Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 514

SUBJECT: Business and System Requirements for the Home Health Prospective Payment System (HH PPS)

This Program Memorandum (PM) identifies business and systems requirements for the implementation of HH PPS. Each requirement specifies an action that must be taken and identifies the primary action agent, although conforming changes for certain actions may be required by additional parties. All changes specified below, with the exception of enhancements detailed in §II.X., are effective for home health claims with service dates on or after October 1, 2000.

I. Background Information

A. *Statutory Overview*

The Balanced Budget Act of 1997 (BBA 97), amended by the Omnibus Consolidated Emergency Supplemental Appropriations Act of 1998 (OCESAA 98) and the Balanced Budget Refinement Act of 1999 (BBRA 99), created a prospective payment system for Medicare home health services (HH PPS) specifying the following affecting claims operations and individual claim payment*:*

- Requires payment be made on the basis of a prospective amount
- Allows the Secretary of the Department of Health and Human Services (DHHS) to determine a new unit of payment
- Requires the new unit of payment to reflect different patient conditions (case mix) and wage adjustments
- Allows for cost outliers (supplemental payment for exceptional high-cost cases)
- Requires proration of the payment when a beneficiary chooses to transfer among home health agencies (HHAs) within an episode
- Requires services to be recorded in 15 minute increments on claims
- Requires Unique Physician Identification Numbers (UPINs) to appear on claims for prescribing physicians
- Eliminates periodic interim payments (PIP) for HHAs
- Requires consolidated billing by HHAs for all services and supplies for patients under a home health plan of care (POC)
  - -- BBRA 99 removes durable medical equipment (DME) from the scope of consolidated billing under BBA 97
- Requires an effective date for implementation of the system of October 1, 2000

Note that UPINs and 15 minute increments mentioned in BBA 97 are already captured on Medicare home health claims.

Also, existing laws affecting claims payment, such as those on the payment floor and Medicare Secondary Payer, are still valid and are not changed by HH PPS.

B. *Regulatory Overview*

HCFA made the following regulatory decisions regarding elements of the law listed above, and codified these provisions in a final rule published in the ***Federal Register*** on June 28, 2000:

- The unit of payment is a 60 day episode
- Each episode is anticipated to be paid in two split payments, one billed as a Request for Anticipated Payment (RAP) at the beginning of the episode and one as a claim at the end of the episode
- Only claims (not RAPs) will provide line-items detailing the individual services delivered
- Home Health Resources Groups (HHRGs), also called HRGs and represented by HCFA Health Insurance Prospective Payment System (HIPPS) coding, will be the basis of payment for each episode; HHRGs will be produced through publicly available Grouper software that will determine the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the Outcome and Assessment Information Set [OASIS] data set) are input or "grouped" in this software
- HHRGs can be changed mid-episode if the patient experiences a Significant Change In Condition (referred to below as a SCIC adjustment)
- Episodes will be truncated and given Partial Episode Payments (referred to below as PEP adjustments) if beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60 day period
- Payments are case-mix and wage adjusted employing Pricer software (a module that will be attached to existing Medicare claims processing systems) at the Regional Home Health Intermediary (RHHI) processing Medicare home health claims
- There will also be reducing adjustments in payment when the number of visits provided during the episode are four or less (referred to below as Low Utilization Payment Adjustments: LUPAs)
- There will be downward adjustments in HHRGs if the number of therapy services delivered during an episode does not meet a threshold of 10 therapy visits or more (referred to below as the therapy threshold)
- There will be cost outlier payment, if applicable, in addition to an episode payment
- The primary HHA under consolidated billing must identify itself to HCFA and its claims processing agents (only that one HHA, the primary or the one establishing the beneficiary's plan of care, can bill for home health services other than DME; if multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency)

C. *Administrative Implementation Overview*

The specific requirements in §II (below) reflect in detail the following implementation decisions that have been made by HCFA:

Basic systems and formats used in home health processing will not be changed:

- HH PPS will operate on the platform of existing Medicare claims processing systems including the Common Working File (CWF) and the Fiscal Intermediary Standard System (FISS) or Arkansas Part A Standard System (APASS)

- HH PPS will employ claims formats such as the paper and electronic UB-92 and related transaction formats (i.e., the 835 electronic and paper remittances, Medicare Summary Notice [MSN])-- no new fields will be added to either the remittance or the claim form

- Shifting payment for home health claims between the Part A and B trust funds, as stipulated by §4611 of BBA 97, will still be required, though the mechanism will change when the basis of payment changes to episodes (amounts of Part A and Part B visits and dollars on each claim will be captured in value codes internally generated by the Standard Systems, without changes for providers or the claims splitting of the current process)

Episodes, as the payment unit, will also become the unit of tracking in claims systems:

- In general, episodes will be distinct (not overlapping) and contiguous in time for cases of continuous care (one ending on one day, the next starting the very next day even if no services are provided that next day)

- More than one episode for a single beneficiary may be opened by the same or a different HHA for different dates of service; this will occur, particularly if a transfer or discharge and readmission to the same provider situation exists, in order to assure continuity of care and payment

Some new subsystems will be created to mesh with existing claims processing systems:

- There will be an inquiry system into CWF 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 their beneficiaries over time. This inquiry system is referred to below as the Health Insurance Query for HHAs (HIQH)

- 80 HHRGs for claims will be 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 -- current OASIS Haven software will be updated to integrate the Grouper, and free Grouper software will also be downloadable from the HCFA website; Grouper will output an HHRG for an episode to be put on a claim

- All HH PPS claims will run through Pricer software, which, in addition to pricing HIPPS codes for HHRGs, will maintain six national standard visit rates to be used in outlier and LUPA determinations

HH PPS billing will be limited to a subset of types of bill:

- Episodes paid under HH PPS will be restricted to homebound beneficiaries under existing Plans of Care (POCs) (i.e., UB-92 types of bill (TOB) 32x and 33x), though 34x bills will be used by HHAs for services not bundled into HH PPS rates

- Requests for Anticipated Payment will be submitted using TOB 322 only

- The claim for an episode (TOB 329) will be processed in Medicare systems as an adjustment to the RAP triggering full or final episode payment, so that the claim will become the single adjusted or finalized claim for an episode in claims history-- claims will be able to be adjusted by HHAs after submission

- There will <u>not</u> be late charge bills (TOB 325 or 335) under HH PPS-- services can only be added through adjustment of the claim (TOB 327 or 337)

New codes will appear on standard formats under HH PPS:

- The TOB frequency code of "9" has been created specifically for HH PPS billing
- A 0023 revenue code will appear on both RAPs and claims, with new HIPPS codes for HHRGs in the HCPCS field of a line item
- Source of Admission codes "B" (transfer from another HHA) and "C" (discharge and readmission to the same HHA) have been created for HH PPS billing
- Other currently existing National Uniform Billing Committee (NUBC) or ANSI ASC X12 (the group overseeing electronic remittances and claims) coding may be employed in home health transactions for the first time

Transition to HH PPS will occur in a compact time period:

- Services delivered on September 30, 2000 and before must be billed under the existing cost reimbursement system; services from October 1, 2000 and after must be billed on distinct PPS claims
- The cost-based claims system will be maintained several years into HH PPS in order to accommodate the current timely filing period for claims and previous years cost settlement
- Cost reports will continue to exist despite the that fact most payments will no longer be cost based; reports will distinguish between the two different payment systems that will exist in CY 2000, although HHAs will submit a single cost report in accordance with their current cost report year
- HHAs are encouraged to bill as promptly as possible in order to assure cash flow, and Medicare systems are being redesigned to accommodate and encourage this practice

II. Specific Business and Systems Requirements

The requirements below are grouped by subject, with manual sections to be affected noted for each subject. This transmittal will be replaced by revisions to all the listed sections of the Medicare Intermediaries Manual (MIM) and the Home Health Agency manual (HIM-11) and possibly additional sections as well. These manual sections will be published as soon as possible after the publication of this PM. Other related instructions are expected to be prepared for the Carriers Manual, encompassing both carrier and DME Regional Carrier effects, and a PM on transition issues.

The requirements groups below are arranged as follows:

A. Implementing the A-B shift under HH PPS
B. Provider Change of Ownership (CHOW)
C. General Claim Requirements
D. Coordination of Benefits
E. Enforcement of Consolidated Billing
F. Audit and Reimbursement/ PS&R Requirements
G. Common Working File (CWF) Requirements
H. Demand Billing and Appeals
I. Education issues for providers
J. The HH PPS Episode
K. Claim Requirements
L. Medical Review Requirements
M. Beneficiary Notices
N. Medicare Secondary Payer (MSP)

O. National Claims History (NCH) Requirements
P. Outcomes and Assessment Information Set (OASIS) Related Requirements
Q. HH PPS Pricer Requirements
R. Remittance Advice Instructions
S. Request for Anticipated Payment (RAP) Requirements
T. RHHI file maintenance
U. Standard System editing requirements
V. Transition to HH PPS
W. Workload Reporting and Claims Timeliness
X. Enhancements to the HH PPS system

A. Implementing the A-B shift under HH PPS (MIM §3604, HIM-11 §475)

CWF will apply entitlement edits and A-B shift edits before PPS edits.

Standard Systems (referred to below as SS) will pass one or more value codes (VCs) designated to A-B visits and A-B dollars on all HH PPS claims processed for payment.

SS will read Part A and B visits rejected by CWF with trailer 16, if all visits are Part A, SS will send CWF a TOB 33x with VC 62 (Part A visits) and VC 64 (Part A dollar amount) only, or if all visits are Part B, SS will send a TOB 32x with VC 63 (Part B visits) and VC 65 (Part B dollar amount) only (8029 and 8031 error codes). SS will populate all four VCs if both A and B visits are on the claim (8030) and these value codes can appear on either TOB 32x or 33x. SS will then return the claim to CWF for approval.

SS will prorate episode payment on a basis of a number of visits to populate VC 64 (Part A dollar amount) and/or VC 65 (Part B dollar amount).

If an unsolicited cancel-only response (trailer 20) is received from CWF, SS will create a 32G or 33G adjustment claim, and return it to CWF with action code 1.

SS will assure Record Identification Code (RIC) sent to CWF must match the type of bill (TOB) on the claim. If A & B visits on same claim, RIC must match submitted TOB.

CWF will change RIC code to new code U if both value codes 64 and 65 are on a claim.

B. Provider Change of Ownership (CHOW) (MIM §§3009, 3638, HIM-11 §140, 432)

SS will set a reason code and RHHIs will Return to Provider (RTP) any Requests for Anticipated Payment (RAPs) and claims in episodes where the 6 digit base Medicare provider number changes.

HCFA will instruct providers that if claims are returned to provider due to the provider number changing, providers must submit a claim with old provider number for the existing episode as a Partial Episode Payment (PEP) and submit a RAP with the new provider number to receive payment for a new episode.

C. General Claim Requirements (MIM §§3600.1, 3604, HIM-11 §§475,462)

HCFA will instruct providers that each Home Health Resource Group (HRG) will be represented in the system by 8 Health Insurance PPS (HIPPS) codes.

HCFA will define a generic description for revenue code 0023 ("Home Health Services") in instructions.

SS will return the reimbursement for the HIPPS code in the 0023 line of the claim for RAPs and paid

claims.

HCFA will instruct providers never to submit charges on 0023 lines, since this field will be overlaid with the HH PPS reimbursement amount.

SS will reject type of bill 325 or 335.

HCFA will continue to educate providers to submit all non-covered charges submitted, per Change Request 1001. Programming changes to pass the non-covered charges from the SS to CWF (and any adaptation of HH PPS design to accommodate them) will be scheduled post 10/1.

D. Coordination of Benefits (COB)

Per HCFA decision, SS will send only the claim for COB. SS will send claim as an original, debit only claim, not as an adjustment. This occurs between the RHHI and the COB trading partner insurer and does not affect CWF.

E. Enforcement of Consolidated Billing (MIM §3640, HIM-11 §460)

1. Billing Instructions:

HCFA will require HHA providers to submit line item dates on Durable Medical Equipment (DME) items.

HCFA will instruct providers to bill each month's DME rental as a separate line item.

HCFA will not require HHAs to adopt broader use of HCFA Common Procedure Coding System (HCPCS) codes in billing with the advent of HH PPS.

HCFA will continue to allow HHAs to bill DME not under a Plan of Care (POC) on the 34x type of bill.

HCFA will request that HHAs use revenue code 623 to report all wound care supplies, including but not limited to surgical dressings, separate from any other non-routine supplies reported under either revenue codes 62x or 27x during the same episode.

HH PPS will cause no changes in the billing of outpatient services by HHAs (i.e., vaccines, splints, antigens, casts, or therapy visits) which are billed on the 34x type of bill.

2. Crossover Editing:

CWF A-B crossover edits will prevent duplicate billing among RHHIs for all DME. Since consolidated billing does not apply to DME, the first claim in will be processed/paid, and subsequent claims for the same item in the same time period will be rejected by CWF/denied back to providers.

CWF will develop A-B crossover edits for a defined list of 178 HCPCS for non-routine medical supplies among all institutional bill types so that services billed after the posting of a HH episode will be rejected back to the SS. The SS will deny the items on the non-primary HHA claim.

CWF will develop A-B crossover edits for a defined list of 178 HCPCS for non-routine medical supplies among all institutional bill types, so that if services other than those billed by the primary HHA have been paid prior to the posting of an HH episode, CWF will return an unsolicited trailer 20 to the SS, and the SS will reprocess the previously paid claim as a debit/credit to deny items on the non-primary HHA claim.

CWF will develop crossover edits for therapies (42x, 43x, 44x) among all institutional bill types so that

services billed after the posting of a HH episode will be rejected back to the SS. The SS will deny items on the non-primary HHA claim.

CWF will develop crossover edits for therapies (42x, 43x, 44x) among all institutional bill types so that if services other than those billed by the primary HHA have been paid prior to the posting of an HH episode, CWF will return an unsolicited trailer 20 to the SS, and the SS will reprocess the previously paid claim as a debit/credit to deny items on the non-primary HHA claim.

If revenue code 636 and HCPCS for osteoporosis drug are billed on 34X claim, CWF will check to ensure that provider of 34x bill is same as provider on episode record. If an open episode exists, SS will edit accordingly.

3. Inquiries by other provider types: CWF will provide information on the HH episode in the Health Insurance Query Access (HIQA) system for other non-HHA institutional provider types to view. HIQA will show the from and through dates of most current episode unless provider submits earlier dates.

F. Audit and Reimbursement/Provider Statistical and Reimbursement (PS&R) System Requirements

1. The End of Periodic Interim Payments (PIP) under HH PPS:

HCFA will notify providers regarding the elimination of Periodic Interim Payments (PIP) under HH PPS.

SS will not allow a PIP indicator on HH provider files after 10/1/00.

Data centers must run report of PIP providers and automatically update provider files.

2. PS&R Requirements:

HCFA will assure all claims in a given episode are applied to the provider fiscal year in which the episode ends for cost reporting and PS&R purposes.

HCFA will assure PS&R will continue to track cost payments for covered osteoporosis drugs on only 34x claims under HH PPS.

HCFA will assure PS&R will pick up the claim frequency code, which is the third digit of the type of bill.

HCFA will assure PS&R will capture cancel only codes, i.e., track number of RAPs paid without claim paid through capture of unique two-digit cancel only code.

HCFA will assure PS&R will track number of visits through use of value codes with count of Part A and B visits.

HCFA will assure claim record layouts for HH PPS are available for PS&R programming purposes.

HCFA will assure new PS&R data will be collected, in new approved tables, to track payments by provider and by type of payment. Tables will include payments by HHRG level, LUPAs, SCICs, and PEPs.

PS&R users will do enough monthly reporting to complete the set of new HH PPS tables specified by HCFA.

HCFA will complete instructions on the new PS&R tables.

HCFA will create mechanism for Network Data Mover (NDM) transmission of HH PPS PS&R data and create a repository for the data in the HCFA data center.

3. Cost Reporting/Cost Settlement Issues:

HCFA will assure cost report settlement will continue for non-HH PPS services, drugs and items on 34x bills that HHAs bill, and interim payments will be on a percentage of charges.

HCFA will make clear there will be no short cost report periods, and both payment systems will be reported in the same cost report for the year in which the transition occurs. New schedules will be developed to track both PPS and cost reimbursement on single cost report for the transition year.

HCFA will require RHHIs to maintain the current cost statistics for transition for a year (i.e. visits by type of rate).

4. Monitoring of overpayments: HCFA will determine a way in systems to monitor overpayments including what will be reported on, what system will do this beyond PS&R, what frequency of reporting is required, and how to link identified overpayments to the generation of demand letters.

G. Common Working File (CWF) Requirements (MIM §§3500, 3640, 3802, 3638.4, 3682 HIM-11§§475, 462, 300, and new sections)

1. CWF Episode file and Health Insurance Query for HHAs (HIQH)

CWF will have and update an episode history auxiliary file, separate from the Home Health Benefit Period (HHBP) auxiliary file.

CWF will track episode records by beneficiary and update based on the daily claims process.

The episode auxiliary file will have 10 fields: period start date, period end date, contractor number, provider number, HRG, Date of Earliest Billing Activity (DOEBA), Date of Latest Billing Activity (DOLBA), principle and secondary diagnosis codes (1 field), LUPA indicator and period status indicator. The trailer will reflect everything in the episode period. (Record layouts and additional information are defined in CWF CR#18986.)

In the CWF episode record, the period status indicator will be the two-digit patient status code from claim.

CWF will have all claims update HHBP and episode record DOEBA and DOLBA and visits.

The CWF date of accretion on the episode will be the date the RAP or No-RAP LUPA (defined in Claim Requirements below) is accepted and applied.

CWF will maintain 36 iterations of episodes in the episode file, and when the 37th and subsequent episodes come in, episodes will be dropped by age (i.e., the oldest will be dropped).

The HIQH transaction will be able to access all 36 episode iterations displayed two at a time. If specific dates are not given, the default will be to display the two most recent episodes.

In the HIQH response, providers will receive HICN, episode start and end date, period status indicator and contractor and provider numbers, home health benefit periods, episode periods, Medicare Secondary Payer (MSP) information, Health Maintenance Organization (HMO) enrollment information and hospice periods along with other HIQA header information that pertains to home health. HCFA must educate on this.

CWF will not support an unformatted HUQH record parallel to HUQA (the unformatted version of HIQA).

2. CWF editing of claims against the episode file:

CWF will assure that an episode will open even if the RAP shows zero reimbursement.

CWF will calculate the end date when creating an episode record from a RAP (even if no-pay) or from No-RAP LUPA.

CWF will reject any claim with statement dates overlapping any existing episode on the CWF episode record without the appropriate patient status or source code indicators (transfer or discharge/readmit).

CWF edits against episode record will allow same day transfers (the termination date of one episode and the start date of the next may be equal if 2 HHAs are involved).

All visits reported on the claim must fall within the episode period or the claim will be rejected by CWF.

CWF will produce a response trailer for the RAP and claim.

CWF will use 23 for the new trailer for HH PPS RAPs and claims.

If the claim patient status is 30, CWF will assure that the through date will equal the CWF calculated episode end date.

CWF will auto-cancel the claims of episodes shortened because of the receipt of a RAP or No-RAP LUPA with a transfer or readmit indicator and send an unsolicited response to the SS.

If a HH claim is received and CWF finds an inpatient, outpatient or SNF claim within the episode dates, CWF will compare the line item visit dates to the statement dates on that claim and reject the HH claim if any date falls within the range of the statement dates of the other claim.

If 2 admission dates on 2 RAPs cause episode spans to overlap, CWF will reject the later received RAP with a trailer and a new error code if an earlier received RAP without a transfer indicator is present. A No-RAP LUPA is also rejected if it overlaps an episode period without a transfer indicator.

If CWF receives a RAP with a readmit indicator from a provider with an open episode, the RAP will post if no claim is in paid status or post and adjust previous episode period end date in previous episode record if the claim is in paid status.

If a claim in an episode is denied or auto-canceled, CWF will not cancel the episode.

If a claim in an episode is canceled by the FI or the provider, CWF will cancel the episode.

H. Demand Billing and Appeals

HCFA will instruct providers that appeal rights under HH PPS will be triggered by claims alone.

HCFA will instruct how a mechanism comparable to demand bills under the current Interim Payment System (IPS) will be applied to the HH PPS environment.

I. Education issues for providers (MIM§§3638, 3640, 3682, 3780, HIM-11 §§475, 439, new sections)

HCFA will set a "guiding" HH PPS education time line with milestones for national coordination.

HCFA will educate affected non-HHA institutional billers and processors and also Audit Intermediaries (AIs) on the effects of HH consolidated billing.

HCFA will educate affected physician/professional billers and processors on the effects of HH consolidated billing.

HCFA will educate both hospices and HHAs to use HIQH.

RHHIs will cover the following topics, among others, to the extent they are trained by HCFA and the Blue Cross Blue Shield Association (BCBSA): billing continuous care, MSP, RAPs, consolidated billing (DME and under arrangement), Haven software, cost reports, transition periods, new CWF inquiries, new payment basis and types (LUPAs, PEPs, Outliers, etc.), payment system links to OASIS, HH PPS background (including demos), snowbird issues, medical review, time frames for claims, transfer issues, coordination with plan of care, incentives for timely billing, therapy thresholds, and MSN/remit changes.

HCFA will brief Administrative Law Judges (ALJs) and the press office on HH PPS.

HCFA CO will provide national coordination for HH PPS on the use of different media: websites, satellite broadcasts, town hall meetings, national articles, and computer-based training.

HCFA will work with RHHIs to develop clear avenues for inquiries on HH PPS.

RHHIs may use or HCFA will coordinate use of advisory groups and State associations in educational efforts.

J. The HH PPS Episode

RHHIs, with HCFA training, will ensure providers have universal understanding of the HH PPS episode as a period of up to 60 consecutive days, starting with first service delivery date reported on the RAP.

HCFA will instruct providers that multiple, non-overlapping episodes for the same beneficiary can be open at one time.

HCFA will instruct providers that only the primary HHA can bill when overlapping services are billed and one agency should be under arrangement to another (not transfer).

SS and CWF will edit the claim through date so that it will not be greater than the first service date of the episode plus 59 days.

K. Claim Requirements (MIM §§3600, 3603, 3604, 3639, 3640, HIM-11 §§475, new sections)

1. Provider Instructions for a Claim:

HCFA will instruct that the claim will be submitted with a type of bill frequency of 9 and that the claim is subject to interest and the payment floor.

HCFA will require source of admission codes on claim. Any appropriate NUBC approved code will be accepted.

HCFA will instruct that any appropriate NUBC approved patient status code will be required on the claim.

HCFA will instruct and SS will assure that the through date of the claim equals the date of the last service provided in the episode unless the patient status is 30, in which case the through date should be day 60.

Providers may submit claims earlier than the 60th day if the POC goals are met and the patient is discharged, or the beneficiary died. The episode will be paid in full unless there is a readmission of a discharged beneficiary, or a transfer to another HHA prior to the day after the HH PPS period end date.

Providers may submit claims earlier than the 60th day if the beneficiary is discharged with the goals of the POC met, and if readmitted or if a transfer to other HHA-- the episode will be paid as a PEP.

If the beneficiary goes into the hospital through the end of the episode, the episode is paid in full whether the patient is discharged or not.

HCFA will instruct providers that a PEP is given if a transfer situation, or if all treatment goals are reached with discharge and there is a re-admission within the 60 day episode. PEPs are shown on the claim by patient status code 06.

HCFA will instruct providers to report all SCICs occurring in one 60-day episode on the same claim.

HCFA will instruct providers that the dates on 0023 lines on all claims will be the date of the first service supplied at that level of care.

HCFA will instruct providers to submit no late charges on claims under HH PPS. Claims must be adjusted instead.

HCFA will instruct providers that they must use the E0 condition code if submitting adjustments to change the patient status on a claim.

HCFA will instruct that a claim is paid as a LUPA if there are four or less visits total in an episode, regardless of changes in HIPPS code.

HCFA will instruct how to accommodate beneficiary selection of HMO during an episode.

2. Claims with no RAP submitted:

HCFA will assure systems can accommodate providers just sending a claim (no RAP) in the situation where providers know a LUPA will be delivered from the outset of the episode. These cases are known as "No-RAP LUPA" situations.

HCFA will instruct providers that before submitting No-RAP LUPAs, written orders must be signed.

HCFA will insure providers understand the risk of a No-RAP LUPA situation. There will be no RAP to tie the beneficiary to the provider as primary while services are being delivered.

3. Processing of claims:

SS will edit the admission date and from date and earliest dated HIPPS code on claim to match RAP. If the claim fails this edit, SS will set a reason code, and RHHIs will RTP the claim.

If a claim, other than a No-RAP LUPA, is received without the RAP for the same episode in pending or final status, SS will RTP the claim as is currently done on adjustments with no matching claim, but will assign a new reason code with a different external narrative.

If the RAP for an episode is in house but pending (any suspense status or on the payment floor, FISS: any

S status or PB9996), SS will recycle the claim. If recycling the claim, RHHI will set up a reason code to mark the claim dirty.

SS will define a new claim path for the 329 or 339 TOB.

SS will edit so that the from date, first 0023 date, admission date and first revenue code date on the claim all match each other on an initial episode of continuous care.

On the claim, SS will calculate the 0001 line to show a summary of charges submitted on final, not including any 0023 lines.

SS will create a new reason code defined as "Home Health Claim" (FISS: parallel to current reason code 37192).

In a PEP situation only: if the first provider bills the claim with visits overlapping a second provider's episode period, the claim will be rejected by CWF with a UR reject code which indicates the date of the first overlapping visit. The first provider, when receiving the rejected claim, can rebill only the non-overlapping dates and seek payment under arrangement with the second provider for other visits.

SS will place the changed HIPPS codes in the panel code field of the claim.

SS will pass changed HIPPS codes to CWF in the extra HCPCS field created with claim expansion.

L. Medical Review Requirements (Program Integrity Manual)

RHHI medical reviewers will add language to external message for additional development request (ADR) reason codes to include OASIS.

RHHI medical reviewers will have access to the Provider Enrollment Chain and Ownership System (PECOS) database, containing information on common ownership of HHAs (slated for 7/00).

If an RHHI medical reviewer determines common ownership in a transfer situation, they will reject the transfer claim with a message that the second provider must seek payment under arrangement with the other agency.

Medical reviewers will determine that the principle diagnosis on the UB-92 claim form must match the principal diagnosis on the 485 plan of care form and on the OASIS assessment.

RHHI medical reviewers will use HIMR to access beneficiary episode record on CWF to monitor discharges to related agencies processed by other RHHIs

SS will create a new line-level pricing indicator for when medical reviewers change a HIPPS code.

M. Beneficiary Notices [Medicare Summary Notice (MSN)/Explanation of Medicare Benefits (EOMB)]

SS will create an MSN message for the general information section based on a RAP, to read "Our records indicate that you are receiving home health services from agency xxxxxx. If this is incorrect please contact us at the number on the front of this form."

RHHIs will not revise the 7R file to send 0023 lines on claims to the MSN.

HCFA will work with APASS and AHS to define all modifications needed for HH PPS on EOMB-comparable documents.

N. Medicare Secondary Payer (MSP) (MIM §§3682.4, 3899, HIM-11 §496)

There are no changes for the MSP pay modules because of HH PPS.

HCFA will educate providers that for MSP, providers may have to track the visits of primary payers in 60 day increments to match claims.

For working aged, no conditional payments can be made, so Medicare systems will evaluate on claims only if secondary payment is due.

In addition to working aged, HCFA will not make interim or conditional payments, for other types of MSP (including no fault, workman's comp and liability). The prompt payment period would not apply until 120 days from first date of service. The claim could be paid by this point in time therefore the prompt payment period would apply only to the claim).

HCFA will insure MSP savings calculations are not done on RAP if $0 because savings in this case would be the difference if Medicare was primary as opposed to secondary.

Medicare will pay the difference of the primary payer payment and the full episode payment due on claims for all MSP types.

For calculation of MSP savings, take cost avoidance only on denied claims.

MSP override capabilities will apply to both RAP and claims

CWF and SS MSP edits apply to RAP and claims but have to be adjusted for episode payment basis.

O. National Claims History (NCH) Requirements

The NCH Nearline file will store both the RAP and the claim transactions. During the final action processing of the Standard Analytic Files, the claim as an adjustment will overlay the RAP.

For the A-B shift affecting claims, charges under HH PPS will not have to be split by the SS into charges to Part A or Part B for passing to NCH. Splitting of charges may be performed in MQA. process, as determined by input from NCH data users.

CWF Medicare Quality Assurance (MQA) system/NCH must review HH PPS requirements for other changes and MQA needs.

P. Outcomes and Assessment Information Set (OASIS) Related Requirements (MIM §§3117.2, 3604, 3639 HIM-11 §§204.2, 204.5, 240.3, 475)

HCFA will revise HIM-11 §§204.2, 204.5, and 240.3 on timing of recertification to parallel OASIS regulations, and make conforming revisions to the MIM.

HCFA will add an additional item to OASIS instrument to indicate whether 10 or more therapy visits are projected.

HCFA will insure that all new eligible patients who become Medicare eligible must have a new start of care

(SOC) assessment, and for Medicare payment purposes the episode would start with the SOC assessment.

HCFA will assure the HIPPS code will be determined by a Grouper at the HHA site, based on OASIS data.

HCFA will instruct providers to submit the following, an output of the Grouper: start of care date (M0030--date fields in OASIS are 8 bytes), assessment completed date (from item M0090 on OASIS) and reason for assessment (M0100-2 bytes) on the claim in the treatment authorization code field on all HH PPS claims. This is to tie an individual OASIS assessment to individual claims/episodes. This claim element will be called the claims-OASIS matching key.

Grouper will output the claims-OASIS matching key.

SS will edit to ensure the presence of an 18 character claims-OASIS matching key in the treatment authorization field on the claim.

HCFA will instruct providers to report the claims-OASIS matching key for the latest dated assessment in the episode period on SCIC claims.

HCFA instructions will stipulate that the investigation devices (IDE) revenue code (624) should be disallowed on HH claims, since the treatment authorization field required for IDE will be used for the claims-OASIS matching key.

Q. HH PPS Pricer Requirements (MIM §§3640, 3656 3892 HIM-11 §475, new sections)

1. General Requirements:

Pricer will return the following information on all claims: Output HIPPS codes, weight used to price each HIPPS code, payment per HIPPS code, total payment, outlier payment and return code. If any element does not apply to the claim, Pricer will return zeroes.

Pricer will wage index adjust all PPS payments based on the Metropolitan Statistical Area (MSA) reported in value code 61 on the claim.

If input data is invalid, Pricer will return one of a set of error return codes to indicate the invalid element.

Pricer must key application of fiscal year rate changes to through date on the claim.

2. Pricing of RAPs:

Pricer will employ RAP logic for type of bill 322 and 332 only.

On the RAP, Pricer will multiply the wage index adjusted rate by .60 if the claim from date and admission date match and the initial payment indicator is = 0.

On the RAP, Pricer will multiply the wage index adjusted rate by .50 if the claim from date and admission date do not match and the initial payment indicator is = 0.

On the RAP, Pricer will multiply the wage index adjusted rate by .00 if the initial payment indicator equals 1.

Pricer will return the payment amount on RAP with return code 03 for 0 percent payment, 04 for 50 percent payment and 05 for 60 percent payment.

3. Pricing of Claims:

Pricer will employ claim logic for type of bill 329, 339, 327, 337, 32G, 33G, 32I, 33I, 32J, 33J, 32M and 33M only.

Pricer will make payment determinations for claim in the following sequence: LUPA, therapy threshold, HHRG payments (including PEP and SCIC), then outlier, in accordance with logic in HCFA paper.

Pricer will pay claims as LUPAs when there are less than 5 occurrences of all HH visit revenue codes: 42x, 43x, 44x, 55x, 56x and 57x.

Pricer will pay visits on LUPA claims at national standardized rates, and the total of visit amounts will be final payment for the episode.

If Pricer determines the claim to be a LUPA, all other payment calculations will be bypassed.

Pricer will return claim LUPA payments, with return code 06.

HCFA will supply Pricer with a table of "fall back" HIPPS codes so HIPPS can be down coded when thresholds are not met.

If one of the 320 HIPPS codes that indicate therapy is present, Pricer will check for the presence of 10 therapy visits by revenue codes (42x, 43x, 44x). Ten therapies in total for episode is threshold.

If 10 occurrences of therapy revenue codes are not found when HIPPS code indicates therapies, Pricer will reprice the claim based on the table of "fall back" HIPPS codes.

Pricer will return both the input HIPPS code and an output HIPPS code. The output code will be different from the input code only if the therapy threshold is not met.

If the PEP indicator is Y, Pricer will multiply the wage index adjusted rate by the number of HHRG days over 60.

If the PEP indicator is Y and there are two or more HIPPS codes on the claim, Pricer will multiply each HHRG payment by the number of PEP days/60. Each result will then be multiplied by the number of HHRG days/the number of PEP days. The sum of these amounts is the total HHRG payment for the episode.

If a SCIC, Pricer will pro-rate the episode in accordance with the multiple HHRG lines that come in on the claim.

Pricer will perform the outlier calculation on all claims unless the claim is a LUPA.

Pricer passes back to the SS a single outlier amount, no matter how many HIPPS codes are on claim.

Pricer will perform an outlier calculation that requires total numbers of visits per discipline to be multiplied by national standard per visit rates. The total result is compared to an outlier threshold which is determined by adding the rate for the HIPPS code to a standard fixed-loss amount. If the total result is greater than the threshold, Pricer will pay 80 percent of the difference between the two amounts in addition to the episode rate determined by the HIPPS code.

Pricer will return claim payments with no outlier payment with return code 00.

Pricer will return claim payments with outlier payment with return code 01.

Pricer will return the following additional information on claims: the dollar rate used to calculate revenue code costs and the costs calculated for each revenue code. If any revenue code is submitted with zeroes, Pricer will return zeroes in these fields.

4. Annual Updates: HCFA will annually update the following information used by Pricer: Federal episode rate, outlier threshold amount, outlier loss-sharing ratio, RAP payment percentage, labor and non-labor percentages, hospital wage index, HHRG weight table, national per visit rate table.

R. Remittance Advice Instructions (MIM §3602.7, HIM-11 new section)

1. General Requirements:

HCFA will not make additional changes for HH PPS to the paper remittance format, the 835 v. 3051.4A.01 implementation guide or PC-Print.

HCFA will inform providers that line level payment data will be reported only in v. 3051.4A.01 and later versions. Other versions will report claim level summary payment data.

HCFA will educate providers regarding the meaning of the two HIPPS codes on their Electronic Remittance Advices (ERAs) in cases where the HIPPS code is changed by the Pricer or by medical review.

HCFA will instruct providers about remittances under HH PPS and the continued use of the existing debit-credit process for processing the claim for the episode.

HCFA will determine, or provide guiding principles, for all new types of claim rejections under HH PPS as to whether to reject as provider liable or beneficiary liable, to enable assignment of the CO or PR group code as appropriate.

2. Specific Instructions:

A. <u>835 Version 3051.4A.01 Line Level Reporting Requirements for the RAP.</u>

1. Enter HC (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SVC01-02. The HIPPS code is being treated as a type of level 3 HCPCS in this version.

2. Enter 0 (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount you are paying in SVC03.

3. Enter 0023 (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service.

5. If the HIPPS has been down coded or otherwise changed during adjudication, enter the billed HIPPS in 2-070-SVC06-02 with qualifier HC in 2-070-SVC06-01.

6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than 0023 is billed, report the line item date associated with that revenue code instead of the claim from date.

7. Enter group code OA (Other Adjustment), reason code 94 (Processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. Report the difference as a

negative amount.

8. Enter 1S (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.

9. Enter RB (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.

10. 2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply to HHA claims, and should not be reported for either the first or the final remittance advice for a HH PPS episode.

11. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when 4 or fewer visits) rather than on the HIPPS.

12. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial episode payments.

B. 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim (More than 4 Visits)

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives. See the 835 implementation guide for further information on the correction reversal process.

2. Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

3. The full payment for the episode can now be reported for the end of episode bill.

a. Repeat steps A1-11 for the service as a reprocessed bill. Report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.

b. In addition to the HIPPS code service loop, also enter the actual individual HCPCS for the services furnished. Include a separate loop for each service. Revenue code 270 services will not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

c. Report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero rate if denying the service) in step 9.

d. Report group code CO, reason code 97 (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCSs in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Do not report any allowed amount in 2-110.A-AMT for these lines. Do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

e. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME is paid, report in a separate loop(s), and enter the allowed amount for the DME in 2-110.A-AMT.

4. If Pricer determines that a cost outlier is payable for the claim, enter ZZ (outlier amount) in 2-062-AMT01 and the amount of the outlier in AMT02.

NOTE: Since this is a claim level segment, this must also be reported in 835 versions 3030M and 3051.3A.

5. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

C. 835 Version 3051.4A.01 Line Level Reporting Requirements Claim (4 or fewer Visits)

1. Follow B steps 1-2.

2. Now that the first payment has been reversed, pay and report the claim on a per visit basis rather than on a prospective basis. Enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.

3. Report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. Enter B6 in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. Report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

S. Request for Anticipated Payment (RAP) Requirements (MIM §§3600, 3603, 3604, 3639, 3640, HIM-11 §475, new sections)

1. Provider Instructions for RAPs:

HCFA will instruct providers that to send a RAP, a service must be delivered but written orders do not have to be in hand nor does the assessment form have to be transmitted.

HCFA will instruct providers that all HH episodes must be opened on CWF history by the submission of a RAP or LUPA final.

RHHIs will convey as part of provider education the incentive to get the RAP in as soon as possible.

HCFA will require submitted RAP TOB to be 322 or 332 only.

HCFA will require that providers place source of admission codes on RAP.

HCFA will instruct providers that the admission date on the RAP, and on a LUPA final, must remain constant for related episodes of continuous care. The date must be the first service date of the first episode in the "spell."

HCFA will require that the statement covers "from" date on RAP will match the "through" date.

A patient status code will be required on RAP. The only acceptable code is 30.

HCFA will instruct providers that they must submit one revenue code line on RAP. The line will show the new revenue code 0023, HIPPS code, first date of service, and zero charges on 0023 line.

Providers may submit 0001 line on the RAP, but SS will ignore it.

SS will allow only 328, 338, 329, 339 or 32I, 33I (cancel only--C) adjustments can be made to a 322 or 332.

2. Processing of RAPs:

CWF and SS will accept new source of admission code C to reflect PEP due to discharge and goals met.

If source code on RAP indicates transfer or discharge and readmission, CWF will open new episode on history.

On RAP, SS will calculate 0001 to match the 0023 line

HCFA will create a distinct no-pay code for no-pay RAPs (provider who has 0% as RAP payment allowance)

SS will edit so that the from date and the first 0023 date on the RAP match on the initial episode of a period of continuous care.

If a claim is not received within 60 days from the end of episode, SS will automatically cancel the RAP for that episode, using a unique two-digit cancel only code created by HCFA. This code will be seen on both the debit and the credit actions in SS financial processing. The claim will be cancel-only at CWF.

T. RHHI file maintenance(MIM §3604 HIM-11§ 475)

RHHIs will set up revenue code 294 to require a HCPCS code.

SS will send a loadable file of HIPPS codes to the RHHIs, to be loaded in locality one.

RHHIs will activate all provider-specific files attributes necessary for HH PPS in provider specific files.

RHHIs will set the revenue code file so that revenue codes 58x and 59x cannot be billed as covered under HH PPS (on TOBs 32x, 33x).

RHHIs will add revenue code 0023 to the revenue code file with an effective date of 10/01/00, and set up revenue code 0023 to require a HCPCS code.

U. Standard System editing requirements (MIM §3640 HIM-11 §475, new sections)

1. General Requirements:

SS will ensure that the total charges field will be sent to CWF.

SS will modify the edit that compares the provider effective date to the admission date for TOB 32x, 33x to compare to the statement "from" date.

SS will revise duplicate editing to allow for same day transfers.

SS will reject claims rejected by CWF because of dates overlapping with an existing episode.

SS will autocancel RAPs when claims are processed (FISS overlay, APASS has link) using a unique two-digit cancel-only code (created by HCFA), to be seen on debit and credit actions in SS financial processing. The claim will be cancel-only at CWF.

When the claim is received, SS will pull up the Intermediary Control Number (ICN) from the RAP and populate the claim. (This action is specific to FISS. APASS will take similar action.)

When the claim is received, SS will plug in the transaction type on the claim.

SS will modify financial logic that requires FISS adjustment reason code and requester identification for 329 and 339 bills (page 6 of the FISS claim).

HCFA will supply SS with 80 HHRGs represented as 640 HIPPS codes: 80 indicate computed from complete data, and 560 indicate computed from derived data.

SS will deny RAPs and No-RAP LUPAs if the physician signing the plan of care is on the sanctioned provider list.

SS will have all claims with partial denials process back through entire claim path, excluding medical policy.

SS will develop an interface with HIQH.

SS will send the following actions codes to CWF: 1 on RAP, No-RAP LUPA or TOB 32G or 33G; 3 on claims other than No-RAP LUPAs; 4 for cancel-only claims; and 7 for RAPs that are suspended.

SS will pass both debits and credits to PS&R with 329 or 339 types of bill, even when the credit may be blank.

SS will create a mechanism to transmit RAPs to CWF that suspended in the claim path prior to submission to CWF.

SS will not apply sequential edits .

SS must create an HUSP (secondary payment transaction record) for all RAPs with MSP information and send it to CWF to update/create an MSP auxiliary file.

SS will modify edits for HH TOB frequency, admit date and patient status to create separate editing for service dates prior to HH PPS implementation and for service dates after HH PPS implementation.

2. Interface with Pricer:

HCFA will provide SS with specifications for a 450 byte Pricer input record layout.

SS will pass the following claim elements to Pricer for all claims: National Provider Identifier (NPI), Health Insurance Claim (HIC) number, provider number, type of bill, statement from and through dates, admission date and HIPPS codes.

SS will place the return code passed back from Pricer on the header of all claims.

If the claim is a LUPA, SS will apportion the payment amounts returned from Pricer to the visit lines, so they can pass accurately to the ERA.

SS will pass a Y medical review indicator to Pricer if a HIPPS code is present in the panel field on a line and the line item pricing indicator shows that the change came from MR. In all other cases an N indicator will be passed.

SS will pass an initial payment indicator to Pricer, extracted from field 19 of the Provider Specific File.

SS will assure all claims with covered visits will flow to Pricer, but only covered visits will be passed to Pricer.

SS will pass Pricer all six HH visit revenue codes sorted in ascending order, with a count of how many times each code appears on the claim, and those that do not appear on the claim will be passed with a quantity of zero.

If there is one HIPPS code on the claim and the patient status is not 06, SS will pass 60 days of service for the HIPPS code, regardless of visit dates on the claim.

If the claim is a PEP, SS will calculate the number of days between the first service date and the last service date and pass that number of days for the HIPPS code.

If the claim is a SCIC, SS will calculate the number of days for all HIPPS codes from the inclusive span of days between first and last service dates under that HIPPS code.

SS will pass a Y/N medical review indicator to Pricer for each HIPPS code on the claim.

SS will pass Pricer a Y/N PEP indicator for every claim.

SS will pass Pricer a Y PEP indicator if the claim shows a patient status of 06. Otherwise the indicator will be N.

SS will place the payment amount returned by Pricer in the total charge and the covered charge field on the 0023 line.

SS will place any outlier amount on the claim as value code 17 amount and plug condition code 61 on the claim.

When Pricer returns an 06 return code (LUPA payment), SS will place it on the claim header in the return code field and create a new "L" indicator in the header of record (CWF HUOP--outpatient transaction record) sent to CWF/NCH.

SS will integrate Pricer for customer service into SS by 10/1/00 and create a new on-line screen to do it.

V. Transition to HH PPS (Program Memorandum on transition issues)

HCFA will define the one time POC transition for the period of 9/00 thru 12/00.

HCFA will instruct providers that CWF and SS will edit to reject claims that overlap September/October 2000 dates. Bills must fall under one system or the other by service date (all claims must be totally one or the other payment system).

HCFA will instruct providers to submit a new RAP or No-RAP LUPA for all patients already under care on 10/01/00. All open billing periods must be closed 9/30/00.

SS will set a reason code if a RAP or claim comes in without 0023 revenue code and with service dates greater than 9/30/00. RHHIs will set up this reason code to RTP.

W. Workload Reporting and Claims Timeliness

SS will send both RAPs and claims to the 1566 workload report.

SS will assure claim timeliness, interest and payment floor requirements are not applied to any RAP. The RAP is not viewed as a claim though an institutional claim format is used.

X. Enhancements to the HH PPS system (to be addressed after October 1, 2000)

1. Standard System Enhancements:

In SS, change the claim summary order of posting to allow option of date of service order in addition to processed order.

SS DME processing needs to be less manual.

An edit is needed in SS comparing the value code 61 amount to a table of reasonable codes associated with the State code in the physical address in the provider address file.

Once this mechanism is created, the RHHI provider audit group must determine, by State code logical MSAs for that State.

Once the mechanism is created, HCFA will require the table of reasonable MSAs by State will be user updated (maintained by RHHI audit and reimbursement staff).

For new providers, HCFA will establish a table of reasonable MSAs for that provider's location when that provider gets an OSCAR number.

HCFA will determine the maximum number of MSAs that will be allowable on the provider file. The list will be maintained by the RHHIs.

Both SSs will have something like the current page 14 information in FISS for inpatient claims.

2. CWF Enhancements

CWF will expand the Part B batch inquiry process to make information on HH episodes available to Part B provider types to view, including from and through dates of the episode.

CWF/SS will have an on/off switch that can be applied to RAPs for every kind of MSP (most likely for no-fault, worker's comp, and liability).

CWF 68xx errors may need to be modified.

3. Other Enhancements:

HCFA will consider promoting bench marking efforts from national PS&R data.

HCFA will produce a PC-based software product of Pricer (for customer service reps, cost/audit people and providers). The PC version will be designed so that it can be loaded once on the LAN, and won't require individual loading on each PC.

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

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

This PM may be discarded after June 1, 2001.

If you have any questions, contact your Regional Office.