Medlearn Matters
Information for Medicare Providers
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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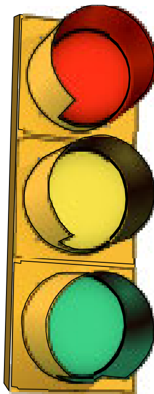
Payment Safeguards for Home Health Prospective Payment System Claims Failing to Report Prior Hospitalizations Correctly

Provider Types Affected

Home Health Agencies (HHAs).

Provider Action Needed

Home Health Agencies should be aware of payment safeguards being implemented for Home Health Prospective Payment System Claims failing to report prior hospitalizations correctly.



STOP

Failure to report periods of hospitalization within 14 days of the start of a home health episode can result in claims being returned/adjusted and may also result in post-payment adjustments.

CAUTION

Please be sure to understand the importance of identifying recent hospital stays and reporting that information correctly.

GO

Report hospital stays correctly to assure timely and accurate payments for Home Health claims.

Background

Payments for Home Health Prospective Payment System (HH PPS) claims are based on payment groups. These payment groups, also known as Home Health Resource Groups (HHRGs), are derived from beneficiary assessment data reported by home health agencies (HHAs) on the Outcomes and Assessment Information Set (OASIS). Each HHRG has an associated weight value that increases or decreases Medicare's payment for an episode of care, and this payment is 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.

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To assure correct HH PPS payments, the Centers for Medicare & Medicaid Services is modifying the Medicare claims processing programs to avoid excess payments on HH PPS claims when certain OASIS assessment information does not accurately reflect recent hospitals stays by the Medicare beneficiary.

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. However, analysis now shows that Medicare has paid a number of claims with HIPPS codes representing no hospital discharge in cases where Medicare claims history indicates that an inpatient stay did occur during the 14 days prior to the start of care.

The following requirements describe the changes to address the payment vulnerability that has been 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 by converting the fourth position of the HIPPS code from K or M to J or L, respectively, and payment will then be made accordingly.
- The electronic remittance advice (ERA) notice for such adjusted claims will contain a remark that “This item or service does not meet the criteria for the category under which it was billed.” In addition, the ERA will show both the HIPPS code originally submitted on the claim and the adjusted HIPPS code that was actually used for payment.

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, and this post-payment identification is needed 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 Regional Home Health Intermediary for adjustment.

Implementation

The Implementation Date for these changes is April 1, 2004.

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Related Instructions

Comprehensive information on Home Health billing can be found in Chapter 10 of Medicare's Claims Processing Manual. That publication can be found at:

http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf

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