| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 434** | **Date: January 30, 2009** |
| | **Change Request 6305** |

**Subject: Correction to Home Health Prospective Payment System (HH PPS) Episode Sequence Edits**

**I. SUMMARY OF CHANGES:** This transmittal describes Medicare systems changes to ensure that episode sequence is enforced accurately under the HH PPS.

**New / Revised Material**
**Effective Date: January 1, 2008**
**Implementation Date: July 6, 2009**

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

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

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| **N/A** | |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
Not Applicable.

**IV. ATTACHMENTS:**

**One-Time Notification**

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

# Attachment – One-Time Notification

| Pub. 100-20 | Transmittal: 434 | Date: January 30, 2009 | Change Request: 6305 |
|---|---|---|---|

**SUBJECT: Correction to Home Health Prospective Payment System (HH PPS) Episode Sequence Edits**

**Effective Date**: January 1, 2008

**Implementation Date:** July 6, 2009

## I. GENERAL INFORMATION

**A. Background:** Medicare implemented refinements to the HH PPS case-mix system in January 2008. One of these refinements was to pay HH PPS episodes differently depending upon whether the episode was an early episode (the first or second episode in a sequence of related episodes) or a later episode (the third or later episode in such a sequence). The accuracy of these payments is enforced by edits in the Common Working File (CWF) system, which compares the payment codes on incoming claims to previously paid episodes, and rejects claims that are priced based on the incorrect episode sequence.

Payment codes (known as HIPPS codes) that begin with a 5, represent episodes in which the HHA provided 20 or more therapy services. Payments for episodes with 20 or more therapies are identical regardless of whether the episode is early or later. Consequently, the initial requirements for HH PPS case-mix refinements excluded HIPPS codes beginning with 5 from the edits that enforce correct episode sequence.

In a case where the 20 therapy services are expected from the beneficiary's initial assessment and the HHA reports the HIPPS code beginning with 5 on the Request for Anticipated Payment (RAP) and claim for the episode, it is correct to exclude the episode from episode sequence edits. However, when the 20 therapy services are not expected, the first position of the HIPPS code on the RAP and claim indicate whether the episode was early or later. When the Medicare HH PPS Pricer program finds that 20 therapy services were provided, it recodes the first position of the HIPPS code to a 5. The Pricer then uses the treatment authorization code information on the claim to recode the remaining positions of the code.

The Pricer recodes the episode before the claim is submitted to the Common Working File (CWF) to determine whether the episode sequence information used for recoding was correct. When the claim is then submitted to CWF with the HIPPS code beginning with 5, it is excluded from episode sequencing edits and is not returned to the HH PPS Pricer for correction. In these cases, which represent a small volume of claims nationally, the episode may be paid at the incorrect payment group. The requirements in this transmittal will prevent these payment errors.

Additionally, Change Request (CR) 6027 made a revision to HH PPS episode sequence edits intended to ensure that fully denied episodes are not considered in determining whether an episode is early or later. Requirement 6305.4 below corrects an error in the business requirements of CR 6027, Pub. 100-04, Transmittal 1505, dated May 16, 2008.

**B. Policy:** This instruction contains no policy changes. The requirements below revise Medicare systems to conform more accurately to current policy.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6305.1 | Medicare systems shall apply episode sequence edits to the provider-submitted HIPPS code on HH PPS claims when the recoded HIPPS code in the APC-HIPPS field contains a 5 in the first position. | | | | | | | | | X | |
| 6305.2 | Medicare systems shall correctly assign payment groups on HH PPS claims when an episode sequence edit applies and the HIPPS code in the APC-HIPPS field contains a 5 in the first position APC-HIPPS field. | | | | | | X | | | | HH Pricer |
| 6305.2.1 | Medicare systems shall install a new HH Pricer program that contains revised recoding logic. | | | | | | X | | | | |
| 6305.2.2 | Medicare systems shall revise recoding logic for HH PPS claims to recode HIPPS codes which contain a 5 in the first position when a recode indicator of 1 or 3 is present. | | | | | | | | | | HH Pricer |
| 6305.3 | Medicare contractors shall adjust HH PPS claims based on the incorrect payment group when brought to their attention by the HHA. | | | | | X | | | | | |
| 6305.4 | Medicare systems shall recognize a full coverage denial of a HH PPS episode by the presence of non-payment code 'N' and one of the set of ANSI claim adjustment reason codes in CR 6027 on any line of the claim. | | | | | | | | | X | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6305.5 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly | | | | | X | | | | | |

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

## IV. SUPPORTING INFORMATION

**A. Recommendations and supporting information associated with listed requirements:**
*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 6305.1 thru 6305.4 | HH PPS claims include any record with type of bill 32x or 33x other than requests for anticipated payment (322 or 332). |
| 6305.1 | This requirement refers to CWF edits and informational unsolicited responses 524P and 524Q. |
| 6305.4 | This requirement revises requirement 6027.1.2. |

**B. All other recommendations and supporting information: N/A**

## V. CONTACTS

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## VI. FUNDING

**A. For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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