

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

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(Rev. 2209 05-06-11)
(Rev. 2249 07-01-11)

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(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

This chapter, in general, describes billing and claims processing requirements that are applicable only to home health agencies. For general bill processing requirements refer to the appropriate other chapters in the Medicare Claims Processing Manual. For a description of home health coverage policies see Chapter 7 in the Medicare Benefit Policy Manual.

A. Where and How to Bill

Institutional providers, including home health agencies, use one of two institutional claim formats to bill Medicare. In the great majority of cases, these providers are required to use the electronic HIPAA standard institutional claim transaction, the 837I. The minority of providers that are eligible for an exception to electronic claim submission use the paper Form CMS-1450, also known as the UB-04. Such claim forms are submitted to certain Medicare Administrative Contractors (MACs) with jurisdiction over home health and hospice claims. Some home health agencies may also become approved as Durable Medical Equipment (DME) suppliers, in which case they would submit bills for DMEPOS services to the DME MACs on a professional claim format (the 837P or paper Form CMS-1500).

References to the claim form in this chapter refer to the paper Form CMS-1450 (UB-04) unless otherwise noted. However, the instructions regarding specific data requirements apply also to the electronic 837I.

B. Services to Include on the Claim for Home Health Benefits

Effective for all services provided on or after October 1, 2000, all services under the home health plan of care, except the following, are included in the home health PPS payment amount. Services that may be included in the plan of care but excluded from the HH prospective payment system (HH PPS) are:

- Osteoporosis drugs (although the cost of administration is within the PPS rate); and
- Durable medical equipment, including prosthetics, orthotics, and oxygen

The DMEPOS services may be included on type of bill 32X for the home health benefits, and are paid in addition to the PPS payment. See §20 for additional instructions regarding competitively bid DME. Osteoporosis drugs must be billed on type of bill 34X.

Other services not under an HH plan of care provided by an HHA are billed using type of bill 34X. Such services not under a plan of care, and services not part of the home health

benefit, are often referred to as “Part B and other health services.” See §90 for guidance as to the payment methodologies used by Medicare to reimburse these services, and see §40.4 in this chapter for information on deductible and coinsurance.

10.1 - Home Health Prospective Payment System (HH PPS)

(Rev. 1, 10-01-03)

HH-467, A3-3639

10.1.1 - Creation of HH PPS and Subsequent Refinements

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The HH PPS was initially mandated by law in the Balanced Budget Act of 1997 and legislative requirements were modified in various subsequent laws. Section 1895 of the Social Security Act contains current law regarding HH PPS.

Final regulations describing the initial implementation of the HH PPS were issued in July 2000 and effective for dates of service on and after October 1, 2000. Final regulations describing refinements to the HH PPS system were issued in August 2007 and are effective for episodes of care beginning on and after January 1, 2008. The instructions that follow reflect the policies that remain in effect based on the August 2007 regulations and any subsequent payment update rules and notices.

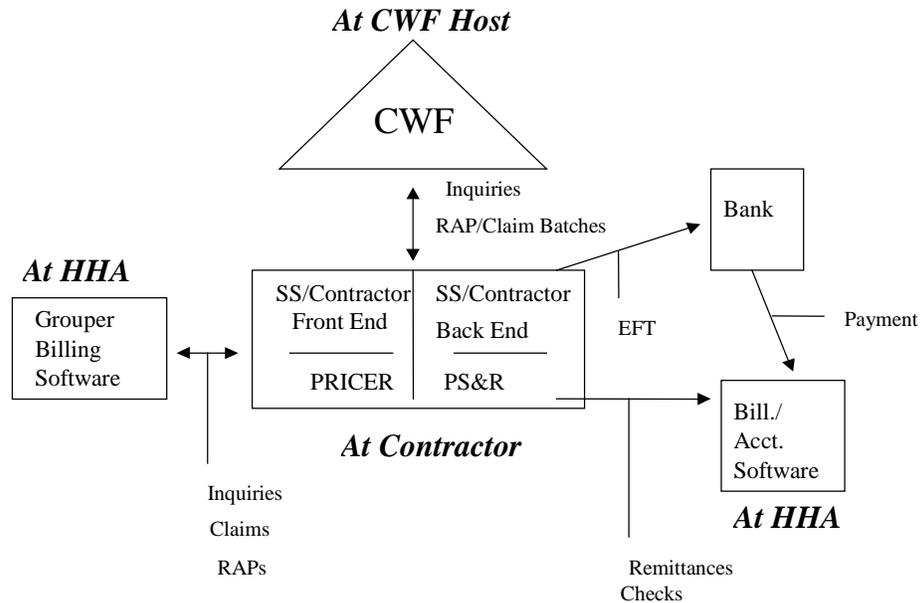
10.1.2 - Reserved

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

10.1.3 - Configuration of the HH PPS Environment

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The configuration of Medicare home health claim processing is similar to previous Medicare claims processing systems. The flow from the HHA at the start of billing, to the receipt of remittances and electronic funds transfer (EFT) by the agency, to the recording of payment in either billing or accounting systems (bill/acct software) can be envisioned as follows:



Subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing.

- Grouper determines HHRGs for claims at HHAs by inputting **OASIS** data. (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment.) OASIS software was updated to integrate the Grouper from the advent of HH PPS, and CMS has made Grouper specifications available on its Web site for those designing their own software.
- ELGH is an **inquiry system** in CWF available via Medicare contractor remote access, through which HHAs and other providers can ascertain if a home health episode has already been opened for a given beneficiary by another HHA, and track episodes of beneficiaries for whom they are the primary HHA. HHAs may also access this information via the HIPAA Eligibility Transaction System or HETS. Refer to §§30.1 and 30.2 for a detailed description.

Pricer software is used to process all HH PPS claims and is integrated into the Medicare claims processing systems. In addition to pricing HIPPS codes for HHRGs, this software maintains national standard visit rate tables to be used in outlier and LUPA determinations. Refer to §70 for a detailed description of the Pricer software.

10.1.4 - The HH PPS Episode - Unit of Payment

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The episode is the unit of payment for HH PPS. The episode payment is specific to one individual homebound beneficiary. It pays all Medicare covered home care that is reasonable and necessary for the patient's care, including routine and nonroutine supplies

used by that beneficiary during the episode. It is the only Medicare form of payment for such services, with the exceptions described in §10.B.

See §40 for details on billing these services. The cost of routine supplies has been included in the calculation of the episode payments.

10.1.5 - Number, Duration, and Claims Submission of HH PPS Episodes (Rev. 1, 10-01-03) HH-467.8, A3-3639.8

The beneficiary can be covered for an unlimited number of nonoverlapping episodes. The duration of a single full-length episode is 60 days. Episodes may be shorter than 60 days.

For example, an episode may end before the 60th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened episodes, in which more home care is delivered in the same 60-day period. Claims for episodes may be submitted prior to the 60th day if the beneficiary has been discharged and treatment goals have been met, though payment will not be pro-rated unless more home health care is subsequently billed in the same 60-day period.

Other claims for overlapping episodes may also be submitted prior to the 60th day if the beneficiary has been discharged, dies or is transferred to another HHA. In transfer cases payment for the episode will be prorated.

The initial episode begins with the first service delivered under that plan of care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.).

More than one episode for a single beneficiary may be opened by the same or different HHAs for different dates of service. This will occur particularly if a transfer to another HHA, or discharge and readmission to the same HHA, situation exists. Refer to §10.1.5.1 below for more information on multiple agencies furnishing home health services. Allowing multiple episodes is intended to assure continuity of care and payment.

10.1.5.1 - More Than One Agency Furnished Home Health Services (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care and other HHAs serving the same beneficiary during the episode. Nonprimary HHAs can receive payment under arrangement only from the primary HHA for services on the plan of care where prior arrangement exists. The primary agency's status as primary is established through the submission, receipt and processing of a

Request for Anticipated Payment (RAP) for the first episode of home health care for the beneficiary. The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies existing before the delivery of services for services called for under the plan of care.

Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the Common Working File (CWF) indicates an episode of care is open for a beneficiary, the Medicare contractor returns to the provider the RAP of any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

In order to ensure that other providers who may intend to provide HH services to a beneficiary have the benefit of the most current information via the CWF, CMS encourages primary HHAs to submit their RAPs as promptly as possible.

In rare cases, a Medicare beneficiary may receive an organ transplant and the organ donor's post-operative services are covered by the Medicare program. Since the donor is frequently not a Medicare beneficiary, services for the donor are billed using the Medicare beneficiary's Medicare number. If both the organ recipient and organ donor are receiving post-operative home health services, CWF cannot process HH PPS episodes for both patients for the same dates of service. In this case, the HH episode for the organ recipient is accepted by CWF. The HH episode for the donor is processed by the Medicare contractor outside CWF.

10.1.5.2 - Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes on HH PPS Episodes (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

If a Medicare beneficiary is covered under an MA organization during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the Medicare payment source changes. With that assessment, an RAP may be sent to Medicare to open an HH PPS episode.

If a beneficiary under fee-for-service receiving home care elects MA organization during an HH PPS episode, the episode will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The MA organization becomes the primary payer upon the MA organization enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

For additional information about MA eligibility changes, see section 80.

10.1.6 - Split Percentage Payment of Episodes and Development of Episode Rates (Rev. 1647, Issued: 12-12-08, Effective: 01-01-07, Implementation: 03-16-09)

A split percentage payment is made for most HH PPS episode periods. There are two payments (initial and final). The first paid in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. There are two exceptions to split payment, the No-RAP LUPA, discussed in §§10.1.18 and 40.3 in this chapter, and the RAPs paying zero percent as discussed in §10.1.12 in this chapter.

There is a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments is 60 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments is 50 percent of the estimated casemix adjusted episode payment.

There is no set length required for a gap in services between episodes for a following episode to be considered initial rather than subsequent. If any gap occurs, the next episode is considered initial for payment purposes.

Payment rates for HH PPS episodes were developed from audited cost reports of previous years' data, from claims for each of the six home health visit disciplines and other services delivered by HHAs. These amounts were updated for inflation, and also include:

- Nonroutine medical supplies, even those that could have been unbundled to Medicare Part B;
- Therapy services that could have been unbundled to Part B; and
- Adjustments for OASIS reporting costs, both one time and ongoing.

After these adjustments, the resulting rates were further standardized so that case-mix and wage indexing could be appropriately applied, adjusted for budget neutrality, and then reduced to allow for a pool for outlier payments.

Section 1895(b)(3)(ii)(V) of the Social Security Act requires that each home health agency submit data for the measurement of health care quality. In calendar year 2007 and each subsequent year, if a home health agency does not submit the required data, their payment rates for the year are reduced by 2 percentage points. This reduction process is described in section 120 of this chapter.

New payment rates for each calendar year are issued annually in a Recurring Update Notification instruction. This Notification includes both the national standard rates and the rates for agencies that did not submit required quality data.

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix (Rev. 1647, Issued: 12-12-08, Effective: 01-01-07, Implementation: 03-16-09)

There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types:

- Skilled nursing facilities;
- Outpatient hospital services;
- Home health agencies;
- Rehabilitation hospitals; and
- Others.

While there are commonalities among these systems, there are also variations in how each system operates and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

The term prospective payment for Medicare does not imply a system where payment is made before services are delivered, or where payment levels are determined prior to the providing of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment is made at the beginning of the episode with as little as one visit delivered. HH PPS also means a shift of the basis of payment from payment tied to a claim or distinct revenue or procedural code, to an episode.

Case-mix is an underlying concept in prospective payment. With the creation of inpatient hospital PPS, the first Medicare PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. Other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care, use this concept of case-mix complexity, meaning that patient characteristics affect the complexity, and therefore, cost of care. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

For individual Medicare inpatient acute care hospital bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing contractor. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and reassess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted

episode payment is based on elements of the OASIS data set including the therapy visits provided over the course of the episode. The number of therapy visits projected at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted on the claim for the episode. Though therapy visits are adjusted only with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the Medicare contractor processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

10.1.8 - Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: HHRGs and HIPPS Codes (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under the home health prospective payment system, a case-mix adjusted payment for a 60-day episode is made using one of 153 HHRGs. On Medicare claims, these HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes. HIPPS codes allow the HHRG code to be carried more efficiently and include additional information necessary for non-routine supply payments.

HIPPS code rates represent specific characteristics (or case-mix) on which Medicare payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among providers. HIPPS codes are used in association with special revenue codes used on institutional claims submitted to Medicare contractors. One revenue code is defined for every Medicare prospective payment system that uses HIPPS codes. HIPPS codes are placed in HCPCS/Accommodation Rates/HIPPS Rate Codes field of the claim. The associated revenue code is placed in the Revenue Codes field.

10.1.9 - Composition of HIPPS Codes for HH PPS (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

For HH PPS episodes beginning on and after January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes are 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 covered 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 level 4 = HIPPS code 4CHLV
- 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 5BHKX

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.

10.1.10 - Provider Billing Process Under HH PPS

(Rev. 1, 10-01-03)

HH-467.15, A3-3639.15

The next four sections describe the basic HH PPS billing process, not including payment adjustments. Payment adjustment follows in subsequent sections.

10.1.10.1 - Grouper Links Assessment and Payment

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool. OASIS is entered, formatted and locked for electronic transmission to State agencies. HAVEN software, made publicly available by CMS, supports OASIS and its transmission. HAVEN versions were produced incorporating the Grouper module necessary for HH PPS, along with other changes needed for the new payment system, prior to the advent of that system. However, some HHAs have chosen software vendors to create their own software applications for these purposes.

Grouper software determines the appropriate case-mix group for payment of a HH PPS 60-day episode from the results of an OASIS submission for a beneficiary as input or “grouped” in this software. Grouper outputs case-mix groups as CMS HIPPS (Health Insurance Prospective Payment System) coding. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number that is not used in billing. Under HH PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims. Note that if an OASIS assessment is rejected upon transmission to a State Agency and consequently corrected resulting in a different HIPPS code, the RAP and/or claim for the episode must also be re-billed using the corrected HIPPS code.

10.1.10.2 - Health Insurance Beneficiary Eligibility Inquiry for Home Health Agencies

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

An inquiry facility is available for HHAs and other providers and suppliers to learn the beneficiary’s eligibility and entitlement status, whether a home health episode has started but not ended, and where in a sequence of adjacent episodes an episode for given dates of service will fall. See §30 for a description.

10.1.10.3 - Submission of Request for Anticipated Payment (RAP)

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met.

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the State;
- Once a physician’s verbal orders for home care have been received and documented;
- A plan of care has been established and sent to the physician; and
- The first service visit under that plan has been delivered.

An episode will be opened on CWF with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

RAPs are submitted using Type of Bill 322. RAPs must include the information output by Grouper for HH PPS in addition to other claim elements. While Medicare requires

very limited information on RAPs (RAPs do not require charges for Medicare), HHAs have the option of reporting service lines in addition to the Medicare requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected payment amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine payment or for later data collection.

The HH Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

10.1.10.4 - Claim Submission and Processing

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services are provided for the episode and the physician has signed the plan of care and any subsequent verbal order. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

HH claims must be submitted with type of bill (TOB) 329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode. At a provider's option, any durable medical equipment, oxygen or prosthetics, and orthotics provided may also be billed on HH PPS claim, and this equipment will be paid in addition to the episode payment.

However, osteoporosis drugs must be billed separately on 34X claims, even when an episode is open. Pricer will determine claim payment as well as RAP payment for all PPS supplies and services on TOB 32X (or 33X) claims. Payment for bill type 34X is dependent upon the Part B methodology used for the service, as defined by the HCPCS code.

An HH PPS claim with TOB 329 is processed in Medicare claims processing systems as a debit/credit adjustment against the record created by the RAP. The related remittance advice will show the RAP payment was recouped in full and a 100 percent payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100 percent payment is made in the next calendar or fiscal year, at that year's rates, since claim payment rates are determined using the Statement Covers Period "Through" date on the claim, for all services in the episode.

Once the final payment for an episode is calculated, Medicare claims processing systems will determine whether the claim should be paid from the Medicare Part A or Part B trust

fund. This A-B shift determination will be made only on claims, not on RAPs. HHA payment amounts are not affected by this process. Value codes for A and B visits (value codes 62 and 63) and dollar amounts (64 and 65) may be visible to HHAs on electronic claim remittance records, but providers do not submit these value codes or determine to distinguish Part A or Part B visits.

10.1.11 - Payment, Claim Adjustments and Cancellations

(Rev. 1, 10-01-03)

HH-467.20, A3-3639.20

A number of conditions can cause the episode payment or the RAP to be adjusted or cancelled.

The HHA must cancel a RAP sent in error. RAPs cannot be adjusted. They may be rebilled with appropriate information after cancellation. Type of bill (TOB) 328 is used for a cancel transaction, for both claims and RAPs

Claims may be cancelled by HHAs or adjusted. Adjustments (TOB 327) are used to correct information which may change payment. A cancellation is needed to change the beneficiary HICN or the HHA's provider number, if originally submitted incorrectly.

Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment. RAPs can only be canceled, not adjusted, but may be re-billed after cancellation.

10.1.12 - Request for Anticipated Payment (RAP)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The RAP is submitted by HHAs to their Medicare contractor to request the initial split percentage payment for an HH PPS episode, after receiving verbal orders and delivering at least one service to the beneficiary. Though they are submitted on standard institutional claim formats and result in Medicare payment for home services, the RAP is normally not considered a Medicare home health claim and is not subject to many of the stipulations applied to such claims in regulations. (Note that RAPs may be considered claims for purposes of other Federal laws and regulations.) In addition to a split percentage payment (see §10.1.6), RAPs may be paid zero percent if Medicare is the secondary payer (see §30.10), or if a provider has lost the privilege of receiving RAP payment. In particular, RAPs are not subject to any type of payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode. These claims are still subject to the payment floor and payment of interest, if applicable.

10.1.13 - Transfer Situation - Payment Effects

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HH PPS system, beneficiaries must be able to transfer

among HHAs, and episode payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs submit a RAP with a transfer indicator in the condition code field on the institutional claim when an episode may already be open for the same beneficiary at another HHA. In order for a receiving (new) HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). The receiving HHA must also document in its records that it accessed the Medicare inquiry system to determine whether or not the patient was under an established home health plan of care and contacted the initial HHA on the effective date of transfer.

In such cases, the previously open episode will be automatically closed in Medicare claims processing systems as of the date services began at the HHA the beneficiary transferred to, as reported in the RAP; and the new episode for the "transfer to" agency will begin on that same date. Payment will be pro-rated for the shortened episode of the "transferred from" agency, adjusted to a period less than 60 days either according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency. Note that HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

In rare cases, a beneficiary may elect to transfer between HHAs and their admission date at the "transfer to" HHA may fall on the day immediately following the end of an episode at the "transferred from" agency. The "transferred from" agency may not have submitted a RAP for the new episode of continuous care, so the "transfer to" HHA may not see a record of an open episode when they access the Medicare inquiry system. They will likely see the record of the immediately adjacent episode and should provide the same notifications to the beneficiary as in any other transfer situation. Documentation of these notifications may be needed if the transfer is disputed and verification is required as described in the Medicare Benefit Policy Manual, chapter 7, section 10.8.E.

10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under HH PPS, HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days. Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period (see §10.1.15). A new episode can be opened by the HHA. Medicare systems will allow this in cases where the CMS certification number (CCN) on the new RAP matches the CCN on the prior episode. The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock").

Note that beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, the discharge is not recognized for Medicare payment purposes. All the HH services provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim.

When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period. Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA, and is not expected to return for treatment under any existing plan of care.

10.1.15 - Adjustments of Episode Payment - Partial Episode Payment (PEP)

(Rev. 1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened episodes. In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called partial episode payments (PEP).

PEP adjustments occur as a result of the two following situations:

- a. When a patient has been discharged and readmitted to home care within the same 60-day episode, which will be indicated by using a Patient Discharge Status code of 06 on the final claim for the first part of the 60 day episode; or
- b. When a patient transfers to another HHA during a 60-day episode, also indicated with a Patient Discharge Status code of 06 on their final claim.

Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. **This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service to and including the day of the last billable service.**

For episodes beginning on or after January 1, 2008, the non-routine supply payment amount is also subject to this proration on a basis of days.

10.1.16 - Payment When Death Occurs During an HH PPS Episode **(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)**

If a beneficiary dies during an episode, full payment will be made for the episode, including payment adjustments applicable to given services actually delivered prior to death. However, there is one exception to this statement. Partial episode payment (PEP) adjustments will not apply to the claim, because no more home care can be delivered in the 60-day period. The Statement Covers Period “through” date on the claim closing the episode in which the beneficiary died should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

If an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history. If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an episode basis, rather than a visit basis.

LUPA episodes beginning on or after January 1, 2008, may be subject to an additional payment adjustment. If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only episode of care the beneficiary received, Medicare will make an additional add-on payment. Medicare will add to these claims a lump-sum established in regulation and updated annually. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit.

10.1.18 - Adjustments of Episode Payment - Special Submission Case: “No-RAP” LUPAs

(Rev. 1, 10-01-03)

HH-467.26, A3-3639.26

Normally, there will be two percentage payments (initial and final) paid for an HH PPS episode, the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which a HHA knows that an episode will be four visits or less even before the episode begins or before the RAP is submitted, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment. **In such cases and only in such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage payment that otherwise would later likely be largely recouped.** Physician orders must be signed when these claims are submitted. If a HHA later needs to add visits to the claim, so that the claim will have more than four visits and no longer

be a LUPA, the claim should be adjusted and the full episode payment based on the HIPPS code will be made.

10.1.19 - Adjustments of Episode Payment - Confirming OASIS Assessment Items

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The total case-mix adjusted episode payment is based on the OASIS assessment. Depending on the dates of service covered by the episode, Medicare claims systems may confirm certain OASIS assessment items in the course of processing a claim and adjust the HH PPS payment accordingly.

10.1.19.1 - Adjustments of Episode Payment - Therapy Thresholds

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The number of therapy visits projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode.

The HH PPS adjusts Medicare payment based on whether one of three therapy thresholds (6, 14 or 20 visits) is met. As a result of these multiple thresholds, meeting a threshold can change the payment equation that applies to a particular episode. Also, additional therapy visits may change the score in the service domain of the HIPPS code.

Due to the complexity of the payment system regarding therapies, the Pricer software in Medicare's claims processing system will recode all claims based on the actual number of therapy services provided. This recoding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment.

Since the number of therapy visits provided can change the payment equation used under the refined four-equation case mix model, in some cases this recoding may change several positions of the HIPPS code. In these cases, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

10.1.19.2 - Adjustments of Episode Payment – Early or Later Episodes

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The HH PPS uses a 4-equation case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early episode of care (1st or 2nd episode in a sequence of adjacent covered episodes) or a

later episode of care (the 3rd episode and beyond in a sequence of adjacent covered episodes).

Early episodes include not only the initial episode in a sequence of adjacent covered episodes, but also the next adjacent covered episode, if any, that followed the initial episode. Later episodes are defined as all adjacent episodes beyond the second episode. Episodes are considered to be adjacent if they are separated by no more than a 60-day period between claims.

Any Medicare fee-for-service covered episode for a beneficiary is considered in determining adjacent covered episodes. A sequence of adjacent covered episodes is not interrupted if a beneficiary transfers between HHAs. Episodes covered by Medicare Advantage plans are not considered in determining adjacent episodes.

Example: A patient is admitted to Agency A on July 5th into a payment episode that ends on the date of Sept 2nd. The patient is then recertified on Sept 3rd, with an end of episode date of November 1st. Agency B admits on Jan 1.

When determining if two eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1. Continue counting to, and including, the first day of the next episode.

In this example, November 1st was the last day of the episode and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent.

The episode starting January 1st would be reported by Agency B as “early”. December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “later.”

HHAs report whether an episode is “early” or “later” using OASIS item M0110. This OASIS information is then used to determine the HIPPS code used for billing. The first position of the HIPPS code shows whether an episode is “early” or “later.” Since HHAs may not always have complete information about previous episodes, the HIPPS code is validated by Medicare systems. The Common Working File reads the episode history described in section 30.5 to determine whether an episode has been coded correctly based on the most current information available to Medicare. If the HIPPS code disagrees with Medicare’s episode history, the claim will be recoded.

The receipt of any episode may change the sequence of previously paid claims. For instance, a claim may be paid as “early” because the HHA was not aware of prior episodes and the previous HHA had not billed for the prior episodes. When the earlier dated episodes are received, Medicare systems will initiate an automatic adjustment to recode the previously paid claim and correct its payment.

When claims are recoded, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

10.1.20 - *RESERVED*

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 2209; Issued: 05-06-11; Effective Date: 01-01-10; Implementation Date: October 3, 2011, for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements; and January 3, 2012, for Business Requirements for 7395.4, 7395.6, and their associated sub-requirements.)

HH PPS payment groups are based on averages of home care experience. When cases “lie outside” expected experience by involving an unusually high level of services in 60-day periods, Medicare claims processing systems will provide extra or “outlier” payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations *shall* be made by comparing the **total of the products** of:

- The number of visits of each discipline on the claim **and** each wage-adjusted national standardized per visit rate for each discipline; with
- The **sum** of the episode payment **and** a wage-adjusted standard fixed loss threshold amount.

If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode.

Outlier payment amounts are wage index adjusted to reflect the CBSA in which the beneficiary was served. Outlier payments are to be made for specific episode claims. The outlier payment is a payment for an entire episode, and therefore carried only at the claim level in paid claim history; and not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment *shall* be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim in history using value code 17 with an associated dollar amount representing the outlier payment.

Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

Effective January 1, 2010, the outlier payments made to each HHA will be subject to an annual limitation. Medicare systems will ensure that outlier payments comprise no more than 10% of the HHA's total HH PPS payments for the year. Medicare systems will track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier payments that each HHA has received. When each HH PPS claim is processed, Medicare systems will compare these two amounts and determine whether the 10% has currently been met.

If the limitation has not yet been met, any outlier amount *shall* be paid normally. (Partial outlier payments *shall* not be made. Only if the entire outlier payment on the claim does not result in the limitation being met, *shall* outlier payments be made for a particular claim.) If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the episode *shall* be paid but any outlier amount *shall* not be paid. When the calculated outlier amount is not paid, HHAs will be alerted to this by the presence of the following codes on their remittance advice:

Group code CO: "Contractual Obligation"

Claim adjustment reason code B5: "Coverage/program guidelines were not met or were exceeded."

Remittance advice remark code N523: "The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid."

Since the payment of subsequent claims may change whether an HHA has exceeded the limitation over the course of the timely filing period, Medicare systems will conduct a quarterly reconciliation process. All claims where an outlier amount was calculated but not paid when the claim was initially processed *shall* be reprocessed to determine whether the outlier has become payable. If the outlier can be paid, the claim *shall* be adjusted to increase the payment by the outlier amount. *Additionally, if any HHAs are found to have been overpaid outlier during the quarterly reconciliation process, claims shall be adjusted to recover any excess payments.*

These adjustments will appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (type of bill 3XI) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

10.1.22 - Multiple Adjustments to Episode Payments

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Episode payment adjustments as described above apply only to claims, not to requests for anticipated payment (RAPs). Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold or PEP adjustment. LUPA episodes also will not receive outlier payments. For other HH PPS claims, multiple adjustments may apply on the same claim, though some combinations of adjustments are unlikely. All claims except LUPA claims will be considered for outlier payment. Payment adjustments are calculated in Pricer software (see section 70).

10.1.23 - RESERVED

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

10.1.24 - Glossary and Acronym List

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Admission Date - For HH PPS, the date of the first service delivered by the HHA in an episode or a series of continuous episodes. It is placed in the Admission/Start of Care Date field on the institutional claim.

Claim – The second of two transactions submitted for a HH PPS episode to receive the second split percentage payment for the episode.

CMS - The Center for Medicare & Medicaid Services, the Federal Agency administering the Medicare program.

DME - Durable Medical Equipment.

DME- MAC - DME Medicare Administrative Contractor - 4 Medicare contractors nationally processing DME on professional claim formats.

DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics and Supplies.

Episode – The unit of payment for HH PPS, covering up to 60 days of HH services.

Grouper - A software module that “groups” information for payment classification. For HH PPS, data from the OASIS assessment tool is grouped to form HHRGs and corresponding HIPPS codes. Specifications for the HH PPS Grouper are posted on the CMS Web site. The Grouper module is also built into PPS-compatible versions of HAVEN software.

HAVEN -- Publicly available software that automates the entry and transmission of OASIS assessment information.

HCPCS Code(s) - Healthcare Common Procedure Coding System. Coding for services or items used in the HCPCS/Accommodation Rates/HIPPS Rate Codes field on institutional claim formats. A list of HCPCS is accessible on the CMS Web site.

HH - Home Health

HHA(s) - Home Health Agency(ies)

HHRG - Home Health Resource Group. One of the case-mix groups that determine HH PPS episode payment rates.

HIPPS - Health Insurance Prospective Payment System. Coding used in the HCPCS/Accommodation Rates/HIPPS Rate Codes field on institutional claim formats to represent case-mix groups in certain CMS prospective payment systems.

Inquiry System (ELGH) - An online transaction providing information on HH PPS episodes for specific Medicare beneficiaries. This system is based on batch claim data available in the Common Working File, a component of Medicare claims processing systems, and is available to providers via their Medicare contractor.

LUPA - Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of by the HH PPS case-mix system.

MAC – Medicare Administrative Contractor, one of the contractors to CMS that processes Medicare claims.

National Standard Per Visit Rates - National rates for each 6 home health disciplines based on historical claims data. These rates are used in payment of LUPAs and calculation of outliers.

No-RAP LUPAs - A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.

NRS – Non-Routine Supplies

OASIS - Outcome and Assessment Information Set. The HH patient assessment instrument required by CMS.

Outlier - An addition to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. Pricer computes HH PPS outliers as part of Medicare claims payment for all non-LUPA episodes.

Patient Status Code – a code in the Patient Discharge Status field on institutional claims which describes patient status at discharge or the end of the billing period.

PEP - Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharges with readmissions).

PPS - Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

Pricer - Software modules in Medicare claims processing systems used to calculate payments under prospective payment systems.

RAP - Request for Anticipated Payment. First of two transactions submitted for a HH PPS episode to receive the first split percentage payment for the episode.

Revenue Code - Four position payment codes for services or items placed in the Revenue Codes field on institutional claim formats. An “x” in the last digit of revenue codes means that value can vary from 0-9.

TOB - Type of Bill (e.g., 32X, 34X). Coding representing the nature of each institutional claim (i.e., type of provider, such as home health; payment source, such as specific Medicare trust fund; and frequency of bill) - an “x” in the last digit of numeric three digit TOB means that value can be from 0-9.

20 - Home Health Prospective Payment System (HH PPS) Consolidated Billing (Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare payment for all such items and services is to be made to a single home health agency (HHA) overseeing that plan. This HHA is known as the primary HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or “otherwise.” Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;

- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Exception: Therapy services are not subject to the home health consolidated billing methodology when performed by a physician.

Medicare periodically publishes Routine Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes, which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

The HHA that submits a Request for Anticipated Payment (RAP) or No-RAP LUPA claim successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given episode in the Common Working File (CWF). If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Contractors will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within an episode (see §20.2 for details). Contractors will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under an HH plan of care (using type of bill 34X) when the primary HHA has already billed other services under an HH plan of care (type of bill 32X) for the beneficiary. Institutional providers may access information on existing episodes through the home health CWF inquiry process. See §30.1.

Durable Medical Equipment (DME) is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier or an HHA (including HHAs other

than the primary HHA). Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted by multiple providers for the same dates of service for the same beneficiary. In the event of duplicate billing, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent payment for the purchase and the rental of the same item for the same dates of service. In this event, the first claim received, regardless of whether for purchase or rental, will be processed and paid.

The exception to the above, however, is competitive bidding for certain DME. HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program, must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP Codes where beneficiaries receiving these items maintain their permanent residence. Home health agency claims submitted for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs, who will have jurisdiction over all claims for competitively bid items.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis in addition to episodes payments. For more detailed information, refer to §20.2.3 and §90.1.

20.1 - Beneficiary Notification and Payment Liability Under Home Health Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

20.1.1 - Responsibilities of Home Health Agencies

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

PM A-02-104

Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made. The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services that the physician has ordered on the beneficiary's home health plan of care.

However, providing services either directly or under arrangement requires knowledge of the services provided during the episode. An HHA would not be responsible for payment to another provider in the situation in which they have no prior knowledge (e.g., they are unaware of physicians orders) of the services provided by that provider during an episode to a patient who is under their home health plan of care.

In certain circumstances where the primary HHA is unaware of services provided during the episode and the beneficiary is properly notified, the beneficiary may be liable for

payment for these services. In order to protect the beneficiary from unexpected liability in these cases, and in order to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a home health patient notify the beneficiary of the possibility that they will be responsible for payment.

Notification about home health consolidated billing must begin with the beneficiary's admission to home health care. Under the Medicare Home Health Services Conditions of Participation: **Patient rights**, (42 CFR, §484.10 (c) (i)), the HHA must advise the patient, in advance, of the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will furnish care, and the frequency of visits proposed to be furnished. It is, therefore, the responsibility of the HHA to fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by his/her primary HHA.

In addition, under the Conditions of Participation: **Patient liability for payment**, (42 CFR, §484.10(e)), HHAs are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient. Information regarding patient liability for payment must be provided by the HHA both orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA.

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing **(Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)**

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

Additionally, information about current home health episodes may be available from Medicare contractors. Institutional providers (providers who bill using the institutional claim format) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists or suppliers who bill using the professional claim format also have access to a similar electronic inquiry via the HIPAA standard eligibility transaction – the 270/271 transaction. They may also, as a last resort,

call their contractor's provider toll free line to request home health eligibility information available on the Common Working File. The contractor's information is based only on claims Medicare has received from home health agencies at the day of the contact.

Beginning October 2010, another source of information is available via the CWF. Medicare systems will maintain a data file that captures and displays the dates when Medicare paid physicians for the certification or recertification of the beneficiary's HH plan of care. Physicians submit claims for these services to contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for an HH episode promptly in order to receive their initial 60% or 50% payment for that episode.

But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that an HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems display, for each Medicare beneficiary, the code for certification (G0180) or recertification (G0179) and the date of service for either of the two codes.

Suppliers and providers should note that this information is supplementary to the previously existing sources of information about HH episodes. Like HH episode information maintained on CWF, certification information is only as complete and timely as billing by providers allows it to be. For many episodes, a physician certification claim may never be billed. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

If a therapy provider or a supplier learns of a home health episode from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH episode, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health episode and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

20.1.3 - Responsibilities of Hospitals Discharging Medicare Beneficiaries to Home Health Care

**(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)
PM A-02-106**

A hospital discharging a Medicare beneficiary to home health care can also play an important role in alerting the beneficiary to their potential liability under home health consolidated billing. Under the Medicare Conditions of Participation (COP) for Hospitals: **Discharge planning**, (42 CFR, §482.43 (b) (3) and (6)), hospitals must have in effect a discharge planning process that applies to all patients, and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf. In addition, under 42 CFR, §482.43 (c) (5), the patient and family members must be counseled to prepare them for post-hospital care and under 42 CFR, §482.43 (d) **Transfer or referral**, the hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

Hospitals, therefore, should counsel beneficiaries being discharged to receive home health services, that his/her "primary" home health agency; i.e., the agency establishing his/her plan of care, will provide all home health services. Hospitals should provide a list of home health agencies for beneficiaries to choose from; in addition, when referring the beneficiary to his/her chosen home health agency, the hospital should notify the agency and include any counseling notes, which should serve as a reminder to the home health agency to also notify the beneficiary that **all** home health services will be provided by them as the "primary" home health agency. Hospitals play a key role in making beneficiaries, and/or their caregivers, aware of Medicare home health coverage policies to help ensure that those services are provided appropriately.

20.2 - Home health Consolidated Billing Edits in Medicare Systems (Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

In short, consolidated billing requires that only the primary HHA bill services under the home health benefit, with the exception of DME and therapy services provided by physicians, for the period of that episode. The types of service most affected are nonroutine supplies and outpatient therapies, since these services are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

Home health consolidated billing editing is applied when the episode claim has been received and processed in CWF. Edits are applied if the claim subject to consolidated billing contains dates of service between and including the episode start date and the last billable service date for the episode if the patient is discharged or transferred. If the patient is not discharged or transferred, the episode end date is used for editing purposes. Any line item services within the episode start date and last billable service date or episode end date, whichever is appropriate for the patient status, will be edited. CWF sends information to contractors that enable them to reject or deny line items on claims subject to consolidated billing.

Claims subject to consolidated billing may be identified in one of two ways. Claims may be edited when the HH PPS claim had been received before the claim for services subject to consolidated billing. In these cases, the line items subject to consolidated billing are rejected or denied prior to payment. Claims may also be identified when the HH PPS claim is received after the other claims subject to consolidated billing. In these cases, the claim for services subject to consolidated billing has already been paid. CWF then notifies the contractor to make a post-payment rejection or denial.

For post-payment rejections of claims billed on institutional claims, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed on professional claims, those contractors will follow their routine overpayment identification and recovery procedures. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

Whether a claim for services subject to consolidated billing is identified pre- or post-payment, messages explaining line-item actions for home health consolidated billing appear on remittance advice for providers and Medicare Summary Notices (MSNs) for beneficiaries.

Claims subject to home health consolidated billing receive the following remittance advice codes:

- Reason Code B15: “Payment adjusted because this procedure/service is not paid separately”
- Remark Code N70: “Home health consolidated billing and payment applies”

Since home health consolidated billing is not an ABN situation, coding on incoming claims cannot allow Medicare systems to fully identify the payment liability for any denial. As described in §20.1, whether the denial is the liability of the primary HHA or the beneficiary is determined by whether the services are provided under arrangement and whether the beneficiary received notice of their potential liability. These denials are shown as provider liability on remittance advices (group code CO) to ensure therapy providers or suppliers explore whether a payment arrangement exists or can be made for the services. Despite this coding limitation, Medicare recognizes that ultimately beneficiaries may be liable for these services.

20.2.1 - Nonroutine Supply Editing **(Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)**

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code. This list is updated periodically by Recurring Update Notification. When an HH PPS episode that has been updated by the receipt of a final claim for the episode exists at CWF, any claim with a nonroutine supply HCPCS code that is submitted to a DME MAC with a date of service that overlaps the episode dates will be denied. Supplies are billed to DME MACs using the professional claim format, in

which line items have both a 'from' and 'to' date. The line item 'from' date is used to enforce consolidated billing of nonroutine medical supplies.

Claims submitted by providers using the institutional claim format may include a nonroutine supply HCPCS code in addition to the other services provided. These supplies (e.g., supplies for certain emergency, surgical, diagnostic, and end stage renal disease services) are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, therefore these supplies do not fall within the bundling provisions of HH PPS. As a result, supplies reported on institutional claims are not subject to consolidated billing edits by CWF.

20.2.2 - Therapy Editing

(Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes are subject to consolidated billing when submitted on types of bill 13x, 23x, 34x, 74x, 75x or 85x.

On claims submitted by practitioners using the professional claim format, CWF enforces consolidated billing for outpatient therapies using a list of HCPCS codes which represent therapy services. This list is also updated periodically by Recurring Update Notification.

Therapy services on professional claims are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.

20.2.3 - Other Editing Related to Home Health Consolidated Billing

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

CWF edits to prevent duplicate billing across two Medicare contractors. Consequently, CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though HH consolidated billing does not apply to DME by law.

If revenue code 0636 and the HCPCS code for an osteoporosis drug is billed on a 34X bill type claim during an open HH episode, CWF must edit to ensure that the provider of the 34X bill is the same as the primary provider of the open episode, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the episode payment. HH consolidated billing will not affect billing of DME or services outside the home health benefit, even when these services are billed by HHAs.

20.2.4 - Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

If only a RAP for the episode has been received and the incoming claim with services subject to consolidated billing contains dates of service within the full 60-day home health episode period, CWF returns an alert to the Medicare contractor to notify them that the claim may be subject to consolidated billing. The Medicare contractor processes the claim to payment, but passes on the alert to the provider on the remittance advice that accompanies the payment in the form of the following remark code:

N88 - "This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, will be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."

This remark code is applied at the line level on the electronic remittance advice. It indicates to providers that the services may be denied and claim payment may be recouped if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing. No message reflecting the alert is displayed to the beneficiary on the Medicare Summary Notice.

20.2.5 - No RAP Received and Therapy Services Rendered in the Home (Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

There may be situations in which a beneficiary is under a home health plan of care, but CWF does not yet have a record of either a RAP or a home health claim for the episode of care. To help inform independent therapy providers billing professional claims to Medicare contractors that the services they rendered in the home setting may be subject to consolidated billing, providers will receive the following remark code on the remittance advice when Medicare pays them for the service:

N116 - This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Medicare systems processing professional claims will provide this message when the place of service on the claim is "12 home," the HCPCS code is a therapy code subject to home health consolidated billing and CWF has not returned a message indicating the presence of a RAP.

30 - Common Working File (CWF) Requirements for the Home Health Prospective Payment System (HH PPS)

(Rev. 1, 10-01-03)

HH-468, A3-3640

30.1 - Health Insurance Eligibility Query to Determine Episode Status

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under the HH PPS and home health consolidated billing (described elsewhere in this chapter), one HHA is considered the “primary” home health agency in billing situations. This primary agency is the only agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. When a homebound beneficiary seeks care from an HHA or from an institutional therapy provider subject to home health consolidated billing, the provider needs to determine if the beneficiary is already being served by an HHA - an agency that then would be considered primary.

Providers may send an inquiry to determine the beneficiary’s entitlement and eligibility status into the Common Working File or CWF, through their Medicare contractor. They must send the ANSI X12N 270 transaction set and will receive the ANSI X12N 271 transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

Medicare contractors processing institutional claims will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The Medicare contractor will create the 271 response or DDE screen from the ELGA transaction record.

The response shows whether or not the beneficiary is currently in a home health episode of care. If the beneficiary is not already under care at another HHA, he/she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode is already open at another HHA if the beneficiary has chosen to transfer.

See Chapter 31 for a description of the data elements and related requirements.

30.2 - CWF Response to Inquiry

(Rev. 1, 10-01-03)

HH468.2, A3-3640.2

CWF will return information on the two episode periods in the CWF episode file (the File) closest to the date the HHA or other provider entered in the “applicable date” field. If a date is not specified, information on the two most recent episode periods in the File will be returned. See Chapter 31 for complete data sets returned to specific provider types.

30.3 - Timeliness and Limitations of CWF Responses

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Inquirers receive a response within a very short time frame. However, these responses are not truly “real time.” The CWF auxiliary file that retains episode information is updated by, and is only as current as, each RAP or claim batch run in CWF. All processed RAPs and claims will update the episode file, even if RAPs have zero payment, or if claims or RAPs are ultimately denied. The CMS removes episodes from the file only when:

- HHAs cancel their own RAPs for episodes not yet closed;
- HHAs cancel their own claims, for closed episodes; or
- When a Medicare contractor processing HH claims cancels a claim or a RAP for specific reasons (i.e., fraud).

In general, responses will be as current as the previous day. Therefore, even when a response indicates a beneficiary is not currently in an episode, the possibility exists that a RAP or claim could be in process, and the inquiring agency would still not be the primary HHA for a beneficiary for whom a “clear” inquiry was received. In such cases, the inquiring agency will not learn that it is not the primary HHA immediately.

Also possible but even more rare, claims or RAPs from two different HHAs for the same beneficiary for the same date may be in the same batch of claims or RAPs sent to CWF. In such cases, the arbitrary claim process will still result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

30.4 - Provider/Supplier Inquiries to Medicare Contractors Based on Eligibility Responses

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Institutional providers and/or suppliers may want to follow-up on information they receive, usually to contact the primary agency on file to bill under arrangement. The provider or supplier may determine the HHA’s Medicare contractor from the CMS Web site which has a list of Medicare contractors that process HH claims by State. The provider or supplier also may ask its own Medicare contractor through existing provider inquiry channels. That Medicare contractor will instruct the provider regarding which Medicare contractor that processes HH claims to contact to learn which HHA is involved.

Medicare contractors that process HH claims may provide information on either the provider or contractor that these providers may request. Information released will be determined by each contractor, such as HHA name and address, but must be enough for the inquiring provider/supplier to contact either the primary HHA, if under that contractor’s jurisdiction, or another contractor, if the provider number is attached to another contractor. If an instance ever exists where a provider is an individual, such as a

provider doing business using a Social Security Number as a tax identification number, information cannot be released, since it would violate the individual's right to privacy.

30.5 - National Home Health Prospective Payment Episode History File (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

CWF maintains a national episode history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. Only Medicare contractors, not providers, may view this file.

The episode file, populated as soon as the first HH PPS episode is opened for a beneficiary with either a RAP or a claim, contains:

- The beneficiary's Health Insurance Claim Number (HICN);
- The pertinent Contractor and Provider Numbers;
- Period Start and End Dates - the start date is received on an RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized;
- Date of Earliest Billing Activity (DOEBA) and Date of Latest Billing Activity (DOLBA) – line item dates of service of the first and last HH visits reported on the final claim for the episode;
- Patient Status Indicator - the patient discharge status code on an HH PPS claim, indicating the status of the HH patient at the end of the episode. This indicator will also be populated by RAPs, but the value will always be "30";
- Transfer/Readmit Indicator – code values in this field indicate the reason this episode record was allowed to overlap the 60-day period of the previous episode:

'B' indicates the episode record was a transfer from another HHA (i.e., condition code 47 was on the RAP or claim;

'C' indicates the episode record was a discharge and admission from the same HHA (i.e., CCNs on the two episodes are the same).

This transfer/readmit indicator is present on the internal episode file used in CWF editing but it is not displayed on the episode history screen. If contractors need to validate this data, they must research the claim record on CWF history.

- The HIPPS Code – the code representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);

- Principal Diagnosis Code and First Other Diagnosis Code – diagnosis codes reported on the RAP or claim;
- A LUPA Indicator - received from the shared system indicating whether or not there was a LUPA episode; and
- A RAP Cancellation Indicator - showing whether or not a RAP has been auto-canceled for this episode because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel only code “B,” this indicator is a value of “1.” For episodes beginning on or after January 1, 2008, this indicator is also used when a final claim has been denied as fully non-covered by medical review. In these cases, the indicator is a value of “2.” In all other cases, the value is “0.”

The episode file contains the 36 most recent episodes for any beneficiary. Episodes that precede the most recent 36 will be dropped off the file and will not be retrievable online. The date of accretion, meaning dates on which episode records are created or updated, for an episode is the date the RAP or claim is accepted or applied.

30.6 - Opening and Length of HH PPS Episodes

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Within CWF, the episode history auxiliary file is separate from the home health benefit period auxiliary file, which existed prior to HH PPS. All HH PPS claims will update both these files. In most cases, receipt and processing of a RAP will open an HH PPS episode in an episode file, even if the RAP or claim has zero payment.

Note that claims will open episodes in only one special circumstance. This is when a provider knows from the outset that it will provide four or fewer visits for the entire episode, which always results in a LUPA; and therefore decides to forego the RAP so as to avoid recoupment of the difference of the large initial percentage episode payment and LUPA visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

Multiple episodes can be open for the same beneficiary at the same time. The same HHA may require multiple episodes be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. CWF will post RAPs received with appropriate transfer and readmit indicators to facilitate the creation of multiple episodes.

Same day transfers are permitted, such that an episode for one agency, based on the claim submitted by that agency, can end on the same date as an episode was opened by another agency for the same beneficiary. Both HHA's services for this date will be approved for

payment, without regard for whether the same HH disciplines (e.g. skilled nursing, physical therapy, etc.) from both HHAs provided services.

When episodes are created from RAPs, CWF calculates a period end date that does not exceed the start date plus 59 days. CWF will assure no episode exceeds this length under any circumstance, and will auto-adjust the period end date to shorten the episode if needed based on activity at the end of the episode (i.e., shortened by transfer).

30.7 - Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAPs and HHA Claim Activity

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Medicare contractors that process HH claims reject RAPs and claims with statement dates overlapping existing episodes unless a transfer or discharge and readmit situation is indicated. These contractors also reject claims in which the dates of the *covered* visits reported for the episode do not fall within the episode period established by the same agency.

Episode lengths are shortened when another RAP or claim indicating transfer or discharge/readmission is received. The episode defaults to the day of the first date of service of the new RAP or claim. If a full episode payment has been made for the now shortened episode, the contractor will adjust the episode to reflect a PEP payment. Any line items that fall after the beginning of the new episode are then noncovered.

If a RAP or claim is canceled by an HHA, CWF cancels the episode. If a RAP is canceled and payment is recouped and the RAP when a corresponding final bill has not been received, the episode remains open at CWF.

30.8 - Other Editing and Changes for HH PPS Episodes

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

CWF assures that the final “through date” on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary remains in the care of the same HHA (patient status code 30). If the patient dies, represented with a patient status code of 20, the episode does not receive a PEP adjustment, though other adjustments may apply, but the through date on the claim indicates the date of death instead of the end of the episode period. When the patient status of a claim is 06, indicating transfer, the episode period end date is adjusted to reflect the “through date” of that claim, and payment is also adjusted. When the status of the claim is 01, no change is made in the episode length or claims payment unless a separate RAP or claim is received which overlaps that 60-day period and contains either a transfer or discharge and readmit indicator.

CWF also acts on condition codes on RAPs. For example, CWF acts on condition code 47, indicating transfer to another HHA in the same 60-day period, and opens a new episode. CWF will also open a new episode when the CMS certification number (CCN)

for the provider on the incoming RAP matches the CCN on the episode the RAP overlaps. This indicates a discharge and readmission situation.

CWF recognizes internal action codes, generated by the Medicare claims processing systems, and cancel-only codes, assigned by CMS, that have been assigned to specific HH PPS transactions and situations to aid in processing these claims.

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility (SNF) services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive home care simultaneously. Thus, if an HH PPS claim is received, and CWF finds dates of service on the HH claims that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), Medicare systems will reject the HH claim. This would still be the case even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later, but contained dates of service duplicating dates of service within the HH PPS episode period.

30.10 - Medicare Secondary Payment (MSP) and the HH PPS Episodes File

(Rev. 1, 10-01-03)

HH-468.10, A3-3640.10

Normal MSP requirements apply to both RAPs and claims. Refer to the Medicare Secondary Payer (MSP) Manual for further details.

30.11 - Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The following chart summarizes basic effects of HH PPS claims processing on the episode record:

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP	<ul style="list-style-type: none"> • Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank 	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Subsequent Episode RAP	<ul style="list-style-type: none"> • Opens another subsequent episode using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through next 60 days • DOEBA and DOLBA are left blank 	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Initial RAP with condition code 47	<ul style="list-style-type: none"> • Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank • Changes the Period End Date of the prior episode to be the day before the RAP's "from" date. 	<ul style="list-style-type: none"> • The Period End Date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the "from" date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider or Contractor	<ul style="list-style-type: none"> • The episode record is deleted from CWF 	<ul style="list-style-type: none"> • No episode record is present to prevent RAP submission or No-RAP LUPA claim submission by another provider, making that provider the primary HHA for the dates of the episode
RAP Cancellation by System	<ul style="list-style-type: none"> • The episode record remains open on CWF 	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • In order to receive payment for this episode, the original RAP must be resubmitted before the final claim is submitted • To correct information on this RAP, the original RAP must be cancelled by the HHA and then re-submitted once more with the correct information
Claim (full	<ul style="list-style-type: none"> • 60-day episode record is 	<ul style="list-style-type: none"> • Other RAPs submitted during this open

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
episode)	<ul style="list-style-type: none"> • completed; • Period End Date remains at the 60th day • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode 	<ul style="list-style-type: none"> • episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Claim (discharge with goals met prior to Day 60)	<ul style="list-style-type: none"> • Episode record completed • Period End Date remains at the 60th day; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode 	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Claim (transfer)	<ul style="list-style-type: none"> • Episode record completed • Period End Date reflects claim “Through” date; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode 	<ul style="list-style-type: none"> • A RAP or No-RAP LUPA claim will be accepted if the “from” date is on or after episode “through” date
No-RAP LUPA Claim	<ul style="list-style-type: none"> • Opens an episode record using claim’s “from” date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode 	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • Other No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim
Claim Adjustment	<ul style="list-style-type: none"> • No impact on the episode unless adjustment changes patient status to transfer or service lines are added or removed to change the DOEBA or DOLBA date. 	<ul style="list-style-type: none"> • No impact
Claim Cancellation	<ul style="list-style-type: none"> • The episode is deleted from 	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
by Provider or Contractor	CWF	submission by another provider, making that provider the primary HHA for the dates of the episode
Claim Cancellation by System	<ul style="list-style-type: none"> The episode record remains open on CWF 	<ul style="list-style-type: none"> Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

40 - Completion of Form CMS-1450 for Home Health Agency Billing
(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

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 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. This section provides detailed information 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.)

40.1 - Request for Anticipated Payment (RAP)
(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The following data elements are required to submit a request for anticipated payment under HH PPS. 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 using the coding described below.

Each RAP must report a payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim 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 HHA's 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 HHA's 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).

1st 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 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 or provider-submitted final claims to process as adjustments against original RAPs. Provider may not submit adjustments (frequency code ‘7’) to 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.

Point of Origin for Admission or Visit

Required - Indicates the patient’s point of origin for the admission.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code.

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 the RAP is for an episode in which the patient has transferred from another HHA, the HHA enters condition code 47.

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.

Occurrence Codes and Dates

Conditional – The HHA enters any NUBC approved code to describe occurrences that apply to the RAP. Occurrence code values are two alphanumeric digits, and the corresponding 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.

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.

Conditional - Any NUBC approved Value code to describe other values that apply to the RAP. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single HIPPS code 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 if they choose, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023

revenue code. 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

Required – Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the RAP. 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 enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for 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 dates in positions 3-4 and 7-8 are converted 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. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

This is 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 date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	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 contractor 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-CM code and principle diagnosis reported on the claim must match the primary diagnosis code reported on the OASIS form item M1020 (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-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (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-CM 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-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 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. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

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. Home health services under a plan of care are 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.

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).

1st 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 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

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 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.

Point of Origin for Admission or Visit

Required - The HHA enters the same point of origin 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 and the CMS certification number (CCN) also changes, the service dates on the claims must fall within the effective dates of the terminating CCN. To ensure this, RAPs for all episodes with “from” dates before the termination date of the CCN 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 CCN, 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

Conditional – The HHA enters any NUBC approved code to describe conditions that apply to the claim.

If the RAP is for an episode in which the patient has transferred from another HHA, the HHA enters condition code 47.

HHAs that are adjusting previously paid claims enter one of the condition codes representing Claim Change Reasons (code values D0 through E0). 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. HHAs use D9 if multiple changes are necessary.

When submitting a HH PPS claim as a demand bill, HHAs use condition code 20. See §50 for more detailed instructions regarding demand billing.

When submitting a HH PPS claim for a denial notice, HHAs use condition code 21. See §60 for more detailed instructions regarding no-payment billing.

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.

Occurrence Codes and Dates

Conditional - The HHA enters any NUBC approved code to describe occurrences that apply to the claim.

Occurrence Span Code and Dates

Conditional - 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.

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 the Medicare contractor’s online claim 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 §1812 (a)(3) of the Social Security Act.

Code	Title	Definition
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.
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 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

HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. The fifth position of the code

represents the non-routine supply (NRS) severity level. This fifth position may differ to allow the HHA to change a code that represents that supplies were provided to a code that represents that supplies were not provided, or vice versa. However, the fifth position may only change between the two values that represent the same NRS severity level. Section 10.1.9 of this chapter contains the pairs of corresponding values. If these criteria are not met, Medicare claims processing systems will return the claim.

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	<p>Medical/Surgical Supplies (Also see 062X, an extension of 027X)</p> <p>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.</p> <p>Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount.</p> <p>NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills</p>
042X	<p>Physical Therapy</p> <p>Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
043X	<p>Occupational Therapy</p> <p>Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

044X	Speech-Language Pathology Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, 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 Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, 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 Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, 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) Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: Contractors 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. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20.

0274	Prosthetic/Orthotic Devices Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.
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029X	<p>Durable Medical Equipment (DME) (Other Than Renal)</p> <p>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.</p> <p>Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.</p>
060X	<p>Oxygen (Home Health)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.</p>

Revenue Code for Optional Reporting of Wound Care Supplies

0623	<p>Medical/Surgical Supplies - Extension of 027X</p> <p>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.</p>
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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.

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

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

The HH PPS includes a separate case-mix adjustment for non-routine supplies. Non-routine supply severity levels are 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 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 0023 revenue code line, the HHA must report the HIPPS code that was reported on the RAP. The first four positions of the code must be identical to the value reported on the RAP. The fifth position may vary from the letter value reported on the RAP to the corresponding number which represents the same non-routine supply severity level but which reports that non-routine supplies were not provided.

HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code.

To report HH visits on episodes beginning before January 1, 2011, the HHA reports a single HCPCS code to represent each HH care discipline. These codes are:

G0151 Services of physical therapist in home health or hospice setting, each 15 minutes.

G0152 Services of an occupational therapist in home health or hospice setting, each 15 minutes.

G0153 Services of a speech language pathologist in home health or hospice setting, each 15 minutes.

G0154 Services of skilled nurse in the home health or hospice settings, each 15 minutes.

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports one of the following HCPCS code to represent each HH care discipline:

Physical Therapy (revenue code 042x)

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.

G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.

G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

Occupational Therapy (revenue code 043x)

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.

G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.

G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Skilled Nursing (revenue code 055x)

G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

G0163 Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Medical Social Services (revenue code 056x)

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (revenue code 057x)

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding all skilled nursing and skilled therapy visits

In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, we would expect the HHA to report the G-code which reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code which reflects the service for which most of the time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

Service Date

Required - On the 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code. 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 under Revenue Codes. 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 - Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the claim. 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 under Revenue Codes. 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 enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

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

7-8	M0090 (Date assessment completed) – alpha code for 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 dates in positions 3-4 and 7-8 are converted 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. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

This is 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 date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	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 a placeholder value as defined in section 60.

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.

The claims-OASIS matching key on the claim will match that submitted on the RAP.

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-CM code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

The principal diagnosis code on the claim will match that submitted on the RAP.

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-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (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-CM 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-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 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.

40.3 - HH PPS Claims When No RAP is Submitted - "No-RAP" LUPAs (Rev. 1, 10-01-03) HH-475.3, A3-3638.25

A RAP and a claim must be submitted for all episodes for which Medicare makes payment based on HIPPS codes. However, if the HHA is aware prior to billing Medicare that it will supply four or fewer visits in the episode, it may submit only a claim. In these cases, the claim is called a "No-RAP LUPA," since the HHA is aware the claim will be paid a LUPA payment adjustment based on national standard visit rates. HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in a recoupment of funds for the episode since the payment for a RAP will exceed payment for four or fewer visits. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim causes the creation of an episode record in CWF and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk of not being established as the primary HHA for that period.

If the agency chooses to submit this “No-RAP LUPA” claim, the claim form should be coded like other claims as described in §40.2.

40.4 - Collection of Deductible and Coinsurance from Patient
(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The following table is a summary of deductible and coinsurance by bill type:

Bill Type	Rule
Patient Under Home Health Part A or Part B Plan of Care (Bill Type 32X) (May be processed as TOB 33X)	No deductible applicable; and No coinsurance applicable Exception: Coinsurance applies on DME and orthotic/prosthetic claims.
Patient Not Under Plan of Care, Part B Medical and Other Health Services and Osteoporosis Injections (Bill Type 34X)	Deductible applies; and Coinsurance applies Exception: Deductible and coinsurance may be waived for certain preventive services (see Chapter 18)

There is usually no requirement for Part B deductible or coinsurance under a home health plan of care. An exception to this rule applies to osteoporosis injections where a Part B deductible and coinsurance must be collected, even if the drug is provided under a plan of care.

Where deductible and coinsurance apply for Part B medical and other health services **not** covered under a plan of care, the HHA collects the amount of any unmet deductible from the patient. To determine this amount the HHA interviews the patient. If the patient is unable to conduct their own affairs, the HHA interviews a member of the patient’s family or other acceptable representative.

Another exception is the services paid under the DMEPOS fee schedule.

The following rules apply to payment and patient liability for DME and prosthetics and orthotics when furnished by an HHA not under PPS.

According to Federal regulations found in 42 CFR 410.2, a nominal charge provider means a provider that furnishes services free of charge or at a nominal charge, and is either a public provider or another provider that (1) demonstrates to CMS’ satisfaction that a significant portion of its patients are low-income; and (2) requests that payment for its services be determined accordingly.

40.5 - Billing for Nonvisit Charges

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Under HH PPS all services under a plan of care must be billed as an HH PPS episode. All services within an episode of care must be billed on one claim for the entire episode. Medicare contractors do not accept bill types 329 and 339 without any visit charges.

Non-visit charges incurred after termination of the plan of care are payable under Part B medical and other health services on TOB 34X.

50 - Beneficiary-Driven Demand Billing Under HH PPS

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in a Home Health Advance Beneficiary Notice (HHABN), which also must be signed by the beneficiary or appropriate representative. Instructions for the HHABN are found in Chapter 30 of this manual, §60.

Beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the “demand bill” are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA’s judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the *Medicare contractor* determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is an episode of care, usually 60 days in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care, and (2) at least one service must have been provided to the beneficiary, so that a request for anticipated payment (RAP) can be sent to Medicare and create a record of an episode in Medicare claims processing systems. Therefore, demand billing under HH PPS must conform to ALL of the following criteria:

- Situations in which disputed services are called for under a plan of care, but the HHA believes the services do not meet Medicare criteria for coverage;
- Claims sent to Medicare with TOB 32X and 33X; and

- Episodes on record in Medicare claims processing systems (at least one service in episode).

A - Interval of Billing

Under HH PPS, the interval of billing is standard. At most, a RAP and a claim are billed for each episode. Providers may submit a RAP after the delivery of the first service in the 60-day episode, and they must submit a claim either after discharge or after the end of the 60-day episode. This does not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

B - Timeliness of Billing

The CMS requests that HHAs submit demand bills promptly. Timely filing requirements were not changed by HH PPS (see Chapter 1 for information on timely filing). CMS has defined “promptly” for HH PPS to mean submission at the end of the episode in question. The beneficiary must also be given either a copy of the claim or a written statement of the date the claim was submitted. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments are automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §40.3.

C - Claim Requirements

Original HH PPS claims are submitted with TOB 329 in form locator (FL) 4, and provide all other information required on that claim for the HH PPS episode, including all visit-specific detail for the entire episode (the HHA must NOT use 3X0). When such claims also serve as demand bills, the following information must **also** be provided: condition code “20” in FL 24-30; and the services in dispute shown as noncovered (FL 48) line items. Demand Bills may be submitted with all noncovered charges. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 327, may also be submitted but must have been preceded by the submission of a 329 claim for the same episode. RAPs are not submitted as demand bills, but must be submitted for any episode for which a demand bill will be submitted. Such RAPs should not use condition code 20, only the claim of the episode uses this code.

Cases may arise in which the services in dispute are visits for which an HHA has physician’s orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of these visits that is not covered by Medicare may be covered by another payer (e.g., an 8 hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as a single line item, representing the portion potentially covered by Medicare with a covered charge amount and the portion to be submitted for consideration by other insurance with a noncovered

charge amount on the same line. Units reported on this line item should represent the entire elapsed time of the visit (the sum of the covered and noncovered portions), represented in 15 minute increments.

D - Favorable Determinations and Medicare Payment

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will change only with the addition of covered visits if one or more of the following conditions apply:

- An increase in the number of therapy visits results in meeting the therapy threshold for an episode in which the therapy threshold was not previously met - in such cases, the payment group of the episode would be changed by the *contractor* in medical review;
- An increase in the number of overall visits that either:
 1. Changes payment from a low-utilization payment adjustment to a full episode; or
 2. Results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode).
- A favorable ruling on a demand bill adds days to:
 3. An episode that received a partial episode payment (PEP) adjustment, or
 4. A period within an episode that received a significant change in condition (SCIC) adjustment.

If a favorable determination is made, *contractors* will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

E - Appeals

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims. HH PPS RAPs do not have appeal rights; rather, appeals rights are tied to the claims that represent all services delivered for the entire episode unit of payment.

F – Specific Demand Billing Scenarios

1. Independent Assessment. Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all such cases, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. HHABNs can be used for this purpose.

2. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, an HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and an HHABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an HHABN. Billing services in excess of the benefit is discussed in C in this section.

3. One-Visit Episodes. Since intermittent skilled nursing care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient

status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, an HHA should still give the beneficiary an HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in Chapter 1 of this manual, Section 60. Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in 1. immediately above.

60 - No Payment Billing

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

No-Payment Billing and Receipt of Denial Notices Under HH PPS

Claims for homebound Medicare beneficiaries under a physician plan of care and electing fee-for-service coverage are reimbursed under HH PPS. Under HH PPS, home health agencies may continue to seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

A - Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 3x0, and condition code 21. The statement dates on the claim should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also key in the charge for each line item on the claim as a non-covered charge.

In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (1AFK1) as a proxy and the following placeholder value for the OASIS Matching Key, "11AA11AA11AAAAAAAAA.":

The claim must meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be

used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems also ensure that a matching RAP has not been paid for that billing period.

B - Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on the claim are non-covered.

C - Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period

In certain cases, CMS allows the use of no payment claims in association with an HHABN involving custodial care and termination of a benefit during an episode period. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there an HHABN must be used assuming a triggering event occurs (i.e., the initiation of completely noncovered care). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a previous episode period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The HHABN for notification of the beneficiary, using Option Box 1 language, with the beneficiary selecting the third checkbox indicating both services and billing is desired, and then also the following checkbox for Medicare billing on that notice, and,
2. A condition code 21 no-payment claim to bill all subsequent services.

NOTE: Providers can never pre-select HHABN options for beneficiaries, in accordance with existing liability notice policy. In each case, the beneficiary must be consulted as to the option they want to select. The HHABN options presented relative to specific billing scenarios above, and in the rest of the document, are only illustrations and in no way authorization for pre-empting a beneficiary's right to choose a specific option.

70 – HH PPS Pricer Program (Rev. 1, 10-01-03) HH-475.4

70.1 - General

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Home health services billed on TOB 32X or 33X *are* reimbursed based on calculations made by the HH Pricer. The HH Pricer *is* a module within CMS' claims processing systems. The HH Pricer makes all payment calculations applicable under HH PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, therapy threshold adjustments, and outlier payments.

Medicare claims processing systems must send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the shared systems. The following *sections describe* the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make payment determinations. No part of the Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare. The following is presented for Medicare contractors and as information for the HHAs, in order to help HHAs understand their HH PPS payments and how they are determined.

70.2 - Input/Output Record Layout

(Rev. 2209; Issued: 05-06-11; Effective Date: 01-01-10; Implementation Date: October 3, 2011, for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements; and January 3, 2012, for Business Requirements for 7395.4, 7395.6, and their associated sub-requirements.)

The HH Pricer input/output file is 500 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 if it is sent to the HH Pricer in the future.
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 <i>CMS certification</i> number, copied from the claim form.
29-31	X(3)	TOB	Input item: The <i>type of bill</i> 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

File Position	Format	Title	Description
			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.
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: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-46	X(9)	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

File Position	Format	Title	Description
			placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code <i>unless the claim is recoded due to therapy thresholds or changes in episode sequence.</i>
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	<i>Fields for</i> five more occurrences of all HRG/HIPPS code related fields defined above. <i>Not used.</i>
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 LUPA. Otherwise, the dollar amounts used by the Pricer

File Position	Format	Title	Description
			to impute the costs of the claim for purposes of calculating an outlier payment, if any.
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
			02 <i>Final payment where outlier applies, but is not payable due to limitation.</i>
			03 Initial percentage payment, 0%
			04 Initial percentage payment, 50%
			05 Initial percentage payment, 60%
			06 LUPA payment only
			07 <i>Not used.</i>
			08 <i>Not used.</i>
			09 Final payment, PEP
			11 Final payment, PEP with outlier
			12 <i>Not used.</i>
			13 <i>Not used.</i>
			14 LUPA payment, 1 st episode add-on payment applies
			Error return codes:
			10 Invalid TOB
			15 Invalid PEP days
			16 Invalid HRG days, greater than 60
			20 PEP indicator invalid
			25 Med review indicator invalid
			30 Invalid MSA/CBSA code
			35 Invalid Initial Payment Indicator
			40 Dates before 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

File Position	Format	Title	Description
			with revenue codes 042x, 043x, and 044x.
408-412	9(5)	REVENUE - SUM 1-6- QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a 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: Medicare systems set this indicator to 'B' when condition code 47 is present on the RAP or claim. The indicator is set to '1' in all other cases.
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: 0 = default value 1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 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: 1 = early episode 2 = late episode

File Position	Format	Title	Description
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 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

File Position	Format	Title	Description
			patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
447-456	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA during the current calendar year.
457 - 467	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA during the current calendar year.
468-500	X(33)	FILLER	

Input records on RAPs will include all input items except for “REVENUE” 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 the HIPPS code will be placed in the total charges and the covered charges field of the 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. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

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 contractor 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 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 as follows.

- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru D	0-4	C1 (Min)	A
E thru H	5-8	C2 (Low)	B
I +	9+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru E	0-5	F1 (Min)	F
F	6	F2 (Low)	G
G +	7+	F3 (Mod)	H

- change the 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th position value
0-5	K
6	L
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 as follows:

- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru F	0-6	C1 (Min)	A
G thru N	7-14	C2 (Low)	B
O+	15+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	F3 (Mod)	H

- change the 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY- THR value	Resulting HRG - OUTPUT – CODE 4 th position value
14-15	K
16-17	L
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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru B	0-2	C1 (Min)	A
C thru E	3-5	C2 (Low)	B
F+	6+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru H	0-8	F1 (Min)	F
I	9	F2 (Low)	G
J +	10+	F3 (Mod)	H

- change the 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY- THR value	Resulting HRG - OUTPUT – CODE 4 th position value
0-5	K
6	L
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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru H	0-8	C1 (Min)	A
I thru P	9-16	C2 (Low)	B
Q+	17+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru G	0-7	F1 (Min)	F
H	8	F2 (Low)	G
I +	9+	F3 (Mod)	H

- change the 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY- THR value	Resulting HRG - OUTPUT – CODE 4 th position value
14-15	K
16-17	L
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 than 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 4 th position value	REVENUE - SUM 1-3- QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		

11-13	P		
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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 20 or more:

- change the first position of the HIPPS code to 5
- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	F3 (Mod)	H

- change the 4th position of the HIPPS code to K.

If the HIPPS code begins with 3 or 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5
- recode the 2nd position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 nd position value
A thru G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	C3 (Mod)	C

- recode the 3rd position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	F3 (Mod)	H

- change the 4th position of the HIPPS code to K.

3. HRG payment calculations.

- 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 determined in step c is greater than \$0.00, calculate .80 times the result. This is the outlier payment amount.
- e. Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:
 - i. Multiply the amount in the “PROV-PAYMENT-TOTAL” field by 10% to determine the HHA’s outlier limitation amount.
 - ii. Deduct the amount in the “PROV-OUTLIER-PAY-TOTAL” from the outlier limitation amount. This result is the available outlier pool for the HHA.
 - iii. If the available outlier pool is greater than or equal to the outlier payment amount calculated in step d, return the outlier payment 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.
 - iv. If the available outlier pool is less than the outlier payment amount calculated in step d, return no payment amount in the “OUTLIER-PAYMENT” field. Assign return code 02 to this record.
- f. If the result determined in step c 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.

70.5 - Annual Updates to the HH Pricer

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the Federal Register:

- The Federal standard episode amount;
- The Federal conversion factor for non-routine supplies;
- The fixed loss amount to be used for outlier calculations;

- A table of case-mix weights to be used for each HRG;
- A table of supply weights to be used to adjust the non-routine supply conversion factor;
- A table of national standardized per visit rates;
- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and nonlabor percentages.
- Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and contractors about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the HH Pricer.

80 - Special Billing Situations Involving OASIS Assessments

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

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 *Payment Source*

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, a 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 (*OBQI/OBQM/PBQM*) reports. Otherwise, that patient will not be included in the HHA's *quality measure* 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 *M2420* (Discharge Disposition) should be marked with Response 2 (Patient remained in the community (*with formal assistive services*)). CMS realizes that the wording for M0100 and *M2420* 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 (*M2200*). 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, *2011*, 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, *2011* 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, *2011*. 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, *2011*, 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.

3. Payment Source Changes Involving Medicaid

There may be cases where a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicaid and the patient experiences a change in status that allows their home health services to meet coverage criteria for Medicare FFS. In these cases, 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, a RAP may be sent to Medicare to open an HH PPS episode. The OASIS guidance provided above for changes from Medicare Advantage to Medicare FFS apply in this case also.

If a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicare FFS and ceases to meet Medicare coverage criteria, the patient should be discharged for Medicare purposes. Patient status code "06" should not be used. This discharge has no payment impact on the Medicare HH PPS episode. If the patient being discharged to Medicaid-only coverage 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 *Statement Covers Period "From" and "Through" dates* that reflect 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 61 and 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, the *two home health episodes* would be considered continuous. The RAP for the episode beginning after the hospital discharge would be submitted with *Statement Covers Period "From" and "Through" dates reflecting* 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 61 and 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, *two home health episodes* 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 *Statement*

Covers Period “From” and “Through” dates reflecting 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.

Even though the OASIS assessment on which payment is based is not transmitted to the State, the RAP and claim must include a treatment authorization code. 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.

In all other respects, the RAP and claim for the episode should be identical to other HH PPS RAPs and claims.

90 - Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

HHAs may submit claims for certain Part B medical and other health services for which the HHA may receive payment outside of the prospective payment system (See the Medicare Benefit Policy Manual, chapter 7).

A Patient Not Under A Home Health Plan Of Care

The HHA submits claims with type of bill (TOB) 34X to bill for certain Part B “medical and other health services” when there is no home health plan of care. Specifically the HHA may bill using TOB 34X for the following services. (There must be a physician’s certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Rental or purchase of DME. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Prosthetic devices. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.
- Outpatient physical therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient speech-language pathology services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Diabetes Outpatient Self-Management Training (DSMT). (See the Medicare Benefit Policy Manual, chapter 15, section 300.5.1)
- Bone Mass Measurements. (See the Medicare Claims Processing Manual, chapter 13, section 140.)
- Smoking and Tobacco-Use Cessation Counseling Services. (See the Medicare Claims Processing Manual, chapter 32, section 12.)

Bills for services not under a home health plan of care should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g., monthly, without regard to an episode of care. These items are not reimbursed under HH PPS.

B The Patient is Under a Home Health Plan of Care

If a patient is receiving home health services under a plan of care, the agency may bill for the following services on TOB 34X. All other services are home health services and should be billed as an HH PPS episode with Bill Type 32X.

- A covered osteoporosis drug, and
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines.

DME, orthotic, and prosthetics can be billed as a home health service or as a medical and other health service on bill types 32X, 33X, and 34X as appropriate. Alternately, these services may be provided to HH beneficiaries by a supplier. Refer to instructions in chapter 20 of this manual for submitting claims under arrangement with suppliers.

C Billing Spanning Two Calendar Years

The agency should not submit a Part B medical and other health services bill (bill type 34X only) for an inclusive period beginning in 1 calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits the contractor to apply the appropriate deductible for both years. HH PPS claims (TOB 32X or 33X) may span the calendar year since they represent 60-day episodes, and episodes should be paid based on the payment rates in effect in the calendar year in which they end.

D Billing For Laboratory Services

HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not report laboratory services, even when on the HH plan of care, to a Medicare contractor using an institutional claim format. These services are always billed to Medicare contractors using a professional claim format. To submit such claims, the HHA must have a CLIA number and a professional billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate contractor to obtain a billing number. The survey process is used to validate that laboratory services in an HHA facility are being provided in accordance with the CLIA certificate.

90.1 - Osteoporosis Injections as HHA Benefit

(Rev. 1773; Issued: 07-24-09; Effective Date: 01-01-2010; Implementation Date: 01-04-2010)

A - Billing Requirements

The administration of the drug is included in the charge for the skilled nursing visit billed under bill type 32X or 33X, as appropriate. The cost of the drug is billed under bill type 34X, using revenue code 0636. Drugs that have the ingredient calcitonin are billed using HCPCS code J0630. Drugs that have the ingredient teriparatide may be billed using HCPCS code J3110, if all existing guidelines for coverage under the home health benefit are met. All other osteoporosis drugs that are FDA approved and are awaiting an HCPCS code must use the miscellaneous code of J3490 until a specific HCPCS code is approved for use.

HCPCS code J0630 is defined as up to 400 units. Therefore, the provider must calculate units for the bill as follows:

Units Furnished During Billing Period	Units of Service Entry on Bill
100-400	1
401-800	2
801-1200	3
1201-1600	4
1601-2000	5
2001-2400	6

HCPCS code J3110 is defined as 10 mcg. Providers should report 1 unit for each 10 mcg dose provided during the billing period.

These codes are paid on a reasonable cost basis, using the provider's submitted charges to make initial payments, which are subject to annual cost settlement.

Coverage requirements for osteoporosis drugs are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 50.4.3. Coverage requirements for the home health benefit in general are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.

B - Denial Messages

If the claim for an osteoporosis drug is denied because it was not an injectable drug approved by the FDA, the Medicare contractor shall use the appropriate message below on the MSN:

- MSN Message 6.2: "Drugs not specifically classified as effective by the Food and Drug Administration are not covered."

If the claim for an osteoporosis injection is denied because the patient did not meet the requirements for coverage, the Medicare contractor shall use:

- MSN message 6.5, which reads, "Medicare cannot pay for this injection because one or more requirements for coverage were not met."

C - Edits

Medicare system edits require that the date of service on a 34X claim for covered osteoporosis drugs falls within the start and end dates of an existing home health PPS episode. Once the system ensures the service dates on the 34X claim fall within an HH PPS episode that is open for the beneficiary on CWF, CWF edits to assure that the provider number on the 34X claim matches the provider number on the episode file. This is to reflect that although the osteoporosis drug is paid separately from the HH PPS episode rate it is included in consolidated billing requirements (see §10.1.25 regarding consolidated billing).

Claims are also edited to assure that the claim is an HH claim (type of bill 34X), the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present.

90.2 - Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines (Rev. 1, 10-01-03)

Procedures for billing for pneumococcal pneumonia, influenza virus, and Hepatitis B Vaccines is covered in Chapter 18.

100 - Temporary Suspension of Home Health Services (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

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.

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.

110 – Billing and Payment Procedures Regarding Ownership and Provider Numbers

(Rev. 17, 10-31-03)

110.1 - Billing Procedures for an Agency Being Assigned Multiple Provider Numbers or a Change in Provider Number

(Rev. 17, 10-31-03)

Where a multiple-facility is being assigned separate provider numbers for each component facility or when an agency is assigned a different number, HHAs are required to use the new number for any bill, beginning with the date the new number is effective.

The old provider number is used on claims for services through the day of the termination for the old number. Claims for all Medicare beneficiaries in open HH PPS episodes of care must be closed with discharge claims as of this date. These claims will be paid partial episode payment (PEP) adjustments. For services rendered on and after the effective date of the new provider number, use the new number when submitting bills or other information. A new request for anticipated payment (RAP) must be submitted for each Medicare beneficiary on service under the new number. These RAPs must be dated on or after the effective date of the new number. If there is a gap of days between the termination date of the old number and the effective date of the new number, Medicare payments cannot be made for dates of service in the gap period.

In cases in which the ownership of the agency changes, but the Medicare provider number does not change (new owner accepts the assignment of the existing number), billing for HH PPS episodes is not affected by the change of ownership.

110.2 - Payment Procedures for Terminated HHAs

(Rev. 17, 10-31-03)

Medicare regulations allow that payment may be made for home health services for up to thirty days after a home health agency (HHA) terminates their Medicare provider agreement. This payment may be made if the home health services are furnished under a home health plan of care established before the effective date of the termination.

Under HH PPS, Medicare continues to make full episode payments for episodes which extend beyond a provider's termination date if the home health services are provided under a plan of care established prior to that date and if the home health episode of care ends within the 30 day period. In cases where such an episode begins prior to a provider's termination date and the episode ends after the 30 day allowance period, the portion of these episodes that falls within the 30-day allowance period receives Medicare payment. The payment mechanism under HH PPS for paying for shortened periods of services is the partial episode payment (PEP) adjustment. Medicare systems will make PEP payments for HH PPS episodes which begin prior to a provider's termination date and which end after the 30 day allowance period.

120 - Payments to Home Health Agencies That Do Not Submit Required Quality Data

(Rev. 2249, Issued: 07-01-11, Effective: 10-03-11, Implementation: 10-03-11)

In calendar year 2007 and each subsequent year, if a home health agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points. *From* calendar year 2007 *through calendar year 2011*, CMS considered OASIS data submitted by HHAs to CMS for episodes beginning on or after July 1 of the previous year, and before July 1, of the current year as meeting the reporting requirement. CMS will continue to use that timeframe *for OASIS data reporting* for future years. *Beginning with calendar year 2012, CMS also requires HHAs to submit Home Health Care Consumer Assessment of Health Providers and Systems (HHCAPHS) data to meet the reporting requirement.*

For calendar year 2012 payments, CMS required HHAs to participate in an HHCAPHS dry run in third quarter 2010, and continue monthly data collection and submission beginning in October 2010, through March 2011. If agencies had less than 60 patients between April 1, 2009, and March 31, 2010, then they were exempt from HHCAPHS participation for CY 2012. These HHAs were to complete an HHCAPHS Participation Exemption Request form for CY 2012 on the HHCAPHS Website, <https://homehealthcahps.org>.

For payments in calendar year 2013 and after, HHAs need to participate in monthly data collection and submission from April 1 of the prior year through March 31 of the current year. If agencies had less than 60 patients between April 1 and March 31 of any year and complete a Participation Exemption Request form, then they are exempt from HHCAPHS participation for the following year.

Each fall, Medicare contractors with home health workloads will receive a technical direction letter (TDL) which provides a list of HHAs that have not submitted the *required* OASIS *and/or HHCAPHS* data during the established *timeframes*. These Medicare contractors shall review their paid claims history for claims which have:

- a provider number on the list,
- dates of service from July 1 of the previous year through June 30 of the current year AND
- a beneficiary who is over 18 years of age.

Contractors shall exclude any billings for denial (claims with condition code 21).

If the contractor finds any such claims, the contractor shall notify the HHAs that they have been identified as not being in compliance with the requirement of submitting quality data and are scheduled to have Medicare payments to their agency reduced by

2%. Medicare contractors shall include the model language at the end of this section in their notification letter to the HHA. *The notification letter shall inform the HHA whether they were identified as not being in compliance with the OASIS data requirement, the HHCAHPS data requirement, or both.* Contractors shall send notification letters no later than 10 business days from the receipt of the TDL.

Immediately after the notification letters are issued, Medicare contractors shall submit to the CMS contacts noted in the TDL a list of agencies who received a letter. Medicare contractors shall allow home health agencies who wish to dispute their payment reduction a 30 day period from the date of the notification letter to submit a letter requesting reconsideration and documentation to support a finding of compliance.

Using the model language at the end of this section, contractors shall inform HHAs *about* documentation to support a finding of compliance.

For payments in calendar year 2011 and after, documentation of OASIS compliance may include any of the following:

- evidence of OASIS transmissions during the reporting period (e.g. an OASIS Final Validation Report from the State system showing a timely submission date);
- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA did not receive their CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g. a notification letter from the survey and certification staff at the CMS RO dated after June 30);
- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that they received their CCN too late in the reporting year for the provider to receive their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and submit data (e.g. during the last week of June); or
- for providers who received their initial survey in the period between January 1 and April 30 of the reporting year, evidence that the HHA received their CCN in the last weeks of the reporting year (e.g. in June), took prompt action to request their permanent OASIS transmitter ID from their State OASIS Automation Coordinator and were delayed by CMS or its agents.

For payments in calendar year 2012 and after, documentation of HHCAHPS compliance may include any of the following:

- *For calendar year 2012 only, evidence that the HHA participated in an HHCAHPS dry run for at least 1 month in third quarter 2010 (July, August, September 2010) and submitted the HHCAHPS dry run data to the Home Health CAHPS Data Center by 11:59 pm EST on January 21, 2011;*

- *Evidence that the HHA continuously collected data and submitted data to the Home Health CAHPS Data Center during the required timeframe. For calendar year 2012, the required period of data collection includes the dry run data in the third quarter 2010, the fourth quarter 2010 (all the months of October, November and December 2010), and the first quarter 2011 (all the months of January, February, and March 2011). For calendar year 2013 and after, the required period of data collection includes all months from April 1 of the prior year through March 31 of the current year; or*
- *For HHAs with less than 60 HHCAHPS eligible patients in the year prior to the current reporting year, evidence that the HHA filed the Participation Exemption Request Form, on the form that is on www.homehealthcahps.org, by the deadline date specified in that year's Home Health Prospective Payment System Final Rule.*

The contractor shall inform HHAs that documentation of the following does not support a finding of compliance:

- evidence or admission of error on the part of HHA staff, even if the involved staff members are no longer employed by the HHA and/or a corrective action plan has been or will be put in place after the end of the reporting year;
- evidence or assertion that failure to comply was the fault of a vendor or contractor that was hired by the HHA to perform reporting functions;
- evidence of delays establishing electronic data interchange connectivity between the HHA and the Medicare claims processing contractor for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from the Medicare claims processing contractor; *and*
- in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.

If the contractor receives a reconsideration request and documentation from the HHA within the allowed timeframe, the documentation should be forwarded to the CMS contacts noted in the TDL as soon as possible and no later than 2 business days from receipt. The documentation shall be forwarded in an electronic format (e.g. scanned copies of the documents) via e-mail. CMS will review the documentation and provide a determination to the Medicare contractor within 75 calendar days of the receipt of the TDL.

The following example illustrates the timeframes for the complete process using hypothetical dates:

- 1) CMS issues the TDL providing the list of HHAs on Friday, September 17;
- 2) Contractors must issue notification letters to HHAs by the 10th business day after receipt of the TDL, on October 1;
- 3) The timely reconsideration period ends 30 calendar days later, no later than October 31;
- 4) CMS provides determinations to contractors within 75 days of September 17, no later than December 1.

In its review of the HHA's documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the HHA. The determination will be made based solely on the documentation provided. CMS will not contact the HHA to request additional information or to clarify incomplete or inconclusive information. If clear evidence to support a finding of compliance is not present, the 2% reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

If the CMS determination upholds the 2% reduction, CMS shall provide the Medicare contractor with a statement of the findings that support the decision. The contractor shall notify the HHA in writing and inform them of their right to further appeal the 2% reduction via the Provider Reimbursement Review Board (PRRB) appeals process. Medicare contractors shall include the model language at the end of this section in their dispute determination letter to the HHA. Contractors shall insert the CMS-provided statement of findings in the blank provided in the model language. Contractors shall send this second letter only to HHAs that requested a reconsideration.

If the HHA does not dispute their reduction, the Medicare contractor shall update their provider file for the HHA. The contractor shall set an indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all claims for the upcoming calendar year. If the CMS determination upholds the 2% reduction, the contractor shall update their provider file in this fashion also.

If the CMS determination reverses the 2% reduction, the contractor shall not update their provider file for the HHA and shall notify the HHA that they will receive their full HH PPS payment update for the upcoming year.

Model language for initial notification letters:

“This letter is to officially inform you that CMS has determined your home health agency (HHA) is subject to a reduction in payment for not meeting the Deficit Reduction Act (DRA) of 2005 requirement for HHAs to submit quality data. Therefore, Medicare payments to your agency will be reduced by 2% for [insert upcoming year], unless you can provide evidence that this determination is in error. Currently, the quality data reporting requirement consists of timely submission of Outcomes and Assessment

Information Set (OASIS) data as required by your conditions of participation (CoPs), *and timely submission of Home Health Care Consumer Assessment of Health Providers and Systems (HHCAPHS) data.*

In order to meet the CoPs, OASIS data is required to be transmitted within 30 days of the assessment date. OASIS data submitted within 30 days of the assessment date is considered to have met the requirement of submitting the required quality data. The reporting year for [insert upcoming year] was the period between July 1, [insert previous year] and June 30, [insert current year]. Under the CoPs, assessments in June [insert current year] would meet the requirement if submitted by July 31, [insert current year]. New HHAs, defined as agencies with participation dates in the Medicare program on or after May 1, [insert current year], are excluded from this requirement.

[For letters in calendar year 2012 only:]

In order to meet the HHCAPHS requirement, HHAs needed to participate in an HHCAPHS dry run in third quarter 2010, and continue monthly data collection and submission of data to the Home Health CAHPS Data Center beginning in October 2010, through March 2011. If agencies had less than 60 patients between April, 1, 2009, and March 31, 2010, then they were exempt from HHCAPHS participation for CY 2012. These HHAs were to complete an HHCAPHS Participation Exemption Request form for CY 2012 on the HHCAPHS Website, <https://homehealthcahps.org>.

[For letters in calendar years 2013 and after:]

In order to meet the HHCAPHS requirement, HHAs must collect monthly HHCAPHS data collection and submit data to the Home Health CAHPS Data Center from April 1, [insert the prior year] through March 31, [insert the current year]. If agencies had less than 60 patients between April 1, [insert the year 2 years prior] and March 31, [insert the prior year], then they are exempt from HHCAPHS participation for [insert current year]. These HHAs were to complete an HHCAPHS Participation Exemption Request form on the HHCAPHS Website, <https://homehealthcahps.org>.

CMS review of OASIS *and HHCAPHS* submissions for this period found that your agency is not *excluded or exempt from the reporting requirements* and *[insert whether the HHA was non-compliant with OASIS, HHCAPHS or both]*. [Insert Medicare contractor name]'s review of our paid claims history has shown that you have received Medicare payment for claims with dates of service within the reporting year. Consequently, for episodes that end on or after January 1, [insert upcoming year] and prior to January 1, [insert following year], payments to your agency will be reduced by 2%. The national 60-day episode payment amount and the national standardized per-visit amounts used to calculate low utilization payment adjustments (LUPAs) and outlier payments for providers that did not submit quality data, are listed in separately labeled tables in the recent HH PPS payment update final regulation for [insert upcoming year].

If you believe you have been in compliance with the quality data reporting requirement and have been identified for this payment reduction in error, you must submit a letter requesting reconsideration and provide documentation demonstrating your compliance.

Documentation to support a finding of compliance *with OASIS reporting* may include any of the following:

- evidence of OASIS transmissions during the reporting period (e.g. an OASIS Final Validation Report from the State system showing a timely submission date);
- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA did not receive your CMS Certification Number (CCN) from Medicare until after the close of the reporting year (e.g. a notification letter from the survey and certification staff at the CMS RO dated after June 30);
- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN too late in the reporting year to request and receive your permanent OASIS transmitter ID and submit data (e.g. during the last week of June); or
- if your HHA received your initial survey in the period between January 1 and April 30 of the reporting year, evidence that your HHA received your CCN in the last weeks of the reporting year (e.g. in June), took prompt action to request your permanent OASIS transmitter ID and were delayed by CMS or its agents.

Documentation to support a finding of compliance with HHCAHPS reporting may include any of the following:

- *[For letters in calendar year 2012 only:] Evidence that the HHA participated in an HHCAHPS dry run for at least 1 month in third quarter 2010 (July, August, September 2010) and submitted the HHCAHPS dry run data to the Home Health CAHPS Data Center by 11:59 pm EST on January 21, 2011;*
- *Evidence that the HHA continuously collected data and submitted data to the Home Health CAHPS Data Center during the required timeframe. [For letters in calendar year 2012 only:] The required period of data collection includes the dry run data in the third quarter 2010, the fourth quarter 2010 (all the months of October, November and December 2010), and the first quarter 2011 (all the months of January, February, and March 2011). [For letters in calendar year 2013 and after:] The required period of data collection includes all months from April 1, [insert the prior year] through March 31, [insert the current year]; or*
- *For HHAs with less than 60 HHCAHPS eligible patients in the year from April 1, [insert the year 2 years prior] and March 31, [insert the prior year], evidence that the HHA filed the Participation Exemption Request Form, on the form that is*

on www.homehealthcahps.org, by the deadline date specified in the HH PPS payment update final regulation for [insert current year].

Note that documentation of the following does NOT support a finding of compliance:

- evidence or admission of error on the part of your staff, even if the involved staff members are no longer employed by your HHA and/or a corrective action plan has been or will be put in place after the end of the reporting year;
- evidence or assertion that failure to comply was the fault of a vendor or contractor that was hired by your HHA to perform reporting functions;
- evidence of delays establishing electronic data interchange connectivity between your HHA and [insert Medicare contractor name] for the purpose of billing, since OASIS transmission is not dependent on billing and the HHA should request their OASIS transmitter ID from the State at the same time they request billing system access from [insert Medicare contractor name]; or
- in cases where the ownership of the HHA changed during the reporting year but the CCN of the HHA did not change, evidence that failure to comply was the fault of a previous owner.

The documentation you provide will be directed to CMS for reconsideration. An HHA must submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB). Send your written requests and supporting documentation to [insert contact address] postmarked no later than 30 days from the date of this notification.”

Model language for dispute determination letters:

“This letter is in response to your request for reconsideration of the scheduled 2% reduction in payments to your agency, due to your agency being identified as *[insert whether the HHA was non-compliant with OASIS, HHCAHPS or both]*.

CMS has reviewed the documentation you provided and determined that your agency is subject to the 2% reduction in HH PPS payments for CY[insert upcoming year], due to your agency’s noncompliance with submitting quality data during the *required timeframes*. Specifically, CMS officials found [insert CMS-provided statement of findings]. If your agency wishes to further appeal this determination, the appeals process set forth in 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal) applies.”

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R2249CP</u>	07/01/2011	Calendar Year 2012 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data	10/03/2011	7459
<u>R2230CP</u>	05/27/2011	Revisions to Chapter 10, Home Health Agency Billing	08/28/2011	7338
<u>R2209CP</u>	05/06/2011	Corrections to Home Health Prospective Payment System (HH PPS) Outlier Limitation	10/03/2011	7395
<u>R2043CP</u>	09/03/2010	Calendar Year 2011 Payments to Home Health Agencies That Do Not Submit Required Quality Data	10/05/2010	7114
<u>R1988CP</u>	06/14/2010	Enhancements to Home Health (HH) Consolidated Billing	10/04/2010	6911
<u>R1956CP</u>	04/28/2010	Remittance Advice Coding to Identify Claims Subject to the Limitations on Home Health Prospective Payment System (HH PPS) Outlier Payments	10/04/2010	6897
<u>R1952CP</u>	04/28/2010	Enhancements to Home Health(HH) Consolidated Billing - Rescinded and replaced by Transmittal 1988	10/04/2010	6911
<u>R1904CP</u>	02/05/2010	Coding Patient Transfers Under the Home Health Prospective Payment System (HH PPS)	07/06/2010	6757
<u>R1883CP</u>	12/23/2009	Limitation on Home Health Prospective Payment System (HH PPS) Outlier Payments	01/25/2010	6759
<u>R1773CP</u>	07/24/2009	Revised Processing of Osteoporosis Drugs Under the Home Health Benefit	01/04/2010	6512
<u>R1714CP</u>	04/24/2009	Correction to Editing of Health Insurance Prospective Payment System (HIPPS) Codes on Home Health Prospective Payment System (HH PPS) Claims	10/05/2009	6393

<u>R1647CP</u>	12/12/2008	Payments to Home Health Agencies That Do Not Submit Required Quality Data	03/16/2009	6286
<u>R1505CP</u>	05/16/2008	Correction to Determinations of Early vs. Later Episodes Under the Home Health Prospective Payment System (HH PPS)	10/06/2008	6027
<u>R1476CP</u>	03/07/2008	Correction to Low Utilization Payment Adjustment Add-on Payments Under the Refined Home Health Prospective Payment System (HH PPS)	07/07/2008	5877
<u>R1472CP</u>	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
<u>R1443CP</u>	02/07/2008	Home Health Prospective Payment system (HH PPS) Refinement and Rate Update for Calendar Year (CY) 2008	03/07/2008	5879
<u>R1431CP</u>	02/01/2008	Update to the Implementation Date for Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas	07/07/2008	5868
<u>R1424CP</u>	02/01/2008	Correction to Low Utilization Payment Adjustment Add-on Payments Under the Refined Home Health Prospective Payment System (HH PPS) – Rescinded and Replaced by Transmittal 1476	07/07/2008	5877
<u>R1421CP</u>	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
<u>R1371CP</u>	11/02/2007	Validation of Non-Routine Supply Reporting on Home Health Prospective Payment System (HH PPS) Claims	04/07/2008	5776
<u>R1348CP</u>	10/05/2007	Billing Instructions for the Home Health Prospective Payment System (HH PPS) Case Mix Refinement	11/05/2007	5746
<u>R1246CP</u>	05/22/2007	Home Health Agencies (HHAs) Providing Durable Medical Equipment in Competitive Bidding Areas	04/01/2008	5551
<u>R1224CP</u>	04/20/2007	Home Health Agencies (HHAs) Providing Durable Medical Equipment in Competitive	10/01/2007	5551

Bidding Areas - Replaced by Transmittal
1246

<u>R1079CP</u>	10/20/2006	Changes to the Process for Recovering Medicare Payments for Home Health Prospective Payment (HH PPS) Claims Failing to Report Prior Hospitalizations	01/18/2007	5085
<u>R1036CP</u>	08/18/2006	Updates to Chapter 10 of the Medicare Claims Processing Manual	10/09/2006	5242
<u>R1025CP</u>	08/11/2006	Revised Home Health Advance Beneficiary Notice	09/01/2006	5009
<u>R980CP</u>	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
<u>R941CP</u>	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
<u>R771CP</u>	12/02/2005	Revisions to Pub.100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier (NPI)	01/03/2006	4181
<u>R635CP</u>	08/05/2005	Financial Liability for Services Subject to Home Health Consolidated Billing	11/03/2005	3948
<u>R481CP</u>	02/25/2005	Updated Manual Instructions for the Medicare Claims Processing Manual, Chapter 10	03/28/2005	3691
<u>R427CP</u>	01/14/2005	Revision of Change Request 2928: Implementation of Payment Safeguards for Home Health Prospective Payment System (HH PPS) Claims Failing to Report Prior Hospitalizations	07/05/2005	3616
<u>R362CP</u>	11/05/2004	Update to the Prospective Payment System (PPS) for Home Health Agencies for Calendar Year (CY) 2005	01/03/2005	3556
<u>R358CP</u>	11/05/2004	Inclusion of Forteo as a Covered Osteoporosis Drug and Clarification of Manual Instructions Regarding Osteoporosis Drugs	04/04/2005	3524
<u>R226CP</u>	07/09/2004	Quarterly Update of HCPCS Codes for	10/04/2004	3350

Home Health Consolidated Billing
Enforcement

<u>R165CP</u>	04/30/2004	Enhancement to Home Health Consolidated Billing Edits	10/04/2004	3186
<u>R061CP</u>	01/16/2004	Requests for Anticipated Payment	02/16/2004	2992
<u>R025CP</u>	10/31/2003	Billing Non-Covered Charges to Fiscal Intermediaries-Summary and New Instructions	04/05/2004	2634
<u>R017CP</u>	10/31/2003	Billing and Payment Procedures Regarding Ownership and Provider Numbers	04/05/2004	2927
<u>R013CP</u>	10/24/2003	Implementation of Payment Safeguards for Home Health Prospective Payment System Claims Failing to Report Prior Hospitalization	04/01/2004	2928
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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