Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

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10.1.19 - Adjustments of Episode Payment - Confirming OASIS Assessment Items

(Rev. 13, 10-24-03)

The total case-mix adjusted episode payment is based on the OASIS assessment. Medicare claims systems confirm certain OASIS assessment items in the course of processing a claim and adjust the HH PPS payment accordingly.

10.1.19.1 - Adjustments of Episode Payment - Therapy Threshold

(Rev. 13, 10-24-03)

The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode. Because the advent of 15 minute increment reporting on home health claims only recently preceded HH PPS, therapy hours will be proxied from visits at the start of HH PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent eight hours of therapy.

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

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

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

(Rev. 13, 10-24-03)

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

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

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

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

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