Business Requirements

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I. GENERAL INFORMATION

A. Background: Payments for home health prospective payment system (HH PPS) claims are based on payment groups which are derived from beneficiary assessment data reported by home health agencies (HHAs) on the Outcomes and Assessment Information Set (OASIS). Each of the HH PPS payment groups, known as home health resource groups (HHRGs) has an associated weight value that increases or decreases Medicare's payment for an episode of care relative to a national standard per episode amount. The HHRGs are reported to Medicare on HH PPS claims using the health insurance PPS (HIPPS) code set.

Recent reports to Medicare's four Regional Home Health Intermediaries (RHHIs) by the Office of Inspector General (OIG) have shown that the Medicare program is vulnerable to make excess payments on HH PPS claims when certain OASIS assessment information is reported in error. When HHAs report in OASIS item M0175 that a beneficiary has not been discharged from a hospital within 14 days of the start of home health care, the claim for that beneficiary may in some cases be submitted using a HIPPS code for a higher weighted payment group. The OIG has found that Medicare has paid many claims with HIPPS codes representing no hospital discharge in cases where Medicare claims history shows that an inpatient stay occurred during the 14 days prior to the start of care. The requirements below describe changes to address the payment vulnerability that OIG has identified.

On a pre-payment basis, Medicare systems will compare incoming HH PPS requests for anticipated payment (RAPs) and claims with HIPPS codes representing no hospital discharge to Medicare claims history for the beneficiary. Medicare systems will determine 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 paid at the correct payment level. Requirements one and two, including sub-requirements, describe these changes.

On a post-payment basis, CMS will annually analyze its National Claims History (NCH) to identify HH PPS claims with HIPPS codes representing no hospital discharge for which an inpatient hospital claim was received for dates of service within 14 days of the start of care. These would be inpatient hospital claims that were received after the HH PPS claim had already been paid. This post-payment identification is necessary because under Medicare timely filing guidelines, hospital claims may not be received for 15-27 months from the end of the hospital stay. The CMS will distribute a file of the claims identified in this process to each RHHI for adjustment. Requirements three through five describe these changes.

The Arkansas Part A Shared System (APASS) is exempt from making the changes described in the requirements below.

B. Policy:

Regulations requiring case-mix adjustment of HH PPS payments is found at 42 CFR 484.220. A description of how prior hospitalizations affect HH PPS payment groups is found in the HH PPS final rule (**Federal Register**, vol. 65, no. 128, July 3, 2000), section III.G entitled "Design and Methodology for Case-mix Adjustment of 60-Day Episode Payments."

C. Provider Education:

Intermediaries shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within 2 weeks. Also, intermediaries shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about "Implementation of Payment Safeguards for Home Health Prospective Payment System Claims Failing to Report Prior Hospitalizations**"** is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2928.1	Medicare systems shall return to the provider HH PPS RAPs indicating no hospital discharge within 14 days if a hospital claim is found within 14 days.	CWF, SS
2928.1.1	Medicare systems shall identify HH PPS RAPs indicating no hospital discharge using Types of Bill 322 or 332 if a HIPPS code with a fourth position of "K" or "M" is present.	CWF
2928.1.2	Medicare systems shall compare the "From" date of HH PPS RAPs indicating no hospital discharge to the "Through" dates of claims with type of bill 11x to identify any "Through" dates within 14 days.	CWF
2928.1.2.1	Medicare systems shall count 14 days using the day prior to the HH PPS RAP "From" day as day one.	CWF
2928.1.3	If a hospital claim is found within 14 days, Medicare systems shall return the RAP to the provider with an error code indicating this condition.	CWF, SS
2928.2	Medicare systems shall downcode HH PPS claims indicating no hospital discharge within 14 days if a hospital claim is found within 14 days.	CWF, SS
2928.2.1	Medicare systems shall identify HH PPS claims indicating no hospital discharge using Types of	CWF

	Bill 329, 339 or any associated adjustment bill type if a HIPPS code with a fourth position of "K" or "M" is present.	
2928.2.2	Medicare systems shall compare the "From" date of HH PPS claims indicating no hospital discharge to the "Through" dates of claims with type of bill 11x to identify any "Through" dates within 14 days.	CWF
2928.2.3	Medicare systems shall count 14 days using the day prior to the HH PPS claim "From" day as day one.	CWF
2928.2.4	If a hospital claim is found within 14 days, Medicare systems shall set an indicator on the claim indicating this condition.	CWF
2928.2.5	Medicare systems shall downcode HH PPS claims with an indicator of a hospital claim within 14 days.	SS
2928.2.5.1	Medicare systems shall change a HIPPS code with a fourth position of "M" to a HIPPS code with a fourth position of "L" if the indicator of a hospital claim within 14 days is present.	SS
2928.2.5.2	Medicare systems shall change a HIPPS code with a fourth position of "K" to a HIPPS code with a fourth position of "J" if the indicator of a hospital claim within 14 days is present.	SS
2928.2.5.3	Medicare systems shall not change any HIPPS code that is the result of a medical review determination.	SS
2928.2.5.4	Medicare systems shall create a report of claims that were identified to be downcoded but that were not changed due to a medical review determination.	SS
2928.2.5.5	Medicare systems shall reprice all claims that have been downcoded due to an indicator of a hospital claim within 14 days, sending the downcoded HIPPS code to the HH PPS Pricer.	SS
2928.2.5.6	Medicare systems shall place remark code N180 on the remittance advice for claims downcoded because of a hospital claim within 14 days.	SS
2928.3	RHHIs shall receive from CMS an annual file ("M0175 downcode file") of claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim is found on NCH history for dates of service within 14 days of the start of care.	RHHIs

2928.4	RHHIs shall adjust all HH PPS claims received in the M0175 downcode file.	RHHIs
2928.4.1	RHHIs shall adjust all HH PPS claims received in the M0175 downcode file using the same process as if the claim were identified during initial processing.	RHHIs
2928.4.2	RHHIs shall complete all adjustments associated with the M0175 downcode file within one calendar quarter of receipt, unless otherwise instructed by CMS.	RHHIs
2928.5	RHHIs shall annually notify providers informing them of the dates claim adjustments associated with the M0175 downcode file will begin and how these adjustments can be identified on remittance advices.	RHHIs

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2928.2.1	Adjustment types of bill include 3x7 and any adjustment alpha character frequency code listed in Chapter 25 of the Medicare Claims Processing Manual.
2928.2.5.1 and 2928.2.5.2	The intermediary Shared System shall place the changed HIPPS code value in field currently used for Pricer downcoded HIPPS codes. If a HIPPS code changed due to an inpatient stay is subsequently also downcoded by Pricer due to insufficient therapy visits, the changed HIPPS code shall be overwritten with the HIPPS code returned by Pricer.
2928.2.5.5	Adjusted and repriced claims must be returned to CWF to complete the associated HH PPS episode.
2928.2.5.6	Remark code N180 is defined "This item or service does not meet the criteria for the category under which it was billed."
2928.5	To assist providers in recognizing post-payment adjustments by the RHHIs, adjustments may be identified on the remittance advice by type of bill 3xI and remark code N180.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
2928.2.4	A CWF reject code may serve as the indicator.

C. Interfaces: Other than the need for systems to recognize the new error codes created by requirements 2928.1.3 and 2928.2.4, the interface between the intermediary Shared System and CWF will not be changed by these requirements. Requirement 2928.2.5.5 may require a change to the Shared System's input interface with the HH PPS Pricer software.

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: Test cases must be coordinated with CWF, ensuring hospital inpatient claims are posted for test beneficiaries prior to processing HH PPS RAPs and claims.

IV. OTHER CHANGES

Citation	Change
	N/A

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date:** April 1, 2004 **Pre-Implementation Contact(s):** Wil Gehne, (410) 786-6148, wgehne@cms.hhs.gov Kelly Buchanan (410) 786-6132, kbuchanan@cms.hhs.gov **Post-Implementation Contact(s):** Regional Offices	These instructions should be implemented within your current operating budget.