Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-41 **Date: JULY 27, 2000**

CHANGE REQUEST 1264

SUBJECT: Transition to the Home Health Prospective Payment System (HHPPS)--INFORMATION

Effective October 1, 2000, all Medicare home health services provided under a physician's plan of care will be paid under the HHPPS. Instructions for provider billing and intermediary claims processing are contained in Program Memorandum (PM) AB-00-65 and in revisions to the Medicare Intermediary Manual, Part 3 and the Home Health Agency (HHA) Manual. This PM is to provide information for providers specific to the transition to HH PPS. This information, which is applicable for a limited period of time, will not be reflected in revisions to Health Care Financing Administration (HCFA) manuals.

Inform your providers of the following in your next regularly scheduled provider bulletin, but no later than August 31, 2000.

Advent of the HHPPS--Change in the Unit of Payment

The HHPPS changes the basis of payment for home health services for homebound Medicare beneficiaries under a plan of care. The unit of payment changes from cost reimbursed visits to a 60 day episode period. Transition between these payment systems requires certain procedures to be followed for development of plans of care and Outcome and Assessment Information Set (OASIS) assessments, and submission of claims and cost reports. These procedures are described below.

1. Plan of Care and OASIS Assessment Grace Periods

HCFA is providing a one-time implementation grace period for OASIS assessments and plan of care certifications to alleviate transition concerns associated with all HHAs starting PPS with the same effective date of October 1, 2000.

Plan of Care Certifications:

For established home health beneficiaries as of September 1, 2000, we are providing a one-time grace period that provides a certification period up to a maximum of 90 days (September 1, 2000 through and including November 29, 2000). HHAs, in conjunction with a certifying physician, may have a one-time maximum 90-day plan of care certification. The regulatory requirements governing the Medicare home health benefit before PPS would apply to the certification period up to and including September 30, 2000. The plan of care must reflect a statistical break between the pre-HHPPS physician ordered services (September 1, 2000 through September 30, 2000) and the post-HHPPS physician ordered services (October 1, 2000 through November 29, 2000). Included in the statistical break is the notation of the start of care date/first billable visit date for this beneficiary under HHPPS.

Physician Certification	
Cert. date earlier than 09/01/2000?	One-time additional recertification of the Plan of Care before 10/01/2000
Cert. date after 09/01/2000?	Recertification date from earlier version of the Plan of Care may be used if it falls between 09/01 and 09/30.

OASIS Schedule Grace Periods for Beneficiaries under an Established Plan of Care:

For the period of September 1, 2000, through September 30, 2000, HHAs may use the most recent OASIS start of care or follow-up to group for case mix. HHAs must complete this assessment using the new OASIS B-1 (8/2000) data set and encode it using the HAVEN 4.0 software (or other HAVEN-like vendor software). For the period of August 1, 2000, through August 31, 2000, it is at the HHA's discretion to complete the next scheduled assessment any day September 2000 to group for case mix. These assessment periods will be allowed to extend to the conclusion of the each beneficiary's first episode of care under HHPPS, from any day in September 2000 up to and including, but not beyond November 29, 2000. At the conclusion of each beneficiary's first episode of care, HHAs will resume OASIS requirements governing re-assessment during the last 5 days of the episode certification period.

OASIS Start of Care or Follow-Up	
OASIS completed earlier than 09/01/2000?	One-time additional follow-up OASIS during September
OASIS completed after 09/01/2000?	No additional follow-up OASIS required; earlier OASIS assessment (i.e., occurring between 09/01 and 09/30) can be used

2. Claims Submission to Reflect the Transition to HHPPS

HHPPS is effective for all home health providers simultaneously on October 1, 2000. There will be no transition by cost reporting period. This means that providers must bill services provided on or before September 30, 2000, on claims separate from those with service on or after October 1, 2000. Claims for all services provided on or before September 30, 2000, will be paid under the Interim Payment System (IPS). Claims for all services provided on or after October 1, 2000, will be paid under HHPPS. No claims may be submitted with dates of service spanning September and October 2000 dates. For all beneficiaries who continue to receive services on or after October 1, 2000, requests for anticipated payment (RAPs) may be submitted to receive an initial percentage payment for those beneficiaries under HHPPS.

Even though these beneficiaries will have been admitted earlier, report October 1, 2000, as the admission date on these first HHPPS RAPs and claims. This one-time artificial reporting of the admission date will not be considered a false claim. It is important that all dates on RAPs and HH PPS claims are on or after October 1, 2000, since Medicare systems will process under the HHPPS or the IPS based on dates of service.

Regional Home Health Intermediaries (RHHIs) will continue to maintain parallel claims processing logic for IPS and HHPPS claims for the entire Medicare timely filing period. Claims and adjustments submitted on or after October 1, 2000, for dates of service on or before September 30, 2000, will continue to be paid under the IPS. HHAs that have been billing under the HHPPS demonstration project will also continue to have claims and adjustments for dates of service on or before September 30, 2000, processed and paid under the demonstration methodology for the entire Medicare timely filing period.

3. Health Insurance Prospective Payment System (HIPPS) Codes for Federal Fiscal Year 2001

As the HIPPS codes may change in future years of the HHPPS to reflect refinements to the case-mix system or other payment methodology refinements, a list of HIPPS codes will be published annually in a PM for use in the upcoming fiscal year.

A coding scheme has been developed that reflects the 80 home health resource groups (HHRGs) as 640 home 5-position, alpha-numeric home health HIPPS codes. The first position of every home health HIPPS code will be 'H'. The second, third, and fourth positions of the code will crosswalk to the HHRG system as published in the HHPPS final rule. These positions will only allow alphabetic characters.

The fifth position will indicate which elements of the code were computed (output from the Grouper based on complete OASIS data) or derived (output from the Grouper based on a system of defaults where OASIS data is incomplete). The fifth position will only allow numeric characters.

The HHRG system is published in the HHPPS final rule with identifiers that express the payment groups in terms of the clinical, functional and service domains of the OASIS. For instance, the minimum score in all three domains was represented by an identifier of C0F0S0.

The following chart demonstrates how HIPPS codes are structured and crosswalks these HHRG identifiers to the HIPPS codes as well:

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

Using this coding structure, the 80 HHRGs are presented for Federal fiscal year 2001 by the following 640 HIPPS codes:

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HAEJ1 HAEJ2 HAEJ3 HAEJ4 HAEJ5 HAEJ6 HAEJ7 HAEJ8	Clinical=Min,Functional=Min,Service=Min	C0F0S0
HAEK1 HAEK2 HAEK3 HAEK4 HAEK5 HAEK6 HAEK7 HAEK8	Clinical=Min,Functional=Min,Service=Low	C0F0S1

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HAEL1	Clinical=Min,Functional=Min,Service=Mod	C0F0S2
HAEL2		
HAEL3		
HAEL4		
HAEL5		
HAEL6		
HAEL7		
HAEL8		
HAEM1	Clinical=Min,Functional=Min,Service=High	C0F0S3
HAEM2		
HAEM3		
HAEM4		
HAEM5		
HAEM6		
HAEM7		
HAEM8		
HAFJ1	Clinical=Min,Functional=Low,Service=Min	C0F1S0
HAFJ2		
HAFJ3		
HAFJ4		
HAFJ5		
HAFJ6		
HAFJ7		
HAFJ8		
HAFK1	Clinical=Min,Functional=Low,Service=Low	C0F1S1
HAFK2		
HAFK3		
HAFK4		
HAFK5		
HAFK6		
HAFK7		
HAFK8		
HAFL1	Clinical=Min,Functional=Low,Service=Mod	C0F1S2
HAFL2		
HAFL3		
HAFL4		
HAFL5		
HAFL6		
HAFL7		
HAFL8		
HAFM1	Clinical=Min,Functional=Low,Service=High	C0F1S3
HAFM2		
HAFM3		
HAFM4		
HAFM5		
HAFM6		
HAFM7		
HAFM8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HAGJ1	Clinical=Min,Functional=Mod,Service=Min	C0F2S0
HAGJ2		
HAGJ3		
HAGJ4		
HAGJ5		
HAGJ6		
HAGJ7		
HAGJ8		
HAGK1	Clinical=Min,Functional=Mod,Service=Low	C0F2S1
HAGK2		
HAGK3		
HAGK4		
HAGK5		
HAGK6		
HAGK7		
HAGK8		
HAGL1	Clinical=Min,Functional=Mod,Service=Mod	C0F2S2
HAGL2		
HAGL3		
HAGL4		
HAGL5		
HAGL6		
HAGL7		
HAGL8		
HAGM1	Clinical=Min,Functional=Mod,Service=High	C0F2S3
HAGM2		
HAGM3		
HAGM4		
HAGM5		
HAGM6		
HAGM7		
HAGM8		
HAHJ1	Clinical=Min,Functional=High,Service=Min	C0F3S0
HAHJ2		
HAHJ3		
HAHJ4		
HAHJ5		
HAHJ6		
HAHJ7		
HAHJ8		
HAHK1	Clinical=Min,Functional=High,Service=Low	C0F3S1
HAHK2		
HAHK3		
HAHK4		
HAHK5		
HAHK6		
HAHK7		
HAHK8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HAHL1	Clinical=Min,Functional=High,Service=Mod	C0F3S2
HAHL2		
HAHL3		
HAHL4		
HAHL5		
HAHL6		
HAHL7		
HAHL8		
HAHM1	Clinical=Min,Functional=High,Service=High	C0F3S3
HAHM2		
HAHM3		
HAHM4		
HAHM5		
HAHM6		
HAHM7		
HAHM8		
HAIJ1	Clinical=Min,Functional=Max,Service=Min	C0F4S0
HAIJ2		
HAIJ3		
HAIJ4		
HAIJ5		
HAIJ6		
HAIJ7		
HAIJ8		
HAIK1	Clinical=Min,Functional=Max,Service=Low	C0F4S1
HAIK2		
HAIK3		
HAIK4		
HAIK5		
HAIK6		
HAIK7		
HAIK8		
HAIL1	Clinical=Min,Functional=Max,Service=Mod	C0F4S2
HAIL2		
HAIL3		
HAIL4		
HAIL5		
HAIL6		
HAIL7		
HAIL8		
HAIM1	Clinical=Min,Functional=Max,Service=High	C0F4S3
HAIM2		
HAIM3		
HAIM4		
HAIM5		
HAIM6		
HAIM7		
HAIM8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HBEJ1	Clinical=Low,Functional=Min,Service=Min	C1F0S0
HBEJ2		
HBEJ3		
HBEJ4		
HBEJ5		
HBEJ6		
HBEJ7		
HBEJ8		
HBEK1	Clinical=Low,Functional=Min,Service=Low	C1F0S1
HBEK2		
HBEK3		
HBEK4		
HBEK5		
HBEK6		
HBEK7		
HBEK8		
HBEL1	Clinical=Low,Functional=Min,Service=Mod	C1F0S2
HBEL2		
HBEL3		
HBEL4		
HBEL5		
HBEL6		
HBEL7		
HBEL8		
HBEM1	Clinical=Low,Functional=Min,Service=High	C1F0S3
HBEM2		
HBEM3		
HBEM4		
HBEM5		
HBEM6		
HBEM7		
HBEM8		
HBFJ1	Clinical=Low,Functional=Low,Service=Min	C1F1S0
HBFJ2		
HBFJ3		
HBFJ4		
HBFJ5		
HBFJ6		
HBFJ7		
HBFJ8		
HBFK1	Clinical=Low,Functional=Low,Service=Low	C1F1S1
HBFK2		
HBFK3		
HBFK4		
HBFK5		
HBFK6		
HBFK7		
HBFK8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HBFL1	Clinical=Low,Functional=Low,Service=Mod	C1F1S2
HBFL2		
HBFL3		
HBFL4		
HBFL5		
HBFL6		
HBFL7		
HBFL8		
HBFM1	Clinical=Low,Functional=Low,Service=High	C1F1S3
HBFM2		
HBFM3		
HBFM4		
HBFM5		
HBFM6		
HBFM7		
HBFM8		
HBGJ1	Clinical=Low,Functional=Mod,Service=Min	C1F2S0
HBGJ2		
HBGJ3		
HBGJ4		
HBGJ5		
HBGJ6		
HBGJ7		
HBGJ8		
HBGK1	Clinical=Low,Functional=Mod,Service=Low	C1F2S1
HBGK2		
HBGK3		
HBGK4		
HBGK5		
HBGK6		
HBGK7		
HBGK8		
HBGL1	Clinical=Low,Functional=Mod,Service=Mod	C1F2S2
HBGL2		
HBGL3		
HBGL4		
HBGL5		
HBGL6		
HBGL7		
HBGL8		
HBGM1	Clinical=Low,Functional=Mod,Service=High	C1F2S3
HBGM2		
HBGM3		
HBGM4		
HBGM5		
HBGM6		
HBGM7		
HBGM8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HBHJ1	Clinical=Low,Functional=High,Service=Min	C1F3S0
HBHJ2		
HBHJ3		
HBHJ4		
HBHJ5		
HBHJ6		
HBHJ7		
HBHJ8		
HBHK1	Clinical=Low,Functional=High,Service=Low	C1F3S1
HBHK2		
HBHK3		
HBHK4		
HBHK5		
HBHK6		
HBHK7		
HBHK8		
HBHL1	Clinical=Low,Functional=High,Service=Mod	C1F3S2
HBHL2		
HBHL3		
HBHL4		
HBHL5		
HBHL6		
HBHL7		
HBHL8		
HBHM1	Clinical=Low,Functional=High,Service=High	C1F3S3
HBHM2		
HBHM3		
HBHM4		
HBHM5		
HBHM6		
HBHM7		
HBHM8		
HBIJ1	Clinical=Low,Functional=Max,Service=Min	C1F4S0
HBIJ2		
HBIJ3		
HBIJ4		
HBIJ5		
HBIJ6		
HBIJ7		
HBIJ8		
HBIK1	Clinical=Low,Functional=Max,Service=Low	C1F4S1
HBIK2		
HBIK3		
HBIK4		
HBIK5		
HBIK6		
HBIK7		
HBIK8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HBIL1	Clinical=Low,Functional=Max,Service=Mod	C1F4S2
HBIL2		
HBIL3		
HBIL4		
HBIL5		
HBIL6		
HBIL7		
HBIL8		
HBIM1	Clinical=Low,Functional=Max,Service=High	C1F4S3
HBIM2		
HBIM3		
HBIM4		
HBIM5		
HBIM6		
HBIM7		
HBIM8		
HCEJ1	Clinical=Mod,Functional=Min,Service=Min	C2F0S0
HCEJ2		
HCEJ3		
HCEJ4		
HCEJ5		
HCEJ6		
HCEJ7		
HCEJ8		
HCEK1	Clinical=Mod,Functional=Min,Service=Low	C2F0S1
HCEK2		
HCEK3		
HCEK4		
HCEK5		
HCEK6		
HCEK7		
HCEK8		
HCEL1	Clinical=Mod,Functional=Min,Service=Mod	C2F0S2
HCEL2		
HCEL3		
HCEL4		
HCEL5		
HCEL6		
HCEL7		
HCEL8		
HCEM1	Clinical=Mod,Functional=Min,Service=High	C2F0S3
HCEM2		
HCEM3		
HCEM4		
HCEM5		
HCEM6		
HCEM7		
HCEM8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HCFJ1	Clinical=Mod,Functional=Low,Service=Min	C2F1S0
HCFJ2		
HCFJ3		
HCFJ4		
HCFJ5		
HCFJ6		
HCFJ7		
HCFJ8		
HCFK1	Clinical=Mod,Functional=Low,Service=Low	C2F1S1
HCFK2		
HCFK3		
HCFK4		
HCFK5		
HCFK6		
HCFK7		
HCFK8		
HCFL1	Clinical=Mod,Functional=Low,Service=Mod	C2F1S2
HCFL2		
HCFL3		
HCFL4		
HCFL5		
HCFL6		
HCFL7		
HCFL8		
HCFM1	Clinical=Mod,Functional=Low,Service=High	C2F1S3
HCFM2		
HCFM3		
HCFM4		
HCFM5		
HCFM6		
HCFM7		
HCFM8		
HCGJ1	Clinical=Mod,Functional=Mod,Service=Min	C2F2S0
HCGJ2		
HCGJ3		
HCGJ4		
HCGJ5		
HCGJ6		
HCGJ7		
HCGJ8		
HCGK1	Clinical=Mod,Functional=Mod,Service=Low	C2F2S1
HCGK2		
HCGK3		
HCGK4		
HCGK5		
HCGK6		
HCGK7		
HCGK8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HCGL1	Clinical=Mod,Functional=Mod,Service=Mod	C2F2S2
HCGL2		
HCGL3		
HCGL4		
HCGL5		
HCGL6		
HCGL7		
HCGL8		
HCGM1	Clinical=Mod,Functional=Mod,Service=High	C2F2S3
HCGM2		
HCGM3		
HCGM4		
HCGM5		
HCGM6		
HCGM7		
HCGM8		
HCHJ1	Clinical=Mod,Functional=High,Service=Min	C2F3S0
HCHJ2		
HCHJ3		
HCHJ4		
HCHJ5		
HCHJ6		
HCHJ7		
HCHJ8		
HCHK1	Clinical=Mod,Functional=High,Service=Low	C2F3S1
HCHK2		
HCHK3		
HCHK4		
HCHK5		
HCHK6		
HCHK7		
HCHK8		
HCHL1	Clinical=Mod,Functional=High,Service=Mod	C2F3S2
HCHL2		
HCHL3		
HCHL4		
HCHL5		
HCHL6		
HCHL7		
HCHL8		
HCHM1	Clinical=Mod,Functional=High,Service=High	C2F3S3
HCHM2		
HCHM3		
HCHM4		
HCHM5		
HCHM6		
HCHM7		
HCHM8		

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HCIJ1 HCIJ2 HCIJ3 HCIJ4 HCIJ5 HCIJ6 HCIJ7 HCIJ8	Clinical=Mod,Functional=Max,Service=Min	C2F4S0
HCIK1 HCIK2 HCIK3 HCIK4 HCIK5 HCIK6 HCIK7 HCIK8	Clinical=Mod,Functional=Max,Service=Low	C2F4S1
HCIL1 HCIL2 HCIL3 HCIL4 HCIL5 HCIL6 HCIL7 HCIL8	Clinical=Mod,Functional=Max,Service=Mod	C2F4S2
HCIM1 HCIM2 HCIM3 HCIM4 HCIM5 HCIM6 HCIM7 HCIM8	Clinical=Mod,Functional=Max,Service=High	C2F4S3
HDEJ1 HDEJ2 HDEJ3 HDEJ4 HDEJ5 HDEJ6 HDEJ7 HDEJ8	Clinical=High,Functional=Min,Service=Min	C3F0S0
HDEK1 HDEK2 HDEK3 HDEK4 HDEK5 HDEK6 HDEK7 HDEK8	Clinical=High,Functional=Min,Service=Low	C3F0S1

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HDEL1 HDEL2 HDEL3 HDEL4 HDEL5 HDEL6 HDEL7 HDEL8	Clinical=High,Functional=Min,Service=Mod	C3F0S2
HDEM1 HDEM2 HDEM3 HDEM4 HDEM5 HDEM6 HDEM7 HDEM8	Clinical=High,Functional=Min,Service=High	C3F0S3
HDFJ1 HDFJ2 HDFJ3 HDFJ4 HDFJ5 HDFJ6 HDFJ7 HDFJ8	Clinical=High,Functional=Low,Service=Min	C3F1S0
HDFK1 HDFK2 HDFK3 HDFK4 HDFK5 HDFK6 HDFK7 HDFK8	Clinical=High,Functional=Low,Service=Low	C3F1S1
HDFL1 HDFL2 HDFL3 HDFL4 HDFL5 HDFL6 HDFL7 HDFL8	Clinical=High,Functional=Low,Service=Mod	C3F1S2
HDFM1 HDFM2 HDFM3 HDFM4 HDFM5 HDFM6 HDFM7 HDFM8	Clinical=High,Functional=Low,Service=High	C3F1S3

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HDGJ1 HDGJ2 HDGJ3 HDGJ4 HDGJ5 HDGJ6 HDGJ7 HDGJ8	Clinical=High,Functional=Mod,Service=Min	C3F2S0
HDGK1 HDGK2 HDGK3 HDGK4 HDGK5 HDGK6 HDGK7 HDGK8	Clinical=High,Functional=Mod,Service=Low	C3F2S1
HDGL1 HDGL2 HDGL3 HDGL4 HDGL5 HDGL6 HDGL7 HDGL8	Clinical=High,Functional=Mod,Service=Mod	C3F2S2
HDGM1 HDGM2 HDGM3 HDGM4 HDGM5 HDGM6 HDGM7 HDGM8	Clinical=High,Functional=Mod,Service=High	C3F2S3
HDHJ1 HDHJ2 HDHJ3 HDHJ4 HDHJ5 HDHJ6 HDHJ7 HDHJ8	Clinical=High,Functional=High,Service=Min	C3F3S0
HDHK1 HDHK2 HDHK3 HDHK4 HDHK5 HDHK6 HDHK7 HDHK8	Clinical=High,Functional=High,Service=Low	C3F3S1

HIPPS codes	Case Mix Description by Domains	HHRG Identifier
HDHL1	Clinical=High,Functional=High,Service=Mod	C3F3S2
HDHL2		
HDHL3		
HDHL4		
HDHL5		
HDHL6		
HDHL7		
HDHL8		
HDHM1	Clinical=High,Functional=High,Service=High	C3F3S3
HDHM2		
HDHM3		
HDHM4		
HDHM5		
HDHM6		
HDHM7		
HDHM8		
HDIJ1	Clinical=High,Functional=Max,Service=Min	C3F4S0
HDIJ2		
HDIJ3		
HDIJ4		
HDIJ5		
HDIJ6		
HDIJ7		
HDIJ8		
HDIK1	Clinical=High,Functional=Max,Service=Low	C3F4S1
HDIK2		
HDIK3		
HDIK4		
HDIK5		
HDIK6		
HDIK7		
HDIK8		
HDIL1	Clinical=High,Functional=Max,Service=Mod	C3F4S2
HDIL2		
HDIL3		
HDIL4		
HDIL5		
HDIL6		
HDIL7		
HDIL8		
HDIM1	Clinical=High,Functional=Max,Service=High	C3F4S3
HDIM2		
HDIM3		
HDIM4		
HDIM5		
HDIM6		
HDIM7		
HDIM8		

4. Implementation of Consolidated Billing

The Balanced Budget Act of 1997 required consolidated billing of all home health services as defined by §1861(m) of the Social Security Act, with the exception of Durable Medical Equipment (DME), while a beneficiary is under a home health plan of care authorized by a physician. Consequently, payment for all such items and services that occur during a HHPPS episode is to be made to a single HHA, and this HHA is known as the primary agency (or the primary HHA) for HHPPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound beneficiaries involving equipment too cumbersome to take to the home.

The HHA that submits the first RAP or claim successfully processed by Medicare systems will be recorded as the primary HHA for a given episode. This record will be kept in a new episode auxiliary file in HCFA's Common Working File (CWF) system. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary, and is recorded as the primary HHA in CWF.

Fiscal intermediaries (including the RHHIs) and carriers will reject any claims from any provider other than the primary HHA that contain billing for the services and items above when billed for dates of service within a primary HHA's billing period. This applies to providers types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers and others).

DME is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DME Regional Carrier or billed by a HHA to an RHHI, even HHAs other than the primary HHA. Medicare systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the intermediary and the carrier at the same time for the same beneficiary.

5. New CWF Inquiry System for HHPPS

A new transaction, identified as HIQH (Health Insurance Query for HHAs), will be available as of October 1, 2000, to provide HHAs with access to the episode information in CWF. This new inquiry will facilitate claims submission given the consolidated billing requirements of HHPPS. HIQH will be accessible via each intermediary's claims interface, modeled on the current HIQA inquiry transaction. Entering the transaction ID HIQH will open an entry screen containing most elements currently required for HIQA, including the beneficiary's Health Insurance Claim (HIC) number, name, and sex plus intermediary and provider numbers and a CWF host. The one new addition to the entry data will be a date when you expect to serve the beneficiary.

When a HHA submits this inquiry, CWF will immediately return information on the two episode periods closest to the date submitted. If no episodes exist in CWF for a beneficiary, a message will be returned to indicate this. If no date is specified, the two most recent episode periods will be returned. For each of these episodes, the following information will be shown:

First, the basic entitlement information from page one of the HIQA inquiry will be shown. This means that although HIQA will remain available to HHAs, a separate HIQA inquiry will not be necessary to establish a beneficiary's Medicare eligibility. Next, specific information about the episode period will be returned, including the start and end dates of the episode and the patient status shown on the most recent claim processed in that episode. The intermediary number where the claim was processed and the provider number of the agency serving the beneficiary will also appear. The patient status codes displayed will be the same codes used on the UB-92 claim form. If a primary HHA exists, the patient status code will show if they are discharging the beneficiary, if they are aware the beneficiary is transferring, or if they plan to keep the beneficiary in their care.

The HIQH transaction will show the two most recent home health benefit periods, which Medicare uses to pay claims from the Part A or Part B trust funds, and the two most recent hospice periods for the beneficiary, if any. If Medicare Secondary Payer information or Health Maintenance Organization (HMO) enrollment information exists for the beneficiary, this information will be returned as well. All information returned from CWF will reflect data available as of the previous days claim submissions.

6. Cost Report Impacts of the HH PPS Transition

Cost reports will still be required after the implementation of HHPPS. Separate cost reports will not have to be filed for services before October 1, 2000, and services on or after October 1, 2000. HHAs will file a cost report in accordance with their normal cost reporting year. The Medicare statistics contained in the cost report will be separated for the October 1, 2000, implementation date. Medicare statistics for services before October 1, 2000 will be cost reimbursed, subject to the per-visit and per-beneficiary limitations. Medicare statistics for services on or after October 1, 2000, will be separately accumulated on the cost report and will differentiate prospectively paid services from other items excepted from PPS payment.

Materials reflecting specific instructional revisions of HHPPS payment will appear in the statistical section and other sections, as applicable, of the cost reporting instructions in the future. Such additions must be cleared by the Office of Management and Budget before being added to the cost reports.

A series of new reports are being developed to reflect HHPPS episode payments and payment adjustments in the provider statistical and reimbursement (PS&R) system.

The *effective date* for this PM is October 1, 2000.

The *implementation date* for this PM is October 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2001.

If you have any questions, contact your regional office.