Medicare
Home Health Agency Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: March 29, 2002*

Section 432, Billing Procedures For an Agency Being Assigned Multiple Provider Numbers or a Change in Provider Number, is revised to describe the handling of Home Health Prospective Payment System (HH PPS) episodes in a change of ownership situation.

Section 439, More Than One Agency Furnished Home Health Services, is revised to delete references to two agencies billing independently for services during the same period of time.

Section 440, Transfer to Another Agency Under the Same Plan of Treatment, is revised to indicate that such transfers are no longer permitted under HH PPS.

Section 465, Clinical Laboratory Improvement Amendments (CLIA), is revised to clarify that laboratory claims are not processed by Regional Home Health Intermediaries (RHHIs).

Section 467.6, New Software for the HH PPS Environment, is revised to add reference tables clarifying existing HH PPS policies.

Section 467.29, Adjustments of Episode Payment--Significant Change in Condition (SCIC), is revised to add a reference flowchart to assist home health agencies in determining whether a SCIC applies.

Section 467.31, Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments, is revised to add reference tables clarifying existing HH PPS policies.

Section 467.33, Exhibit: General Guidance on Line Item Billing Under HH PPS, is revised to correct information on the billing of splints on HH claims.

Section 475.1, Request for Anticipated Payment, is revised to clarify the reporting of diagnosis coding on RAPs.

Section 475.2, HH PPS Claims, is revised to describe billing HH PPS claims in a change of ownership situation, to describe billing for visits that span midnight, and to clarify the reporting of diagnosis coding on claims.

Section 475.5, Special Billing Situations Involving OASIS Assessments, is added to provide guidance in special cases involving where both billing and OASIS assessment requirements must be accommodated.

Section 475.6, Beneficiary-Driven Demand Billing Under HH PPS, is added to define demand billing instructions for HH PPS. Note, parallel instructions have been available in the Medicare Intermediary Manual since November 2000.

Section 475.7 No-Payment Billing and Receipt of Denial Notices Under HH PPS, has been added to define demand billing instructions for HH PPS. Note, parallel instructions have been available in the Medicare Intermediary Manual since November 2000.

Section 497.1, Billing and Payment for Medicare Secondary Payer (MSP) Claims Under the Home Health Prospective Payment System, is added to explain MSP under HH PPS. This section reproduces instructions that were published in the Medicare Intermediary Manual (§3682.4) in October 2000.

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Item 26 - Complete this item to indicate that you accept assignment.

Items 27, 28, 29 - Self-explanatory. Complete these items in all cases. If nothing has been paid on the bill, enter "None" in Item 28.

Items 30, 3l, 33 - Enter your employer identification number in Item 30 or 33. Enter in item 3l the identification number assigned by the carrier for claims from physicians.

Item 32 - Your identification number, if any, for the patient in case of a request for additional information.

429. ESTABLISHING THAT A HHA QUALIFIES TO RECEIVE PART B PAYMENT ON THE BASIS OF REASSIGNMENT

If you wish to receive Part B payment as a reassignee of one or more physicians, furnish the Part B carrier sufficient information to receive payment for their services. Where there is any doubt that you qualify as a reassignee, the carrier will obtain additional evidence.

Where you qualify as a reassignee, you assume the same liability for any overpayment which you may receive as a reassignee, as the physician would have if the payment had been made to him.

431. SCOPE OF WAIVER OF LIABILITY PROVISION

Services provided by you may be covered under a Part A or Part B home health plan, or where there is no acceptable plan they may be covered (and billed on a CMS-l450) as a "medical and other health service." (See §2l9).

For services furnished which are not covered under one of these provisions outlined above because they are found to be not reasonable and necessary, §l879 of the Social Security law provides protection from liability for beneficiaries and/or you who did not know, and had no reason to know that the services were not covered.

If the beneficiary had knowledge or should have had knowledge of the noncoverage of the services, the ultimate liability will rest with the beneficiary. When neither the beneficiary nor you knew, or reasonably could have been expected to know, that the services were not covered, the program accepts liability. Where you had or should have had such knowledge, and the beneficiary did not, liability will fall upon you. When liability falls on you, you may not charge the beneficiary for such services, other than the Part B deductible and coinsurance amounts.

432. BILLING PROCEDURES FOR AN AGENCY BEING ASSIGNED MULTIPLE PROVIDER NUMBERS OR A CHANGE IN PROVIDER NUMBER

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

Use the old provider number on billing forms for services through the day of the termination date of 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.

433. HOME HEALTH SERVICES AFTER TERMINATION OF PROVIDER AGREEMENT

Effective with the date an agreement is terminated, no payment will be made under such agreement for services furnished under a plan of treatment which was established on or after the termination date. However, if the plan was established before the termination date, payment can be made for up to 30 days following the effective date of termination. (See §l46.)

439. MORE THAN ONE AGENCY FURNISHED HOME HEALTH SERVICES

Wherever possible, use the following procedures in the exceptional case where a physician deems it necessary to use two participating HHAs. The physician designates the agency which will render the major services and assume the major responsibility for the patient's care as the primary agency. The primary agency bills for all services rendered by both agencies and keeps all records pertaining to the care, including the plan of treatment and required certifications. The secondary agency is reimbursed through the primary agency under mutually agreed upon arrangements.

440. TRANSFER TO ANOTHER AGENCY UNDER THE SAME PLAN OF TREATMENT

Procedures for transfers under the same plan of treatment which were used under cost reimbursement are no longer valid as of October 1, 2000. 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.

441. HOME HEALTH SERVICES ARE SUSPENDED OR TERMINATED THEN REINSTATED

A physician may feel it necessary to suspend visits for a time to determine whether the patient is sufficiently recovered to do without further home health services. When the suspension is temporary (not more than 60 days) and the physician later determines that the services must be resumed, the resumed services will be paid under the same program. No special entry is needed on the bill to indicate a suspension. The date plan established remains the same as on the initial bill. A no-payment bill is not submitted for the period in which there were no visits.

For Medicare reimbursement, a suspension of home health visits for more than 60 days terminates the plan of treatment unless the physician has reviewed the plan and made an appropriate recertification (see §240.1) within 60 days, which indicates that the lapse of visits is a part of the planned regimen. If there has been no recertification, the patient is considered discharged on the date of last visit.

A physician may determine that home health services furnished are no longer necessary and discharges the patient. The physician may later determine that home health services are again necessary and establish a plan for services related to the same condition or which the individual was previously hospitalized.

442. PREPARATION OF A BILL FOR UTILIZATION CHARGEABLE

Even though no Medicare payment is made, submit a billing form when:

- The patient or his representative refuses to request that payment be made on his behalf. Enter "Refused Payment" in the open area under Item 94:
- You are responsible for not filing a timely claim for payment;
- You fail to submit needed information; or
- The intermediary has notified you that a waiver of liability decision was made that finds you at fault.

NOTE: No-payment bills are not required.

445. SUBMITTING CORRECTED BILLS

Submit a corrected CMS-1450 if any of the following apply:

- o A change in provider number;
- o A change in coinsurance involves an amount greater than $1.99; or
- o A change in visits (decrease or increase).

To correct a previously submitted bill, reproduce a legible copy of the original. In Item 4, Type of Bill, third position, use frequency code 8 (Void/Cancel of Prior Claim). Prepare a new bill using frequency code 7 (Replacement of Prior Claim). Annotate Item 94 "Remarks" with a brief explanation. Send the bills to your intermediary or HMO as appropriate.

Where there are money adjustments other than a coinsurance amount greater than $1.99, record the difference on a record sufficiently documented to establish an accounting data trail, including patient's name and HICN, first and last dates of services, and any unique numbering or filing code necessary to associate the adjustment charge with the original billing.

465. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

A. Background.--CLIA of 1988 changes clinical laboratories certification. Effective September 1, 1992, clinical laboratory services are covered only if the entity furnishing laboratory services has been issued a CLIA number. However, laboratories may be paid for a limited number of laboratory services if they have a CLIA certificate of waiver or a certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

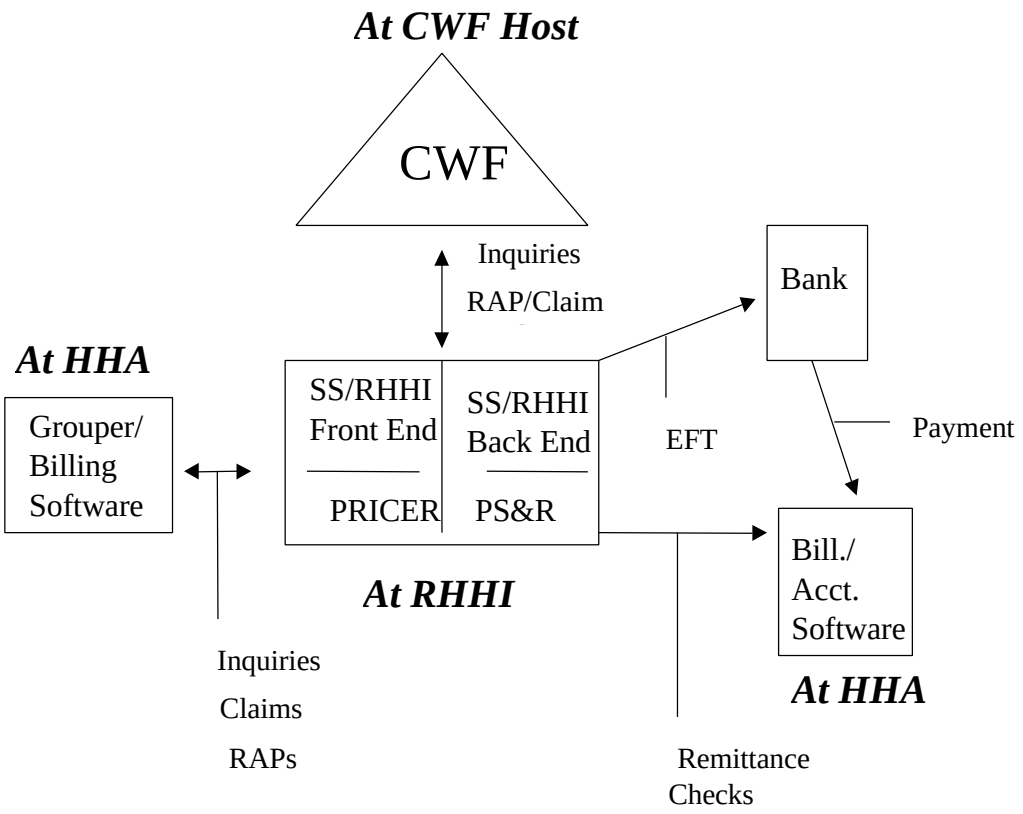
B. General.--HHAs may provide laboratory services within the CLIA certificate to beneficiaries. However, HHAs do not bill Regional Home Health Intermediaries (RHHIs) for laboratory tests. These services are billed to the Medicare carrier with claims jurisdiction. These services are billed using the Form CMS-1500 claim form or electronic equivalent. To submit claims to the carrier, the HHA must have a CLIA number and a billing number. The State Survey Agency should be contacted 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.

o HH PPS will employ formats, such as the paper and electronic **Form CMS-1450 (UB-92)** for RAPs and claims, and related existing transaction formats are still used (i.e., the **835** electronic And paper remittances, Medicare Summary Notice (**MSN**).

467.4 Effective Date and Scope of HH PPS for Claims.--As of October 1, 2000, all HHAs must bill all services delivered to homebound Medicare beneficiaries under a home health plan of care under HH PPS. HH PPS applies to claims billed under the cost reimbursement system on Form CMS-1450 (UB-92), with Form Locator 4 (FL 4), Type of Bill (TOB), completed with: first digit "3", second digit "2" or "3", and a varying third digit represented as "X". HHAs will still occasionally bill Medicare using TOB 34X, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established plan of care prior to this date, all these open claims for services on or before September 30, 2000 need to be closed, though HHAs may submit these bills for several months in accordance with current time limitations for HHA claims. Under no circumstances should a HHA claim span payment systems or September and October 2000 dates.

467.5 Configuration of the HH PPS Environment.--The configuration of Medicare home health claim processing is similar to previous 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 :



467.6 New Software for the HH PPS Environment.--New subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing:

o HHRGs for claims are determined at HHAs by inputting **OASIS** data (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment) into **Grouper** software at the HHA-- OASIS **HAVEN** software was updated to integrate the Grouper from the advent of HH PPS on, and CMS has made Grouper specifications available on its web site for those designing their own software.

o There is an **inquiry system** in CWF-- **HIQH**-- available via RHHI remote access, through which HHAs can ascertain if an episode has already been opened for a given beneficiary by another provider (i.e., that they are clearly the primary HHA), and track episodes of beneficiaries for whom they are the primary HHA.

o All HH PPS claims run through **Pricer** software, which is integrated into the standard 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**.**

The tables which follow summarize information in §467.1 through 467.6.

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***	***Key sections 3638.12 - 3640.12, 3656.6, 3752-3754 Medicare Intermediary Manual (September 2000); Key sections 467-475, 485 Home Health Manual (August 2000)***
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
Determine a new unit of payment	Determines basis of payment is 60-day episode	Description of episode payment and adjustments
	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
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
Allow cost outliers	Gives outlier methodology	Description of billing/payment process
Pro-rate payment for transfers	Reflects law	Description of billing process for transfers
Eliminate PIP payments with advent of HH PPS	Addresses public comments on elimination of PIP in Final Rule	
Require consolidated billing, except DME	Creates concept of primary agency in consolidated billing	Description of effects on billing and claim payment
Require ultimate effective date of October 1, 2000	Reflects law	Creation of recent program memorandum on Phase-in plan (8/31/00; A-00-59)
	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)
Require reporting services in 15-minute increments		Manualization (puts in instructions) of previous requirements for billing
Require UPINs on claims		Requirement existed prior to HH PPS

Cost-reimbursement Billing Environment 'vs.' HH PPS

FEATURE	Cost-Reimbursement	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)
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
Payment for home health services 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
Payment based on individual service or item	**YES**	**NO**, based on episode, bundling items and services for 60-day period
Claims are processed by Medicare Regional Home Health Intermediaries (RHHIs)	**YES**	**YES**, RAPs and claims
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 on **September 30, 2000 and before**	Services on **October 1, 2000 and after**
Claims span calendar year	**NO**	**YES**, HH PPS; **NO** 34x
Current Medicare information systems and software used in processing claims (i.e., CWF, FISS, APASS, PS&R)	**YES**	**YES**, RAPs and claims
Use of Grouper software at HHA	**NO**	**YES**
Use of CWF HIQH inquiry system	**NO**	**YES**
Use of Pricer software at RHHI	**NO**	**YES**

467.7 The HH PPS Episode--Unit of Payment.--The episode is the unit payment for HH PPS. The episode payment is specific to one individual homebound beneficiary, reimburses all home care, routine and non-routine supplies used by that beneficiary during the episode, and is the only Medicare form of payment for such services, with the following exceptions: DME, osteoporosis drugs, and other services or items HHAs may deliver to homebound beneficiaries that are not part of the Medicare home health benefit (i.e., vaccines). Routine supplies have not been separately reimbursable for Medicare home health care, and will not be reimbursed in addition to episode payments.

467.8 Number, Duration and Claims Submission of HH PPS Episodes.--The beneficiary can be covered for an unlimited number of non-overlapping 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. 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. Claims for episodes may also be submitted prior to the 60th day if the beneficiary has been 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. Allowing multiple episodes is intended to assure continuity of care and payment.

467.9 Effect of Election of HMO and Eligibility Changes on HH PPS Episodes.--The home health prospective payment system only applies to Medicare fee-for-service claims for homebound beneficiaries. 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. 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 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.

467.10 Split Percentage Payment of Episodes and Development of Episode Rates.--A split percentage payment will be made for most episode periods. There will be 2 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 reimbursement for the episode.

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 from claims for each of the six home health visit disciplines. These amounts were updated for inflation, and also include: non-routine 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.

467.11 Basis of Medicare Prospective Payment Systems and Case-Mix.--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 and rehabilitation hospitals. While there are definite 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.

Regarding the creation of the inpatient hospital prospective payment system, in 1982, the Tax Equity and Fiscal Responsibility Act or TEFRA, required Medicare hospital reimbursement limits to include a case-mix adjustment, and amendments to the Social Security Act in 1983 created a national hospital inpatient prospective payment system for Medicare. This legislation was passed in an effort to capture an effective framework for monitoring the quality of care and the utilization of services.

The term prospective payment might imply a system where payment would be made before services are delivered, or payment levels were determined prior to the completion 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. PPS also means a shift of the basis of payment, such as from payment tied to a claim or distinct revenue or procedural code, to a basis such as episode or diagnosis related group (DRG).

Case-mix is related to the creation of PPS through efforts to make payment systems more effective. With the creation of inpatient hospital 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. This concept is replicated in other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care--the concept of case-mix complexity. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

It is DRGs, or diagnosis related groups, that link case-mix to inpatient hospital payment. The DRG Definitions Manual defines a DRG as "a manageable, clinically coherent set of patient classes that relate a hospital's case-mix to the resource demands and associated costs experienced by the hospital". For individual Medicare inpatient 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. 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 only adjusted 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.

467.12 Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes.--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), comparable to DRGs under Medicare's inpatient hospital PPS. On Medicare claims, these HHRGs are represented as HIPPS codes. HIPPS codes allow the HHRG code to be carried more efficiently and include additional information on how the HHRG was derived.

Health Insurance Prospective Payment System (HIPPS) codes thus represent specific patient characteristics (or case-mix) on which Medicare payment determinations are made. For HHAs, a specific set of these payment codes represent case-mix groups based on research into utilization and resource use patterns. Other HIPPS coding is used to bill Medicare for skilled nursing facility PPS. Appropriate HIPPS codes must be used when billing Medicare within specific prospective payment systems, and are used in association with special revenue codes used on CMS-Form 1450 (UB-92) claims forms for institutional providers.

467.13 Composition of HIPPS Codes for HH PPS.--The following scheme has been developed to create distinct 5-position, alphanumeric home health HIPPS codes. 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 will be released in annual HH PPS Program Memoranda providing specific payment system information and annual rate updates. Note the second through fourth positions of the HH PPS HIPPS code will only allow 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 based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters. Codes with a fifth position value other than "1" are 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.

467.14 Significance of HIPPS Coding for HH PPS.--Based on this coding structure:

o The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG, but only one of the eight, with a final digit of "1", indicates a complete data set.

o The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, all eight codes for that HHRG will be priced identically by the Pricer software.

o HIPPS codes created using this structure are only valid on claim lines with revenue code 0023.

467.15 Overview of the Provider Billing Process Under HH PPS.--The next four sections of this manual lay out the basic HH PPS claim process, not including payment adjustments. Payment adjustment follows in subsequent sections.

467.16 Overview--Grouper Links Assessment and Payment.--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 via HAVEN software made publicly available by CMS. 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.

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 canceled and re-billed using the corrected HIPPS code.

467.17 Overview--HIQH Inquiry System Shows Primary HHA.--Prior to October 1, 2000, to establish Medicare eligibility, HHAs sent an inquiry into Medicare's beneficiary database, the Common Working File or CWF, through their RHHI. The health insurance query access system, or HIQA, within CWF, allows different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility.

With the advent of HH PPS and home health consolidated billing (described in subsequent sections), a given HHA is considered the "primary" home health agency in billing situations: this primary agency is the only agency billing Medicare for home care for a given homebound beneficiary at a specific time. Given this, when a homebound beneficiary seeks care at 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 can obtain that information through a new on-line inquiry transaction in CWF -- HIQH: Health Insurance Query for HHAs. HIQH, available at the advent of HH PPS, will show whether or not the beneficiary is currently in a home health episode of care. HIQH includes all pertinent eligibility information from HIQA, so both HHAs and hospices need only reference HIQH of the two transactions. The HIQA system has also been updated to display the dates of an open HH episode if one exists.

If the beneficiary is not already under care at another HHA, he or 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.

The agency's primary status, or change of primary status from one agency to another in a transfer situation, will be reflected in the HIQH or HIQA inquiry system following submission of a request for anticipated payment (RAP).

467.18 Overview--Request for Anticipated Payment (RAP).--After the assessment is completed and locked for transmission, and once a physician's verbal orders for home care have been received and documented, a plan of care has been established and the first service visit under that plan has been delivered, the HHA can submit a request for anticipated payment, or RAP, to Medicare. An episode will be opened on CWF and visible in HIQH or HIQA 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 Type of Bill (Form Locator 4) 322. RAPs incorporate 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 reimbursement amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine reimbursement or for later data collection.

Once coding is complete, and at least one billable service had been provided in the episode, RAPs or claims are to be submitted to RHHIs processing Medicare home health RAPs and claims. 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.

467.19 Overview--Claim Submission and Processing.--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 provided in the episode are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply. HH claims must be submitted with a new type of bill - 329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment, oxygen or prosthetics and orthotics provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims by providers with episodes open. Pricer will determine claim payment as well as RAP payment for all PPS claims.

The claim will be processed in Medicare 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% 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% payment is made in the next calendar or fiscal year, at that year's rates. Claim payment rates are determined using the statement "through" date on the claim.

Once the final payment for an episode is calculated, Medicare 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 only be made on claims, not on RAPs. HHA reimbursement 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 paid claim records, but providers will never submit these amounts directly.

467.20 Overview--Payment, Claim Adjustments and Cancellations.--This completes the basic process for payment illustrated in the four sections above. However, a number of conditions can cause the episode payment to be adjusted. Both RAPs and claims may be canceled by HHAs if a mistake is made in billing (TOB 328), though episodes will be canceled in CWF as well. 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, and then re-billed, not adjusted.

467.21 Definition of the Request for Anticipated Payment (RAP).--The RAP is submitted by HHAs to their RHHIs to request the initial split percentage payment for an HH PPS episode, after 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 not considered a Medicare home health claim and is not subject to many of the stipulations applied to such claims in regulations**. 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 and delayed in processing.

467.22 Definition of Transfer Situation--Payment Effects.--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 will be allowed to submit a RAP with a transfer indicator in Form Locator 20 (Source of Admission) of Form CMS-1450 (UB-92) even when an episode may already be open for the same beneficiary at another HHA. In such cases, the previously open episode will be automatically closed in Medicare systems as of the date services began at the HHA the beneficiary transferred to, 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.

467.23 Definition of Discharge and Readmission Situation Under HH PPS--Payment Effects.--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: 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. 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) of Form CMS-1450 (UB-92) can be used to send "a transfer to same HHA" indicator on a RAP, so that 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.**

467.24 Payment When Death Occurs During an HH PPS Episode.--If a beneficiary's death occurs during an episode, the full payment due for the episode will be made. This means that partial episode payment (PEP) adjustments will not apply to the claim, but all other payment adjustments apply. 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.

467.25 Adjustments of Episode Payment--Low Utilization Payment Adjustments (LUPAs).--**If an HHA provides 4 visits or less, they will be reimbursed based on 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, non-routine 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 5 or more, payments will be adjusted to an episode basis, rather than a visit basis.

467.26 Adjustments of Episode Payment--Special Submission Case: "No-RAP" LUPAs.--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 an HHA knows that an episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment. **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 automatically against other payments.** Physician orders must be signed when these claims are submitted. If an HHA later needs to add visits to the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the HHA should submit an adjustment claim so the intermediary may issue full payment based on the HIPPS code.

467.27 Adjustments of Episode Payment--Therapy Threshold.--The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. 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 8 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 representing the same payment group: one if a beneficiary does not receive the therapy hours projected, and another if he or she does meet the "therapy threshold". Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and Medicare systems will correct payment without access to the full OASIS data set.

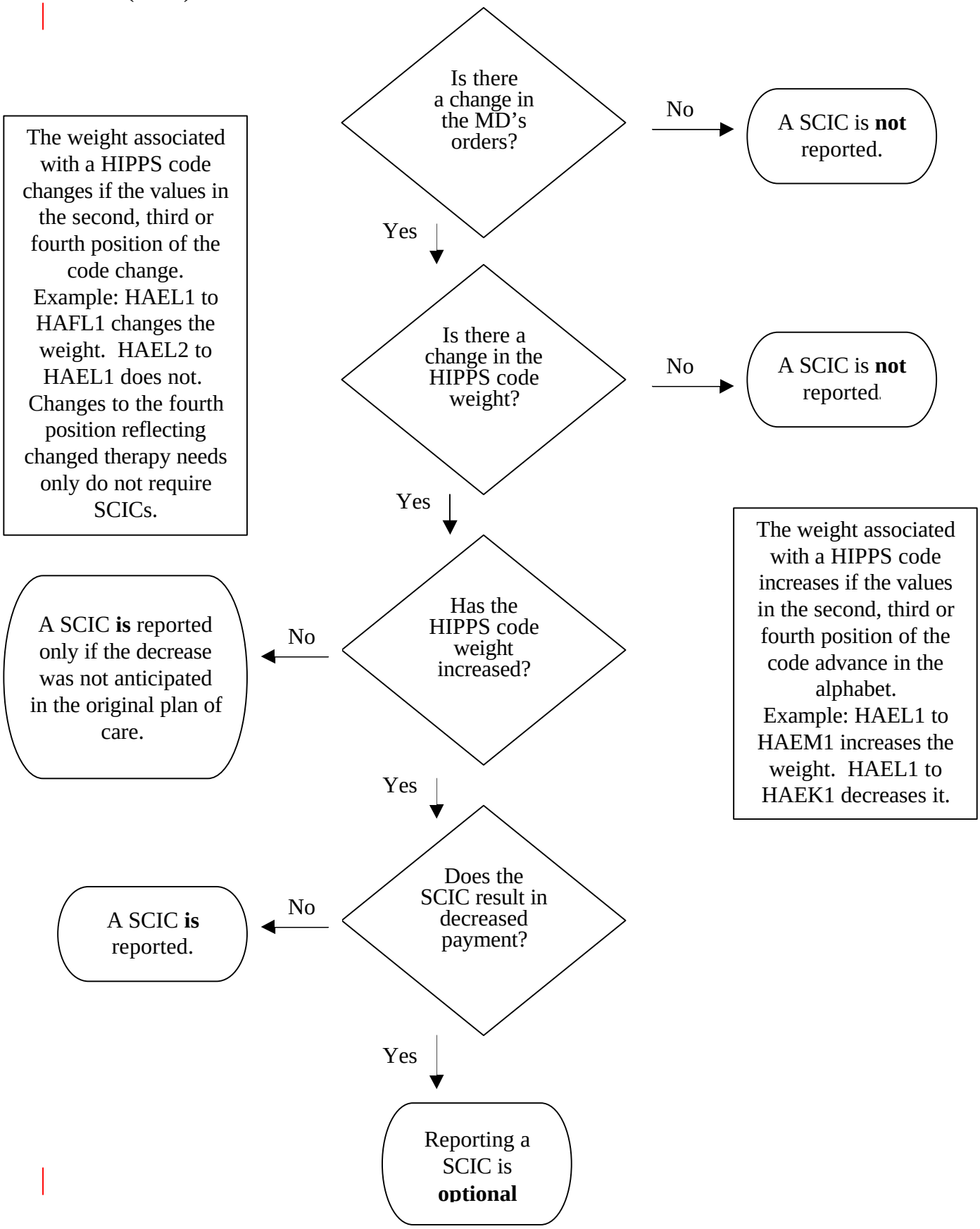
If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code. HHAs will receive the difference between full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code. The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS 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 systems will re-price the claim and pay the full episode payment based on the original HIPPS. Note that a HIPPS code may also be changed based on medical review of claims.

467.28 Adjustments of Episode Payment--Partial Episode Payment (PEP).--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 (PEPs). When either the agency the beneficiary is transferring from is preparing the claim for the episode, or an agency that has discharged a patient knows when preparing the claim that the same patient will be readmitted in the same 60 days, the claim should contain patient status code 06 in Form Locator 22 (Patient Status) of the Form CMS-1450 (UB-92). 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.**

467.29 Adjustments of Episode Payment--Significant Change in Condition (SCIC).--While HH PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes a change in patient condition will occur 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, the HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode, even in the rare case of two different HIPPS codes applying to services on the same day. Since a line-item date is required in every case, Pricer will then be able to calculate the number of days of care provided under each HIPPS code, and **pay proportional amounts under each HIPPS based on the number of days of service provided under each payment group** (count of days under each HIPPS 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, and 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 reimbursement and separate segments showing the reimbursement 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. One, if the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply. Two, 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 requied to be reported. Exceptions are not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode). Payment will be made based on six HIPPS, determined by RHHI medical review staff, if more than six HIPPS are billed.

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. This decision tree can then be used to determine whether or not a SCIC adjustment must be reported.


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
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.
Yes
Reporting a SCIC is **optional**
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.
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.

467.30 Adjustments of Episode Payment--Outlier Payments.--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 a 60-day period, Medicare 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: each wage and case-mix adjusted national standardized per visit rate for each discipline and the number of visits of each discipline on the claim, with the sum of: the case-mix adjusted 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 payment. Outlier payment amounts are wage index adjusted to reflect the MSA in which the beneficiary was served. The outlier payment is a payment for an entire episode, and therefore only carried at the claim level in paid claim history, not allocated to specific lines of the claim. Separate outliers will not be calculated for different HIPPS codes in a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

Outlier payments will be made on remittances for specific episode claims. HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total reimbursement 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 attached amount, and a condition code, 61, in Form CMS-1450 (UB-92) Form Locators 24-30. 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.

467.31 Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments.--Episode payment adjustments as described above only apply to claims, 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. Of 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 which follows summarizes information in §467.23 through 467.31.

Matrix of HH PPS Episode Payment Adjustments

TYPE:	**Eligibility Change**	**Death** of Beneficiary	Low-Utilization Payment Adjustment (**LUPA**)	**Therapy Threshold**
Description	HH PPS applies to FFS Medicare only, change to/from this status will open/close episode, with PEP if mid-episode and not LUPA	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	None amidst 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	Mostly likely PEP or LUPA	None ex-clusively	Count of all visits	Count of therapy visits (Rev. 300 Codes: 42x, 43x, 44x)
Other Adjustment?	Can be LUPA or PEP, if PEP may have others	All others except PEP can apply	No	All others except LUPA
Billing Re-quirements	None ex-clusively, may use RAP, must use claim, claim has no-RAP LUPA option if LUPA	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	CWF receives eligibility status change, claim is changed if needed	No payment change for death, Pricer calculates episode payment	Pricer calculates payment by national std. visit rates	Pricer changes "high" HIPPS to "low" if threshold not met*, prices claim after change

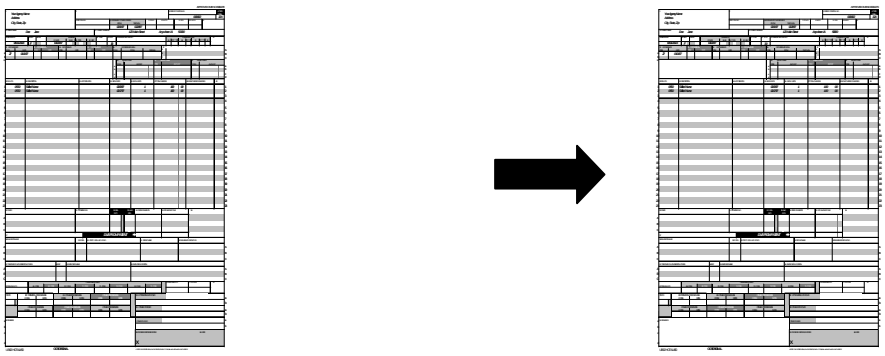
*Provider can re-bill entire episode if needed to report corrected information, including HIPPS

Matrix of HH PPS Episode Payment Adjustments (Cont.)

TYPE:	Partial Episode Payment Adjustment (**PEP**)	Significant Change in Condition (**SCIC**)	**Outlier**
Description	Episode is shortened because beneficiary receives HH care elsewhere in 60-day period (transfer, readmission) or eligibility change	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)
Frequency	Once, ends episode	Unlimited per episode	One per episode
Wage Adjusted?	Episode is	Episode is	Yes
Case-mix Adjusted?	Episode is	Yes, with each HIPPS code	No
Calculation Basis	Days in episode (first billable service date to last)	Count of days for each HIPPS code by first to last billable service date	Difference of HIPPS or visits for episode, less fixed loss
Other Adjustment?	All others except LUPA	All others except LUPA	All others except LUPA
Billing Re-quirements	Requires RAP and claim billed, signal with use of discharge date and patient status “06” on claim	Requires RAP and claim billed, claim has more than one HIPPS, 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
Activation	Pricer calculates, CWF adjusts claim if PEP is not shown with 06 on billed claim	Pricer calculates payment for each HIPPS and adds for episode payment	Pricer calculates on all episodes except LUPA and pays when applicable

467.32 Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustments.--The next few pages illustrate Request for Anticipated Payment (RAP) and claim submission, and more common payment adjustments, under this payment system.

1. One 60-Day Episode, No Continuous Care (Patient Discharged):



RAP	**Claim**
Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**	*Submitted after discharge or 60 days* with **Patient Status Code 01** Contains same **HIPPS Code** as RAP
Does not give any **line-item detail** for Medicare use as primary payer (*can carry charges on lines not used by Medicare*)	Gives **all line-item detail** for the entire **HH Episode**
From and **Through Dates** match, date of first service delivered	**From Date** same as RAP, **Through Date** Discharge or Day 60
Creates **HH Episode** in **HIQH Inquiry System**	Closes **HH Episode** in **HIQH Inquiry System**
Triggers initial percentage payment for 60-day **HH Episode**	Triggers final percentage payment

467.33 Exhibit: General Guidance on Line Item Billing Under HH PPS.--The following tables are added for quick reference on billing most line-item on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first tables grouping services, and the second items and supplies:

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 42x, 43x, 44x, 55x, 56x, 57x w/Gxxxx HCPCS for increment reporting**, *(NOTE revenue codes 58x and 59x 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
PPS CLAIM?	**Yes, RAPs and Claims**	**Yes, Claims only** [34x* no 485/non-PPS]	**Yes, Claims only**

NOTE: For HH PPS, HHA submitted IC TOB must be 322-- may be adjusted by 328; Claim TOB must be 329-- may be adjusted by 327, or 328.

*** 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).**

TYPE OF LINE ITEM	DME** (non-implantable, other than Oxygen & P/O)	Oxygen & P/O (non-implantable P/O)	Non-routine*** Medical Supplies	Osteoporosis Drugs	Vaccines	Other Outpt. Items (antigens, splints & casts)
CLAIM CODING	**Current revenue codes 29x, 294** for drugs/supplies for effective DME use w/HCPCS	**Current revenue codes 60x** (Oxygen) **and 274** (P/O) w/HCPCS	**Current revenue code 27x**, and voluntary use of 623 for wound care supplies	**Current revenue code 636 & HCPCS**	**Current revenue codes 636** (drug) and HCPCS**, 771** (administration)	**Current revenue code 271** & HCPCS
TYPE OF BILL (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,** 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	**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 the Medicare FI (§3629) and Home Health (§473) Manuals.**
*****Routine supplies are not separately billable or payable under Medicare home health care. When billing on type of bill 32x, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270. See § 463.D.1.**

FLs 50A, B, and C. Payer Identification
Required. If Medicare is the primary payer, enter "Medicare" on line A. When Medicare is entered on line 50A, this indicates that you have developed for other insurance coverage and have determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. See §§248, 250, 25l, 252, and 253 to determine when Medicare is not the primary payer. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on the RAP.

FL 51. Medicare Provider Number
Required. Enter 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 the 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. (See §432) In this case, 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.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Not Required.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56. (Untitled)
Not Required.

FL 57. (Untitled)
Not Required.

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, enter the patient's name as shown on his HI card or other Medicare notice.

FLs 59A, B, and C. Patient's Relationship to Insured
Not Required.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

FLs 61A, B, and C. Group Name
Not Required.

FLs 62A, B, and C. Insurance Group Number
Not Required.

FL 63. Treatment Authorization Code
Required. Enter 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).

These OASIS items should appear on the claim exactly as they appear on the OASIS assessment, matching the 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, 624, will not be allowed on HH PPS RAPs. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Not Required.

FL 65. Employer Name
Not Required.

FL 66. Employer Location
Not Required.

FL 67. Principal Diagnosis Code
Required. Enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill 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), and on the Form CMS-485, form item 11 (ICD-9-CM/Principle Diagnosis).

FLs 68-75. Other Diagnoses Codes
Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do 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), and on Form CMS-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on Form CMS-485, form item 13, may be reported in FLs 68-75 on the RAP if they are reported in the narrative form item 21 of Form CMS-485. 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 all three forms. Beyond these guidelines, Medicare does not require that the sequence of the codes on the three forms must be identical.

FL 76. Admitting Diagnosis
Not Required.

FL 77. E-Code
Not Required.

FL 78. Untitled
Not Required.

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Not Required.

FL 81. Other Procedure Codes and Dates
Not Required.

FL 82. Attending/Requesting Physician I.D.
Required. Enter the UPIN and name of the attending physician that has established the plan of care with verbal orders.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks
Required. Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

FL 85. Provider Representative Signature
Not Required.

FL 86. Date
Not Required.

475.2 HH PPS Claims.--The following data elements are required to submit a claim under home health PPS. 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, submit a claim to receive the balance of payment due for the episode.

HHAs should be aware that HH PPS claims will be processed in Medicare claims systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §475.3). 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 reimbursement on the claim can be easily understood. Detailed remittance advice information is contained in §485.

Coding required for a HH PPS claim is as follows:

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

FL 2. Untitled
Not required.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-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 treatment).

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 depending upon a beneficiary’s eligibility, HHAs are encouraged 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	Use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims may be submitted at any point within the timely filing period after the payment of the original claim.
8-Void/Cancel of a Prior Claim	Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP and claim must be submitted for the episode to be paid.

FL 22. Patient Status (Cont.)

Code	Definition
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 a HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claim record to 06.

In cases where an HHA is changing the intermediary to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the intermediary the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be partial episode payment (PEP) adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new intermediary.

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 only applies to Medicare fee-for-service.

For guidance on OASIS assessment procedures in these cases, contact your state's OASIS Education Coordinator.

FL 23. Medical Record Number
Required. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes
Optional. Enter any NUBC approved code to describe conditions that apply to the claim.

Required. If adjusting a HH PPS claim (TOB 3x7), report one of the following:
Claim Change Reasons

Code	Definition
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer

Code	Definition
D9	Any Other Change
E0	Change in Patient Status

If adjusting the claim to correct a HIPPS code, report condition code D9. Enter 'Remarks' in FL 84 indicating the reason for the HIPPS code change.

Required: If canceling the claim (TOB 3x8), report one of the following:

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment. Use when D5 is not appropriate.

Enter 'Remarks' in FL 84 indicating the reason for cancellation of the claim.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HH PPS claims.

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

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. 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 bill if convenient.

FL 36. Occurrence Span Code and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY. Reporting of occurrence span code 74 to show the dates of an inpatient admission within an episode is not required.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. If submitting an adjustment (type of bill 3x7) to a previously paid HH PPS claim, enter the control number assigned to the original HH PPS claim here. Insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show 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 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. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLs 39-41. Value Codes and Amounts
Required. Home health episode payments must be based upon the site at which the beneficiary is served. Claims 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. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

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.

Optional. Enter any NUBC approved code to describe other values that apply to the claim. 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 non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so 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." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

NOTE: In the course of processing a home health claim, Medicare systems will place two or more additional value codes on the electronic claim record. These codes may be visible to an HHA with Direct Data Entry access if a claim is later adjusted. These value codes are 17 (outlier amount, if applicable), 62 (HH visits—Part A), 63 (HH visits—Part B), 64 (HH reimbursement—Part A) and/or 65 (HH reimbursement—Part B). These value codes are never submitted by an HHA on an original claim.

FL 42 and 43 Revenue Code and Revenue Description
Required. 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 systems will reject the claim.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), report one or more additional 0023 revenue code lines to reflect each change. SCICs are determined by an additional OASIS assessment of the beneficiary which changes the 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 47. See Section 475.1, FL 44, for more detailed information on the HIPPS code. In the rare instance when a beneficiary is assessed more than once in one day, report one 0023 line for that date, indicating the HIPPS code derived from the assessment that occurred latest in the day.

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 42X, 43X, 44X, 55X, 56X and 57X) must be reported as a separate line. Any of the following revenue codes may be used:

27X Medical/Surgical Supplies. (Also see 62X, an extension of 27X.)

Code indicates the charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

Required detail: With the exception of revenue code 274, only service units and a charge must be reported with this revenue code. If also reporting revenue code 623 to separately and specifically identify wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for the 623 revenue code line and other supply revenue codes are mutually exclusive. Report only non-routine supply items in this revenue code or in 623. See §206.4 regarding distinguishing routine from non-routine supplies. Revenue code 274 requires a HCPCS code, the date of service, service units and a charge amount.

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

Revenue code for optional reporting of wound care supplies:

62X Medical/Surgical Supplies - Extension of 27X

Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed.

Subcategory	Standard Abbreviation
3 - Surgical Dressings	SURG DRESSING

Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, 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 623. Notwithstanding the standard abbreviation "surg dressings", use this line item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Section 206.4 defines routine vs. nonroutine supplies. 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's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

You may continue to report a “Total” line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum of charges billed. Medicare claims 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, report the HIPPS code (See §475.1 for definition of HIPPS codes) which was reported on the RAP. On claims reflecting a significant change in condition (SCIC), report on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment.

For revenue code lines other than 0023, which detail all services within the episode period, report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43.

FL 45. Service Date
Required. On each 0023 revenue code line, report 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, report service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. 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. Do not report units of service on 0023 revenue code lines (the field may be zero or blank). For line items detailing all services within the episode period, report 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 (42x, 43x, 44x, 55x, 56x, and 57x) report as units of service a number of fifteen minute increments that comprise the time spent treating the beneficiary. Each visit must be reported as a separate line item. 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.

FL 47. Total Charges
Required. Zero charges must be reported on the 0023 revenue code line. Medicare claims systems will place the episode reimbursement amount for the claim in this field on the electronic claim record. For LUPA claims, the per visit reimbursement will be reported on individual line items.

For other 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 systems will not make any payment determinations based upon submitted charge amounts.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. Report all non-covered charges, including no-payment claims.

Claims with Both Covered and Non-Covered Charges.-- Report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. On the UB-92 flat file, use record type 61, Field No. 10 (total charges) and Field No. 11 (non-covered charges).

Claims with All Non-Covered Charges-- Submit claims when all of the charges on the claim are non-covered (no-payment claim). Complete all items on a no-payment claim in accordance with instructions for completing payment claims with the exception that all charges are reported as non-covered.

Examples of Completed FLs 42 through 48.--The following provides examples of revenue code lines should be completed based on the reporting requirements above.

Report the multiple 0023 lines in a SCIC situation as follows:

FL 42	FL 44	FL 45	FL 46	FL 47	FL48
0023	HAEJ1	10012000		0.00	
0023	HAFM1	10012000		0.00	

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

If claiming a conditional payment under any of the circumstances described under FLs 58A, B, or C, enter the involved claim number for that coverage on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where you are claiming a payment under the circumstances described in FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

FLs 62A, B, and C. Insurance Group Number
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

FL 63. Treatment Authorization Code
Required. Enter 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). Copy these OASIS items exactly as they appear on the OASIS assessment, matching the 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.

The investigational device (IDE) revenue code, 624, will not be allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Required. Where you are claiming a payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

Code Structure:

Code	Title	Definition
1	Employed Full Time	Individual claimed full time employment.
2	Employed Part Time	Individual claimed part time employment.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory.

Code	Title	Definition
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8		Reserved for national assignment.
9	Unknown	Individual's employment status is unknown.

FL 65. Employer Name
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc. in which the employer is located.

FL 67. Principal Diagnosis Code
Required. Enter the ICD-9-CM code for the principal diagnosis. 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, do not fill 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), and on the Form CMS- 485, form item 11 (ICD-9-CM/Principle 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. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do 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), and on Form CMS-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on Form CMS-485, form item 13, may be reported in FLs 68-75 on the claim if they are reported in the narrative form item 21 of Form CMS-485. 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 all three forms. Beyond these guidelines, Medicare does not require that the sequence of the codes on the three forms must be identical.

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

E. Annual Updates to the HH Pricer.--Rate and weight information used by the HH Pricer is updated annually. Updates occur each October, to reflect the Federal fiscal year. The following update items 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 non-labor percentages.

475.5 Special Billing Situations Involving OASIS Assessments.--Maintaining the link between payment episode periods and OASIS assessment periods is central to the 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.

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 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 a claim "through" date 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 you 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 a claim "through" date 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 a claim "through" date 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. "1111111111111111") in order to pass Medicare claims system edit which requires this field to contain a numeric value. This is the only circumstance in which the 'claims-OASIS matching key' on a RAP or claim for payment may be filled with ones. (See §475.7 for the 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 beginning10-2-2002 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

475.6 Beneficiary-Driven Demand Billing Under HH PPS.--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 non-custodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in an Advance Beneficiary Notice (ABN), which also must be signed by the beneficiary or appropriate representative. In short, 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 judgement 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 ABN 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 changed 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 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 type of bill 32x and 33x; and,
- Episodes on record in Medicare systems (at least one service in episode).

A. Interval of Billing.--Under HH PPS, the interval of billing has 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.--Several CMS memoranda to HHAs serving Medicare beneficiaries since 1998 request prompt filing of demand bills. This request should be met to the greatest degree possible, even though the HH PPS billing interval is fixed (A. above), and timely filing requirements for claims remain the same as under the cost reimbursement system. 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 days from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §3638.25.

C. Overlap with Cost Reimbursement System Billing.--Note that statute on timely filing for Medicare claims allows a period of several months after October 1, 2000, in which home health claims can be submitted under both the interim payment system (IPS) and the prospective payment system. This is also true of demand bills, but like these other claims, demand bills must cover a discrete period in time under one or the other payment system, not spanning both systems. IPS claims must be limited to services on or before September 30, 2000; HH PPS claims for services on or after October 1, 2000.

D. Claim Requirements.--Original HH PPS claims are submitted with type of bill (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 (do 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 non-covered (FL 48) line items. 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 with indication of demand billing.

Cases may arise in which the services in dispute are visits for which an agency 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 non-covered 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 non-covered portions), represented in 15 minute increments.

E. Favorable Determinations and Medicare Payment.--Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare reimbursement. 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 only change 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); and

? A favorable ruling on a demand bill adds days to: (1) an episode that received a partial episode payment (PEP) adjustment, or (2) A period within an episode that received a significant change in condition (SCIC) adjustment.

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

F. 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 which represents all services delivered for the entire episode unit of payment.

G. Non-Covered Charges on Demand Bills.--Demand bill final claims may be received with all non-covered charges. In such a case, assuming medical review determines that no services are in fact covered, the standard systems are to send a cancel claim to Common Working File (CWF) with cancel only code F in order to cancel the RAP already paid, show in CWF the recovery of the RAP reimbursement and remove the episode period from the HEHH in CWF. This process is specific to entirely non-covered claims with condition code 20 only, and requires no special billing action on the part of the HHA.

475.7 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 as 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.

The Medicare interim reimbursement minus the EGHP payment for Medicare covered services: $500 - $300 = $200. Medicare pays $200.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits at $50 per visit. The Medicare interim rate is 90 percent ($500 X 90 percent) which equals $450. The EGHP paid $300 for Medicare covered services. As secondary payer Medicare pays:

The Medicare interim reimbursement minus the EGHP's payment for Medicare covered services: $450 - $300 = $150. Medicare pays $150.

Special Entries on the Bill

Show the identifying information in Items 57-75 on the first payer line, value code l2 or 43 with the amount paid in value codes (Items 46-49) and the address of the EGHP in Item 34 or remarks (Item 94).

F. EGHP Denies Claim for Primary Benefits.--Primary Medicare benefits may be paid (if the beneficiary is not appealing the EGHP denial) when an EGHP denies a claim for primary benefits because:

- The employer does not employ 20 or more employees;
- The beneficiary is not entitled to benefits under the plan;
- Benefits under the EGHP are exhausted for the services involved; or
- The services are not covered by the EGHP.

Where the EGHP denies payment for any of these reasons, enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, provide a reason for the denial in remarks (Item 94). Your intermediary will process the claim for payment.

If an EGHP denies a claim for primary benefits because the plan offers only secondary coverage of services covered by Medicare and it does not allege and you do not know that the employer has fewer than 20 employees, Medicare benefits may not be paid (primary or conditional). Enter occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, enter the annotation "Plan offers secondary coverage of services covered by Medicare." Your intermediary will develop to determine if payment can be made. If it is determined that the EGHP employs 20 or more employees your intermediary will deny the claim. Otherwise payment will be made. If the EGHP alleges, or you have documentation that the employer has less than 20 employees, primary Medicare benefits may be paid. Enter the annotation "plan offers secondary coverage of services covered by Medicare/EGHP has fewer than 20 employees" in remarks "Item 94" to avoid development of the claim by your intermediary.

G. Conditional Payments.--If the beneficiary has appealed, or is protesting the EGHP denial of the claim for any reason other than that the EGHP offers only secondary coverage of services covered by Medicare or it denied the claim because the time limit for filing the claim with the EGHP has expired (whether appealed or not) conditional primary Medicare benefits may be paid.

Request conditional payment in this case by entering value code 12 with zero value in Items 46-49 to indicate the type of other insurer and that conditional payment is requested and occurrence code 24 (insurance denied) and the date of denial in items 28-32 (occurrence codes). Enter the identity of the EGHP on line A of Item 57, any identifying information about the insured on line A of Items 65-75, and the address of the EGHP in Item 34 or remarks (Item 94). In addition, enter the annotation "Beneficiary has appealed or is protesting EGHP denial" or "Time limit for filing the claim has expired" as appropriate in remarks (Item 94).

497.1 Billing and Payment for Medicare Secondary Payer (MSP) Claims Under the Home Health Prospective Payment System.--The preceding sections (§§494 – 497) describe billing and payment procedures for Medicare Secondary Payer (MSP) claims under cost reimbursement. The billing and payment scenarios they describe continue to be applicable to home health claims for dates of service on or before September 30, 2000. Claims for home health services under a plan of care (claims with types of bill 32x and 33x) for dates of service on or after October 1, 2000, are paid under the home health prospective payment system (HH PPS). The HH PPS does not change the principles of MSP payment established in regulation. The policy contained in regulations at 42 CFR Part 411, subparts B, C, D, E, F, G and H continue to apply. When Medicare is secondary payer, payment is to be made on the basis of the formula contained in 42 CFR 411.33(e). However, the following billing and claims processing changes resulted from the HH PPS.

A. MSP Determinations on Requests for Anticipated Payment (RAPs).--When Medicare is secondary payer and the criteria for payment on a per episode basis are met, Medicare does not make payment based on a request for anticipated payment (RAP). Medicare makes secondary payment only based on a claim for the 60-day episode, which will show the primary payer's payment if one has been made. HHAs must send all MSP claims to the primary payer first for payment before submitting claims to Medicare.

1. RAPs Submitted Without MSP Value Codes.--Upon receipt of a RAP with no MSP value codes, Medicare's CWF will apply existing edits against the MSP auxiliary file to RAPs, checking to see if the episode period service date falls within an MSP period. If an MSP period corresponding to the service dates exists, CWF will return an error indicating that primary coverage exists. Upon receipt of this error, Medicare's standard systems at the RHHI will remove payment from the RAP and return it to CWF to complete processing. The RAP will create a HH PPS episode record in CWF and otherwise process with zero payment. When the RAP is returned from CWF, the RHHI will place it in a final paid status and a record of the RAP processing with zero payment will appear on the HHA's remittance advice. First claim development is performed only on claims, not on RAPs.

2. RAPs Submitted With MSP Value Codes.--Upon receipt of a RAP with MSP value codes, Medicare's standard systems at the RHHI will create a record of an MSP period and transmit it to CWF before transmitting the RAP. This record will create or update the CWF MSP auxiliary file, as appropriate. Medicare's standard systems at the RHHI will not calculate payment for the RAP and transmit it to CWF with zero payment to complete processing. The RAP will create a HH PPS episode record in CWF and otherwise process with zero payment. When the RAP is returned from CWF, the RHHI will place it in a final paid status and a record of the RAP processing with zero payment will appear on the HHA's remittance advice. First claim development is performed only on claims, not on RAPs. Apply this same process to RAPs submitted with MSP value codes which have zero dollar amounts associated with them and a C in the primary payer field. Medicare does not make conditional payments based on RAPs.

B. MSP Determinations on Claims-- For claims for services receiving a full episode payment, or for other types of payment adjustments (e.g., when there are four visits or less in a 60-day episode) apply the MSP formula to the applicable unit of Medicare payment.

Examples of MSP Calculations:

1. MSP for HH PPS Payment Made on 60-day Episode.--A HHA furnished 25 Medicare covered visits during a 60-day episode to a beneficiary. The HHA's total charges were $2800 for the 60 days of care (25 visits at $112 each). The third party payer paid $2360. The HHA is not obligated to accept the third party payment as payment in full. The HH PPS amount for the period is $2700.

Medicare pays the lowest of the following amounts for the episode period:

- The gross amount payable by Medicare minus the Medicare deductible: $2700-0=$2700;
- The gross amount payable by Medicare minus the third party payment: $2700-$2360= $340;
- The HHA's charges minus the third party payment: $2800-$2360= $440; or
- The providers charges minus the Medicare deductible: $2800-0=$2800

Medicare's secondary payment for the 60-day episode of care is $340 (the lowest of the four calculations). Note that since Medicare payment is made on a per episode basis under HH PPS, MSP is also calculated on a per episode basis and therefore there is only one calculation for each episode of care. Educate providers as part of HH PPS that it may be advisable to track payments from payers other than Medicare on the same per-episode basis.

2. MSP for HH PPS when the criteria for per episode payment is not met and Medicare payment is on a per visit basis.--A HHA furnished 3 Medicare covered skilled nursing visits during a 60-day episode to a beneficiary. The HHA's total charges were $336 for the care (three visits at $112 each). The HHA is not obligated to accept the third party payment as payment in full. The third party payer paid $94.40 per visit or a total payment of $283.20 for the three visits. The HH PPS amount per visit is $108 or a total of $324 for the three visits.

Medicare pays the lowest of the following amounts for each visit:

- The gross amount payable by Medicare minus the Medicare deductible: $108-0=$108;
- The gross amount payable by Medicare minus the third party payment: $108-$94.40= $13.60;
- The HHA's charges minus the third party payment: $112-$94.40= $17.6; or
- The providers charges minus the Medicare deductible: $112-0=$112

Medicare's secondary payment for each visit is $13.60 (the lowest of the four calculations). Note that since Medicare payment is made on a per visit basis, MSP is calculated on a per visit basis and therefore there would be three calculations since there were three visits. Medicare's total secondary payment is $40.80 ($13.60 for each of three visits).

3. MSP for HH PPS Payment Made on 60 Day Episode When the Provider is Obligated to Accept the Third Party Payment as Payment in Full.--A HHA furnished 25 Medicare covered visits during a 60-day episode to a beneficiary. The HHA's total charges were $2800 for the 60 days of care (25 visits at $112 each). The third party payer paid $2360. The provider is obligated to accept the third party's payment as payment in full. The HH PPS amount for the period is $2700.

Medicare pays the lowest of the following amounts for the episode period:

- The gross amount payable by Medicare minus the Medicare deductible: $2700-0=$2700;

- The gross amount payable by Medicare minus the third party payment: $2700-$2360= $340;

- The amount the HHA is obligated to accept as payment in full minus the third party payment: $2360-$2360= $0; or

- The amount the HHA is obligated to accept as payment in full minus the Medicare deductible: $2360-0=$2360.

Medicare's secondary payment for the 60-day episode of care is $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per episode basis, MSP is calculated on a per episode basis, and therefore there is one calculation since there is one episode of care.

4. MSP for HH PPS When the Criteria for Per Episode Payment is Not Met, the Provider is Obligated to Accept the Third Party Payment as Payment in Full and Medicare Payment is on a Per Visit Basis.--A HHA furnished three Medicare covered skilled nursing visits during a 60-day episode to a beneficiary. The HHA's total charges were $336 for the care (three visits at $112 each). The third party payer paid $94.40 per visit or a total payment of $283.20 for the three visits. The HHA is obligated to accept the third party's payment as payment in full. The HH PPS amount per visit is $108 or a total of $324 for the three visits.

Medicare pays the lowest of the following amounts for each visit:

- The gross amount payable by Medicare minus the Medicare deductible: $108-0=$108;

- The gross amount payable by Medicare minus the third party payment: $108-$94.40= $13.60;

- The amount the HHA is obligated to accept as payment in full minus the third party payment: $94.40-$94.40= $0; or

- The amount the HHA is obligated to accept as payment in full minus the Medicare deductible: $94.40-0=$94.40.

Medicare's secondary payment for each visit is $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per visit basis, MSP is calculated on a per visit basis and therefore there would be three calculations since there were three visits. Medicare's total secondary payment is $0 ($0 for each of three visits).

498. HOW TO DETERMINE CURRENT MEDICARE INTERIM REIMBURSEMENT AMOUNT

Where application of the procedure requires determining the current Medicare interim reimbursement amount, use the following guidelines before adjustment for other insurance payment:

- Percentage of billed charges - Multiply the current percentage of charges used for the interim rate by the total covered charges. Do not make any reductions for deductible or coinsurance.

- Per Visit - Multiply the per visit interim rate times the number of covered visits.

- Periodic Interim Payments (PIP) - Determine a per visit amount based on your current PIP amount (see CMS-Pub. 15-1 §2407). Multiply this amount by the number of covered Medicare visits.

Your intermediary can advise you of the applicable per diem or percentage rates and of any changes to them.

If you are not on PIP, your interim reimbursement on a bill-by-bill basis will be eliminated or reduced based on instructions in §§494, 495, 496, and 497.

If you are on PIP, a reduction in your interim reimbursement received through PIP is necessary. Where Medicare is determined not to have any liability your PIP amount will be reduced to reflect that no interim reimbursement is due. Where Medicare is determined to be secondarily liable and the primary payer is an insurer addressed in §494 or §495, your PIP amount will be reduced to reflect the primary payment. Where Medicare is determined secondarily liable and the primary payer is an EGHP as addressed in §496 or §497, your PIP amount will be reduced to reflect any excess of the primary payment over the applicable deductible and coinsurance.

Any reduction in your PIP amount may be accomplished by your intermediary offsetting against the next payment, or by taking estimated deductions into account in establishing the PIP amount.

NOTE: No reduction is made to your PIP amount with regard to conditional payments since in these situations payment is made although conditionally, as if Medicare were fully liable for the stay.