Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

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(Rev. 61, 01-16-04)

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10 - General Guidelines for Processing Home Health Agency (HHA) Claims

(Rev. 1, 10-01-03)

A3-3638.20, HH-401-402, HH-429

This chapter, in general, describes bill 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 coverage policies see Chapter 10 in the Medicare Benefit Policy Manual and/or the Medicare National Coverage Determinations Manual.

A - Where and How to Bill

Form CMS-1450, the UB-92, is used by institutional providers, including home health agencies, to bill Medicare. Such claim forms are submitted to the regional home health intermediaries (RHHIs). Home health agencies (HHAs) bill all their home health services on this form. Some home health agencies may also become approved as DME suppliers, in which case they would submit bills for DMEPOS services to the carrier on Form CMS-1500 or the electronic equivalent.

Reference to the claim form in this chapter reference the paper or hard-copy version of the Form CMS-1450 (UB-92) unless otherwise noted. However, the instructions regarding specific data requirements apply also to electronic equivalents of the form.

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 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

DMEPOS services may be included on the bill type 32X for the home health benefits, and are paid in addition to the PPS payment. Osteoporosis drugs must be billed on bill type 34X.

Other services not under a HH plan of care provided by a 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. Physical therapy, occupational therapy and speech language pathology services not delivered under a HH plan of care (optional Form CMS-485), are paid under the Medicare Physician Fee Schedule (See Chapter 5.) Such services must be delivered under other plans of care (Forms 700 and 701).

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

(Rev. 1, 10-01-03)

HH-467.1, A3-3639.1

The following chart summarizes the publication and content of key legislation, regulation and instructions implementing HH PPS.

LEGISLATION	REGULATION	INSTRUCTIONS
Balanced Budget Act of 1997 (BBA 97), Omnibus Consolidated Emergency Supplemental Appropriation Act of 1998 (OCESAA), Balanced Budget Refinement Act of 1999 (BBRA 99): Amendments to the Social Security Act	HH PPS Proposed Rule October 28, 1999; HH PPS Final Rule July 3, 2000	**This Chapter (Originally)**
Pay on a prospective basis	Creates two split percentage payments at beginning and end of episode	Description and billing procedures for Request for Anticipated Payment (RAP) and HH PPS claim in this chapter
Determine a new unit of payment	Determines basis of payment is 60-day episode	Description of episode payment and adjustments in this chapter
[Not in legislation]	Specifies adjustments to episode payment: Significant Change in Condition (SCIC), Partial Episode Payment (PEP), Low Utilization Payment Adjustment (LUPA), therapy threshold and outlier	Description of payment and processing of these adjustments as part of billing in this chapter
Reflect patient condition in payment - case-mix	Identifies 80 payment groups represented by Home Health Resource Groups (HHRGs)	Use of Health Insurance Prospective Payment System (HIPPS) codes on RAPs and claims to represent HHRGs described in this chapter
Allow cost outliers	Gives outlier methodology	Description of billing/payment process in this chapter

LEGISLATION	REGULATION	INSTRUCTIONS
Balanced Budget Act of 1997 (BBA 97), Omnibus Consolidated Emergency Supplemental Appropriation Act of 1998 (OCESAA), Balanced Budget Refinement Act of 1999 (BBRA 99): Amendments to the Social Security Act	HH PPS Proposed Rule October 28, 1999; HH PPS Final Rule July 3, 2000	**This Chapter (Originally)**
Pro-rate payment for transfers	Reflects law	Description of billing process for transfers in this chapter
Eliminate PIP payments with advent of HH PPS	Addresses public comments on elimination of PIP in Final Rule	Citation of law and regulations in this table
Require consolidated billing, except DME	Creates concept of primary agency in consolidated billing	Description of effects on billing and claim payment in this chapter
Require ultimate effective date of October 1, 2000	Reflects law	Creation of program memorandum on Phase-in plan (8/31/00; A-00-59)
[Not in legislation]	Refers to new software modules in payment process: Grouper and Pricer software	Description of Pricer logic (note OASIS is incorporated into HAVEN/software specification for OASIS) in this chapter
Require reporting services in 15-minute increments	[Not in regulation]	Description of billing in this chapter
Require UPINs on claims	[Not in regulation]	Requirement existed prior to HH PPS

10.1.2 - Commonalities of the Cost Payment and HH PPS Environments

(Rev. 1, 10-01-03)

HH-467.3, A3-3639.3

Much of home health billing remains the same under HH PPS as it was under the prior payment system:

Cost-Payment Billing Environment vs. HH PPS		
FEATURE	**Cost-Payment**	**HH PPS**
Payment is for individual beneficiary who is homebound and under a Physician's Plan of Care (POC)	**YES**, 32X and 33X claims	**YES**, 32X RAPs and claims (may be shifted to 33X in processing)
Payment for services and items not under POC on 34X bills	**YES**	**YES**, not paid under HH PPS
Payment is adjusted for site of service	**YES**, with implementation of BBA 97 requirement	**YES**, now applied in Pricer software for HH PPS
Payment for home health services under a POC must be shifted between Part A and B trust funds	**YES**, with implementation of BBA 97 requirement	**YES**, but mechanism changes with implementation of HH PPS for trust fund allocations determined in processing
Payment based on individual service or item	**YES**	**NO**, based on episode and bundling items and services for 60-day period for HH PPS including LUPAs in a single payment
Claims are processed by Medicare Regional Home Health Intermediaries (RHHIs)	**YES**	**YES**, RAPs and claims along with other HH claims and services not under POC
Current claims and ancillary formats employed (i.e., UB-92, 837, 835, MSN)	**YES**	**YES**, with new requirements for HH PPS
Claims span September and October 2000	**NO**	**NO**
Claim submission effective dates	Services under POC on **September 30, 2000 and before**	Services under POC on **October 1, 2000 and after**
Claims span calendar year	**NO**	**YES**, HH PPS; **NO** 34X
Current Medicare . claims processing systems and software used in processing claims (i.e., CWF, FISS,	**YES**	**YES**, RAPs and claims along with other HH claims and service under POC

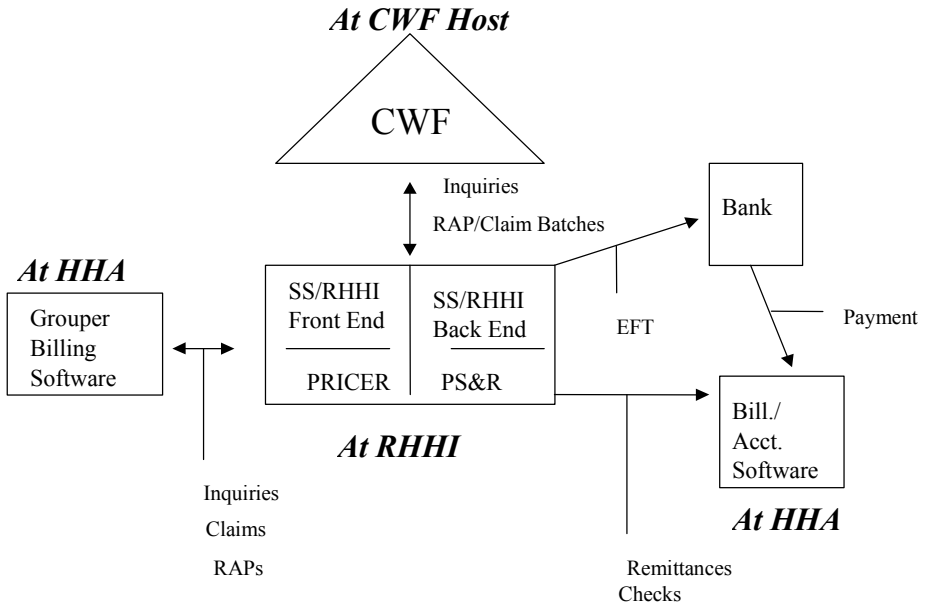
Cost-Payment Billing Environment vs. HH PPS		
FEATURE	**Cost-Payment**	**HH PPS**
APASS, PS&R)		
Use of Grouper software at HHA	**NO**	**YES,** for HH PPS
Use of CWF HIQH inquiry system (ELGH, the 270 equivalent HIPAA-compliant replacement transaction for HIQH, inquiry system as of 10/16/2003)	**NO**	**YES,** for HH PPS
Use of Pricer software at RHHI	**NO**	**YES,** for HH PPS

10.1.3 - Configuration of the HH PPS Environment

(Rev. 1, 10-01-03)

HH-467.5, A3-3639.5, HH-467.6, A3-3639.6

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 or 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, (and the HIQH until ELGH is implemented for HIPAA), is an inquiry system in CWF available via RHHI remote access, through which HHAs and other providers that bill FIs 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. 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. 1, 10-01-03)

HH-467.7, A3-3639.7

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 §10.1.23 and §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. 1, 10-01-03)

A3-3638.16, HH-439, 440, A3-3638.5

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 of a Request for Anticipated Payment (RAP) (see §40.1). 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 RHHI denies the RAP of any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

Effective with HH PPS, if a patient transfers from one agency to another under HH PPS, a new plan of treatment is required in order to correspond with the new HH PPS episode period.

10.1.5.2 - Effect of Election of HMO and Eligibility Changes on HH PPS Episodes

(Rev. 1, 10-01-03)

HH-467.9, A3-3639.9

If a Medicare beneficiary is covered under a health maintenance organization (HMO) 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, a RAP may be sent to Medicare to open an HH PPS episode.

If a beneficiary under fee-for-service receiving home care elects HMO 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 HMO becomes the primary payer upon the HMO enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

10.1.6 - Split Percentage Payment of Episodes and Development of Episode Rates

(Rev. 1, 10-01-03)

HH-467.10, A3-3639.10

A split percentage payment will be made for most episode periods. There will be 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 will be 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 will be 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 will equal 50 percent of the estimated case-mix 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 will be considered initial for payment purposes.

Payment rates for HH PPS episodes were developed from audited cost reports of previous years' data (before implementation) 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.

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix

(Rev. 1, 10-01-03)

HH-467.11, A3-3639.11

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 will be 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 intermediary (FI). 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 re-assess 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 hours or visits provided over the course of the episode. The number of therapy hours or visits projected at the start of the episode, entered in OASIS, will be confirmed by the hour or visit information submitted on the claim for the episode. Though therapy hours or 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 RHHIs 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: (H)HRGs and HIPPS Codes

(Rev. 1, 10-01-03)

HH-467.12, A3-3639.12

Under the home health prospective payment system, a case-mix adjusted payment for a 60-day episode is made using one of 80 HHRGs (also occasionally abbreviated to HRG.) 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 on how the HHRG was derived.

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 claims submitted to Medicare FIs. One revenue code is defined for every Medicare prospective payment system that uses HIPPS codes. HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") of the claim. The associated revenue code is placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim.

10.1.9 - Composition of HIPPS Codes for HH PPS

(Rev. 1, 10-01-03)

HH-467.13, HH-467.14, A3-3639.13, A3-3639.14

The distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.
- The second, third, and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the HH PPS final rule, and future HHRG and HIPPS code lists are released in annual HH PPS Program Memoranda providing specific payment system information and annual rate updates if such changes occur. Note the

second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

- The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper. This position does not correspond to HHRGs since these codes do not differentiate payment groups. The fifth position will allow only numeric characters and a fifth position value other than "1," which is produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

The first position of every home health HIPPS code will be "H." The remaining four positions discussed above can be summarized as follows:

(Clinical)Position #2	**(Functional) Position #3**	**(Service) Position #4**	**Position #5**	**Domain Level**
A (HHRG: C0)	E (HHRG: F0)	J (HHRG: S0)	1 = 2nd, 3rd & 4th positions computed	= min
B (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	2 = 2nd position derived	= low
C (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	3 = 3rd position derived	= mod
D (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	4 = 4th position derived	= high
	I (HHRG: F4)		5 = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru Z	9, 0	expansion values for future use

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

Based on this coding structure:

- The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG.

- The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, the Pricer software will price all eight codes for that HHRG identically.
- 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. 1, 10-01-03)

HH-467.16, A3-3639.16

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 HHRG (Home Health Resources 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 HHRGs 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. 1, 10-01-03)

An inquiry facility is available for HHAs and other providers and suppliers to learn the beneficiary's eligibility and entitlement status, and whether a home health episode has started but not ended. See §30 for a description.

10.1.10.3 - Submission of Request for Anticipated Payment (RAP)

(Rev. 1, 10-01-03)

HH-467.18, A3-3639.18

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 completed and locked for transmission;
- Once a physician's verbal orders for home care have been received and documented;
- A plan of care has been established and transmitted 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 on the Form CMS-1450 (UB-92) billing form under TOB (Form Locator 4) 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.

When at least one billable service has been provided in the episode, RAPs are to be submitted to RHHIs. 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. 1, 10-01-03)

HH-467.19, A3-3639.19

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 "through" date on the claim Form Locator 6, 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. 1, 10-01-03)

HH-467.21, A3-3639.21

The RAP is submitted by HHAs to their RHHIs 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 submitted on a Form CMS-1450 (UB-92) and resulting 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 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, and these claims are still subject to the payment floor and payment of interest if clean, meaning not needing special development to be processed, and delayed in processing. RAPs are allowable transactions for ANSI X12N formats.

10.1.13 - Transfer Situation - Payment Effects

(Rev. 1, 10-01-03)

HH-201.8.E, HH-467.22, A3-3639.22

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 Form Locator 20 (Source of Admission) of Form CMS-1450 (UB-92) or electronic equivalent even 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 RHHI 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.

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

(Rev. 1, 10-01-03)

HH-467.23, A3-3639.23

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. Payment is for 60 days less the number of days after the date of the delivery of last billable service until what would have been the 60th day (see §10.1.15). The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock"). As with transfers, Form Locator 20 (Source of Admission) can be used to reflect a "transfer" to the same HHA, that is, when a patient unexpectedly returns in the same 60-day period. The new episode can be opened by the HHA.

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. 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. 1, 10-01-03)

HH-467.28, A3-3639.28

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 status code of 06 in Form Locator 22 on the UB-92 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 status 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.

10.1.16 - Payment When Death Occurs During an HH PPS Episode

(Rev. 1, 10-01-03)

HH-467.24, A3-3639.24

If a beneficiary dies during an episode, full payment will be made for the episode, including payment adjustments applicable 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 "through" date on the claim (Form Locator 6) of Form CMS-1450 (UB-92) 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. 1, 10-01-03)

HH-467.25, A3-3639.25

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.

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. 13, 10-24-03)

The total case-mix adjusted episode payment is based on the OASIS assessment. Medicare claims systems 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 Threshold

(Rev. 13, 10-24-03)

The number of therapy hours 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. Because the advent of 15 minute increment reporting on home health claims only recently preceded HH PPS, therapy hours will be proxied from visits at the start of HH PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent eight hours of therapy.

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational, or speech therapy combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS codes representing the same payment group; one if a beneficiary does not receive the therapy hours projected, and another if they do meet the "therapy threshold." Therefore, when the therapy threshold is not met and the HIPPS code output by the Grouper indicated it would be, there is an automatic "fall back" HIPPS code, and Pricer software in Medicare claims processing systems will correct payment without access to the full OASIS data set.

The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare claims processing systems would pay the full episode payment based on the HIPPS code. Note that HIPPS codes may also be changed based on the medical review of claims, but Pricer software enforces the therapy threshold. Pricer will automatically change the HIPPS to the fallback code if the threshold is not met, but providers must adjust the HIPPS on their own claims if instead they originally billed the fallback code and then unexpectedly met or exceeded the threshold.

10.1.19.2 - Adjustments of Episode Payment - Hospitalization Within 14 Days of Start of Care

(Rev. 13, 10-24-03)

Whether a beneficiary was a hospital inpatient during the 14 days before the start of a HH PPS episode will be confirmed by searching Medicare claims history for a processed

inpatient hospital claim during that period. Under the HH PPS case-mix system if a beneficiary was in a nursing facility during the 14 days before the start of an episode but was not also a hospital inpatient during that period, the episode will receive a higher case-mix score than if a hospitalization was also present.

Certain HIPPS codes, which represent the HH PPS case-mix group, indicate the presence of a nursing facility discharge within 14 days but no hospitalization during that period. Only when both these conditions are met do HIPPS codes result with "K" or "M" in their fourth position.

Medicare systems will compare incoming RAPs and claims with these HIPPS codes to Medicare claims history for the beneficiary and determine during processing whether an inpatient hospital claim has been received for dates of service within 14 days of the start of care. If an inpatient hospital claim is found, Medicare systems will take action on the RAP or claim. The RAPs will be returned to the provider to alert them to the hospital stay and allow them to correct the HIPPS code. The claims will be automatically adjusted to correct the HIPPS code and will be paid at the correct payment level.

Under Medicare timely filing guidelines, hospital claims may be received for 15-27 months from the end of the hospital stay. As a result of this lengthy timely filing period, there may also be cases where the HH PPS claim has been processed before the inpatient hospital claim is received. In these cases, absence of the inpatient claim in Medicare claims history could mean either no hospital stay occurred or the hospital claim has not yet been submitted. As a result, Medicare systems are unable to confirm the lack of hospitalization before the HH PPS claim is paid. To account for these cases, CMS will annually analyze its claims history to identify HH PPS claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim with dates of services within 14 days was received after the HH PPS claim had already been paid. Such claims will be subject to post-payment adjustment, to correct the HIPPS code used for payment.

Whether this payment adjustment is made on a pre-payment or a post-payment basis, the electronic remittance advice (ERA) will be coded so the adjustment can be clearly identified. The ERA will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment. A distinct remark code will also be applied to the ERA for these claims.

10.1.20 - Adjustments of Episode Payment - Significant Change in Condition (SCIC)

(Rev. 1, 10-01-03)

HH-467.29, A3-3639.29

While HH PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes an unexpected change in patient condition will occur that is significant enough to require the patient to be re-assessed during the 60-day episode period and to require new physician's orders. In such cases, each new HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode upon closure.

Pricer will then use the line item dates to calculate the number of days of care provided under each HIPPS codes, and **pay proportional amounts under each HIPPS code based on the number of days of service provided under each payment group** (count of days under each HIPPS code from and including the first billable service to and including the last billable service). The total of these amounts will be the full payment for the episode.

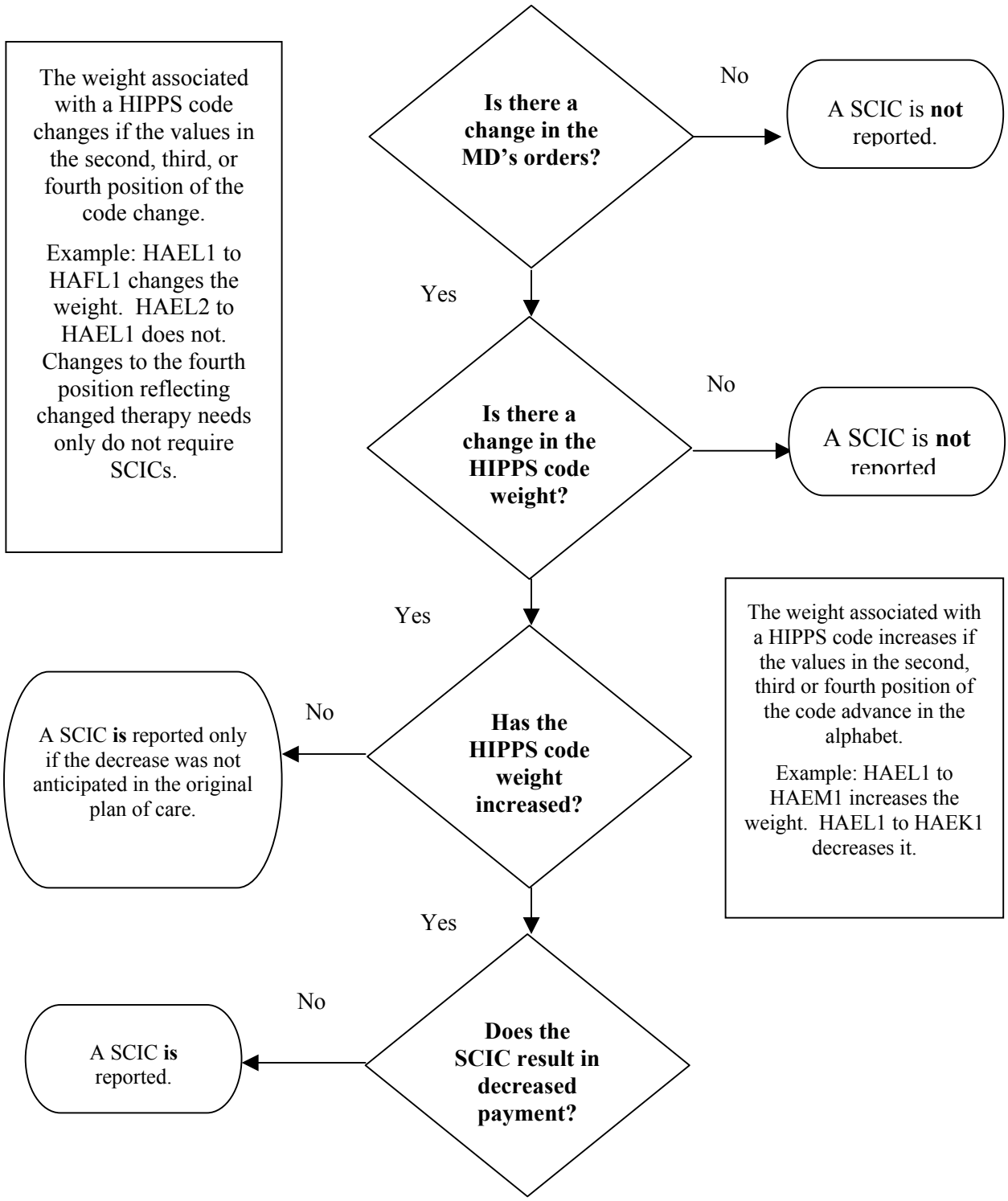
Such adjustments are referred to as significant change in condition (SCIC) adjustments. The electronic remittance advice including a claim for a SCIC-adjusted episode will show the total claim payment and separate segments showing the payment for each HIPPS code.

There is no limit on the number of SCIC adjustment that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode, with two exceptions:

1. If the patient is re-assessed and there is no change in the HIPPS code, including a change reflecting whether or not the therapy threshold was met, the same HIPPS code does not have to be submitted twice, and no SCIC adjustment will apply. If the therapy increases, the episode should be cancelled and re-submitted under the higher payment group.
2. If the HIPPS code weight increased but the pro-ration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

The weight associated with the HIPPS code increases if the values in the second, third and fourth position in the HIPPS code advance in the alphabet, representing increasing complexity in the clinical, functional or service domain of a payment grouping for a needier patient. Exceptions are not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS codes for an episode). If more than six HIPPS codes are submitted, the RHHI medical review staff determines which six will be used as the basis for payment.

The flowchart that follows outlines the decision process for billing SCIC claims. Whenever a change in condition occurs within an episode, HHAs should compare the HIPPS codes and associated payments resulting from the multiple OASIS assessments.


The weight associated with a HIPPS code changes if the values in the second, third, or fourth position of the code change.
Example: HAEL1 to HAFL1 changes the weight. HAEL2 to HAEL1 does not. Changes to the fourth position reflecting changed therapy needs only do not require SCICs.
Is there a change in the MD's orders?
No
A SCIC is not reported.
Yes
Is there a change in the HIPPS code weight?
No
A SCIC is not reported
Yes
The weight associated with a HIPPS code increases if the values in the second, third or fourth position of the code advance in the alphabet.
Example: HAEL1 to HAEM1 increases the weight. HAEL1 to HAEK1 decreases it.
Has the HIPPS code weight increased?
No
A SCIC is reported only if the decrease was not anticipated in the original plan of care.
Yes
Does the SCIC result in decreased payment?
No
A SCIC is reported.

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 1, 10-01-03)

HH-467.30, A3-3639.30

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 will 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 HRG 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 MSA in which the beneficiary was served. Outlier payments are 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. Separate outliers will not be calculated for different HIPPS codes with a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim in history with a value code, 17, in Form CMS-1450 (UB-92) Form Locators 39-41, with an associated amount.

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.

10.1.22 - Adjustments of Episode Payment - Exclusivity and Multiplicity of Adjustments

(Rev. 1, 10-01-03)

HH-467.31, A3-3639.31

An Acronym List is in §10.1.24, to help with interpretation of this section, which, due to format constraints, could not spell out all terms

Episode payment adjustments as described above apply only to, not requests for anticipated payment (RAPs). Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment, and 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 (i.e., a significant change in condition (SCIC) and therapy threshold adjustment in a shortened episode (PEP adjustment)). All claims except LUPA claims will be considered for outlier payment. Payment adjustments are calculated in Pricer software (see subsequent Pricer section).

The table that follows summarizes HH PPS Episode Payment Adjustments.

Matrix of HH PPS Episode Payment Adjustments				
TYPE:	Partial Episode Payment Adjustment (PEP) 10.1.15	Death of Beneficiary 10.1.16	Low-Utilization Payment Adjustment (LUPA) 10.1.17	Therapy Threshold 10.1.19
Description	**Episode is shortened because beneficiary receives HH care elsewhere in 60-day period (transfer, readmission or eligibility change)**	**Beneficiary dies during open episode**	**Completed episode is four or fewer visits**	**40 of 80 HH PPS payment groups require 10 or more therapy visits in episode, each of 40 "high" can fall back to one of 40 "low"**
Frequency	**Once, ends episode**	**Once, ends episode**	**Once per episode**	**Once per episode**
Wage Adjusted?	**Episode is**	**Episode is**	**Yes, visit payment is**	**Episode is**
Case-mix Adjusted?	**Episode may be**	**Episode may be**	**No**	**Episode is**
Calculation Basis	**Days in episode (first billable service date to last)**	**None exclusively**	**Count of all visits**	**Count of therapy visits (Rev. Codes: 42x, 43x, 44x)**
Other Adjustment?	**All others except LUPA**	**All others except PEP can apply**	**No**	**All others except LUPA**
Billing Requirements	**Requires RAP and claim be billed, signal with use of discharge in through date and patient status "06" on claim**	**May use RAP, claim with no-RAP LUPA option, claim has patient status code 20 (FL22)**	**May use RAP, must use claim, claim has no-RAP LUPA option**	**Requires RAP and claim billed**
Activation	**Pricer calculates, CWF adjusts claim if PEP is not shown with 06 on billed claim**	**No payment change for death, Pricer calculates episode payment**	**Pricer calculates payment by national std. visit rates**	**Pricer changes "high" HIPPS code to "low" if threshold not met*, prices claim after change**

*Provider can re-bill entire episode if needed to report corrected information, if more therapies are added to exceed the threshold and the HIPPS code is not changed.

TYPE:	Significant Change in Condition (SCIC) 10.1.20	Outlier 10.1.21	Eligibility Change 10.1.26
Description	**Patient experiences change(s) in condition significant enough to require re-assessment during episode**	**Payment made in addition to episode payment for high-cost patients (no stay outlier since episodes are unlimited)**	**HH PPS applies to FFS Medicare only, change to/from this status will open/close episode, with PEP if mid-episode and not LUPA**
Frequency	**Unlimited per episode**	**One per episode**	**None amidst episode**
Wage Adjusted?	**Episode is**	**Yes**	**Episode is**
Case-mix Adjusted?	**Yes, with each HIPPS code**	**No**	
Calculation Basis	**Count of days for each HIPPS code by first to last billable service date**	**Difference of HIPPS code or visits-based reimbursement for episode, less fixed loss**	**Mostly likely PEP or LUPA**
Other Adjustment?	**All others except LUPA**	**All others except LUPA**	**Can be LUPA or PEP, if PEP may have others**
Billing Requirements	**Requires RAP and claim billed, claim has more than one HIPPS code, do not report if payment group same or financial loss with sicker pt.**	**Requires RAP and claim billed, providers do not bill for outlier payment**	**None exclusively, may use RAP, must use claim, claim has no-RAP LUPA option if LUPA**
Activation	**Pricer calculates payment for each HIPPS code and adds for episode payment**	**Pricer calculates on all episodes except LUPA and pays when applicable**	**CWF receives eligibility status change, claim is changed if needed**

10.1.23 - Exhibit: General Guidance on Line Item Billing Under HH PPS

HH-467.33, A3 - 3639.33

(Rev. 1, 10-01-03)

An Acronym List is offered in §10.1.24, to help with interpretation of this section, which, due to format constraints, could not spell out all terms

The following tables are added for quick reference on billing most line-items on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first table groups services, and the second table groups items and supplies:

Quick Billing Reference for Services			
TYPE OF LINE ITEM	**Episode**	**Services/Visits**	**Outlier**
CLAIM CODING	New 0023 revenue code with new HIPPS code (HHRG) on HCPCS field of same line	Current revenue codes 042X, 043X, 044X, 055X, 056X, 057X w/Gxxxx HCPCS for increment reporting, (**NOTE** revenue codes 058x and 059x not permitted for HH PPS)	Determined by Pricer - NOT billed by HHAs
TYPE OF BILL (TOB)	Billed on 32X only (have 485, patient homebound)	Billed on 32X only if POC; 34X*if no 485	Appears on remittance only for HH PPS claims (via Pricer)
PAYMENT BASIS	PPS episode rate: (1) full episode w/ or w/out SCIC adjustment; (2) less than full episode w/ PEP adjustment, (3) LUPA paid on visit basis (4) therapy threshold adjustment	When LUPA on 32X, visits paid on adjusted national standardized per visit rates; paid as part of Outpatient PPS for 34X*	Addition to PPS episode rate payment only, NOT LUPA, paid on claim basis, not line item

Quick Billing Reference for Services			
TYPE OF LINE ITEM	**Episode**	**Services/Visits**	**Outlier**
PPS CLAIM?	Yes, RAPs and Claims	Yes, Claims only [34X*no 485/non-PPS]	Yes, Claims only

NOTE: For HH PPS, HHA submitted RAP TOB must be 322 - may be cancelled by 328; Claim TOB must be 329 - may be adjusted by 327, or 328; 33X equivalents will also be processed. "485" is the CMS form number for the Plan of Care (POC)

*34X claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on CWF (exceptions noted on chart below).

Quick Billing Reference for Supplies						
TYPE OF LINE ITEM	**DME**** **(nonimplantable, other than Oxygen & P/O)**	**Oxygen & P/O** **(nonimplantable P/O)**	**Nonroutine***** **Medical Supplies**	**Osteoporosis Drugs**	**Vaccines**	**Other Outpatient Items (antigens, splints & casts)**
CLAIM CODING	Current revenue codes 029X, 0294 for drugs/supplies for effective DME use w/HCPCS	Current revenue codes 060X (Oxygen) and 0274 (P/O) w/HCPCS	Current revenue code 027x and voluntary use of 0623 for wound care supplies	Current revenue code 0636 & HCPCS	Current revenue codes 0636 (drug) and HCPCS, 771 (administration HCPCS)	Current revenue code 0271 & HCPCS
TOB	Billed to RHHI on 32X if 485, 34X* if no 485	Billed to RHHI on 32X if 485, 34X* if no 485	Billed on 32X if 485, or 34* if no 485	Billed on 34X* only	Billed on 34X* only	Billed on 34X* only
PAYMENT BASIS	Fee Schedule	Fee Schedule	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*	Cost, paid separately with open HH PPS episode, but subject to HH consolidated billing	Paid as part of Outpatient PPS, and paid separately with or without open HH PPS episode	Paid as part of Outpatient PPS, and paid separately with or without open HH PPS episode
PPS CLAIM?	Yes, Claim only [34X* no 485/non-PPS]	Yes, Claim only [34X* no 485/non-PPS]	Yes, Claim only [34X* no POC/non-PPS]	No (34X* claims only)	No (34X* claims only)	No (34X* claims only)

NOTE: For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).

* 34X claims for HH services, **except as noted for specific items above**, will not be paid separately if a HH episode for same beneficiary is open on CWF.

** Other than DME treated as routine supplies according to Chapter 4.

*** Routine supplies are not separately billable or payable under Medicare home health care. When billing on TOB 32X, catheters and ostomy supplies are considered nonroutine supplies and are billed with revenue code 027X.

10.1.24 - Exhibit: Acronym List

(Rev. 1, 10-01-03)

HH-467.34, A3-3639.34

Admission Date - For HH PPS, date of first service of episode **or** first service in a period of continuous care (multiple episodes) placed in Form Locator 17 of the Form CMS-1450 (UB-92).

Claim - Second of two transactions at opening and closing of HH PPS episode to receive one of two split percentage payments.

CMS - The Center for Medicare & Medicaid Services, the Federal Agency administering the Medicare program and the Federal portions of Medicaid and the Child Health program.

DME - Durable Medical Equipment. Billed by revenue codes and/or HCPCS. Paid by CMS according to a CMS DME fee schedule accessible on the CMS Web site http://cms.hhs.gov/researchers/default.asp.

DMERC - DME Regional Carrier - 4 Medicare carriers nationally processing DME on CMS-1500 claims.

Episode - 60-day unit of payment for HH PPS.

FI – Fiscal Intermediary (intermediary)

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 output HIPPS codes. Specifications for the HH PPS Grouper are posted on the CMS Web site http://cms.hhs.gov/researchers/default.asp, and the Grouper module is also built into PPS-compatible versions of HAVEN software, software publicly available automating the OASIS assessment tool.

HCPCS Code(s) - Healthcare Common Procedure Coding System. Coding for services or items used on the Form CMS-1450 (UB-92) in FL 44 or Form CMS-1500 claim forms. A list of HCPCS is accessible on the CMS Web site at http://cms.hhs.gov/researchers/default.asp.

HH - Home Health

HHA(s) - Home Health Agency(ies)

(H)HRG - Home Health Resource Group. One of 80 HH episode payment rates.

HIPPS - Health Insurance Prospective Payment System. Procedural coding used in FL 44 of the Form CMS-1450 (UB-92) in association with certain CMS prospective payment systems (skilled nursing facility, home health). Eight HIPPS codes are assigned to each HHRGs for HH PPS.

Inquiry System (HIQH) - An online transaction providing information on HH PPS episodes for specific Medicare beneficiaries for HHAs and hospices. Like the current HIQA eligibility inquiry system, this system will be based on batch claim data available

in the Common Working File, a component of Medicare claims processing systems, available to providers via their RHHIs.

Line Item - Service or item-specific detail of claim. Contains repeated entries of Form Locators 42-49 on CMS Form-1450 (UB-92).

LUPA - Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates **instead of** HHRGs

National Standard Per Visit Rates - National rates for each 6 home health disciplines based on historical claims data. 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.

OASIS - Outcome Assessment Information Set. The HH 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 - on Form Locator 22 of the Form CMS-1450 (UB-92) describes patient status at discharge/end of period; of note for HH PPS in the code list filling this location: "01"= "discharge to home/self care," "06" = "discharged/transferred home/HHA care" and "30" = "still a patient."

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).

POC - Plan of care. Medicare HH services for homebound beneficiaries must have a physician-established plan (see "485" below).

P/O(S) - Prosthetics and orthotics. The (S) is used to also include the supplies and other items associated with the prosthetics and orthotics.

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, specific to certain benefits, used in pricing claims, most often under prospective payment systems.

RAP - Request for Anticipated Payment. First of two transactions at opening and closing of HH PPS episode to receive one of two split percentage payments. Note although the RAP uses a Form CMS-1450 (UB-92), it is not a claim according to Medicare statutes, and is not subject to the payment floor, among other differences from claims.

Revenue Code - Payment codes for services or items placed in Form Locator 42 of the Form CMS-1450 (UB-92.) Note that a new revenue code 0023 will be used on a distinct line item when billing episode payments. (HIPPS code in HCPCS field, separate line

items for visits and supplies follow on claim). An "x" in the last digit of three digit revenue codes means that value can vary from 0-9.

RHHI - Regional Home Health Intermediary. Four FIs nationally designated to process Medicare home health and hospice claims.

SCIC - Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under that HHRG, and all pro-rated amounts added for the final episode payment.

Source of Admission Code - Form Locator 20 of the Form CMS-1450 (UB-92) - of note are new codes for HH PPS: "B" = "transfer from another home health facility," and "C" = "readmission to the same HHA."

TOB - Type of Bill (i.e., 32X, 34X). Coding representing the nature of each Form CMS-1450 (UB-92) claim (i.e., type of benefit, such as homebound home health; payment source, such as specific Medicare trust fund; and frequency of bill, such as initial or cancellation) - an "x" in the last digit of numeric three digit TOB means that value can be from 0-9.

UB-92 - The claim or bill form, in either paper or electronic version, used by most institutional health care providers. Published by CMS as the Form CMS-1450, but the standard itself is maintained by a nongovernmental body: the National Uniform Billing Committee. Law requires the use of the 837 claim instead of the electronic UB-92 by October 2003.

October 1, 2000 or 10/01/00 - Legislated effective date for HH PPS.

1500 - The claim form, in either paper or electronic version (NSF), used by most noninstitutional health care providers and suppliers to bill Medicare carriers. Published as Form CMS-1500.

485 - CMS form number for Plan of Care (see "POC" above).

10.1.25 - HH PPS Consolidated Billing and Primary HHAs

(Rev. 1, 10-01-03)

HH-467.35, A3-3639.35, PM-AB-00-112

The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services is to be made to a single home health agency (HHA) overseeing that plan, and this HHA is known as the primary agency or 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 a 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.

Medicare periodically publishes instructions containing a list of nonroutine supply codes and therapy codes that must be included in consolidated billing. The list changes from year to year as a result of changes in HCPCS codes, which Medicare also publishes annually.

The HHA that submits the first 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 CWF based HIQH inquiry system for HH PPS. 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, from the first day of that episode until day 60 or last billable service date, if discharged. This applies to provider types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers). Providers and suppliers may access information on existing episodes through the ANSI X12N 270/71 inquiry process system. See §30.1.

DME is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DMERC or billed by an HHA (including HHAs other than the primary HHA) to a RHHI. Refer to §90.1. Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the FI and the carrier at the same time for the same beneficiary. In the event of duplicate billing to both the RHHI and the DMERC, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent the simultaneous payment for the purchase and the rental of the same item.

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, and are billed on a claim with a bill-type that is not specific to HH PPS (TOB 34X). When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be

permitted to bill osteoporosis drugs for them. For more detailed information, refer to §90.1.

20 - Completion of Home Health Prospective Payment System (HH PPS) Consolidated Billing Enforcement

(Rev. 1, 10-01-03)

PM-AB-01-111, PM AB-01-65, Dated 4/26/01

Home Health consolidated billing editing is applied when the episode claim has been received and processed in CWF. CWF sends information to FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing.

The CMS implemented enforcement of home health consolidated billing in stages. The first stage of enforcing editing for consolidated billing involved editing claims when the HH PPS claim had been received before other claims in the same time period subject to consolidated billing. The second stage was applying this editing when the HH PPS claim was received after the other claims subject to consolidated billing in the episode created by that HH PPS claim.

Messages explaining line-item denials for home health consolidated billing denial appear on remittance advice for providers and Medicare Summary Notices (MSNs) for beneficiaries. For denials on claims billed to FIs, recoveries will be made automatically in the claims process. For denials on claims billed to carriers, criteria in overpayment recovery instructions from policy for furnishing demand letters and appeal right will be followed. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

Based upon revisions to the procedure codes, CMS issues annually, a new list of procedures that, when billed by various types of providers submitting claims to either Medicare FIs or carriers at the same time as a home health episode are subject to denial because payment is provided to the home health agency creating the episode.

20.1 - Exception of Supplies from Consolidated Billing Edits on Institutional Claims

(Rev. 1, 10-01-03)

Claims for certain emergency, surgical, diagnostic, and ESRD services may include a medical supply HCPCS code in addition to the other services provided. Because these supplies are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, these supplies do not fall within the bundling provisions of home health prospective payment. These claims will not be subject to consolidated billing edits by FIs.

20.2 - Only RAP Received and Services Fall Within 60 Days after RAP Start Date

(Rev. 1, 10-01-03)

PM-AB-01-70, Dated 5/1/01

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 FI or carrier to notify them that the claim may be subject to consolidated billing. The FI or carrier 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 (ERA). 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 (MSN).

If a claim for the episode has been received, these edits are applied if the claim subject to consolidated billing contains dates of service between 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 will be used for editing purposes. CWF returns an update to the FI or carrier. 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 line item denied.

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. 1, 10-01-03)

HH-467.17, HH-468, A3-3639.17, A3-3640, A3-3508, PM AB-03-036

With the advent of 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, the HHA wants to determine if the beneficiary is already being served by another agency - an agency that then would already be considered primary.

HHAs may send an inquiry to determine the beneficiary's entitlement and eligibility status into Medicare's beneficiary database, the Common Working File or CWF, through their RHHI. Effective October 16, 2003, the HA 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.

RHHIs 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 RHHI 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. 1, 10-01-03)

HH-468.3, A3-3640.3

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 an RHHI 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 RHHIs Based on Eligibility Responses

(Rev. 1, 10-01-03)

HH-468.4, A3-3640.4

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 RHHI from the CMS Web site which has a list of RHHIs by State, or may ask its FI through existing provider inquiry channels. The FI will instruct the provider regarding which RHHI to contact to learn which HHA is involved.

RHHIs may provide information on either the provider or contractor that these providers may request. Information released will be determined by each RHHI, such as HHA name and address, but must be enough for the inquiring provider/supplier to contact either the primary HHA, if under that RHHI's jurisdiction, or another RHHI (contractor number), if the provider number is attached to another RHHI. 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. 1, 10-01-03)

HH-468.5, A3-3640.5

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 Regional Home Health Intermediary, RHHI, (Contractor) and Provider Numbers;
- Period Start and End Dates - the start date is received on a 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;

- DOEBA and DOLBA, Dates of Earliest and Latest Billing Activity (respectively) - dates needed to attribute episode payment to the correct Medicare trust fund, drawn from the existing home health benefit period file;
- Patient Status Indicator - the patient 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 - source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge);
- The HIPPS Code(s) - up to six for any episode, representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
- Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or overlaying 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," in all other cases, the value is "0."

Separate from the episode file, CWF passes the Claims-OASIS matching key on the RAP or claim to CMS' National Claims History (NCH). This enables NCH claims data to be linked to individual OASIS assessments supporting the payment of individual claims. The LUPA indicator is also passed to NCH, in additional to routinely passed claim data.

A transfer/readmit indicator, populated by the source of admission code taken from the RAP or claim as an indicator of the type of admission, 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 validity this data used in CWF editing, they must research the claim record on CWF history. 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. 1, 10-01-03)

HH-468.6, A3-3640.6

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 particular the DOEBA, DOLBA and visit counts. In most cases, receipt 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, as opposed to RAPs, 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.

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. 1, 10-01-03)

HH-468.7, A3-3640.7

RHHIs reject RAPs and claims with statement dates overlapping existing episodes, including No-RAP LUPA claims, unless a transfer or discharge and readmit situation is indicated. RHHIs also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. Sixty-day episodes, starting on the original period start date, remain on record in these cases.

Episode lengths are shortened when another RAP or claim indicating transfer 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 RHHI 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 payment is recouped 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. 1, 10-01-03)

HH-468.8, A3-3640.8

CWF assures that the final “from 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 source of admission codes on RAPs. For example, CWF acts on "B," indicating transfer, and "C," indicating readmission after discharge by the same agency in the same 60-day period, open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone do not trigger creation of a new episode. 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 Other Claim Types for Consolidating Billing

(Rev. 1, 10-01-03)

HH-468.9, A3-3640.9

Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility 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 skilled nursing facility (SNF) claim (not including the dates of admission and discharge), the RHHI 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.

A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment may apply. Occurrence span code 74, previously used in such situations, should not be employed on HH PPS claims. 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, there would be one shortened HH PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall.

CWF edits to prevent duplicate billing among RHHIs and DME regional carriers. 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. By law, consolidated billing is required for home health services, to be implemented along with HH PPS. In short, consolidated billing requires that only the HHA responsible for a given HH PPS episode, the primary HHA, bill services under the home health benefit, with the exception of DME, for the period of that episode. The types of service most affected are nonroutine supplies and outpatient therapies, since these service are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code in the final rule for HH PPS. (This list will be updated periodically by Program Memorandum.) When an open HH PPS episode exists at CWF, any HH claims with dates of service that overlap the episode dates billed by other agencies will be rejected.

CWF enforces consolidated billing for outpatient therapies, recognized under revenue codes 042X, 043X, 044X on FI claims, so that only those therapy services billed by the primary HHA will be paid and posted. These revenue codes have been cross-referenced to a list of HCPCS codes in the HH PPS final rule approximating the same services for use in editing against carrier claims. (CMS will periodically issue temporary instructions to update this list.)

If revenue code 0636 and the HCPCS code for 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 .

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. 1, 10-01-03)

HH-468.11, A3-3640.11

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 (Percentage Payments 0-60)	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next 60 days	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from can not 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 RHHI	The episode record is deleted from CWF	• No episode exits to prevent RAP submission or No-RAP LUPA claim submission
RAP Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present • To correct information on this RAP, the original RAP must be replaced, cancelled by the HHA and then re-submitted once more with the correct information

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Claim (full episode)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Claim (discharge with goals met prior to Day 60)	Episode record completed; episode "thorough" date remains at the 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	• 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	Opens an episode record using claim's "from" date; the "through" date is automatically calculated to extend through 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • Other No-RAP LUPA claims will be rejected unless a transfer source code 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)	No impact on the episode unless adjustment changes patient status to transfer	• No impact
Claim Cancellation by Provider or RHHI	The episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP LUPA claim submission
Claim Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present

40 - Completion of Form CMS-1450 for Home Health Agency Billing

(Rev. 1, 10-01-03)

HH-475, A3-3638.22, A3-3638.13

The Form CMS-1450 (also known as the UB-92) is a uniform institutional provider bill suitable for use in billing multiple third party payers. Because it serves the needs of many payers, a particular payer may not need some data elements. Fields labeled not required are not needed for Medicare HH PPS fee-for-service billing. Note example of fields, when given, reflect the hard copy claim form. The CMS encourages use of the electronic formats, and, as of October 2003, only the ANSI ASC X12N 837 claims will be permitted for electronic use. 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. 61, 01-16-04)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, 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 a request for anticipated payment (RAP) with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, a RAP and a claim will be submitted for each episode period. Each claim, usually following a RAP and at the end of an episode, 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 next remittance advice.

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 next remittance advice (RA) will be used to recoup the overpaid amount.

While a RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims. 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 HH episodes 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 UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

Form Locator (FL) 1. (Untitled) 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 (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH RAP billing.

FL 3. 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.

FL 4. TOB 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).

lst 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 a 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 a 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 code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If a 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.

RHHIs will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

FL 5. Not required for Medicare HH RAP billing.

FL 6. 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.). All dates are in the format MM-DD-YY.

FL 7. Not required for Medicare HH RAP billing.

FL 8. Not required for Medicare HH RAP billing.

FL 9. Not required for Medicare HH RAP billing.

FL 10. Not required for Medicare HH RAP billing.

FL 11. Not required for Medicare HH RAP billing.

FL l2. Patient's Name

Required - Patient's last name, first name, and middle initial.

FL l3 Patient's Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate

Required - Month, day, and year of birth (MM-DD-YY) of patient.

Left blank if the full correct date is not known.

FL l5. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH RAP billing.

FL l7. Admission Date

Required - Date the patient was admitted to home health care (MM-DD-YY). On the first RAP in an admission, this date should match the statement covers "from" date in FL 6. 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 episode should, therefore, match the date submitted on the first RAP in the admission.

FL 18. Not required for Medicare HH RAP billing.

FL 19. Not required for Medicare HH RAP billing.

FL 20. Source of Admission

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

Code	Definition
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital (CAH)
B	Transfer from Another HHA
C	Readmission to Same HHA

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

FL 21. Not required for Medicare HH RAP billing.

FL 22. Patient Status

Required - Indicates the patient's status as of the "through" date of the billing period (FL 6). 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 structure

Code	Definition
30	Still patient

FL 23. Medical Record Number

Optional - This is the number assigned to the patient's medical/health record. The RHHI must carry information entered in this field through their system and return it to the biller.

FLs 24 - 30. Condition Codes

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

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" in FL 84, indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

FL 31. Not required for Medicare HH RAP billing.

FL 32, 33, 34, and 35. Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YY).

Fields 32A-35A must be completed before fields 32B-35B are used.

FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "through" date is in the date field.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

For a complete list of Occurrence Codes, see Chapter 25, .

FL 36. Occurrence Span Code and Dates

Not Required - Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If canceling a RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, HHAs show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

FL 38. Not required for Medicare HH RAP billing.

FLs 39-41. 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 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.

A description of the MSA system and codes can be found at the following Web site:

http://www.census.gov/population/estimates/metro-city/a99mfips.txt

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or nondollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the biller must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." FLs 39a through 41a must be used before FLs 39b through 41b (i.e., the first line is used before the second line).

For a complete list of value codes, see Chapter 25.

FL 42 and 43 Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

Revenue Code.	Description
0023	Home Health Services

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. 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.

HHAs may report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of the charges billed. However, Medicare claims processing systems will overlay this amount with the total payment for the RAP.

FL 44. HCPCS/Rates

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.

FL 45. 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.

FL 46. Units of Service

Optional - Units of service are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line. Medicare claims processing systems will place the payment amount for the RAP in this field on the electronic claim record.

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.

FL 48. Noncovered Charges

Not Required - The HHA does not report noncovered charges for Medicare on RAPs.

FL 49. Not required for Medicare HH RAP billing.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare. It must be entered on the same line (A, B, or C) as "Medicare" in FL 50.

If a Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number, indicating patient status 06. This claim will be paid a PEP adjustment. Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases report the new provider number in this field.

FLs 52A, B, and C. 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.

FL 53. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 56. Not required for Medicare HH RAP billing.

FL 57. Not required for Medicare HH RAP billing.

FLs 58A, B, and C. 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 in FLs 50-54, record the patient's name as shown on the patient's HI card or other Medicare notice.

FLs 59A,B,and C. Patient's Relationship to insured , Not required for Medicare HH RAP billing

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required.

See Chapter 25.

FL 61. Not required for Medicare HH RAP billing.

FL 62. Not required for Medicare HH RAP billing.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

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.

FL 64. Not required for Medicare HH RAP billing.

FL 65. Not required for Medicare HH RAP billing.

FL 66. Not required for Medicare HH RAP billing.

FL 67. 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 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

FLs 68-75. Other Diagnoses 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. None of these other diagnoses may duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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 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 guidelines.*

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH RAP billing.

FL 77. Not required for Medicare HH RAP billing.

FL 78. Not required for Medicare HH RAP billing.

FL 79. Not required for Medicare HH RAP billing.

FL 80. Not required for Medicare HH RAP billing.

FL 81. Not required for Medicare HH RAP billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has established the plan of care with verbal orders.

FL 83. Not required for Medicare HH RAP billing.

FL 84. Remarks

Required - Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

FL 85. Not required for Medicare HH RAP billing.

FL 86. **Not required for Medicare HH RAP billing.**

40.2 - HH PPS Claims

(Rev. 61, 01-16-04)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under a HH plan of care (not under HH PPS), see §90. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After a 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 remittance advice information is contained in Chapter 22.

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 HH episodes 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 UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

FL 1. (Untitled) 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. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH PPS claim billing

FL 3. Patient Control 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.

FL 4. TOB

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).

lst 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 a HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims system determine whether a 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 a 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.

HH PPS claims will be submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." FIs 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, an adjustment must be submitted by the HHA.

FL 5. Not required for Medicare HH PPS claim billing.

FL 6. Statement Covers Period (From-Through)

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 than the "from" date. The patient status code in FL 22 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 a discharge claim is submitted due to change of FI, see FL 22 below. If the beneficiary has died, the HHA reports the date of death in the through date. In such cases, the "through" date field should represent the date of discharge or last billable service 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.

All dates are submitted in the format MM-DD-YY.

FL 7. Not required for Medicare HH PPS claim billing.

FL 8. Not required for Medicare HH PPS claim billing.

FL 9. Not required for Medicare HH PPS claim billing.

FL 10. Not required for Medicare HH PPS claim billing.

FL 11. Not required for Medicare HH PPS claim billing.

FL 12. Patient's Name

Required - Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required - Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate

Required - Enter the month, day, and year of birth (MM-DD-YY) of patient. If the **full** correct date is not known, leave blank.

FL 15. **Patient's Sex**

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH PPS claim billing.

FL l7. Admission Date

Required - The HHA enters the same date of admission that was submitted on the RAP for the episode (MM-DD-YY).

FL 18. Not required for Medicare HH PPS claim billing.

FL 19. Not required for Medicare HH PPS claim billing.

FL 20. Source of Admission

Required - Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Not required for Medicare HH PPS claim billing.

FL 22. Patient Status

Required - Enter 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. Revise the list to reflect recently added NUBC codes (62, 63, any other more recent ones)

Code	Definition
0l	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization, **OR** Discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice or discontinued care
20	Expired (or did not recover - Religious Nonmedical Patient)

Code	Definition
30	Still patient or expected to return for outpatient services
40	Expired at home (Hospice claims only
42	Expired - place unknown (Hospice claims only
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharge/transferred within this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care

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 the ownership of an HHA is changing which causes the six digit Medicare provider number to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number 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 partial episode payment (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 six digit Medicare provider number, billing for episodes is also unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare+Choice plan as of a certain date, the provider should submit a claim for the shortened period prior to the HMO 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 Medicare+Choice, since HH PPS applies only to Medicare fee-for-service.

If HHAs require guidance on OASIS assessment procedures in these cases, refer them to the appropriate state OASIS education coordinator.

FL 23. Medical Record Number

Required - Enter the number assigned to the patient's medical/health record. The RHHI must carry it through their system and return it on the remittance record.

FLs 24 - 30. Condition Codes

Optional - Enter any NUBC approved code to describe conditions that apply to the claim.

Claim Change Reasons

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS*/HIPPS Rate Codes*
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

If adjusting the claim to correct a HIPPS code, HHAs use condition code *D2* and enter "Remarks" in FL 84 indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3x8), HHAs report the condition codes D5 or D6 and enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

For a complete list of Condition Codes see Chapter 25.

FL. 31. Not required for Medicare HH PPS claims billing

FL 32, 33, 34, and 35. Occurrence Codes and Dates

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

See Chapter 25.

FL 36. Occurrence Span Code and Dates

Optional - 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.

For a complete list of Occurrence Span codes see Chapter 25.

FL 37. Internal Control Number (ICN)/ 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. The HHA inserts the ICN/DCN of the claim to be adjusted here. The HHA shows payer A's ICN/DCN on line "A" in FL 37, and shows the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

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 an ICN/DCN on all HH PPS claims, only on adjustments to paid claims.

FL 38. Not required for Medicare HH PPS claim billing.

FLs 39-41. Value Codes and Amounts

Required - See §40.1, FL 39 - 41.

For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: FI value codes. Providers reports code *61*. The FI places codes *17 and* 61 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

Code	Title	Definition
17	Outlier Amount	*The amount* of any outlier payment returned by the Pricer with this code. (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 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

Code	Title	Definition
		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 §1812a)(3) of the Social Security Act.
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 FI 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.*

FL 42 and 43 Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by "X" in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim. If there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more then once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change. Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero charges in FL 46. See §40.1, FL 44, for more detailed information on the HIPPS code.

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 Medical/Surgical Supplies (Also see 062X, an extension of 027X)

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. Revenue code 0274 requires a HCPCS code, the date of service units and a charge amount.

042X Physical Therapy

Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

043X Occupational Therapy

Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

044X Speech-Language Pathology

Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), 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: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), 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: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), 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: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: FIs 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 RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

029X Durable Medical Equipment (DME) (Other Than Renal)

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.

060X Oxygen (Home Health)

Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

062X Medical/Surgical Supplies - Extension of 027X

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.

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.

Chapter 7 of the Medicare Benefit Policy Manual defines routine vs. nonroutine supplies. HHAs will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. 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.

HHAs may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum charges billed. Medicare claims processing systems will assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates

Required - On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a significant change in condition (SCIC), the HHA reports on each

additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

FL 45. Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. 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 FL 43 above. For service visits that begin in one calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

FL 46. Units of Service Required

The HHA should not report units of service on 0023 revenue code lines. 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 FL 43. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as units of service a number of fifteen 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.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line (the field may be zero or blank). Medicare claims processing systems will place the episode payment amount for the claim in this field on the electronic claim record. For LUPA claims, the per visit payment will be reported on individual line items.

For line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. 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.

FL 48. Noncovered Charges

Required - The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. The HHA reports all noncovered charges, including no-payment claims.

Claims with Both Covered and Noncovered Charges

The HHA reports (along with covered charges) all noncovered charges, related revenue codes, and HCPCS codes, where applicable. On the UB-92 flat file, the HHA uses record type 61, Field No. 10 (total charges) and Field No. 11 (noncovered charges).

HHA Bills with All Noncovered Charges

The HHA submits claims when all of the charges on the claim are noncovered (no-payment claim). The HHA completes all items on a no-payment claim in accordance with instructions for completing claims for payment, with exceptions including all charges reported as noncovered. See Chapter 1 for further instructions on no-payment bills.

[space holder]

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

The HHA reflects a change in Medicare provider number within a 60-day episode by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. In this case, it reports the original provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - See Chapter 25.

FL 53. Not required for Medicare HH PPS claim billing.

FL 54. Not required for Medicare HH PPS claim billing.

FL 55. Not required for Medicare HH PPS claim billing.

FL 56. Not required for Medicare HH PPS claim billing.

FL 57. Not required for Medicare HH PPS claim billing.

FLs 58A, B, and C. Insured's Name

Required only if MSP involved. See the Medicare Secondary Payer Manual. Enter the beneficiary's name as shown on the Health Insurance Claim card. The name should be recorded on line A if Medicare is prime, line B if Medicare is secondary, and line C if Medicare is the tertiary payer. This placement, A, B, or C, should correspond with the line Medicare was recorded on in FL50.

FLs 59A, B, and C. Patient's Relationship To Insured

Required only if MSP involved. See the Medicare Secondary Payer Manual.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

Required only if MSP involved. See the Medicare Secondary Payer Manual. Enter the Medicare health insurance claim number as shown on the Medicare card. Place this information on Line A, B, or C as consistent with FL 58.

FLs 61A, B, and C. Group Name

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FLs 62A, B, and C. Insurance Group Number

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FL 64. Employment Status Code

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 65. Employer Name

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

Where the HHA is claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, it enters the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 67. 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 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FLs 68-75. Other Diagnoses 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 listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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 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 guidelines.*

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH PPS claim billing.

FL 77. Not required for Medicare HH PPS claim billing.

FL 78. Not required for Medicare HH PPS claim billing.

FL 79. Not required for Medicare HH PPS claim billing.

FL 80. Not required for Medicare HH PPS claim billing.

FL 81. Not required for Medicare HH PPS claim billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has signed the plan of care.

FL 83. Not required for Medicare HH PPS claim billing.

FL 84. Remarks

Optional - Remarks are required only in cases where the claim is cancelled or adjusted.

FL 85. Not required for Medicare HH PPS claim billing.

FL 86. Not required for Medicare HH PPS claim billing.

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. 1, 10-01-03)

HH-400, HH-463, definition of nominal charge provider from 42 CFR 410.2 Definitions, A3-3638.10

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

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 are 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. 1, 10-01-03)

A3-3638.14

Under HH PPS all services under a plan of care must be billed as a HH PPS episode. All services within an episode of care must be billed on one claim for the entire episode. RHHIs 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.25, 10-31-03)

(Rev. 61, 01-16-04)

A3-3638.30, PM-A-01-05

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), Form CMS-R-296, which also must be signed by the beneficiary or appropriate representative.

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 Regional Home Health Intermediary (RHHI) determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

With the advent of HH PPS, the Medicare payment unit for home care changes from visits to episodes, 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, initially under HH PPS, demand billing 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 will change and become standard. At most, a RAP and a claim will be 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 will 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

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). The 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 will be 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 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 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 eight hour home health aide visit in which the first two hours may be covered by Medicare and the remaining six 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 RHHI 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:

    a. An episode that received a partial episode payment (PEP) adjustment, or

    b. A period within an episode that received a significant change in condition (SCIC) adjustment.

If a favorable determination is made, RHHIs 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

HHABN policy has continued to change, but documentation of this policy can be found at:

- *The ABN Web site; and*
- *Chapter 30 (Financial Liability Protections), §60, of this Manual.*

The Notice of Exclusions from Medicare Benefits (NEMB) can also be referenced on the ABN Web site.

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 cases of statutory exclusions, 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. Since the HHABN is not appropriate in these

cases, the provider is free to develop their own written notice, but Medicare does have a voluntary form, the NEMB, could be used for this purpose.

2. Termination of the Benefit During the Episode Period. The HHABN is likely to be warranted in cases when only non-skilled, not medically necessary or non-covered services remain to be delivered under the plan of care, or when the beneficiary is no longer homebound, during the 60 days of the original episode period. These situations can be triggering events under existing HHABN policy (i.e., termination of the benefit), since the close of the episode, or the end of the benefit, occurs at this point, and a Medicare "paper" discharge can be done (i.e., the final claim for the episode prepared and submitted). At this point two billing options exist:

a. If there is no doubt the benefit has been completed, meaning the ordering physician, beneficiary and provider agree Medicare coverage has ended, the HHA has the option of billing the balance of the 60 day period remaining after the benefit has ended on a no payment claim as described in section 60 below. As with other statutory exclusions or services not part of a recognized Medicare benefit, notification of the beneficiary as to his/her liability prior to delivery of the service if the provider intends to charge may still be required by the HH COPs. A form such as the NEMB can be used in these cases.

b. If there is doubt/dispute as to the benefit is continuing, the whole 60-day episode period must be billed on a single HH PPS demand bill, and HHABNs must be given when triggering event(s) occur.

3. 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, a 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 a 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.

4. 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, a HHA should still give the beneficiary a 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 25, 10-31-03)

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 as of October 1, 2000. After the advent of this payment system, home health agencies (HHAs) 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 in Form Locator (FL) 4, and condition code 21 in FL 24-30 of the Form CMS-1450 claim form. The statement dates on the claim, FL 6, 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 FL 48 of each line. 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 (HAEJ1) as a proxy, a 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching-Key in FL 63, and 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 must also ensure that a matching RAP has not been paid for that billing period. FL 20, source of admission, and treatment authorization codes, FL 63, should be unprotected for non-pay bills.

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 ABN must be used if a triggering event occurs. However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during an 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, selecting Option A on that form, and,*
2. *A condition code 21 no-payment claim to bill all subsequent services.*

***NOTE**: Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must be consulted as to the option they want to select. The ABN 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.*

Termination of the benefit during the episode is discussed in Section 50 F, above.

70 - HH PPS Pricer Program

(Rev. 1, 10-01-03)

HH-475.4

70.1 - General

(Rev. 1, 10-01-03)

HH-475.4.A

Effective for dates of service on or after October 1, 2000, all home health services billed on TOB 32X or 33X will be reimbursed based on calculations made by the HH Pricer. The HH Pricer operates as 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, significant change in condition (SCIC) adjustments and outlier payments. (See §§10.1.17-10.1.22.) 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 describes 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 RHHIS 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. 61, 01-16-04)

The HH Pricer input/output file will be 450 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 when it is implemented.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from FL 60 of the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit OSCAR system provider number, copied from FL 51 of the claim form.
29-31	X(3)	TOB	Input item: The TOB code, copied from FL 4 of 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

File Position	Format	Title	Description
			set a Y if the patient status code in FL 22 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 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%
37-43	X(7)	FILLER	Blank.
44-46	X(3)	FILLER	Blank.
47-50	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code, copied from the value code 61 amount in FLs 39-41 of 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 FL 6 of 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 FL 6 of the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from FL 17 of the 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

File Position	Format	Title	Description
		CODE	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 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 in all cases except when the therapy threshold for the claim was not met.
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	Five more occurrences of all HRG/HIPPS code related fields defined above, since up to six HIPPS codes can be automatically processed for payment in any one episode.
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

File Position	Format	Title	Description
			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 low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by the Pricer 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 03 Initial percentage payment, 0% 04 Initial percentage payment, 50% 05 Initial percentage payment, 60% 06 LUPA payment only 07 Final payment, SCIC 08 Final payment, SCIC with outlier 09 Final payment, PEP 11 Final payment, PEP with outlier 12 Final payment, SCIC within PEP 13 Final payment, SCIC within PEP with outlier **Error return codes:** 10 Invalid TOB

File Position	Format	Title	Description
			15 Invalid PEP days
			16 Invalid HRG days, > 60
			20 PEP indicator invalid
			25 Med review indicator invalid
			30 Invalid MSA code
			35 Invalid Initial Payment Indicator
			40 Dates < 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 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 low utilization payment adjustment (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.
431-450	X(20)	FILLER	Blank.

Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HRG" 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 each HIPPS code will be placed in the total charges and the covered charges field of the appropriate 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. 1, 10-01-03)

HH-475.4.C

On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

1. 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 .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA-1" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by .22332 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.

2. a. If the "INIT-PYMNT-INDICATOR" equals 0, 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, 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. 1, 10-01-03)

HH-475.4.D

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 FI initiated adjustments), Pricer will perform the following calculations in the numbered order:

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 and sum the six products. The result is the total payment for the episode. Return this amount in the "TOTAL-PAYMENT" field with return code 06. No further calculations are required.

    b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

2. Therapy threshold determination.

    a. If the "REVENUE-SUM1-3-QTY-THR" (the total of the quantities associated with therapy revenue codes, 042x, 043x, 044x, which will be passed from the shared systems sorted in this order) is less than 10, perform the following:

    If the "MED-REVIEW-INDICATOR" is a Y for any HRG, do not alter the HIPPS code reported in "HRG-INPUT-CODE." Copy that code to the "HRG-OUTPUT-CODE" field. Proceed to the next HRG occurrence.

    If "MED-REVIEW-INDICATOR" is an N for any HRG, read the table of HIPPS codes for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be meet for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

    If the code in the first column does not match the code in the second column (indicating the therapy threshold is unmet for that code), place the code from the second column in the "HRG-OUTPUT-CODE" field.

    b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE"

fields. Proceed to HRG payment calculations. Use the weights associated with the codes in the "HRG-OUTPUT-CODE fields for all further calculations involving each HRG.

3. HRG payment calculations.

   a. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is an N:

      Find the weight for the "HRG-OUTPUT-CODE" from weight table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal standard episode

      rate for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by .22332 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.

      Proceed to the outlier calculation (see 4 below).

   b. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is a Y:

      Perform the calculation of the case-mix and wage index adjusted payment for the HRG, 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).

   c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is an N:

      Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the "HRG-NO-OF-DAYS" field for that code divided by sixty. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will returned in separate occurrence of the "HRG-PAY" fields, so that the shared systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

   d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a Y:

      Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the "PEP -DAYS" field divided by 60. Multiply the result by

the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field. Repeat this for up to six occurrences of "HRG-CODE." These amounts will returned separately in the corresponding "HRG-PAY" fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 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 is greater than $0.00, calculate .80 times the result. Return this 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.
    e. If the result 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. 1, 10-01-03)

HH-475.4.E

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each October, to reflect the Federal fiscal year and at other points in the year when required by legislation. The following update items, when changed, will be published annually in the "Federal Register:"

- The Federal standard episode amount;
- 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 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.

80 - Special Billing Situations Involving OASIS Assessments

(Rev. 61, 01-16-04)

HHA 475.5

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 Health Maintenance Organization (HMO) Enrollment Status

1 - Payment Source Changes From HMO to Medicare Fee-For-Service (FFS)

If a Medicare beneficiary is covered under an HMO 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 a Medicare HMO 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 monitoring (OBQM) reports. Otherwise, that patient will not be included in the HHA's OBQM 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 M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, that too should be marked.) CMS realizes that the wording for M0100 and M0880 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 as changed from HMO to FFS.

In cases where the patient changes from HMO 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 HMO 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 in FL 63 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 (M0825). 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 (RFA#4) 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 a 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 HMO. The HHA had conducted a follow-up OASIS assessment on January 19, 2001, 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, 2001 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, 2001. 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, 2001, 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 HMO 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 HMO

In cases where the patient elects HMO 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 HMO becomes the primary payer upon the HMO 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 HMO enrollment date. If the patient has elected to move from Medicare FFS to a Medicare HMO and 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 claim "from" and "through" dates* in FL 6 of the UB-92 claim form (or electronic equivalent) that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. 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 in FL 63. 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 61and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last five days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted *with claim "from" and "through" dates* in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. 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 in FL 63. 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 61and 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, home care 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 claim "from" and "through" dates* in FL 6 that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. 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 in FL 63. 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.

Since the OASIS assessment on which payment is based is not transmitted to the State, the claim for the episode must not report a 'claims-OASIS matching key' in the treatment authorization field of the claim form. Instead, this field on the claim form for the RAP or claim should be filled with a string of ones (e.g. "11111111111111111") in order to pass a Medicare claims system edit which requires this field to contain a numeric value. This is one of the two circumstances in which the 'claims-OASIS matching key' on a RAP or claim for payment may be filled with ones. (See Chapter 1 for the other use of this practice on no-payment claims.) In all other respects, the RAP and claim for the episode should be identical to other HH PPS RAPs and claims.

Inpatient Hospital Stays and the End of Episodes - Five Scenarios

The chart below presents the information in this section in tabular form. Each example assumes an episode beginning 10-2-2002 which would otherwise end 11-30-2002 ("Day 60"). The subsequent episode could begin 12-1-2002 ("Day 61") and end 1-29-2003.

Scenario Example	OASIS Impact	Claim Impact
1) Hospitalized on Days 60 AND 61 • Beneficiary is assessed for recertification on 11-26-2002 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-2-2002 • Returns to same HHA, receives next visit 12-3-2002	Start of Care (SOC) assessment upon return from hospital	Episodes are NOT considered continuous care: • RAP submitted with "From" and admission date of 12-3-2002, • New episode now extends to 1-31-2003 • Matching key reflects SOC assessment
2) Discharge on Day 60 or 61, HIPPS code changes • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HBGK1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 11-30-2002 (Day 60) • Returns to same HHA, receives next visit and resumption assessment 12-2-2002, HIPPS code: HCHL1.	Resumption of Care (ROC) assessment upon return from hospital, submitted as SOC	Episodes are NOT considered continuous care: • RAP submitted with "From" and admission date of 12-2-2002, • New episode now extends to 1-30-2003 • Matching key reflects SOC assessment
3) Discharge on Day 60 or 61, HIPPS code unchanged • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-1-2002 (Day 61) • Returns to same HHA, receives next visit and resumption assessment on or after 12-2-2002, HIPPS code: HDIM1.	ROC assessment upon return from hospital	Episodes ARE considered continuous care: • RAP submitted with "From" date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment

Scenario Example	OASIS Impact	Claim Impact
4) Hospitalized on Day 61, HIPPS code changes • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HAEK1 • Admitted to hospital on 12-1-2002 (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives first visit in episode and resumption assessment 12-5-2002, HIPPS code: HBFL1.	ROC assessment upon return from hospital, submitted as SOC	Episodes are NOT considered continuous care • RAP submitted with "From" and admission date of 12-5-2002, • New episode now extends to 2-2-2003 • Matching key reflects SOC assessment
5) Hospitalized on Day 61, HIPPS code unchanged • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 12-1-2002, after HH visit same day (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives next visit and resumption assessment 12-5-2002, HIPPS code: HDIM1.	ROC assessment upon return from hospital	Episodes ARE considered continuous care • RAP submitted with "From" date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment

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

(Rev. 1, 10-01-03)

HH-461, A3-3638.9, A3-3638.19

Form CMS-1450 is submitted 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.) Refer to instructions in Chapter 20 of this manual and §90.1 in this chapter for submitting claims under arrangement with suppliers.

A - Patient Not Under A Home Health Plan Of Care

The HHA uses a Form CMS-1450 (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.)
- Outpatient speech pathology services. (See the Medicare Benefit Policy Manual, Chapter 15.)
- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, Chapter 15.)

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.

Note that HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not bill RHHIs for laboratory tests. These services are billed to Medicare carriers with jurisdiction on the CMS-1500 claim form. To submit such claims to the carrier, the HHA must have a CLIA number and a billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate carrier 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.

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 Form CMS-1450 (Bill Type 34X). All other services are home health services and should be billed as a 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.

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 one 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 FI 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 attributed to the Federal fiscal year or calendar year in which they end.

90.1 - Osteoporosis Injections as HHA Benefit

(Rev. 1, 10-01-03)

A3-3638.21

A - Billing Requirements

The cost of administering the drug is included in the charge for the skilled nursing visit billed under bill type 32X or 33X, as appropriate. An episode claim showing a skilled nursing visit must be received from the HHA billing the injection in order for the claim for the injection to process. The cost of the drug is billed under bill type 34X with revenue code 0636 and HCPCS code J0630. This code is defined as up to 400 units. Therefore, the provider must calculate units for FL 46 of 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

This is considered part of the home health benefit under Part B.

B - Denial Messages

If the claim for an osteoporosis drug is denied because it was not an injectable drug approved by the FDA, the FI 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 of the drug, the FI 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

If the service dates on the 34X claim fall within a 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).

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 Chapter18.

100 - Temporary Suspension of Home Health Services

(Rev. 1, 10-01-03)

A3-3638.17

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.

When services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), if the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 0023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.

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.