| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1476** | **Date: March 7, 2008** |
| | **Change Request 5877** |

**NOTE: Transmittal 1424, dated February 1, 2008 is being rescinded and replaced with Transmittal 1476, dated March 7, 2008 to incorporate new information in section 80 inadvertently omitted from Transmittal 1421, CR 5893. All other information remains the same.**

**Subject: Correction to Low Utilization Payment Adjustment Add-on Payments Under the Refined Home Health Prospective Payment System (HH PPS)**

**I. SUMMARY OF CHANGES:** This transmittal describes systems changes necessary to prevent low utilization payment adjustment add-on payments on HH PPS claims in situations where the add-on does not apply. It also corrects errors and oversights in various sections of Chapter 10.

**New / Revised Material**
**Effective Date: January 1, 2008**
**Implementation Date: July 7, 2008**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | 10/10.1.9/Composition of HIPPS Codes for HH PPS |
| R | 10/40.1/Request for Anticipated Payment (RAP) |
| R | 10/40.2/HH PPS Claims |
| R | 10/70.2/Input/Output Record Layout |
| R | 10/70.3/Decision Logic Used by the Pricer on RAPs |
| R | 10/70.4/Decision Logic Used by the Pricer on Claims |
| R | 10/80/Special Billing Situations Involving OASIS Assessments |
| R | 10/100/Temporary Suspension of Home Health Services |

**III. FUNDING:**

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

Not Applicable.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

***Unless otherwise specified, the effective date is the date of service.***

# Attachment – Business Requirements

| Pub. 100-04 | Transmittal:1476 | Date: March 7, 2008 | Change Request: 5877 |
|---|---|---|---|

**NOTE: Transmittal 1424, dated February 1, 2008 is being rescinded and replaced with Transmittal 1476, dated March 7, 2008 to incorporate new information in section 80 inadvertently omitted from Transmittal 1421, CR 5893. All other information remains the same.**

**SUBJECT: Correction to Low Utilization Payment Adjustment Add-on Payments Under the Refined Home Health Prospective Payment System (HH PPS)**

**Effective Date: January 1, 2008**

**Implementation Date: July 7, 2008**

## I. GENERAL INFORMATION

**A. Background:** The August 29, 2007 Final Rule describing refinements to the home health prospective payment system (HH PPS) created an additional payment that is made when HH PPS episodes subject to low utilization payment adjustments (LUPAs) are the first episode in a sequence of adjacent episodes or are the only episode of care received by a beneficiary. This payment is often referred to as the "LUPA add-on."

The initial implementing instructions for HH PPS refinements were published in Transmittal 1348, Change Request (CR) 5746. These instructions described the criteria Medicare systems would use to identify claims that would qualify for the LUPA add-on payment. These criteria were:

- That the claim has four or fewer visits,
- That the HIPPS code on the claim begins with a 1 or 2, indicating the claim is for an early episode in a sequence of adjacent episodes,
- That the claim admission date and statement covers "From" date match, indicating the claim is the first episode provided at a given provider, AND
- That the source of admission code on the claim is not B, indicating the claim is not a transfer from another HHA, or C, indicating the claim is a discharge and readmission to the same HHA within the same 60-day period.

These criteria sought to identify LUPA add-on claims from data on the face of the claim only, without requiring additional editing of the claim against claims history in the Common Working File (CWF). While these criteria will identify LUPA add-on claims for all cases, they will also pay the LUPA add-on in cases that are not appropriate.

If a patient is admitted to a first episode at one HHA, then discharged and readmitted to the same or another HHA within the 60-day period between episodes that defines a sequence of adjacent episodes, the criteria described above would be met but the claim would be the second in the sequence. In this case the LUPA add-on should not apply. The business requirements below add additional criteria to Medicare claims processing to ensure LUPA add-on payments are not made incorrectly after the implementation date.

**B. Policy:** There is no new policy created by this CR. LUPA add-on payments should only be made for the first episode in a sequence of adjacent episodes or are the only episode of care received by a beneficiary.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 5877.1 | Medicare systems shall ensure that LUPA add-on payments are made only on the first or only episode in a sequence of adjacent episodes. | | | | | | | | | X | |
| 5877.1.1 | Medicare systems shall identify claims that have received LUPA add-on payments by the presence of Pricer return code 14. | | | | | | | | | X | |
| 5877.1.2 | If Pricer return code 14 is present, Medicare systems shall read HH episodes to determine whether the episode is the first or only episode in a sequence of adjacent episodes. | | | | | | | | | X | |
| 5877.1.3 | If the Pricer return code 14 is present and the episode is not the first or only episode in a sequence, Medicare systems shall reject the claim for repricing. | | | | | | | | | X | |
| 5877.2 | Medicare systems shall reprice episodes that are identified as not qualifying for the LUPA add-on. | | | | | | X | | | | |
| 5877.2.1 | Upon receipt of the rejected claim described in 5877.1.3, Medicare systems shall set the recoding indicator in the Pricer input record to a new value of 2 and reprice the claim. | | | | | | X | | | | HH Pricer |
| 5877.2.2 | Medicare systems shall deduct the LUPA add-on from claims with Pricer recoding indicator 2 and change the Pricer return code to 06 (defined as LUPA payment only). | | | | | | | | | | HH Pricer |
| 5877.3 | Medicare contractors shall adjust all claims that received the LUPA add-on which were received between January 1, 2008 and July 6, 2008. | | | | | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 5877.4 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" | | | | | X | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | | | | | | | | |

## IV. SUPPORTING INFORMATION

**A. For any recommendations and supporting information associated with listed requirements, use the box below:**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 5877.1 – 5877.2.2 | These business requirements apply to types of bill 32x or 33x only. |
| 5877.2.1 | Recoding indicator 2 will be defined as "HIPPS code shows early episode, but this is not a first or only episode." |

**B. For all other recommendations and supporting information, use this space: N/A**

## V. CONTACTS

**Pre-Implementation Contact(s):** Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov

**Post-Implementation Contact(s):** Appropriate Regional Office

## VI. FUNDING

**A.** ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**B.** ***For Medicare Administrative Contractors (MAC)*****: N/A**

## 10.1.9 - Composition of HIPPS Codes for HH PPS

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

For HH PPS episodes beginning on and after October 1, 2000 but before January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

- The second, third, and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the original 2000 HH PPS final rule. HIPPS code lists are maintained on the CMS Web site. Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

- The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper. This position does not correspond to HHRGs since these codes do not differentiate payment groups. The fifth position will allow only numeric characters and a fifth position value other than "1," which is produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

**The first position of every home health HIPPS code will be "H."** The remaining four positions discussed above can be summarized as follows:

| (Clinical) Position #2 | (Functional) Position #3 | (Service) Position #4 | Position #5 | Domain Level |
|---|---|---|---|---|
| **A** (HHRG: C0) | **E** (HHRG: F0) | **J** (HHRG: S0) | **1** = 2nd, 3rd & 4th positions computed | = min |
| **B** (HHRG: C1) | **F** (HHRG: F1) | **K** (HHRG: S1) | **2** = 2nd position derived | = low |
| **C** (HHRG: C2) | **G** (HHRG: F2) | **L** (HHRG: S2) | **3** = 3rd position derived | = mod |
| **D** (HHRG: C3) | **H** (HHRG: F3) | **M** (HHRG: S3) | **4** = 4th position derived | = high |
| | **I** (HHRG: F4) | | **5** = 2nd & 3rd positions derived | = max |
| | | | **6** = 3rd & 4th positions derived | |
| | | | 7 = 2nd & 4th positions derived | |

| (Clinical) Position #2 | (Functional) Position #3 | (Service) Position #4 | Position #5 | Domain Level |
|---|---|---|---|---|
| | | | **8** = 2nd, 3rd & 4th positions derived | |
| | | **N** thru **Z** | **9, 0** | expansion values for future use |

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

Based on this coding structure:

- The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG.

- The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, the Pricer software will price all eight codes for that HHRG identically.

For HH PPS episodes beginning on and after January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is no longer a fixed value. The refined HH PPS uses a four-equation case-mix model which assigns differing scores in the clinical, functional and service domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores that follow.

- The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system.

- The fifth position indicates a severity group for non-routine supplies (NRS). The HH PPS grouper software will assign each episode into one of 6 NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number 1 through 6 before submitting the claim.

Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

| | Position #1 | Position #2 | Position #3 | Position #4 | Position #5 | | |
|---|---|---|---|---|---|---|---|
| | **Grouping Step** | **Clinical Domain** | **Functional Domain** | **Service Domain** | **Supply Group – supplies provided** | **Supply Group – supplies not provided** | **Domain Levels** |
| **Early Episodes (1st & 2nd )** | **1** (0-13 Visits) | **A** (HHRG: C1) | **F** (HHRG: F1) | **K** (HHRG: S1) | **S** (Severity Level: 1) | **1** (Severity Level: 1) | = min |
| | **2** (14-19 Visits) | **B** (HHRG: C2) | **G** (HHRG: F2) | **L** (HHRG: S2) | **T** (Severity Level: 2) | **2** (Severity Level: 2) | = low |
| **Late Episodes (3rd & later)** | **3** (0-13 visits) | **C** (HHRG: C3) | **H** (HHRG: F3) | **M** (HHRG: S3) | **U** (Severity Level: 3) | **3** (Severity Level: 3) | = mod |
| | **4** (14-19 Visits) | | | **N** (HHRG: S4) | **V** (Severity Level: 4) | **4** (Severity Level: 4) | = high |
| **Early or Late Episodes** | **5** (20 + Visits) | | | **P** (HHRG: S5) | **W** (Severity Level: 5) | **5** (Severity Level: 5) | = max |
| | | | | | **X** (Severity Level: 6) | **6** (Severity Level: 6) | |
| | 6 thru 0 | D thru E | I thru J | Q thru R | Y thru Z | 7 thru 0 | Expansion values for future use |

Examples:

- First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level and non-routine supplies were not provided = HIPPS code 1AFK1

- Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity leve1 4 = HIPPS code 4CH*L*V

- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score *for all episodes over 20 therapies is the same (minimum)* and supply severity level 6 = HIPPS code 5BH*K*X

Based on this coding structure:

- 153 case-mix groups defined in the 2007 HH PPS final rule are represented by the first four positions of the code.

- Each of these case-mix groups can be combined with any NRS severity level, resulting in *1836* HIPPS codes in all (i.e., 153 case-mix groups times *12 NRS codes (two each per NRS severity level)*.

- Each HIPPS code will represent a distinct payment amount, without any duplication of payment weights across codes.

- HIPPS codes created using this structure are valid only on claim lines with revenue code 0023.

## 40.1 - Request for Anticipated Payment (RAP)

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit an RAP with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the next remittance advice (RA).

If care continues with the same provider for a second episode of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been

submitted. If a prior episode is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the next RA will be used to recoup the overpaid amount.

While an RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims.

**Provider Name, Address, and Telephone Number**

**Required -** The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity.

**Patient Control Number**

**Optional -** The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

**Type of Bill**

**Required -** This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

**Code Structure** (only codes used to bill Medicare are shown).

**lst Digit-Type of Facility**

3 - Home Health

**2nd Digit-Bill Classification (Except Clinics and Special Facilities)**

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

**NOTE:** While the bill classification of "3," defined as "Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)" may also be appropriate to an HH PPS claim depending upon a beneficiary's eligibility, Medicare encourages HHAs to submit all RAPs with bill classification "2." Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

| 3rd Digit-Frequency | Definition |
|---|---|
| 2-Interim-First Claim | For HHAs, used for the submission of original or replacement RAPs. |
| 8-Void/Cancel of a Prior Claim | Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code “2” bill (a replacement RAP) must be submitted for the episode to be paid. If an RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted. |

Medicare contractors will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

**Statement Covers Period (From-Through)**

**Required -** Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the “from” and “through” date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.).

**Patient Name/Identifier**

**Required -** Patient’s last name, first name, and middle initial.

**Patient Address**

**Required -** Patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

**Patient Birth Date**

**Required -** Month, day, and year of birth of patient.

**Left blank** if the full correct date is not known.

**Patient Sex**

**Required - “**M” for male or “F” for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

**Admission/Start of Care Date**

**Required** - Date the patient was admitted to home health care. On the first RAP in an admission, this date should match the statement covers "from" date. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

**Source of Referral for Admission or Visit**

**Required -** Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code. For a complete list of codes, see Chapter 25.

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

**Patient Discharge Status**

**Required -** Indicates the patient's status as of the "through" date of the billing period. Since the "through" date of the RAP will match the "from" date, the patient will never be discharged as of the "through" date. As a result only one patient status is possible on RAPs, code 30 which represents that the beneficiary is still a patient of the HHA.

**Condition Codes**

**Conditional**. The HHA enters any NUBC approved code to describe conditions that apply to the RAP.

If canceling the RAP (TOB 3X8), the agency reports one of the following:
Claim Change Reasons

| Code | Title | Definition |
|---|---|---|
| D5 | Cancel to Correct HICN or Provider ID | Cancel only to correct an HICN or Provider Identification Number. |
| D6 | Cancel Only to Repay a Duplicate or OIG Overpayment | Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate. |

Enter "Remarks" indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

**Occurrence Codes and Dates**

**Optional -** Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

For a complete list of Occurrence Codes, see Chapter 25.

**Value Codes and Amounts**

**Required -** Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

| Code | Title | Definition |
|---|---|---|
| 61 | Location Where Service is Furnished (HHA and Hospice) | MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents. |

**Optional -** Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

For a complete list of value codes, see Chapter 25.

**Revenue Code and Revenue Description**

**Required -** One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

| Revenue Code | Description |
|---|---|
| 0023 | HIPPS - Home Health PPS |

**The 0023 code is not submitted with a charge amount.**

**Optional -** HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

**NOTE:** Revenue codes 058X and 059X are not accepted with covered charges on Medicare home health RAPs under HH PPS. Revenue code 0624 (investigational devices) is not accepted at all on Medicare home health RAPs under HH PPS.

**HCPCS/Accommodation Rates/HIPPS Rate Codes**

**Required -** On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

**Optional -** If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

**Service Date**

**Required -** On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

**Optional -** If additional revenue codes are submitted on the RAP, the HHA reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

**Service Units**

**Optional –** Service units are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports service units as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

**Total Charges**

**Required –** The HHA reports zero charges on the 0023 revenue code line.

**Optional -** If additional revenue codes are submitted on the RAP, the HHA reports any necessary charge amounts to meet the requirements of other payers or its billing software. Medicare claims processing systems will not make any payments based upon submitted charge amounts.

**Payer Name**

**Required -** See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

**Release of Information Certification Indicator**

**Required** - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

**National Provider Identifier – Billing Providers**

**Required -** The HHA enters their provider identifier.

**Insured's Name**

**Required -** On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

**Insured's Unique Identifier**

**Required -** See Chapter 25.

**Treatment Authorization Code**

**Required -** The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

| **Position** | **Definition** | **Format** |
|---|---|---|
| 1-2 | M0030 (Start-of-care date) – 2 digit year | 99 |
| 3-4 | M0030 (Start-of-care date) – alpha code for Julian date | XX |
| 5-6 | M0090 (Date assessment completed) – 2 digit year | 99 |
| 7-8 | M0090 (Date assessment completed) – alpha code for Julian | XX |

| | | |
|---|---|---|
| | date | |
| 9 | M0100 (Reason for assessment) | 9 |
| 10 | M0110 (Episode Timing) – Early = 1, Late = 2 | 9 |
| 11 | Alpha code for Clinical severity points – under Equation 1 | X |
| 12 | Alpha code for Functional severity points – under Equation 1 | X |
| 13 | Alpha code for Clinical severity points – under Equation 2 | X |
| 14 | Alpha code for Functional severity points – under Equation 2 | X |
| 15 | Alpha code for Clinical severity points – under Equation 3 | X |
| 16 | Alpha code for Functional severity points – under Equation 3 | X |
| 17 | Alpha code for Clinical severity points – under Equation 4 | X |
| 18 | Alpha code for Functional severity points – under Equation 4 | X |

**NOTE**: The Julian dates in positions 3-4 and 7-8 are converted from 3 position numeric values to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system.

The following represents an example of a treatment authorization code created using this format:

| Position | Definition | Actual Value | Resulting Code |
|---|---|---|---|
| 1-2 | M0030 (Start-of-care date) – 2 digit year | 2007 | 07 |
| 3-4 | M0030 (Start-of-care date) – code for Julian date | Julian date 245 | JK |
| 5-6 | M0090 (Date assessment completed) – 2 digit year | 2008 | 08 |
| 7-8 | M0090 (Date assessment completed) – code for Julian date | Julian date 001 | AA |
| 9 | M0100 (Reason for assessment) | 04 | 4 |
| 10 | M0110 (Episode Timing) | 01 | 1 |
| 11 | Clinical severity points – under Equation 1 | 7 | G |
| 12 | Functional severity points – under Equation 1 | 2 | B |
| 13 | Clinical severity points – under Equation 2 | 13 | M |
| 14 | Functional severity points – under Equation 2 | 4 | D |
| 15 | Clinical severity points – under Equation 3 | 3 | C |
| 16 | Functional severity points – under Equation 3 | 4 | D |
| 17 | Clinical severity points – under Equation 4 | 12 | L |
| 18 | Functional severity points – under Equation 4 | 7 | G |

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

**Document Control Number (DCN)**

**Required -** If canceling an RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case.

**Principal Diagnosis Code**

**Required -** The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported on the claim must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

**Other Diagnoses Codes**

**Required -** The HHA enters the full ICD-9-CM codes for additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9 guidelines.

OASIS form items M0245 or M0*24*6, which report Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

**Attending Provider Name and Identifiers**

**Required -** The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.

**Remarks**

**Conditional -** Remarks are necessary when canceling *the* RAP, to indicate the reason for the cancellation.

## 40.2 - HH PPS Claims

*(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)*

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See Chapter 1.)

**Billing Provider Name, Address, and Telephone Number**

**Required** – The HHA's minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. Medicare contractors use this information in connection with the provider identifier to verify provider identity.

**Patient Control Number and Medical/Health Record Number**

**Required** - The patient's control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

The HHA may enter the number assigned to the patient's medical/health record. If this number is entered, the Medicare contractor must carry it through their system and return it on the remittance record.

**Type of Bill**

**Required -** This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

> 3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

> 2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
>
> **NOTE:** While the bill classification of 3, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims systems determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - Definition

> 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.
>
> 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

9 - Final Claim for an HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8.

HHAs must submit HH PPS claims with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Medicare contractors do not accept late charge bills, submitted with frequency "5" on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

**Statement Covers Period**

**Required -** The beginning and ending dates of the period covered by this claim. The "from" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "through" date must be 59 days after the "from" date. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal discharge procedures as the "through" date. If a discharge claim is submitted due to change of Medicare contractor, see instructions for patient status code below. If the beneficiary has died, the HHA reports the date of death in the "through date."

Any NUBC approved patient status code may be used in these cases. The HHA may submit claims for payment immediately after the claim "through" date. It is not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

**Patient Name/Identifier**

**Required –** The HHA enters the patient's last name, first name, and middle initial.

**Patient Address**

**Required** - The HHA enters the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

**Patient Birth Date**

**Required** - The HHA enters the month, day, and year of birth of patient. If the **full** correct date is not known, leave blank.

**Patient Sex**

**Required** - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

**Admission/Start of Care Date**

**Required -** The HHA enters the same date of admission that was submitted on the RAP for the episode.

**Source of Referral for Admission or Visit**

**Required -** The HHA enters the same source of admission code that was submitted on the RAP for the episode.

**Patient Discharge Status**

**Required -** The HHA enters the code that most accurately describes the patient's status as of the "Through" date of the billing period. Any applicable NUBC approved code may be used.

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

In cases where an HHA is changing the Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status code 06. Billing for the beneficiary is being "transferred" to the new contractor.

In cases where the ownership of an HHA is changing which causes the Medicare certification number (known as the OSCAR number) to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. In changes of ownership which do not affect the Medicare certification number, billing for episodes is also unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date. The claim should be coded with patient status 06. Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

If HHAs require guidance on OASIS assessment procedures in these cases, they should contact the appropriate state OASIS education coordinator.

**Condition Codes**

**Optional –** The HHA enters any NUBC approved code to describe conditions that apply to the claim. For a complete list of Condition Codes see Chapter 25.

HHAs that are adjusting previously paid claims enter one of the following codes representing Claim Change Reasons:

| Code | Definition |
|---|---|
| D0 | Changes to Service Dates (From and Through dates) |
| D1 | Changes to Charges |
| D2 | Changes to Revenue Codes/HCPCS/HIPPS Rate Codes |
| D7 | Change to Make Medicare the Secondary Payer |
| D8 | Change to Make Medicare the Primary Payer |
| D9 | Any Other Change |
| E0 | Change in Patient Status (Use D9 if multiple changes are necessary) |
| 20 | Demand Bill (See §50) |
| 21 | No payment bill (See Chapter 1) |

If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

**Required -** If canceling the claim (TOB 3X8), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

| Code | Definition |
|---|---|
| D5 | Cancel to Correct HICN or Provider ID |
| D6 | Cancel Only to Repay a Duplicate or OIG Overpayment |

**Occurrence Codes and Dates**

**Optional -** The HHA enters any NUBC approved code to describe occurrences that apply to the claim. For a complete list of Occurrence Codes see Chapter 25.

**Occurrence Span Code and Dates**

**Optional -** The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission during an episode.

For a complete list of Occurrence Span codes see Chapter 25.

**Value Codes and Amounts**

**Required -** Home health episode payments must be based upon the site at which the beneficiary is served. For episodes in which the beneficiary's site of service changes from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

**NOTE:** Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

| Code | Title | Definition |
|---|---|---|
| 17 | Outlier Amount | The amount of any outlier payment returned by the Pricer with this code. (Contractors always place condition code 61 on the claim along with this value code.) |
| 61 | Location Where Service is Furnished (HHA and Hospice) | HHAs report the MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents. |
| 62 | HH Visits - Part A | The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812a)(3) of the Social Security Act. |
| 63 | HH Visits - Part B | The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act. |
| 64 | HH Reimbursement - Part A | The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act. |

| Code | Title | Definition |
|---|---|---|
| 65 | HH Reimbursement - Part B | The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act. |

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 32X, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will not change the TOB and will return the claim to CWF with RIC code U.

**Revenue Code and Revenue Description**

**Required**

See Chapter 25 for explanation of the varying third digit of the revenue code represented by "X" in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim.

For episodes beginning before January 1, 2008, if there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more then once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day. If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change.

Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care and zero charges. See §40.1 for more detailed information on the HIPPS code.

For episodes beginning on or after January 1, 2008, HHAs enter only one 0023 revenue code per claim in all cases.

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 042X, 043X, 044X, 055X, 056X and 057X) must be reported as a separate line. Any of the following revenue codes may be used:

| | |
|---|---|
| 027X (**NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills) | Medical/Surgical Supplies (Also see 062X, an extension of 027X)<br><br>Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. |
| 042X | Physical Therapy<br><br>Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |
| 043X | Occupational Therapy<br><br>Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |

| | |
|---|---|
| 044X | Speech-Language Pathology<br><br>Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |
| 055X | Skilled Nursing<br><br>Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |
| 056X | Medical Social Services<br><br>Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |
| 057X | Home Health Aide (Home Health)<br><br>Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount. |

**NOTE**: FIs do not accept revenue codes 058X or 059X when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

**Revenue Codes for Optional Billing of DME**

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their Medicare contractor processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

| | |
|---|---|
| 029X | Durable Medical Equipment (DME) (Other Than Renal)<br><br>Required detail: the applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. |

| | |
|---|---|
| 060X | Oxygen (Home Health)<br><br>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount. |

**Revenue Code for Optional Reporting of Wound Care Supplies**

| | |
|---|---|
| 062X | Medical/Surgical Supplies - Extension of 027X<br><br>Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive. |

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation “surg dressings,” HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Chapter 7 of Pub. 100-02, Medicare Benefit Policy Manual defines routine vs. nonroutine supplies. HHAs will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS’ future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

**Validating Required Reporting of Supply Revenue Code**

With the advent of the refined HH PPS, the payment system includes a separate case-mix adjustment for non-routine supplies. 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. The 5th position of the HIPPS code can contain two sets of values. One set of codes (the letters S through X) indicate that supplies were provided. The second set of codes (the numbers 1 through 6) indicate the HHA is intentionally reporting that they did not provide supplies during the episode. See section 10.1.9 for the complete composition of HIPPS under the refined HH PPS.

HHAs must ensure that if they are submitting a HIPPS code with a 5th position containing the letters S through X, the claim must also report a non-routine supply revenue with covered charges. This revenue code may be either revenue code 27x, excluding 274, or revenue code 623, consistent with the instructions for optional separate reporting of wound care supplies.

Medicare systems will return the claim to the HHA if the HIPPS code indicates non-routine supplies were provided and supply charges are not reported on the claim. When the HHA receives a claim returned for this reason, the HHA must review their records regarding the supplies provided to the beneficiary. The HHA may take one of the following actions, based on the review of their records:

- If non-routine supplies were provided, the supply charges must be added to the claim using the appropriate supply revenue code.

- If non-routine 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.

After completing one of these actions, the HHA may return the claim to the Medicare contractor for continued adjudication.

**HCPCS/Accommodation Rates/HIPPS Rate Codes**

**Required -** On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a SCIC, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

**Service Date**

**Required -** On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

**Service Units**

**Required -** The HHA should not report service units on 0023 revenue code lines. For line items detailing all services within the episode period, the HHA reports units of

service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

**Total Charges**

**Required -** The HHA must report zero charges on the 0023 revenue code line (the field may be zero or blank).

For line items detailing all services within the episode period, the HHA reports charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). Medicare claims processing systems will not make any payments based upon submitted charge amounts.

**Non-covered Charges**

**Required -** The total noncovered charges pertaining to the related revenue code are entered here.

**Payer Name**

**Required** - See Chapter 25.

**Release of Information Certification Indicator**

**Required** - See Chapter 25.

**National Provider Identifier – Billing Provider**

**Required** - The HHA enters their provider identifier.

**Insured's Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Patient's Relationship To Insured**

**Required only if MSP involved**. See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Unique Identifier**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Group Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Group Number**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Treatment Authorization Code**

**Required** - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

| Position | Definition | Format |
|---|---|---|
| 1-2 | M0030 (Start-of-care date) – 2 digit year | 99 |
| 3-4 | M0030 (Start-of-care date) – alpha code for Julian date | XX |
| 5-6 | M0090 (Date assessment completed) – 2 digit year | 99 |
| 7-8 | M0090 (Date assessment completed) – alpha code for Julian date | XX |
| 9 | M0100 (Reason for assessment) | 9 |
| 10 | M0110 (Episode Timing) – Early = 1, Late = 2 | 9 |
| 11 | Alpha code for Clinical severity points – under Equation 1 | X |
| 12 | Alpha code for Functional severity points – under Equation 1 | X |
| 13 | Alpha code for Clinical severity points – under Equation 2 | X |
| 14 | Alpha code for Functional severity points – under Equation 2 | X |
| 15 | Alpha code for Clinical severity points – under Equation 3 | X |
| 16 | Alpha code for Functional severity points – under Equation 3 | X |
| 17 | Alpha code for Clinical severity points – under Equation 4 | X |
| 18 | Alpha code for Functional severity points – under Equation 4 | X |

**NOTE**: The Julian dates in positions 3-4 and 7-8 are converted from 3 position numeric values to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system.

The following represents an example of a treatment authorization code created using this format:

| Position | Definition | Actual Value | Resulting Code |
|---|---|---|---|
| 1-2 | M0030 (Start-of-care date) – 2 digit year | 2007 | 07 |
| 3-4 | M0030 (Start-of-care date) – code for Julian date | Julian date 245 | JK |
| 5-6 | M0090 (Date assessment completed) – 2 digit year | 2008 | 08 |
| 7-8 | M0090 (Date assessment completed) – code for Julian date | Julian date 001 | AA |
| 9 | M0100 (Reason for assessment) | 04 | 4 |
| 10 | M0110 (Episode Timing) | 01 | 1 |
| 11 | Clinical severity points – under Equation 1 | 7 | G |
| 12 | Functional severity points – under Equation 1 | 2 | B |
| 13 | Clinical severity points – under Equation 2 | 13 | M |
| 14 | Functional severity points – under Equation 2 | 4 | D |
| 15 | Clinical severity points – under Equation 3 | 3 | C |
| 16 | Functional severity points – under Equation 3 | 4 | D |
| 17 | Clinical severity points – under Equation 4 | 12 | L |
| 18 | Functional severity points – under Equation 4 | 7 | G |

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

The investigational device (IDE) revenue code, 0624, is not allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

**Document Control Number (DCN)**

**Required** - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims processing systems will match all HH PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically. Providers do not need to submit a DCN on all HH PPS claims, only on adjustments to paid claims.

**Employer Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Principal Diagnosis Code**

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

**Other Diagnosis Codes**

**Required** - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may **not** duplicate the principal diagnosis as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9 guidelines.

OASIS form items M0245 or M0*24*6, which report Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be

repeated in OASIS form item M0240 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

**Attending Provider Name and Identifiers**

**Required -** The HHA enters the name and provider identifier of the attending physician that has signed the plan of care.

**Remarks**

**Conditional -** Remarks are required only in cases where the claim is cancelled or adjusted.

## 70.2 - Input/Output Record Layout

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

The HH Pricer input/output file is 450 bytes in length. The required data and format are shown below:

| File Position | Format | Title | Description |
|---|---|---|---|
| 1-10 | X(10) | NPI | This field will be used for the National Provider Identifier when it is implemented. |
| 11-22 | X(12) | HIC | Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form. |
| 23-28 | X(6) | PROV-NO | Input item: The six-digit OSCAR system provider number, copied from the claim form. |
| 29-31 | X(3) | TOB | Input item: The TOB code, copied from the claim form. |
| 32 | X | PEP-INDICATOR | Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases. |
| 33-35 | 9(3) | PEP-DAYS | Input item: The number of days to be used for PEP payment calculation. Medicare claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim. |

| File Position | Format | Title | Description |
|---|---|---|---|
| 36 | X | INIT-PAY-INDICATOR | Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values:<br><br>0 = Make normal percentage payment<br><br>1 = Pay 0%<br><br>*2 = Make final payment reduced by 2%*<br><br>*3 = Make final payment reduced by 2%, pay RAPs at 0%* |
| 37-43 | X(7) | FILLER | Blank. |
| 44-46 | X(2) | FILLER | Blank. |
| 47-50 | X(5) | CBSA | Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form. |
| 51-52 | X(2) | FILLER | Blank. |
| 53-60 | X(8) | SERV-FROM-DATE | Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD. |
| 61-68 | X(8) | SERV-THRU DATE | Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD. |
| 69-76 | X(8) | ADMIT-DATE | Input item: The admission date, copied from claim form. Date format must be CCYYMMDD. |
| 77 | X | HRG-MED - REVIEW - INDICATOR | Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases. |
| 78-82 | X(5) | HRG-INPUT-CODE | Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer. |
| 83-87 | X(5) | HRG - OUTPUT - | Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | CODE | This code will match the input code in all cases except when the therapy threshold for the claim was not met. |
| 88-90 | 9(3) | HRG-NO-OF - DAYS | Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code. |
| 91-96 | 9(2)V9(4) | HRG-WGTS | Output item: The weight used by the Pricer to determine the payment amount on the claim. |
| 97-105 | 9(7)V9(2) | HRG-PAY | Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim. |
| 106-250 | Defined above | Additional HRG data | Five more occurrences of all HRG/HIPPS code related fields defined above, since up to six HIPPS codes can be automatically processed for payment in any one episode. |
| 251-254 | X(4) | REVENUE - CODE | Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X, 057X). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim. |
| 255-257 | 9(3) | REVENUE-QTY - COV-VISITS | Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code. |
| 258-266 | 9(7)V9(2) | REVENUE - DOLL-RATE | Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any. |
| 267-275 | 9(7)V9(2) | REVENUE - COST | Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any. |

| File Position | Format | Title | Description | |
|---|---|---|---|---|
| 276-400 | Defined above | Additional REVENUE data | Five more occurrences of all REVENUE related data defined above. | |
| 401-402 | 9(2) | PAY-RTC | Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data. | |
| | | | **Payment return codes:** | |
| | | | 00 | Final payment where no outlier applies |
| | | | 01 | Final payment where outlier applies |
| | | | 03 | Initial percentage payment, 0% |
| | | | 04 | Initial percentage payment, 50% |
| | | | 05 | Initial percentage payment, 60% |
| | | | 06 | LUPA payment only |
| | | | 07 | Final payment, SCIC |
| | | | 08 | Final payment, SCIC with outlier |
| | | | 09 | Final payment, PEP |
| | | | 11 | Final payment, PEP with outlier |
| | | | 12 | Final payment, SCIC within PEP |
| | | | 13 | Final payment, SCIC within PEP with outlier |
| | | | *14* | *LUPA payment, 1st episode add-on payment applies* |
| | | | **Error return codes:** | |
| | | | 10 | Invalid TOB |
| | | | 15<br><br>16 | Invalid PEP days<br><br>Invalid HRG days, > 60 |
| | | | 20 | PEP indicator invalid |
| | | | 25 | Med review indicator invalid |
| | | | 30 | Invalid MSA/CBSA code |
| | | | 35 | Invalid Initial Payment Indicator |
| | | | 40 | Dates < Oct 1, 2000 or invalid |
| | | | 70 | Invalid HRG code |
| | | | 75 | No HRG present in 1st occurrence |
| | | | 80 | Invalid revenue code |
| | | | 85 | No revenue code present on 3x9 or adjustment TOB |
| 403-407 | 9(5) | REVENUE - SUM 1-3-QTY-THR | Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x. | |
| 408-412 | 9(5) | REVENUE - SUM 1-6- | Output item: The total number of visits used by the Pricer to determine if the claim must be paid as | |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | QTY-ALL | a low utilization payment adjustment (LUPA). This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes. |
| 413-421 | 9(7)V9(2) | OUTLIER - PAYMENT | Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. |
| 422-430 | 9(7)V9(2) | TOTAL - PAYMENT | Output item: The total payment determined by the Pricer to be due on the RAP or claim. |
| 431-435 | 9(3)V9(2) | LUPA-ADD-ON-PAYMENT | Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim. |
| 436 | X | LUPA-SRC-ADM | Input Item: The source of admission code on the RAP or claim |
| 437 | X | RECODE-IND | Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values:<br><br>0 = default value<br><br>1 = HIPPS code shows later episode, should be early episode<br><br>*2 = HIPPS code shows early episode, but this is not a first or only episode*<br><br>3 = HIPPS code shows early episode, should be later episode |
| 438 | 9 | EPISODE-TIMING | Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values:<br><br>1 = early episode<br><br>2 = late episode |
| 439 | X | CLINICAL-SEV-EQ1 | Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | | from the 11th position of the treatment authorization code. |
| 440 | X | FUNCTION-SEV-EQ1 | Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code. |
| 441 | X | CLINICAL-SEV-EQ2 | Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code. |
| 442 | X | FUNCTION-SEV-EQ2 | Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code. |
| 443 | X | CLINICAL-SEV-EQ3 | Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code. |
| 444 | X | FUNCTION-SEV-EQ3 | Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code. |
| 445 | X | CLINICAL-SEV-EQ4 | Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code. |
| 446 | X | FUNCTION-SEV-EQ4 | Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code. |

| File Position | Format | Title | Description |
|---|---|---|---|
| 447-450 | X(4) | FILLER | |

Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HRG" related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for each HIPPS code will be placed in the total charges and the covered charges field of the appropriate revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17, Amount. If the return code is 06 (indicating a low utilization payment adjustment), the Medicare claims processing systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice.

## 70.3 - Decision Logic Used by the Pricer on RAPs

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

1. Determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PYMNT-INDICATOR." If the value is 0 *or 1*, use the full standard episode rate in subsequent calculations. If the value is *2 or 3*, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

2. Find weight for "HRG-INPUT-CODE" from the table of weights for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times Federal standard episode rate for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and nonlabor portions of the payment established by CMS. Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to "CBSA" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by the current non-labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion.

Sum the labor and nonlabor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

*Find the non-routine supply weight corresponding to the fifth positions of the "HRG-INPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.*

*Sum the HRG payment and non-routine supply payment.*

3. a. If the "INIT-PYMNT-INDICATOR" equals 0 or 2, perform the following:

   Determine if the "SERV-FROM-DATE" of the record is equal to the "ADMITDATE." If yes, multiply the wage index and case-mix adjusted payment by .6. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 05.

   If no, multiply the wage index and case-mix adjusted payment by .5. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 04.

   b. If the "INIT-PYMNT-INDICATOR" = 1 or 3, perform the following:

   Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 03.

## 70.4 - Decision Logic Used by the Pricer on Claims

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

A. The following calculations shall apply to claims with "From" dates on or after October 1, 2000, and before January 1, 2008. For calculations which apply to claims with "From" dates on or after January 1, 2008, see subsection B below.

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PYMNT-INDICATOR." If the value is 0 or *1*, use the full standard episode rate in subsequent calculations. If the value is *2* or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

    a. If the "REVENUE-SUM1-6-QTY-ALL" (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the six products. The result is the total payment for the episode.

       Return this amount in the "TOTAL-PAYMENT" field with return code 06. No further calculations are required.

    b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

2. Therapy threshold determination.

    a. If the "REVENUE-SUM1-3-QTY-THR" (the total of the quantities associated with therapy revenue codes, 042x, 043x, 044x, which will be passed from the shared systems sorted in this order) is less than 10, perform the following:

       If the "MED-REVIEW-INDICATOR" is a Y for any HRG, do not alter the HIPPS code reported in "HRG-INPUT-CODE." Copy that code to the "HRG-OUTPUT-CODE" field. Proceed to the next HRG occurrence.

       If "MED-REVIEW-INDICATOR" is an N for any HRG, read the table of HIPPS codes for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be met for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

       If the code in the first column does not match the code in the second column (indicating the therapy threshold is unmet for that code), place the code from the second column in the "HRG-OUTPUT-CODE" field.

    b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated

with the codes in the “HRG-OUTPUT-CODE fields for all further calculations involving each HRG.

3. HRG payment calculations.

   a. If the “HRG-OUTPUT-CODE” occurrences are less than 2, and the “PEP-INDICATOR” is an N:

      Find the weight for the “HRG-OUTPUT-CODE” from weight table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to “MSA1.” Multiply the case-mix adjusted rate by the current nonlabor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

      Proceed to the outlier calculation (see 4 below).

   b. If the “HRG-OUTPUT-CODE” occurrences are less than 2, and the “PEP-INDICATOR” is a Y:

      Perform the calculation of the case-mix and wage index adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the “PEP-DAYS” amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (4 below).

   c. If the “HRG-OUTPUT-CODE” occurrences are greater than or equal to 2, and the “PEP-INDICATOR” is an N:

      Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the “HRG-NO-OF-DAYS” field for that code divided by 60. Repeat this for up to six occurrences of the “HRG-OUTPUT-CODE.” These amounts will be returned in separate occurrence of the “HRG-PAY” fields, so that the shared systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a Y:

   Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the "PEP -DAYS" field divided by 60. Multiply the result by the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field. Repeat this for up to six occurrences of "HRG-CODE." These amounts will *be* returned separately in the corresponding "HRG-PAY" fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

4. Outlier calculation:

   a. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the MSA code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

   b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

   c. Subtract the outlier threshold for the episode from the imputed cost for the episode.

   d. If the result is greater than $0.00, calculate .80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.

   e. If the result is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

B. The following calculations shall apply to claims with "From" dates on or after January 1, 2008.

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PYMNT-INDICATOR." If the value is 0 or *1*, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

   a. If the "REVENUE-SUM1-6-QTY-ALL" (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

      If the following conditions are met, calculate an additional LUPA add-on payment:

      - the dates in the "SERV-FROM-DATE" and "ADMIT-DATE" fields match
      - the first position of the HIPPS code is a 1 or a 2
      - the value in "LUPA-SRC-ADM" is not a B or C *AND*
      - *the value in "RECODE-IND" is not a 2.*

      Wage index adjust the current LUPA add-on amount (published via Recurring Update Notification) and return this amount in the "LUPA-ADD-ON-PAYMENT" field.

      Return the sum of all "REVENUE-COST" amounts in the "TOTAL-PAYMENT" field. If the LUPA payment includes LUPA add-on amount, return 14 in the "PAY-RTC" field. Otherwise, return 06 in the "PAY-RTC" field. These distinct return codes assist the shared systems in apportioning visit payments to claim lines. No further calculations are required.

   b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the recoding process in step 2.

2. Recoding of claims based on episode sequence and therapy thresholds.

a. Read the "RECODE-IND." If the value is 0, proceed to step c below.

If the value in "RECODE-IND" is 1, find the number of therapy services reported in "REVENUE - SUM 1-3-QTY-THR." If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in "RECODE-IND" is 3, find the number of therapy services reported in "REVENUE - SUM 1-3-QTY-THR." If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

b. Read the alphabetic values in the "CLINICAL-SEV-EQ" field and "FUNCTION-SEV-EQ" field for which the number at the end of the field names corresponds to the recoded first position of the HIPPS code determined in step a. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric value. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE - SUM 1-3-QTY-THR" field to recode the 2nd, 3rd and 4th positions of the HIPPS code according to the table below:

| CLINICAL-SEV-EQ1 numeric value | Resulting HRG - OUTPUT – CODE 2nd position value | FUNCTION-SEV-EQ1 numeric value | Resulting HRG - OUTPUT – CODE 3rd position value | REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE 4th position value |
|---|---|---|---|---|---|
| 0-4 | A | 0-*5* | F | 0-5 | K |
| 5-*8* | B | *6* | G | 6 | L |
| *9*+ | C | *7*+ | H | 7-9 | M |
| | | | | 10 | N |
| | | | | 11-13 | P |

If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE - SUM 1-3-QTY-THR" field to recode the 2nd, 3rd and 4th positions of the HIPPS code according to the table below:

| CLINICAL-SEV-EQ2 numeric value | Resulting HRG - OUTPUT – CODE $2^{nd}$ position value | FUNCTION-SEV-EQ2 numeric value | Resulting HRG - OUTPUT – CODE $3^{rd}$ position value | REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE $4^{th}$ position value |
|---|---|---|---|---|---|
| 0-6 | A | 0-6 | F | 14-15 | K |
| 7-14 | B | 7 | G | 16-17 | L |
| 15+ | C | 8+ | H | 18-19 | M |

If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE - SUM 1-3-QTY-THR" field to recode the $2^{nd}$, $3^{rd}$ and $4^{th}$ positions of the HIPPS code according to the table below:

| CLINICAL-SEV-EQ3 numeric value | Resulting HRG - OUTPUT – CODE $2^{nd}$ position value | FUNCTION-SEV-EQ3 numeric value | Resulting HRG - OUTPUT – CODE $3^{rd}$ position value | REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE $4^{th}$ position value |
|---|---|---|---|---|---|
| 0-2 | A | 0-8 | F | 0-5 | K |
| 3-5 | B | 9 | G | 6 | L |
| 6+ | C | 10+ | H | 7-9 | M |
| | | | | 10 | N |
| | | | | 11-13 | P |

If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the "REVENUE - SUM 1-3-QTY-THR" field to recode the $2^{nd}$, $3^{rd}$ and $4^{th}$ positions of the HIPPS code according to the table below:

| CLINICAL-SEV-EQ4 numeric value | Resulting HRG - OUTPUT – CODE $2^{nd}$ position value | FUNCTION-SEV-EQ4 numeric value | Resulting HRG - OUTPUT – CODE $3^{rd}$ position value | REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE $4^{th}$ position value |
|---|---|---|---|---|---|
| 0-8 | A | 0-7 | F | 14-15 | K |
| 9-16 | B | 8 | G | 16-17 | L |
| 17+ | C | 9+ | H | 18-19 | M |

Move the resulting recoded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE field for all further calculations.

c. If the first position of the HIPPS code submitted in "HRG-INPUT-CODE" is a 5 and the number of therapy services in "REVENUE - SUM 1-3-QTY-THR" is less then 20, read the value in the "EPISODE-TIMING" field.

   If the value in the "EPISODE-TIMING" field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

   If the value in the "EPISODE-TIMING" field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

   Return to step b and recode the remaining positions of the HIPPS code as described above.

d. In all cases, read only the "REVENUE - SUM 1-3-QTY-THR" field and recode the 4th positions of the HIPPS code according to the table below, if *possible*:

| HIPPS codes beginning with 1 or 3 | | HIPPS codes beginning with 2 or 4 | |
|---|---|---|---|
| REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE 4th position value | REVENUE - SUM 1-3-QTY-THR value | Resulting HRG - OUTPUT – CODE 4th position value |
| 0-5 | K | 14-15 | K |
| 6 | L | 16-17 | L |
| 7-9 | M | 18-19 | M |
| 10 | N | | |
| 11-13 | P | | |

   Move the resulting recoded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE field for all further calculations.

   *If the HIPPS code begins with 1 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Return to step b and recode the remaining positions of the HIPPS code as described above.*

   *If the HIPPS code begins with 3 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS*

*code to 4, and set the "RECODE-IND" to 3. Return to step b and recode the remaining positions of the HIPPS code as described above.*

*If the HIPPS code begins with 2 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-IND" to 1. Return to step b and recode the remaining positions of the HIPPS code as described above.*

*If the HIPPS code begins with 4 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to step b and recode the remaining positions of the HIPPS code as described above.*

*If the HIPPS code begins with 1 or 2 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 20, change the first position of the HIPPS code to 5 and recode the 2nd, 3rd and 4th positions of the HIPPS code according to the table below:*

| *CLINICAL-SEV-EQ2 numeric value* | *Resulting HRG - OUTPUT – CODE 2nd position value* | *FUNCTION-SEV-EQ2 numeric value* | *Resulting HRG - OUTPUT – CODE 3rd position value* | *REVENUE - SUM 1-3-QTY-THR value* | *Resulting HRG - OUTPUT – CODE 4th position value* |
|---|---|---|---|---|---|
| *0-7* | *A* | *0-6* | *F* | *20+* | *K* |
| *8-14* | *B* | *7* | *G* | | |
| *15+* | *C* | *8+* | *H* | | |

*If the HIPPS code begins with 3 or 4 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 20, change the first position of the HIPPS code to 5 and recode the 2nd, 3rd and 4th positions of the HIPPS code according to the table below:*

| *CLINICAL-SEV-EQ4 numeric value* | *Resulting HRG - OUTPUT – CODE 2nd position value* | *FUNCTION-SEV-EQ4 numeric value* | *Resulting HRG - OUTPUT – CODE 3rd position value* | *REVENUE - SUM 1-3-QTY-THR value* | *Resulting HRG - OUTPUT – CODE 4th position value* |
|---|---|---|---|---|---|
| *0-7* | *A* | *0-6* | *F* | *20+* | *K* |
| *8-14* | *B* | *7* | *G* | | |
| *15+* | *C* | *8+* | *H* | | |

3. HRG payment calculations.

   a. If the "PEP-INDICATOR" is an N:

Find the weight for the first four positions of the "HRG-OUTPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal standard episode rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by the current nonlabor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Find the non-routine supply weight corresponding to the fifth positions of the "HRG-OUTPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.

Sum the payment results for both portions of the "HRG-OUTPUT-CODE" and proceed to the outlier calculation (see 4 below).

b. If the "PEP-INDICATOR" is a Y:

   Perform the calculation of the case-mix and wage index adjusted payment for the HRG and supply amounts, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (4 below).

4. Outlier calculation:

   a. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the MSA code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

   b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage

index adjust this sum as described above, using the MSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

c. Subtract the outlier threshold for the episode from the imputed cost for the episode.

d. If the result is greater than $0.00, calculate .80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.

e. If the result is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

## 80 - Special Billing Situations Involving OASIS Assessments

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

Maintaining the link between payment episode periods and OASIS assessment periods is central to HH PPS. However, in some circumstances these periods may be difficult to synchronize. The following instructions provide guidance for some of the more common of these situations.

**A - Changes in a Beneficiary's Medicare Advantage (MA) Organization Enrollment Status**

**1 - Payment Source Changes From MA Organization to Medicare Fee-For-Service (FFS)**

If a Medicare beneficiary is covered under an MA Organization during a period of home care, and subsequently decides to change to Medicare FFS coverage, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Medicare FFS. With that assessment, an RAP may be sent to Medicare to open an HH PPS episode. HHAs are advised to verify the patient's payer source on a weekly basis when providing services to a patient with an MA Organization payer source to avoid the circumstance of not having an OASIS to generate a billing code for the RAP, or having the patient discharged without an OASIS assessment.

If a follow-up assessment is used to generate a new start of care assessment, CMS highly recommends, but does not require, a discharge OASIS assessment be done.

While this is not a requirement, conducting a "paper" discharge at the point where the patient's change in insurance coverage occurred will provide a clear endpoint to the patient's episode of care for purposes of the individual HHA's outcome-based quality monitoring (OBQM) reports. Otherwise, that patient will not be included in the HHA's OBQM statistics. It will also keep that patient from appearing on the HHA's roster report (a report the HHS can access from your state's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection.

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, that too should be marked.) CMS realizes that the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide services though the Medicare payment source has changed from an MA Organization to FFS.

In cases where the patient changes from MA coverage to FFS coverage, the patient's overall Medicare coverage is uninterrupted. This means an HH PPS episode may be billed beginning on the date of the patient's FFS coverage. Upon learning of the change in MA election, the HHA should submit a RAP using the date of the first visit provided after the FFS effective date as the episode "from" date, and using the OASIS assessment performed most recently after the change in election to produce a HIPPS code for that RAP.

The claims-OASIS matching key information should reflect this assessment. If a new start of care (SOC) OASIS assessment was not conducted at the time of the change in pay source, a correction to an existing OASIS assessment may be necessary to change the reported payer source and to complete the therapy item (M0825). The HHA should correct the existing OASIS assessment conducted most closely after the new FFS start date. If more than one episode has elapsed before the HHA learns of the change in payer source, this procedure can be applied to the additional episode(s). If the patient is still receiving services, the HHA must complete the routine follow-up OASIS assessments (RFA4) consistent with the new start of care date. In some cases, HHAs may need to inactivate previously transmitted assessments to reconcile the data collections with the new episode dates.

**EXAMPLE:** A patient has an SOC date of November 22, 2000 as a managed care patient. On December 15 the patient disenrolls from managed care and becomes a Medicare FFS patient, but the HHA was not notified. The HHA finds out about the disenrollment on February 1, 2001, when it bills the MA Organization. The HHA had conducted a follow-up OASIS assessment on January 19, 2001, in keeping with the recertification assessment timing requirements. It did not, however, do an OASIS within

5 days of December 15. How does the HHA get paid under PPS for the services that were provided to this patient between December 15 and February 1?

The HHA should go to the January 19, 2001 OASIS assessment, use the information recorded there, and generate a new start of care assessment using the data from that assessment. This new start of care assessment should reflect December 15 as the start of care date at item M0030 and should accurately reflect the therapy need at M0825 for the episode beginning December 15 in order to generate the HIPPS code for billing purposes. The date the assessment was completed (M0090) should reflect the original date, i.e., January 19, 2001. Timing warnings from the OASIS state system will be generated based on the difference between the start of care date and the date the assessment was completed (> 5 days), but these warnings are unavoidable in these situations and can be disregarded.

Since the January 19 assessment is no longer relevant to this episode, it can be inactivated according to the current policies for correcting OASIS records. The HHA would conduct a routine follow-up assessment (RFA4) based on the December 15 start of care date, that is between February 8 and February 12, 2001, and every 60 days from that point on if the patient continues care.

In the rare situation in which the HHA has not performed OASIS assessments on the patient while the patient was under MA coverage (as is required for all skilled need patients under OASIS regulations) and the patient has been discharged, the HHA may use their medical records to reconstruct the OASIS items needed to determine a HIPPS code applicable to the period of Medicare fee-for-service eligibility and coverage.

**2. Payment Source Changes From FFS to MA Organization**

In cases where the patient elects MA coverage during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment - PEP - adjustment). The MA Organization becomes the primary payer upon the MA enrollment date. The HHA may learn of the change after the fact, for instance, upon rejection of their claim by Medicare claims processing systems. The HHA must resubmit this claim indicating a transfer of payer source using patient status code "06," and reporting only the visits provided under the fee-for-service eligibility period. The claim through date and the last billable service must occur before the MA enrollment date. If the patient has elected to move from Medicare FFS to an MA Organization and is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

**B. Inpatient Hospital Stays On or Near Day 60/61 of Continuous Care Episodes**

**1. Beneficiary is in Hospital on Both Days 60 and 61**

A beneficiary may be in the hospital for the entirety of both day 60 (the last day of one episode) and day 61 (the first day of the next episode of continuous care). In this case,

HHAs must discharge the beneficiary from home care for Medicare billing purposes, because home care could not be provided until what would be, at the earliest, Day 62. There has been a gap in the delivery of home care between the two episodes and so the episodes cannot be billed as continuous care. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates of the UB-*04* claim form (or electronic equivalent) that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be submitted to the State Agency as a Start of Care assessment.

**2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61**

A hospital discharge may occur on day 60 or day 61and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in *the statement covered period* reflected day 61. The RAP would not report a new admission date. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary's admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency.

**3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode**

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the

HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care.

The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode.

**C. Patients for Whom OASIS Transmission to the State Agency is Not Allowed**

Rare cases may arise in which an HHA provides Medicare-covered home health services to a beneficiary for whom an OASIS assessment is normally not required. Examples of this would be pediatric or maternity patients that are entitled to Medicare by their disability status. In these cases, an OASIS assessment must be performed on the patient exclusively in order to arrive at a HIPPS code to place on the RAP and the claim for the episode. This HIPPS code is necessary to serve as the basis of payment for the episode. However, do not transmit this OASIS assessment to the State Agency because it is not allowed by law.

Since the OASIS assessment on which payment is based is not transmitted to the State, *Medicare instructions for episodes beginning before January 1, 2008, required that* the claim for the episode must not report a 'claims-OASIS matching key' in the treatment authorization field of the claim form. Instead, this field on the claim form for the RAP or claim was filled with a string of ones (e.g., "111111111111111111") in order to pass a Medicare claims system edit which requires this field to contain a numeric value. In all other respects, the RAP and claim for the episode *was* to be identical to other HH PPS RAPs and claims.

*For episodes beginning on or after January 1, 2008, the use of a string of ones is no longer practical for Medicare claims processing. The value in the treatment authorization code is used to recode claims in cases where this is necessary. Claims for pediatric or maternity patients may be subject to recoding, so they must contain the accurate treatment authorization code output from the HH PPS Grouper in order to be processed. HHAs should in no way interpret this claims processing requirement to mean that these assessments should be transmitted to the State.*

**Inpatient Hospital Stays and the End of Episodes - Five Scenarios**

The chart below presents the information in this section in tabular form. Each example assumes an episode beginning 10-2-2002 which would otherwise end 11-30-2002 ("Day 60"). The subsequent episode could begin 12-1-2002 ("Day 61") and end 1-29-2003.

| **Scenario Example** | **OASIS Impact** | **Claim Impact** |
|---|---|---|
| 1) Hospitalized on Days 60 AND 61<br>• Beneficiary is assessed for recertification on 11-26-2002<br>• Admitted to hospital on 11-28-2002<br>• Discharged from hospital 12-2-2002<br>• Returns to same HHA, receives next visit 12-3-2002 | Start of Care (SOC) assessment upon return from hospital | Episodes are NOT considered continuous care:<br>• RAP submitted with "From" and admission date of 12-3-2002,<br>• New episode now extends to 1-31-2003<br>• Matching key reflects SOC assessment |
| 2) Discharge on Day 60 or 61, HIPPS code changes<br>• Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HBGK1<br>• Admitted to hospital on 11-28-2002<br>• Discharged from hospital 11-30-2002 (Day 60)<br>• Returns to same HHA, receives next visit and resumption assessment 12-2-2002, HIPPS code: HCHL1. | Resumption of Care (ROC) assessment upon return from hospital, submitted as SOC | Episodes are NOT considered continuous care:<br>• RAP submitted with "From" and admission date of 12-2-2002,<br>• New episode now extends to 1-30-2003<br>• Matching key reflects SOC assessment |
| 3) Discharge on Day 60 or 61, HIPPS code unchanged<br>• Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1<br>• Admitted to hospital on 11-28-2002<br>• Discharged from hospital 12-1-2002 (Day 61)<br>• Returns to same HHA, receives next visit and resumption assessment on or after 12-2-2002, HIPPS code: HDIM1. | ROC assessment upon return from hospital | Episodes ARE considered continuous care:<br>• RAP submitted with "From" date of 12-1-2002 and original admission date,<br>• Original episode period unchanged<br>• Matching key reflects ROC assessment |
| 4) Hospitalized on Day 61, | ROC assessment | Episodes are NOT |

| Scenario Example | OASIS Impact | Claim Impact |
|---|---|---|
| HIPPS code changes<br>• Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HAEK1<br>• Admitted to hospital on 12-1-2002 (Day 61)<br>• Discharged from hospital 12-4-2002<br>• Returns to same HHA, receives first visit in episode and resumption assessment 12-5-2002, HIPPS code: HBFL1. | upon return from hospital, submitted as SOC | considered continuous care<br>• RAP submitted with "From" and admission date of 12-5-2002,<br>• New episode now extends to 2-2-2003<br>• Matching key reflects SOC assessment |
| 5) Hospitalized on Day 61,<br>HIPPS code unchanged<br>• Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1<br>• Admitted to hospital on 12-1-2002, after HH visit same day (Day 61)<br>• Discharged from hospital 12-4-2002<br>• Returns to same HHA, receives next visit and resumption assessment 12-5-2002, HIPPS code: HDIM1. | ROC assessment upon return from hospital | Episodes ARE considered continuous care<br>• RAP submitted with "From" date of 12-1-2002 and original admission date,<br>• Original episode period unchanged<br>• Matching key reflects ROC assessment |

## 100 - Temporary Suspension of Home Health Services

***(Rev. 1476, Issued: 03-07-08, Effective: 01-01-08, Implementation: 07-07-08)***

A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health services. When the suspension is temporary (does not extend beyond the end date of the 60-day episode) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same episode and under the same plan of care as before. The episode from date and the admission date remain the same as on the RAP. No special indication need be made on the episode claim for the period of suspended services. Explanation of the suspension need be indicated only in the medical record.

When services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), if the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment *and the episode begins before January 1, 2008*, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 0023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.

If the suspension extends beyond the end of the current 60-day episode, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new plan of care and submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new plan of care and care was not continuous.