



Related MLN Matters Article #: MM6027

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Correction to Determinations of Early Episodes versus Later Episodes under the Home Health Prospective Payment System (HH PPS)

Key Words

MM6027, CR6027, R1505CP, Correction, Determination, Episode, Hospital, HH, PPS

Provider Types Affected

HH Agencies (HHAs) submitting claims to Medicare Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries

Key Points

- The effective date of the instruction is for HH PPS episodes beginning on or after January 1, 2008.
- The implementation date is October 6, 2008.
- Under the refined HH PPS case-mix system, which was implemented in January 1, 2008, HH episodes are paid differently based on whether the episode is classified as "early" or "later", which are defined as follows:
 - The first two episodes of a sequence of adjacent episodes are considered "early"; while
 - The third episode of that sequence **and** any subsequent episodes are considered "later."
- Providers submit claims for HH PPS episodes and indicate whether the episode is "early" or "later" using the first position of the Health Insurance PPS (HIPPS) code:
 - HIPPS codes beginning with 1 or 2 represent early episodes; and
 - HIPPS codes beginning with 3 or 4 represent later episodes.
- These HIPPS codes are validated in Medicare's Common Working File (CWF) system by comparing the code to the number of episodes on file for the beneficiary.
- If the code submitted by the provider disagrees with Medicare's episode history, the CWF rejects the claim, and the Fiscal Intermediary Shared System recodes the claim as appropriate.
- Currently, the CWF validation process checks episodes based on their start and end dates alone without regard to whether the episodes were covered by Medicare. The current HH PPS episode record does not contain an indicator that shows that the episode is non-covered.

- If a HH PPS episode has been fully denied by medical review because it does not meet Medicare coverage requirements for the HH benefit, the episode **should not be counted** in determining whether an episode is "early" or "later." These episodes should be treated the same as periods without any HH services.
- HH PPS episodes may be fully denied for a number of reasons, including lack of physician orders, lack of qualifying skilled service need, the patient not being homebound, or the services were not reasonable and necessary.

Change Request (CR) 6027 Instructions

- The CWF will exclude episodes that were fully denied by medical review from determinations of whether an episode should be paid as "early" or "later."
- Medicare systems will make changes to correct for cases where a HH PPS episode has been fully denied by medical review because it does not meet Medicare coverage requirements for the HH benefit and does not count the episode in determining whether the episode is "early" or "later."
- Corrections and clarifications to HH billing instructions are also made in the *Medicare Claims Processing Manual* (Chapter 10 (Home Health Agency Billing)), which is included as an attachment to CR6027.
- HHAs may want to pay particular note to the revised Section 70.4 of Chapter 10 (<http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>), which deals with the decision logic used by the HH Pricer software on HHA claims.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6027.pdf> on the CMS website.

The official instruction (CR6027) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1505CP.pdf> on the CMS website.