



News Flash - The revised publication titled Medicare Billing Information for Rural Providers, Suppliers, and Physicians (October 2008), which consists of charts that provide Medicare billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf> on the CMS website.

MLN Matters Number: MM6305

Related Change Request (CR) #: 6305

Related CR Release Date: January 30, 2009

Effective Date: January 1, 2008

Related CR Transmittal #: R4340TN

Implementation Date: July 6, 2009

Correction to Home Health Prospective Payment System (HH PPS) Episode Sequence Edits

Provider Types Affected

Home Health Agencies (HHAs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed



STOP - Impact to You

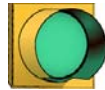
This article is based on Change Request (CR) 6305 which describes Medicare system changes being made to ensure episode sequence is enforced accurately under the Home Health Prospective Payment System (HH-PPS).

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

**CAUTION – What You Need to Know**

CR 6305 corrects Medicare system episode sequence edits to correctly identify cases where 20 or more therapy services have been provided. Currently, these claims are bypassed, and in a limited set of cases, this results in a payment based on the incorrect payment group. Upon implementation, the requirements of CR 6305 will prevent these errors.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Service (CMS) implemented refinements to the Home Health Prospective Payment System (HH-PPS) case-mix system in January 2008. One of these refinements was to pay HH PPS episodes differently depending upon whether the episode was an early episode (the first or second episode in a sequence of related episodes) or a later episode (the third or later episode in such a sequence). The accuracy of these payments is enforced by edits in the Medicare's Common Working File (CWF) system, which compares the payment codes on incoming claims to previously paid episodes and rejects claims that are priced based on the incorrect episode sequence.

Payment codes (known as Health Insurance Prospective Payment System (HIPPS) codes) that begin with a '5' represent episodes in which the HHA provided 20 or more therapy services. Payments for episodes with 20 or more therapies are identical regardless of whether the episode is early or later. Consequently, the initial requirements for HH PPS case-mix refinements excluded HIPPS codes beginning with '5' from the edits that enforce correct episode sequence.

In a case where the 20 therapy services are expected from the beneficiary's initial assessment and the HHA reports the HIPPS code beginning with '5' on the Request for Anticipated Payment (RAP) and claim for the episode, it is correct to exclude the episode from episode sequence edits. However, when the 20 therapy services are not expected, the first position of the HIPPS code on the RAP and claim indicate whether the episode was early or later. When the Medicare HH PPS Pricer program finds 20 therapy services were provided, it recodes the first position of the HIPPS code to a '5'. The Pricer then uses the treatment

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

authorization code information on the claim to recode the remaining positions of the code.

The Pricer recodes the episode before the claim is submitted to the CWF to determine whether the episode sequence information used for recoding was correct. When the claim is then submitted to CWF with the HIPPS code beginning with '5', CWF bypasses the episode sequencing edits and the claim is not returned to the HH PPS Pricer for correction. In these cases, which represent a small volume of claims nationally, the episode may be paid at the incorrect payment group. The requirements provided in CR 6305 will prevent these payment errors from occurring. In addition, claims paid at the incorrect group rate will be adjusted if the submitting HHA brings such claims to the attention of their FI, MAC, or RHHI once CR 6305 is implemented.

Previously, CR 6027 made a revision to HH PPS episode sequence edits intended to ensure that fully denied episodes are not considered in determining whether an episode is early or later. An error in the business requirements of CR 6027 is corrected in CR 6305. A MLN Matters article related to CR 6027 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6027.pdf> on the CMS website.

Note that CR 6305 contains no policy changes.

Additional Information

The official instruction, CR 6305, issued to your FI, MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R434OTN.pdf> on the CMS website.

If you have any questions, please contact your FI, MAC, or RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.