CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 397	**Date: October 31, 2008**
	Change Request 6250

SUBJECT: Claim Adjustments to Correct Home Health Prospective Payment System (HH PPS) Payment Errors

I. SUMMARY OF CHANGES: This transmittal instructs the Regional Home Health Intermediaries to adjust claims to correct errors associated with the implementation of the home health prospective payment system case-mix refinement project.

New / Revised Material
Effective Date: Episodes ending on or after January 1, 2008
Implementation Date: February 2, 2009

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

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

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:

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

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

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 397	Date: October 31, 2008	Change Request: 6250

SUBJECT: Claim Adjustments to Correct Home Health Prospective Payment System (HH PPS) Payment Errors

Effective Date: Episodes ending on or after January 1, 2008
NOTE: Unless otherwise specified, the effective date is the date of service.
Implementation Date: February 2, 2009

I. GENERAL INFORMATION

A. Background:

Medicare implemented refinements to the HH PPS case-mix model effective for episodes beginning on or after January 1, 2008. Medicare systems did not correctly implement certain requirements of the HH PPS refinements initially. These errors resulted in incorrect payments to home health agencies (HHAs) during the first two quarters of calendar year 2008. Certain errors resulted in overpayments to the HHAs, others resulted in underpayments. The errors are described below:

1) The January 1, 2008 version of the HH PPS Pricer software contained an error that caused the supply add-on amount to be paid on episodes that began in 2007 and spanned January 1, 2008. The supply add-on is properly only applicable for episodes beginning on of after January 1, 2008. This error resulted in overpayments of the minimum supply add-on amount of $14.12.

Claims affected: Any HH PPS final claim with a "From" date in 2007 and a "Through" date in 2008 which was processed between January 1, 2008 and February 4, 2008.

2) The January 1, 2008 version of the HH PPS Pricer software contained an error that prevented appropriate upcoding of claims containing exactly 20 therapy visits but which reported a HIPPS code projecting a lower number of therapy visits. This error resulted in underpayments due to claims being paid at a lower-weighted HIPPS code than was appropriate for the services billed.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 which reported 20 therapy visits and which was processed between January 1, 2008 and February 4, 2008.

3) The January 1, 2008 version of the HH PPS Pricer software failed to wage adjust the low utilization payment adjustment (LUPA) add-on payment. This error resulted in overpayments for services provided to beneficiaries who reside in areas where the wage index is less than 1.0. The error resulted in underpayments for services provided to beneficiaries who reside in areas where the wage index is greater than 1.0

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 with four or fewer visits, which was the first episode in a sequence of related episodes and which was processed between January 1, 2008 and February 4, 2008. Adjustments to these claims are already scheduled as part of Change Request 5877.

4) The January 1, 2008 version of the HH PPS Pricer software paid the full non-routine supply add-on amount on claims for episodes subject to partial episode payment (PEP) adjustment. The supply add-on should have been prorated on a basis of days along with the remainder of Medicare's payment for the

episode. The error resulted in overpayments that varied in amount depending on the non-routine supply severity level that applied and the number of days in the PEP proration.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 which was subject to a PEP adjustment and which was processed between January 1, 2008 and February 4, 2008.

5) The February 4, 2008 version of the HH PPS Pricer software corrected the wage-adjustment of LUPA add-on payments but created an additional problem in which the LUPA add-on amount was paid on all HH visit lines on the claim. The LUPA add-on should properly only be paid on the earliest dated HH visit line on a claim. The error resulted in overpayments that varied in amount depending on how many visit lines were included on the claim.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 with four or fewer visits, which was the first episode in a sequence of related episodes and which was processed between February 4, 2008 and March 10, 2008. Adjustments to these claims are already scheduled as part of Change Request 5877.

6) Medicare's Common Working File system failed to recognize episodes that occurred in 2007 when determining episode sequences. This caused claims for later episodes to be recoded and paid as early episodes in error. This error resulted in underpayments since under the refined HH PPS later episodes have higher HIPPS code weights.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 with a HIPPS code indicating a later episode for which the one of the first two episodes in the sequence of related episodes occurred in 2007 and which was processed between January 1, 2008 and July 7, 2008.

7) The March 10, 2008 version of the HH PPS Pricer software, as well as all previous versions, contained an incorrect per-visit rate for speech-language pathology (SLP) services. The Pricer reflected the SLP rate of $124.54, as published in the original HH PPS final rule, rather than the corrected amount of $124.65, as published in the correction notice to that rule. This error resulted in small underpayments in the calculation of LUPA and outlier payments.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 which was subject to LUPA or outlier payment adjustments and which was processed between January 1, 2008 and August 4, 2008.

8) The March 10, 2008 version of the HH PPS Pricer software, as well as all previous versions, contained an error in recoding logic that prevented the clinical domain value of the HIPPS code to be changed appropriately in certain cases. If the grouping step for the episode changed to step two during processing and the corresponding clinical severity value in the treatment authorization code was 'G' or 'N,' the clinical domain value in the HIPPS code was assigned to an incorrectly low weight. This error resulted in underpayments.

Claims affected: Any HH PPS final claim with a "From" date on or after January 1, 2008 which was recoded to a HIPPS code with '2' in the first position, which was processed between January 1, 2008 and August 4, 2008.

9) The August 4, 2008 version of the HH PPS Pricer software did not contain the 2008 wage index file. As a result, all HH claims processed after the version was installed paid incorrectly using the 2007 wage index. This error may have resulted in overpayments or underpayments depending on whether the wage index for a given CBSA increased or decreased between 2007 and 2008.

Claims affected: Any HH PPS final claim with a "Through" date on or after January 1, 2008 which was processed between August 4, 2008 and August 18, 2008.

B. Policy: Medicare contractors will correct HH PPS refinement payment errors, as directed by the business requirements below.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6250.1	Medicare contractors shall adjust home health PPS claims for the following problems when brought to their attention by the provider: -- claims with 20 therapy visits that did not recode properly (issue 2 in the background section) -- claims where LUPA or outlier payments reflected the incorrect SLP per visit rate (issue 7 in the background section)					X					
6250.2	Medicare contractors shall identify home health PPS claims for adjustment which meet the following criteria: -- claim "From" date in calendar year 2007 -- claim "Through" date in calendar year 2008 -- claim receipt date before February 4, 2008. (Note: these criteria identify claims for issue 1 in the background section.)					X					
6250.3	Medicare contractors shall identify home health PPS claims for adjustment which meet the following criteria: -- claim "From" date on or after January 1, 2008 -- patient status code 06 -- claim receipt date before February 4, 2008. (Note: these criteria identify claims for issue 4 in the background section.)					X					
6250.4	Medicare contractors shall identify home health PPS claims for adjustment which meet the following criteria: -- claim "From" date on or after January 1, 2008 -- HIPPS code with '3' or '4' in the first position in the provider-submitted HCPCS field -- HIPPS code with '1' or '2' in the first position in the APC-HIPPS field -- claim receipt date before July 7, 2008 (Note: these criteria identify claims for issue 6 in the background section.)					X					
6250.5	Medicare contractors shall identify home health PPS claims for adjustment which meet the following criteria: -- claim "From" date on or after January 1, 2008 -- HIPPS code with '2' in the first position in the APC-					X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	HIPPS field -- claim receipt date before August 4, 2008 (Note: these criteria identify claims for issue 8 in the background section.)										
6250.6	Medicare contractors shall identify home health PPS claims for adjustment which meet the following criteria: -- claim "Through" date on or after January 1, 2008 -- claim receipt date on or after August 4, 2008 and before August 18, 2008. (Note: these criteria identify claims for issue 9 in the background section.)					X					
6250.7	Medicare contractors shall adjust home health PPS claims identified in requirements 6250.2 through 6250.6 simultaneously, to ensure that overpayments are netted against underpayments.					X					
6250.8	Medicare contractors shall batch adjustments as needed, if the total volume of claims to be adjusted is too large to process at one time.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6250.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6250. 1	Claims affected by these problems will be adjusted on provider request rather than systematically because they affect small volumes of claims or small payment errors and costs of developing systematic adjustment processes for these issues are prohibitive.
6250. 1 through 6250.7	For these requirements, home health PPS claims is defined as types of bill 32x and 33x, excluding 322 and 332.
6250.4	Some claims meeting this condition will have been recoded appropriately and these adjustments will not change the payment to the HHA. However, since there is insufficient data on the face of the claim to determine whether the initial recoding was or was not appropriate, all claims must be adjusted in order to ensure all the necessary corrections are made.

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

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

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