revise the effective and implementation dates (see above). All other information remains the same.

Provider Types Affected

Home Health Agencies (HHAs) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

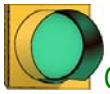
Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6027 which corrects Medicare system determinations of 'early' versus 'later' episodes under the Home Health Prospective Payment System (HH PPS).

CAUTION – What You Need to Know

If a HH PPS episode has been fully denied by medical review because it does not meet Medicare coverage requirements for the Home Health (HH) benefit, the episode should not be counted in determining whether an episode is early or later. Currently, Medicare's common working file (CWF) system does not make this distinction, and CR 6027 corrects this problem.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Under the refined HH Prospective Payment System (PPS) case-mix system which was implemented in January 1, 2008, HH episodes are paid differently based on whether the episode is classified as 'early' or 'later' which are defined as follows:

- The first two episodes of a sequence of adjacent episodes are considered 'early;' while
- The third episode of that sequence and any subsequent episodes are considered 'later.'

Providers submit claims for HH PPS episodes and indicate whether the episode is early or later using the first position of the Health Insurance Prospective Payment System (HIPPS) code:

- HIPPS Codes beginning with 1 or 2 represent early episodes; and
- HIPPS Codes beginning with 3 or 4 represent later episodes.

These HIPPS codes are validated in Medicare's Common Working File (CWF) system by comparing the code to the number of episodes on file for the beneficiary. If the code submitted by the provider disagrees with Medicare's episode history, the CWF rejects the claim, and the Fiscal Intermediary Shared System (FISS) recodes the claim as appropriate.

Currently, these CWF validation process checks episodes based on their start and end dates alone, without regard to whether the episodes were covered by Medicare. The current HH PPS episode record does not contain an indicator that shows that the episode is non-covered.

If a HH PPS episode has been fully denied by medical review because it does not meet Medicare coverage requirements for the HH benefit, the episode should not be counted in determining whether an episode is early or later. These episodes should be treated the same as periods without any home health services.

HH PPS episodes may be fully denied for a number of reasons, including lack of physician orders, lack of qualifying skilled service need, the patient not being homebound, or the services were not reasonable and necessary.

CR 6027 provides instructions that:

- The CWF exclude episodes that were fully denied by medical review from determinations of whether an episode should be paid as "early" or "later."
- Medicare systems make changes to correct for cases where a HH PPS episode has been fully denied by medical review because it does not meet Medicare coverage requirements for the HH benefit, and are not count the episode in determining whether the episode is 'early' or 'later.'

Corrections and clarifications to HH billing instructions are also made in the Medicare Claims Processing Manual (Chapter 10 (Home Health Agency Billing)) which is included as an attachment to CR 6027.HHAs may want to pay particular note to the revised Section 70.4 of Chapter 10. This section deals with the decision logic used by the HH Pricer software on HHA claims.

Additional Information

The official instruction, CR 6027, issued to your RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1505CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

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