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Low Utilization Payment Adjustment (LUPA) Add-on Amounts for Home Health (HH) Occupational Therapy Visits

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Related Change Request (CR) Number: 12315
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Implementation Date: January 3, 2022

Provider Types Affected

This MLN Matters Article is for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- Changes to Original Medicare systems to allow LUPA add-on payments to apply if an occupational therapy visit is the first visit in a period of care
- Affects on Occupational Therapists (OTs)
- How we compute the OT LUPA add-on payment

Make sure your billing staff knows about these changes.

Background

The Consolidated Appropriations Act of 2021 (CAA 2021) allows OTs to do initial and comprehensive assessments for all Medicare patients under the HH benefit when the plan of care doesn't initially include skilled nursing care.

This means that OTs may do the initial assessment and complete the comprehensive assessment only:

- When OT is on the HH plan of care with either Physical Therapy (PT)

And Or

- Speech Therapy (ST) and skilled nursing services aren't initially on the plan of care.

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This change requires CMS to set up a LUPA add-on factor in calculating the LUPA add-on payment amount for the first skilled OT visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care.

There's no current, sufficient data for the average excess of minutes for the first visit in LUPA periods where the OTs do the initial and comprehensive assessments. Therefore, in the Calendar Year (CY) 2020 HH PPS final rule, we finalized the use of the PT LUPA add-on factor of 1.6700. We'll use this as a proxy for the OT LUPA add-on factor for CY 2022. We'll do this until we have CY 2022 data to show the OT add-on factor for the LUPA add-on payment amounts in future years. The similarity in the per-visit payment rates for both PT and OT make the PT LUPA add-on factor the most appropriate proxy until we set up the OT LUPA add-on factor.

CR 12315 also contains requirements for consistent and accurate processing of HH claims under the Patient-Driven Groupings Model (PDGM).

We match all HH claims to their associated Outcomes and Assessment Information System (OASIS) assessment during processing. We use certain OASIS items to decide the Health Insurance Prospective Payment System (HIPPS) code we use for payment. MACs have reported intermittent failures in the claims-OASIS matching process. When MACs see unusually high volume of HH claims in suspense locations awaiting a match, they may recycle claims to the assessment system a second time. MACs may take this action at their discretion or when we tell them to do so. The requirements of CR 12315 fix this issue.

Similarly, on all HH claims, the HH Grouper program must calculate the HIPPS code we use for payment. MACs have reported intermittent cases where HH claims bypass the Grouper and have paid using the provider-submitted HIPPS code. CR 12315 creates a safeguard to prevent this.

More Information

We issued CR 12315 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
November 9, 2021	Initial article released.