Issue #1: Billing Options for HHAs whose systems are not ready on 1/1/2008

We recognize that the PPS refinements, effective 1/1/2008, will require updates to the billing software Home Health Agencies use to submit claims. To assist Home Health Agencies and commercial software vendors, CMS provided the grouper pseudo-code on the CMS Home Health Website on September 28, 2007. The grouper software was posted on the CMS website later in October. After some technical errors were identified and corrected, CMS posted revised grouper software and pseudo-code on the CMS Home Health Website on November 16, 2007. We believe that this still provides an adequate amount of time for Home Health Agencies to update their billing systems. However, we are providing technical guidance on options for submitting claims for Home Health Agencies and/or their software vendors whose systems are not ready to bill accurately January 1, 2008.

The following options are available to HHAs if their billing system is not able to produce an accurate HIPPS code for billing purposes by 1/1/2008. These options will be available to agencies from 1/1/2008 – 3/31/2008. We expect all systems to be ready to bill accurately by April 1, 2008.

1. Use the HAVEN software, scheduled for posting to the CMS Web site on 12/21/2007, to derive a HIPPS code for a correct RAP payment and submit RAPS via Direct Data Entry (DDE) if their vendor software cannot submit HIPPS codes applicable to the refined HH PPS.
2. If using HAVEN is not a feasible option, the agency may submit a RAP using the HIPPS code that reflects the national median case-mix weight and Non Routine Medical Supply (NRS) Severity Level 2. That HIPPS code is 1CGKT, with the case-mix weight of 0.9896. The HHRG associated with this weight is C3F2S1 for early episodes with 0-13 therapy visits. This case-mix weight is among the top 5 highest-frequency case-mix groups in our impact sample, but it has the highest weight of those 5 groups. (We did not choose a default of the mean weight because it is not as representative of all claims, as is the median weight.)

    - 1st or 2nd Episodes, 0 – 13 therapy visits: C3F2S1 = C.M. Weight of 0.9896)
    - NRS Severity Level 2 ($51) as a placeholder for the severity level of NRS payment

    All RAPs would be submitted with HIPPS code 1CGKT, again using DDE if their vendor software cannot accommodate this. All RAPs submitted in this fashion should also report a placeholder treatment authorization code of 11AA11AA11AAAAAAAA.

    - To adhere to Medicare billing requirements, a final bill should be submitted within 60 days of the end of the episode. If the HHA is ready to bill an accurate final claim within this time, the HHA will need to cancel their RAP, resubmit a RAP with an accurate HIPPS code and treatment authorization code and then submit the final claim.

    - If the final claim is not received within that period, CMS recovers the RAP payment. At the point were the HHA is ready to bill accurately, they will resubmit a RAP with the correct codes and submit claims normally thereafter.

    - If the RAP recovery creates a cash flow problem for HHAs still unable to bill by March 31, 2008, the agency will need to cancel and resubmit the RAP with HIPPS code 1CGKT.

NOTE: Options 1 and 2 require the use of DDE to submit RAPs. Regional Home Health Intermediaries (RHHI) report that 85% or more of their HHAs currently have access to DDE, so these options will be available to the great majority of HHAs without special action. HHAs that wish to take advantage of these options but that do not currently have DDE access should apply to their RHHI for access as soon as possible. New applications for DDE access require approximately two weeks to be processed.

3. Finally, if neither of the above two options are feasible, the agency would need to go through existing procedures to request accelerated payments. The procedure for requesting an accelerated payment is covered in the Medicare Financial Manual, Chapter 3, Section 150, Accelerated Payments – FI Only. The amount of the accelerated payment is computed as a percentage (sufficient to alleviate the impaired cash position but in no case to exceed 70 percent) of the amount of net reimbursement represented by unbilled discharges or unpaid bills applicable to covered services rendered to beneficiaries.

Issue#2: Additional Revisions to Grouper, and Possible Underpayment of Claims

CMS was recently advised of 2 areas within the grouper that require revisions. Consequently, there exists a possibility of underpayment of claims in two specific situations described below.

Abt Associates is developing a patch, incorporating the necessary revisions to address the above two situations, and is currently testing those revisions to ensure that the grouper will assign points correctly. Once Abt Associates has completed the appropriate testing and validation, we will be releasing the revised grouper, HAVEN, and associated pseudo code as soon a possible in 2008.

In the interim, HHAs need to be aware of the following two circumstances where claims may be underpaid. Once the revised grouper and HAVEN are released, HHAs may choose to run potentially impacted claims through their updated grouper software to determine whether or not they wish to cancel and resubmit affected claims.

(1) **Subsequent episodes where the Recertification (RFA 4) or Other Follow-up (RFA 5) OASIS assessment contains certain wound items; [RFA = Reason For Assessment]:**

In recertifications or follow-up assessments, for the purposes of computing the score and severity level for the NRS portion of the payment, the grouper is not awarding all points that should be earned in the "Integumentary Status" section of the OASIS assessment (M0440 through M0488). (Note: This grouper problem does not affect the scoring for the episode payment amount.)

Analysis of historical data suggests that 6% to 7% of assessments could be affected by this scoring issue. The grouper is not applying points correctly for these wound items, resulting in an incorrect NRS score being computed.

This may result in an underpayment (approximately) of between $35 and $230.

(2) Certain episodes with specific combinations of diagnosis codes. Assessments potentially affected include: Start of Care (RFA 1), Resumption of Care (RFA 3), Recertification (RFA4), and Other Follow-up (RFA 5):

The second issue arises when certain combinations of certain specific diagnoses appear in certain positions on the OASIS. The cases involved are those where:

- the primary diagnosis is one of the diagnoses that earns a different number of points when it is primary vs. a lower-listed diagnosis; AND
- the primary diagnosis (for classification purposes) is found in M0246a3 or M0246a4; AND
- another ICD-9-CM diagnosis code in the same diagnosis group appears as a lower-listed diagnosis in M0240.

In such a situation, the grouper will currently score the assessment as though the diagnosis is "other" diagnosis, and not the primary diagnosis.

Based on historical information, this is anticipated to affect approximately 0.3% of cases for case-mix scoring, and approximately 0.7% of cases for NRS scoring.

The grouper is not applying points correctly in this circumstance resulting in potential underpayment of the episode. Any of these potential impacts on scoring may or may not affect the actual HHRG assignment for an individual case, since the scoring difference on the particular variables may not cause the assessment's overall score to move below a scoring threshold and into a different case mix group.

Once the changes to the grouper have been incorporated into the HHA's system and the HIPPS code has been recalculated, the HHA has the following options:

1. If the result of the recalculation is that only the NRS scoring is affected, yet the NRS severity level does not change, the HHA would not have to do anything because payment was not affected.
2. If the changes affecting NRS scoring resulted in a higher NRS severity level, the HHA may choose to cancel and resubmit the RAP with the recalculated HIPPS code (because the HIPPS code would be different from that originally submitted), to correct for the original underpayment.
3. If the changes in the revised grouper affect case-mix scoring related to diagnosis OASIS items but the changes in scoring do not affect the payment group, the HHA would not have to do anything because payment was not affected.
4. If the changes in the revised grouper affect case-mix scoring related to diagnosis OASIS items AND affect the payment group, the HHA may chose to cancel and resubmit the RAP with the recalculated HIPPS code to correct for the original underpayment.

It is possible that the changes to the grouper could affect both NRS and case-mix scoring for a given episode. In those circumstances, if the HHA makes the determination that they want to cancel and resubmit the RAP, for either or both reasons, the HHA need only cancel and resubmit the RAP once. For any episode that is affected by any of the above circumstances (or combination thereof), for which the HHA chooses to cancel and resubmit the RAP for payment purposes, the HHA may or may not choose to submit a revised OASIS (for the purposes of correcting the associated HIPPS code) to the State. If the HHA chooses not to revise the OASIS in the State system, they can still use the official "correction" process to get the recalculated HIPPS code, but simply do not transmit. If later corrections are needed for reasons other than correcting the HIPPS Code the agency would use Correction Option #1 – Record submitted and rejected. This will insure that the correction number for this assessment will remain '01'. The OASIS for these episodes will not be used in any survey or quality-related reporting.

- In HAVEN, the user can just highlight the assessment on the Management screen and click the HIPPS button - the results will reflect having passed the assessment through the new grouper.

- Note that clicking the HIPPS button, in HAVEN, does NOT update the assessment fields in the database with the new grouper results.

- If the user goes into data entry with “View Only” checked, they can see the stored grouper values for the assessment.

- In order for the stored values to be updated with the new grouper results, the user would need to submit a correction to that assessment.

If the HHA chooses to revise the OASIS in the State system, solely for the purposes of recalculating/correcting the HIPPS code, they would transmit that revised OASIS to the State.