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News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at *http://www.cms.hhs.gov/MLNProducts* on the CMS website.

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Phase II: Implementation of Case Mix Refinement for the Home Health Prospective Payment System (HH PPS)

Note: This article was changed on December 4, 2007, to correct the HIPPS code structure table and examples on pages 3 and 4 and the "Severity Group Definitions: Four-Equation Model" table on page 8. All other information is unchanged.

Provider Types Affected

Providers submitting claims to Medicare Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries and which are paid under the HH PPS.

Provider Action Needed


STOP – Impact to You

This article is based on Change Request (CR) 5746 which describes provider billing and claims processing changes required by the HH PPS case mix refinement regulation published in the Federal Register on August 29, 2007.


CAUTION – What You Need to Know

Be sure your billing staff are aware of these changes.

GO – What You Need to Do

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

Background

The Balanced Budget Act of 1997, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) of 1999, called for the development and implementation of a prospective payment system (PPS) for Medicare home health services. The Balanced Budget Act (BBA) put in place the interim payment system (IPS) until the PPS could be implemented. The HH PPS final rule was published on July 3, 2000 (*http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2000_register&docid=00-16432-filed.pdf*). Effective October 1, 2000, the HH PPS replaced the IPS for all home health agencies (HHAs). Legislative requirements were modified in various subsequent laws, and the Social Security Act (Section 1895; *http://www.ssa.gov/OP_Home/ssact/title18/1895.htm* on the Internet.) contains current law regarding HH PPS.

The initial requirements for the HH PPS were implemented on October 1, 2000. The final regulation for HH PPS indicated that many of its policies were discretionary and would be the subject of reconsideration and revision in future rulemaking. The Centers for Medicare & Medicaid Services (CMS) has been conducting a policy analysis of how to refine the HH PPS for the last several years, and the results were published in a Final Rule on August 29, 2007, which contains the final policies regarding HH PPS case mix refinements.

To conform to this final rule, CR5746 revises the *Medicare Claims Processing Manual*, Chapter 10 [General Guidelines for Processing Home Health Agency (HHA) Claims], and these revised manual changes are included as an attachment to CR5746.

CR5746 also includes requirements that describe for providers (and their software vendors) the changes to Medicare systems that will be made to implement the new policies of the final rule. One key aspect of the changes is a new HIPPS code structure under HH PPS case mix refinement. That structure is depicted in the following table:

	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 level 4 = HIPPS code 4CHMV.
- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score is high and supply severity level 6 = HIPPS code 5BHNX.

Note: The two sets of possible values in position 5 of the HIPPS code will provide a basis for accurate supply reporting edits that will be defined in future instructions.

The publication of the claim submission requirements in CR5746 is intended to assist providers with their implementation of their claims submission changes. CR5746 requirements are included below, and they apply only to HH PPS claim types (types of bill 32x and 33x) as of the effective date:

- Medicare systems will return claims to the provider if:
  - The new HIPPS codes are submitted on episodes beginning before January 1, 2008.
  - The current HIPPS codes are submitted on episodes beginning after January 1, 2008.
  - Claims for episodes beginning on or after January 1, 2008, contain more than one revenue code 0023 line.
- Medicare systems validate the treatment authorization code except where condition code 21 is present on the claim. If the code is validated, Medicare will return claims to the provider if the treatment authorization code fails any of the following validation edits:
  - The first, second, fifth, sixth, and ninth positions of the treatment authorization codes must be numeric;
  - The third, fourth, seventh, and eighth positions of the code must be alphabetic;
  - The tenth position of the code must contain a value of 1 or 2; and
  - The eleventh through eighteenth positions of the code must be alphabetic.
- Medicare systems will revise the provider submitted HIPPS to the correct code based on the number of therapy services billed.
- Medicare systems will ensure that the provider submitted HIPPS code on a claim or adjustment accurately reflects the position of the episode within a

sequence of adjacent HH episodes. (Medicare defines a sequence of adjacent episodes as episodes with no more than 60 days between each episode end date and the next episode start date.)

- Medicare systems will use a new HH Pricer module that contains revisions reflecting case-mix refinement policies.
- Medicare systems will ensure that claims and adjustments submitted with HIPPS containing 1 or 2 in the 1st position represent the first or second episode in a sequence.
- Medicare systems will identify claims and adjustments with HIPPS codes misrepresenting first or second episodes for re-coding and will re-code such claims and adjustments using the last 9 positions of the treatment authorization code and the re-coding logic in the re-coding tables in the Recoding Information Section of this article.
- Medicare systems will ensure that claims and adjustments submitted with HIPPS containing 3 or 4 in the 1st position represent the third or later episode in a sequence.
- Medicare systems will identify claims with HIPPS codes misrepresenting third or later episodes for re-coding and will re-code such claims and adjustments using the last 9 positions of the treatment authorization code and the re-coding logic in the re-coding tables in the Recoding Information Section of this article.
- Medicare systems will return claims and adjustments re-coded to adjust the episode sequence to the HH Pricer.
- Medicare systems will adjust previously paid episodes when the receipt of earlier dated episodes changes their position in a sequence of episodes.
- Medicare systems will calculate a supply adjustment amount and add it to the otherwise calculated payment amount for the episode.
- Medicare systems will include an add-on amount to per visit payment calculations for low utilization payment adjustments (LUPAs) made on first episodes in a sequence.
- Medicare systems will add an additional payment to the first revenue code calculated on LUPA claims for first episodes in a sequence. In addition:
  - Medicare systems will assign the return code '14' on LUPA claims for first episodes in a sequence.
  - Medicare systems will use the source of admission code in the HH PPS Pricing interface.

Recoding Information

As mentioned previously, Medicare systems will perform re-coding of some claims where the HIPPS code does not reflect correct episodes. The last eight positions of the treatment authorization will contain codes representing the points for the clinical domain and the functional domain as calculated under each of the four equations of the refined HH PPS case mix system. The treatment authorization

code, including these domain codes, will be calculated by the HH PPS Grouper software, so providers transfer this 18 position code to their claims.

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

Position	Definition	Actual Value	Resulting Code
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.

The input/output record for the HH Pricer will be modified to convert existing filler fields into new fields to facilitate recoding. A new nine position field will be created to carry the clinical and functional severity point information. Medicare's FISS system will extract the last nine positions of the treatment authorization code and place it in this new field in the input/output record. This will enable the HH Pricer to recode claims using the point information.

On incoming original RAPs and claims, the HH Pricer will disregard the code in this nine position field, since the submitted HIPPS code is being priced at face value. The code in this nine position field will be used in recoding claims identified by Medicare's Common Working File (CWF) systems as misrepresenting the episode sequence. To enable the Pricer to distinguish these two cases, an additional one position numeric field will be added to the input/output record.

On original RAPs and claims, FISS will populate the new one position field with a zero. If a claim is identified by the provider as a 1st or 2nd episode and the claim is actually a 3rd or later episode, FISS will populate the new field with a 3 to indicate this. If a claim is identified by the provider as a 3rd or later episode and the claim is actually a 1st or 2nd episode, FISS will populate the new field with a 1 to indicate this.

When the new one position field is populated with a 1 or a 3, the HH Pricer will recode the claim using the following steps:

- The HH Pricer will determine, from the new episode sequence and the number of therapy visits on the claim, which equation of the HH PPS case-mix model applies to the claim.
- The HH Pricer will find the two positions in the new nine position field that correspond to the equation identified in step 1.
- The HH Pricer will convert the alphabetic codes in these positions to numeric point values.
- The HH Pricer will read the appropriate column on the case-mix scoring table below to find the new clinical and functional severity levels that correspond to that point value.
- Using the severity levels identified in step 4 and the HIPPS code structure shown in attachment one, the HH Pricer will determine the new HIPPS code that applies to the claim.

The HH Pricer will use the new HIPPS code resulting from these steps to re-price the claim and will return the new code to FISS using the existing output HIPPS code field in the input/output record.

When the first position of the HIPPS code is a 5 and the number of therapy services on the claim are less than 20, the HH Pricer will use the first position of the new nine position field to recode the first position of the HIPPS code and then complete the steps described above. The case-mix scoring table to be used in step 4 is on the following page.

Severity Group Definitions: Four-Equation Model

		1st & 2nd Episodes		3rd+ Episodes		All Episodes
		0 to 13 therapy visits	14 to 19 therapy visits	0 to 13 therapy visits	14 to 19 therapy visits	20+ therapy visits
	Grouping Step:	1	2	3	4	5
	Equation(s) used to calculate points: *(see Table 2a of the 2008 HH PPS Final Rule)*	*1*	*2*	*3*	*4*	*(2&4)*
Dimension	Severity Levels:					
Clinical	C1	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7
	C2	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14
	C3	9+	15+	6+	17+	15+
Functional	F1	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6
	F2	6	7	9	8	7
	F3	7+	8+	10+	9+	8+
Services Utilization (number of therapy visits)	S1	0 to 5	14 to 15	0 to 5	14 to 15	20+ (One Group)
	S2	6	16 to 17	6	16 to 17	
	S3	7 to 9	18 to 19	7 to 9	18 to 19	
	S4	10		10		
	S5	11 to 13		11 to 13		

Additional Information

The official instruction, CR5746, issued to your RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1348CP.pdf* on the CMS website.

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