# Medicare
# Home Health Agency Manual

**Department of Health and Human Services (DHHS)**
**HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

**Transmittal 296** **Date:AUGUST 23, 2000**


**REFER TO CHANGE REQUEST 514**

| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
|---|---|---|
| Table of Contents - Chapter IV | 4-1 - 4-4 (4 pp.) | 39 - 40 (2 pp.) |
| 467.2 - 467.35 | 66.1 - 66.25 (25 pp.) | 66.1 - 66.6 (6 pp.) |
| 468.2 - 473 (Cont.) | 67 - 67.12 (13 pp.) | 67 - 67.46 (47 pp.) |
| 475.1 - 475.4 (Cont.) | 69 - 69.36 (37 pp.) | 68.5 - 68.10 (6 pp.) |
| 476 - 489.7 (Cont.) | 71 - 74.16 (20 pp.) | 71.14 - 74.8 (12 pp.) |

**NEW/REVISED MATERIAL--EFFECTIVE DATE:** ***October 1, 2000***

Section 467, Background on the Home Health Prospective Payment System (HH PPS), is added as a new section to provide information necessary to understand the new payment system. New subsections include overviews of new billing and payment processes, and various HH PPS payment adjustments.

Section 467.1, Creation of the HH PPS, has been added to describe the creation of the new payment system.

Section 467.2, Regulatory Implementation of HH PPS, has been added to describe the basis in regulation of the new payment system.

Section 467.3, Commonalities of the Cost Reimbursement and HH PPS Environments, has been added to facilitate understanding of the new payment system in regard to the prior one.

Section 467.4, Effective Date and Scope of HH PPS for Claims, has been added to describe the scope of the new payment system.

Section 467.5, Configuration of the HH PPS Environment, has been added to describe the systems environment of the new payment system.

Section 467.6, New Software for the HH PPS Environment, has been added to describe the new software required in Medicare systems for the new payment system.

Section 467.7, HH PPS Episode--Unit of Payment, has been added to describe the unit of payment of the new payment system.

Section 467.8, Number, Duration and Claims Submission of HH PPS Episodes, has been added to describe submissions under the new payment system.

Section 467.9 , Effect of Election of HMO and Eligibility Changes on HH PPS Episodes, has been added to describe the effect of HMO election under the new payment system.

Section 467.10, Split Percentage Payment of Episodes and Development of Episode Rates, has been added to describe the split payment provisions of the new payment system.

Section 467.11, Basis of Medicare Prospective Payment Systems and Case Mix, has been added to describe the conceptual basis of case-mix adjusted PPS systems

Section 467.12, Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes, has been added to describe the relationship between payment groups and codes under the new payment system.

Section 467.13, Composition of HIPPS Codes for HH PPS, has been added to describe coding requirements of the new payment system.

Section 467.14, Significance of HIPPS Coding for HH PPS, has been added to further describe coding requirements of the new payment system.

Section 467.15, Overview of the Provider Billing Process Under HH PPS, has been added to provide a general overview of the new payment system.

Section 467.16, Overview--Grouper Links Assessment and Payment, has been added to describe the function of Grouper software under HH PPS.

Section 467.17, Overview--HIQH Inquiry System Shows Primary HHA, has been added to describe the function of the new HIQH transaction under HH PPS.

Section 467.18, Overview--Request for Anticipated Payment (RAP), has been added to describe RAP submission under HH PPS.

Section 467.19, Overview--Claim Submission and Processing, has been added to describe claim submission under HH PPS.

Section 467.20, Overview--Payment, Claim Adjustments and Cancellations, has been added to describe claim adjustment under HH PPS.

Section 467.21, Definition of the Request for Anticipated Payment (RAP), has been added to define RAPs under HH PPS.

Section 467.22, Definition of Transfer Situation--Payment Effects, has been added to define transfer payments under HH PPS.

Section 467.23, Definition of Discharge and Readmission Situation Under HH PPS--Payment Effects, has been added to define discharge/readmission payments under HH PPS.

Section 467.24, Payment When Death Occurs During an HH PPS Episode, has been added to define payments under HH PPS when a beneficiary dies during an episode.

Section 467.25, Adjustments of Episode Payment--Low Utilization Payment Adjustments (LUPAs), has been added to describe LUPA payments under HH PPS.

Section 467.26, Adjustments of Episode Payment--Special Submission Case: "No-RAP" LUPAs, has been added to describe "No-RAP" LUPA payments under HH PPS.

Section 467.27, Adjustments of Episode Payment--Therapy Threshold, has been added to describe therapy threshold adjustments under HH PPS.

Section 467.28, Adjustments of Episode Payment--Partial Episode Payment (PEP), has been added to describe PEP adjustments under HH PPS.

Section 467.29, Adjustments of Episode Payment--Significant Change in Condition (SCIC), has been added to describe SCIC adjustments under HH PPS.

Section 467.30, Adjustments of Episode Payment--Outlier Payments, has been added to describe outlier payments under HH PPS.

Section 467.31 Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments, has been added to describe the relationship of various payment adjustments under HH PPS.

Section 467.32, Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustments, has been added to provide illustration of payment situations decribed in section 3639.15 through 3639.31.

Section 467.33, Exhibit: General Guidance on Line Item Billing Under HH PPS, has been added to provide a reference guide for billing under HH PPS.

Section 467.34, Exhibit: Acronym Table, has been added to provide a reference for acronyms used repeatedly in all subsection of 3639.

Section 467.35, HH PPS Consolidated Billing and Primary HHAs, has been added to describe the consolidated billing requirements of HH PPS.

Section 468**,** New Common Working File (CWF) Requirements for the Home Health Prospective Payment System (HH PPS), has been added as a new section to provide information regarding the new Health Insurance Query Access for HHAs (HIQH) system.

Section 468.1, Creation of the Health Insurance Query System for Home Health Agencies (HIQH), has been added to explain the creation of the new Health Insurance Query Access for HHAs (HIQH) system.

Section 468.2, HIQH Inquiry and Response, has been added to describe inquiries into the HIQH system.

Section 468.3, Timeliness and Limitations of HIQH Responses, has been added to describe limitiations of the HIQH system.

Section 468.4, Inquiries to RHHIs Based on HIQH Responses, has been added to describe inquiries via RHHIs into the HIQH system.

Section 468.5, National Home Health Prospective Payment Episode History File, has been added to describe the episode record accessed by the HIQH system.

Section 468.6, Opening and Length of HH PPS Episodes, has been added to describe how episodes are maintained on the HIQH system.

Section 468.7, Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAP and HHA Claim Activity, has been added to describe how episodes are acted upon in CWF.

Section 468.8, Other Editing and Changes for HH PPS Episodes, has been added to describe editing of episodes performed in CWF.

Section 468.9, Priority Among Other Claim Types and HH PPS Consolidated Billing for Episodes, has been added to describe consolidated billing enforcement performed in CWF.

Section 468.10, Medicare Secondary Payment (MSP) and the HH PPS Episodes File, has been added to describe MSP editing performed in CWF.

Section 468.11, Exhibit: Chart Summarizing Effects of RAP/Claim Actions on the HH PPS Episode File, has been added to provide a reference guide for CWF actions described in various subsections of 3640.

Section 473, Billing For Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines, is reissued with a single addition indicating that the current content applies to claims with dates of service prior to August 1, 2000.

Section 475, Completion of Form HCFA-1450 for Home Health Agency Billing, has been added to describe HH PPS changes regarding uniform billing.

Section 475.1, Requests for Anticipated Payment, has been added to describe the submission of RAPs under HH PPS.

Section 475.2, HH PPS Claims, has been added to describe the submission of claims under HH PPS.

Section 475.3, HH PPS Claims When No RAP is Submitted - "No-RAP" LUPAs, has been added to describe the submission of claims under HH PPS when a RAP was not submitted for an episode.

Section 475.4, HH PPS Pricer Program, has been added to reflect the implementation of a new Pricer software module for HH PPS claims effective October 1, 2000.

Sections 476, Billing for Oral Cancer Drugs, is re-issued to correct page numbering to allow for the insertion of the new sections in this transmittal, as updated the type of bill for billing these items as of October 1, 2000.

Section 477, Billing for Ambulance Services, is re-issued to correct page numbering to allow for the insertion of the new sections in this transmittal, as updated the type of bill for billing these items as of October 1, 2000.

Sections 480, Retention of Health Insurance Records, is re-issued only to correct page numbering to allow for the insertion of the new sections in this transmittal. No changes have been made to the content of these sections.

Section 483, Request for Additional Medical Information, is re-issued only to correct page numbering to allow for the insertion of the new sections in this transmittal. No changes have been made to the content of these sections.

Section 485, HH PPS Remittance Advice Instructions, is added to reflect changes to HHA providers' electronic remittance advices that have been made to accurately represent HH PPS payments.

Section 485.1, Scope of Remittance Changes for HH PPS, is added to define the scope of changes to HHA providers' electronic remittance advices.

Section 485.2, Payment Methodology of the HH PPS Remittance: HIPPS Codes, is added to explain the use of new coding on HHA providers' electronic remittance advices.

Section 485.3, DME and Other Items Not Included in HH PPS Episode Payment, is added to explain how items not included in the HH PPS rate will be reflected on HHA providers' electronic remittance advices.

Section 485.4, 835 Version 3051.4A.01 Line Level Reporting Requirements for RAP Payments, is added to explain detail reporting for RAPs on HHA providers' electronic remittance advices.

Section 485.5, 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (More than 4 Visits), is added to explain detail reporting for claims on HHA providers' electronic remittance advices.

Section 485.6, 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (4 or Fewer Visits), is added to explain detail reporting for claims which are paid as LUPAs on HHA providers' electronic remittance advices.

Section 485.7, Instructions for Versions Subsequent to Electronic 835 Version 3051.4A.01, is added to address future updates to the electronic remittance advice format.

Section 489, Credit Balance Reporting Requirement - General, is re-issued only to correct page numbering to allow for the insertion of the new sections in this transmittal. No changes have been made to the content of this section.

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

CHAPTER IV
BILLING PROCEDURES

Section



Uniform Billing

CHAPTER IV
BILLING PROCEDURES

Section

Retention and Destruction of Health Insurance Records



Time Limitation for Medical Information Requests



Remittance Advice



Overpayments



Billing in Situations Where Medicare Is Secondary Payer

CHAPTER IV
BILLING PROCEDURES

Section

Provider Submission of Electronic Media Claims (EMC)

## 467. BACKGROUND ON THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

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

- Required payment be made on the basis of a prospective amount;
- Allowed the Secretary of the Department of Health and Human Services (**DHHS**) to determine a new unit of payment;
- Required the new unit of payment to reflect different patient-related conditions (**case-mix**) and wage adjustments;
- Allowed for **cost outliers** (supplemental payment for exceptional high-cost cases);
- Required proration of the payment when a beneficiary chooses to transfer among home health agencies (**HHAs**) within an episode;
- Required services to be recorded in 15 minute increments on claims;
- Required **UPINs** (physician identifiers) for prescribing physicians to appear on claims;
- Eliminated **PIP** (periodic interim payment) payments for HHAs;
- Required **consolidated billing** by HHAs for all services and supplies for patients under a home health plan of care (**POC**); and

  -- BBRA 99 removed durable medical equipment (**DME**) from the scope of consolidated billing under BBA 97

- Required an effective date for implementation of the system of October 1, 2000.

UPINs and 15 minutes increments mentioned in BBA 97 have been required on Medicare home health claims since October 1999. Despite the creation of the new payment system, existing laws affecting claims payment, such as those specifying a payment floor and Medicare Secondary Payer payment procedures, are still valid for Medicare claims and were not changed by HH PPS.

467.2 Regulatory Implementation of HH PPS.--Given the creation of the new payment system in law, HCFA codified implementing provisions in a final notice of rulemaking published in the ***Federal Register***. This notice specified:

- The unit of payment is a **60-day episode.**
- Each episode is anticipated to be paid in two split payments, one billed on a **Request for Anticipated Payment** (**RAP**) at the beginning of the episode and one on a claim at the end of the episode.

- Only claims provide line-items detailing the individual services delivered.

- Home Health Resources Groups (**HHRGs**), also called **HRGs,** represented by HCFA **HIPPS** coding on claims, are the basis of payment for each episode; HHRGs are produced through publicly available **Grouper** software that determines the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the **OASIS** data set) are input or "grouped" in this software.

- HHRGs can be changed mid-episode if there is a significant change in the patient's condition (**SCIC adjustment**).

- Episodes can be truncated and given partial episode payments (**PEP adjustment**) 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 are also reducing adjustments in payment when the number of visits provided during the episode fall below a certain threshold (low utilization payment adjustments: **LUPAs**).

- There are downward adjustments in HHRGs if the number of therapy services delivered during an episode does not meet anticipated thresholds-- **therapy threshold**.

- There are **cost outliers**, in addition to episode payments.

- The **primary HHA** under **consolidated billing** must identify itself to HCFA and its claims processing agents through submission of RAPs and claims-- only that one HHA, the primary or the one establishing the beneficiary's plan of care, can bill for home health services under the home health benefit other than DME; if multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency.

467.3 Commonalities of the Cost Reimbursement and HH PPS Environments.--Much of home health billing remains the same under HH PPS as it was under the prior payment system:

- Payment for services remains specific to the individual beneficiary, who is homebound and under a physician's plan of care.

- Payment is adjusted relative to the site services are delivered, as required by BBA 97.

- Shifting payment for home health claims between the Medicare Part A and B trust funds, as stipulated by another section of BBA 97, is still required; the mechanism will change when the basis of payment changes to episodes, but will not require any action on the part of HHAs.

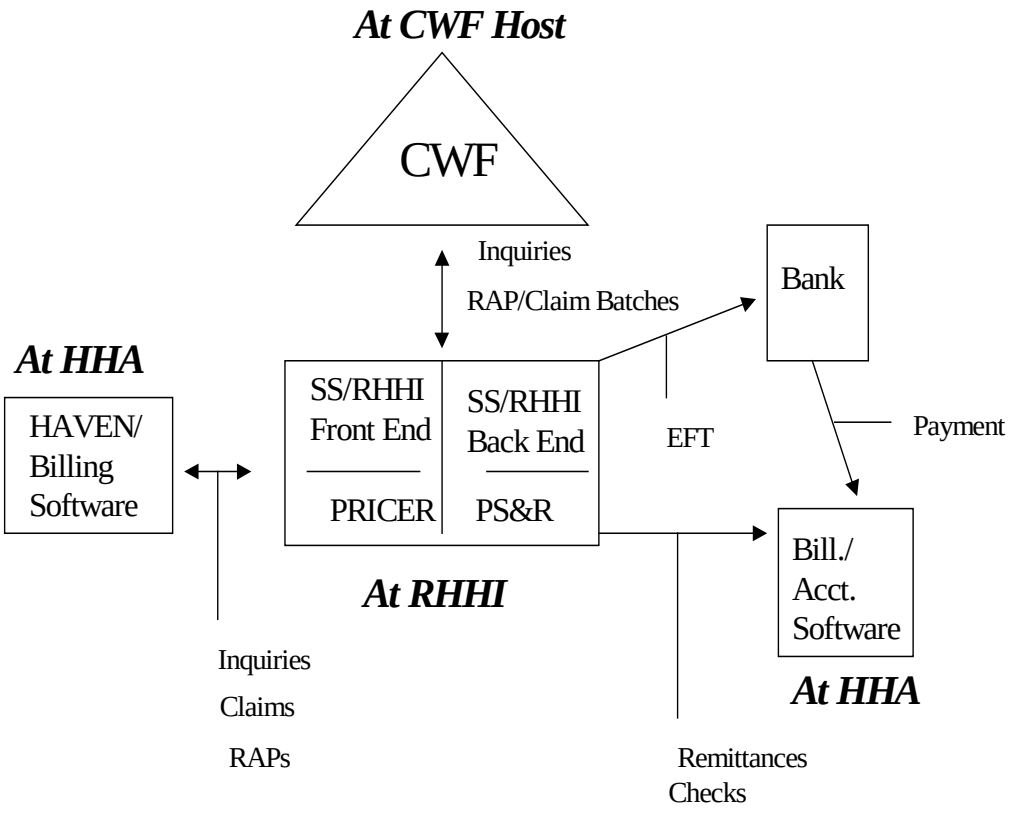
- Claims will be processed by the current Regional Home Health Intermediaries (RHHIs).

- The platform of existing Medicare claims processing systems is used, including the Common Working File (**CWF**) and the Fiscal Intermediary Standard System (**FISS**) or Arkansas Part A Standard System (**APASS**), known together as the standard systems (**SS**), and the **PS&R** system supporting audit and reimbursement functions.

o HH PPS will employ formats, such as the paper and electronic **Form HCFA-1450 (UB-92)** for RAPs and claims, and related existing transaction formats are still used (i.e., the **835** electronic And paper remittances, Medicare Summary Notice (**MSN**).

467.4 Effective Date and Scope of HH PPS for Claims.--As of October 1, 2000, all HHAs must bill all services delivered to homebound Medicare beneficiaries under a home health plan of care under HH PPS. HH PPS will apply to claims billed under the cost reimbursement system on Form HCFA-1450 (UB-92), with Form Locator 4 (FL 4), Type of Bill (TOB), completed with: first digit "3", second digit "2" or "3", and a varying third digit represented as "X". HHAs will still occasionally bill Medicare using TOB 34X, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established plan of care prior to this date, all these open claims for services on or before September 30, 2000 need to be closed, though HHAs may submit these bills for several months in accordance with current time limitations for HHA claims. Under no circumstances should a HHA claim span payment systems or September and October 2000 dates.

467.5 Configuration of the HH PPS Environment.--The configuration of Medicare home health claim processing is similar to previous processing systems. The flow from the HHA at the start of billing, to the receipt or remittances and electronic funds transfer (EFT) by the agency, to the recording of payment in either billing or accounting systems ("bill./acct software) can be envisioned as follows :



467.6 New Software for the HH PPS Environment.--New subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing:

o HHRGs for claims are 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 at the HHA-- OASIS **HAVEN** software was updated to integrate the Grouper from the advent of HH PPS on, and HCFA has made Grouper specifications available on its web site for those designing their own software.

o There is an **inquiry system** in CWF-- **HIQH**-- available 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 beneficiaries for whom they are the primary HHA.

o All HH PPS claims run through **Pricer** software, which is integrated into the standard systems. In addition to pricing HIPPS codes for HHRGs, this software maintains national standard visit rate tables to be used in outlier and LUPA determinations**.**

467.7 The HH PPS Episode--Unit of Payment.--The episode is the unit payment for HH PPS. The episode payment is specific to one individual homebound beneficiary, reimburses all home care, routine and non-routine supplies used by that beneficiary during the episode, and is the only Medicare form of payment for such services, with the following exceptions: DME, osteoporosis drugs, and other services or items HHAs may deliver to homebound beneficiaries that are not part of the Medicare home health benefit (i.e., vaccines). Routine supplies have not been separately reimbursable for Medicare home health care, and will not be reimbursed in addition to episode payments.

467.8 Number, Duration and Claims Submission of HH PPS Episodes.--The beneficiary can be covered for an unlimited number of non-overlapping episodes. The duration of a single full-length episode is 60 days. Episodes may be shorter than 60 days. For example, an episode may end before the 60th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened episodes, in which more home care is delivered in the same 60-day period. Claims for episodes may be submitted prior to the 60th day if the beneficiary has been discharged and treatment goals have been met, though payment will not be pro-rated unless more home health care is subsequently billed in the same 60-day period.

The initial episode begins with the first service delivered under that plan of care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.).

More than one episode for a single beneficiary may be opened by the same or different HHAs for different dates of service. This will occur particularly if a transfer to another HHA, or discharge and readmission to the same HHA, situation exists. Allowing multiple episodes is intended to assure continuity of care and payment.

467.9 Effect of Election of HMO and Eligibility Changes on HH PPS Episodes.--The home health prospective payment system only applies to Medicare fee-for-service claims for homebound beneficiaries. If a Medicare beneficiary is covered under a health maintenance organization (HMO) during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the payment source changes. With that assessment, a RAP may be sent to Medicare to open an HH PPS episode.

If a beneficiary under fee-for-service receiving home care elects HMO during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment-- PEP-- adjustment). The HMO becomes the primary payer upon the HMO enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

467.10 Split Percentage Payment of Episodes and Development of Episode Rates.--A split percentage payment will be made for each episode period. There will be 2 payments (initial and final), the first paid in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible reimbursement for the episode.

There will be a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments will be 60 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments will equal 50 percent of the estimated case-mix adjusted episode payment. There is no set length required for a gap in services between episodes for a following episode to be considered initial rather than subsequent. If any gap occurs, the next episode will be considered initial for payment purposes.

Payment rates for HH PPS episodes were developed from audited cost reports of previous years' data from claims for each of the six home health visit disciplines. These amounts were updated for inflation, and also include: non-routine medical supplies, even those that could have been unbundled to Medicare Part B, therapy services that could have been unbundled to Part B, and adjustments for OASIS reporting costs, both one time and ongoing. After these adjustments, the resulting rates were further standardized so that case-mix and wage indexing could be appropriately applied, adjusted for budget neutrality, and then reduced to allow for a pool for outlier payments.

467.11 Basis of Medicare Prospective Payment Systems and Case-Mix.--There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types: skilled nursing facilities, outpatient hospital services, home health agencies and rehabilitation hospitals. While there are definite commonalities among these systems, there are also variations in how each system operates, and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

Regarding the creation of the inpatient hospital prospective payment system, in 1982, the Tax Equity and Fiscal Responsibility Act or TEFRA, required Medicare hospital reimbursement limits to include a case-mix adjustment, and amendments to the Social Security Act in 1983 created a national hospital inpatient prospective payment system for Medicare. This legislation was passed in a effort to capture an effective framework for monitoring the quality of care and the utilization of services.

The term prospective payment might imply a system where payment would be made before services are delivered, or payment levels were determined prior to the completion of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment will be made at the beginning of the episode with as little as one visit delivered. PPS also means a shift of the basis of payment, such as from payment tied to a claim or distinct revenue or procedural code, to a basis such as episode or diagnosis related group (DRG).

Case-mix is related to the creation of PPS through efforts to make payment systems more effective. With the creation of inpatient hospital PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. This concept is replicated in other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care-- the concept of case-mix complexity. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

It is DRGs, or Diagnosis Related Groups, that link case-mix to inpatient hospital payment. The current DRG Definitions Manual defines a DRG as "a manageable, clinically coherent set of patient classes that relate a hospital's case-mix to the resource demands and associated costs experienced by the hospital". For individual Medicare inpatient bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing intermediary. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs.

In HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment. Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted episode payment is based on elements of the OASIS data set including the therapy hours or visits provided over the course of the episode. The number of therapy hours or visits projected at the start of the episode, entered in OASIS, will be confirmed by the hour or visit information submitted on the claim for the episode. Though therapy hours or visits are only adjusted with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the RHHIs processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

467.12 Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes.--Under the home health prospective payment system, a case-mix adjusted payment for a 60-day episode is made using one of 80 HHRGs (also occasionally abbreviated to HRG), comparable to DRGs under Medicare's inpatient hospital PPS. On Medicare claims, these HHRGs are represented as HIPPS codes. HIPPS codes allow the HHRG code to be carried more efficiently and include additional information on how the HHRG was derived.

Health Insurance Prospective Payment System (HIPPS) codes thus represent specific patient characteristics (or case-mix) on which Medicare payment determinations are made. For HHAs, a specific set of these payment codes represent case-mix groups based on research into utilization and resource use patterns. Though other HIPPS coding is used to bill Medicare for skilled nursing facility PPS, appropriate HIPPS codes must be used when billing Medicare within specific prospective payment systems, and are used in association with special revenue codes used on HCFA-Form 1450 (UB-92) claims forms for institutional providers.

467.13 Composition of HIPPS Codes for HH PPS.--The following scheme has been developed to create distinct 5-position, alphanumeric home health HIPPS codes. The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

The second, third and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the HH PPS final rule, and future HHRG and HIPPS code lists will be released in annual HH PPS Program Memoranda providing specific payment system information and annual rate updates. Note the second through fourth positions of the HH PPS HIPPS code will only allow alphabetical characters.

The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters. Codes with a fifth position value other than "1" are produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

**The first position of every home health HIPPS code will be: 'H'**. The remaining four positions discussed above can be summarized as follows:

| **(Clinical) Position #2** | **(Functional) Position #3** | **(Service) Position #4** | **Position #5** | **Domain Level** |
|---|---|---|---|---|
| **A** (HHRG: C0) | **E** (HHRG: F0) | **J** (HHRG: S0) | **1** = 2nd, 3rd & 4th positions computed | = min |
| **B** (HHRG: C1) | **F** (HHRG: F1) | **K** (HHRG: S1) | **2** = 2nd position derived | = low |
| **C** (HHRG: C2) | **G** (HHRG: F2) | **L** (HHRG: S2) | **3** = 3rd position derived | = mod |
| **D** (HHRG: C3) | **H** (HHRG: F3) | **M** (HHRG: S3) | **4** = 4th position derived | = high |
| | **I** (HHRG: F4) | | **5** = 2nd & 3rd positions derived | = max |
| | | | **6** = 3rd & 4th positions derived | |
| | | | **7** = 2nd & 4th positions derived | |
| | | | **8** = 2nd, 3rd & 4th positions derived | |
| | | **N** thru **Z** | **9**, **0** | expansion values for future use |

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

467.14 Significance of HIPPS Coding for HH PPS.--Based on this coding structure:

o The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG, but only one of the eight, with a final digit of "1", indicates a complete data set.

o The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, all eight codes for that HHRG will be priced identically by the Pricer software.

o HIPPS codes created using this structure are only valid on claim lines with revenue code 0023.

467.15 Overview of the Provider Billing Process Under HH PPS.--The next four sections of this manual lay out the basic HH PPS claim process, not including payment adjustments. Payment adjustment follows in subsequent sections.

467.16 Overview--Grouper Links Assessment and Payment.--Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool. OASIS is entered, formatted and locked for electronic transmission to State agencies via HAVEN software made publicly available by HCFA. HAVEN versions were produced incorporating the Grouper module necessary for HH PPS, along with other changes needed for the new payment system, prior to the advent of that system.

Grouper software determines the appropriate HHRG (Home Health Resources Group) for payment of a HH PPS 60-day episode from the results of an OASIS submission for a beneficiary as input or "grouped" in this software. Grouper outputs HHRGs as HCFA HIPPS (Health Insurance Prospective Payment System) coding. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number that is not used in billing . Under HH PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims. Note that if an OASIS assessment is rejected upon transmission to a State agency and consequently corrected resulting in a different HIPPS code, the RAP and/or claim for the episode must also be canceled and re-billed using the corrected HIPPS code.

467.17 Overview--HIQH Inquiry System Shows Primary HHA.--Prior to October 1, 2000, to establish Medicare eligibility, HHAs sent an inquiry into Medicare's beneficiary database, the Common Working File or CWF, through their RHHI. The Health Insurance Query Access system, or HIQA, within CWF, allows different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility.

With the advent of HH PPS and home health consolidated billing (described in subsequent sections), a given HHA is considered the "primary" home health agency in billing situations: this primary agency is the only agency billing Medicare for home care for a given homebound beneficiary at a specific time. Given this, when a homebound beneficiary seeks care at an HHA, the HHA wants to determine if the beneficiary is already being served by another agency-- an agency that then would already be considered primary. HHAs can obtain that information through a new on-line inquiry transaction in CWF -- HIQH: Health Insurance Query for HHAs. HIQH, available at the advent of HH PPS, will show whether or not the beneficiary is currently in a home health episode of care. HIQH includes all pertinent eligibility information from HIQA, so both HHAs and hospices need only reference HIQH of the two transactions.

If the beneficiary is not already under care at another HHA, he or she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode is already open at another HHA if the beneficiary has chosen to transfer.

The agency's primary status, or change of primary status from one agency to another in a transfer situation, will be reflected in the HIQH inquiry system following submission of a Request for Anticipated Payment (RAP).

467.18 Overview--Request for Anticipated Payment (RAP).--After assessment, and once a physician's verbal orders for home care have been received and documented, a plan of care has been established and the first service visit under that plan has been delivered, the HHA can submit a Request for Anticipated Payment, or RAP, to Medicare. An episode will be opened on CWF and visible in HIQH with the receipt and processing of the RAP. RAPs, or in special cases, claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

RAPs are submitted on the Form HCFA-1450 (UB-92) billing form under Type of Bill (Form Locator 4) 322. RAPs incorporate the information output by Grouper for HH PPS in addition to other claim elements. While Medicare requires very limited information on RAPs-- RAPs do not require charges for Medicare-- HHAs have the option of reporting service lines in addition to the Medicare requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected reimbursement amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine reimbursement or for later data collection.

Once coding is complete, and at least one billable service had been provided in the episode, RAPs or claims are to be submitted to RHHIs processing Medicare home health RAPs and claims. Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

467.19 Overview--Claim Submission and Processing.--The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60 day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services provided in the episode are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply. HH claims must be submitted with a new type of bill - 329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims by providers with episodes open. Pricer will determine claim payment as well as RAP payment for all PPS claims.

The claim will be processed in Medicare systems as a debit/credit adjustment against the record created by the RAP. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

Once the final payment for an episode is calculated, Medicare systems will determine whether the claim should be paid from the Medicare Part A or Part B trust fund. This A-B shift determination will only be made on claims, not on RAPs. HHA reimbursement amounts are not affected by this process. Value codes for A and B visits and dollar amounts may be visible to HHAs on electronic paid claim records, but providers will never submit these amounts directly.

467.20 Overview--Payment, Claim Adjustments and Cancellations.--This completes the basic process for payment illustrated in the four sections above. However, a number of conditions can cause the episode payment to be adjusted. Both RAPs and claims may be canceled by HHAs if a mistake is made in billing (TOB 328), though episodes will be canceled in CWF as well. Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment. RAPs can only be canceled, and then re-billed, not adjusted.

467.21 Definition of the Request for Anticipated Payment (RAP).--The RAP is submitted by HHAs to their RHHIs to request the initial split percentage payment for an HH PPS episode, after delivering at least one service to the beneficiary. Though submitted on a Form HCFA-1450 (UB-92) and resulting in Medicare payment for home services, **the RAP is not considered a Medicare home health claim and is not subject to many of the stipulations applied to such claims in regulations**. In particular, RAPs are not subject to any type of payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode, and these claims are still subject to the payment floor and payment of interest if clean and delayed in processing.

467.22 Definition of Transfer Situation--Payment Effects.--Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HH PPS system, beneficiaries must be able to transfer among HHAs, and episode payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs will be allowed to submit a RAP with a transfer indicator in Form Locator 20 (Source of Admission) of Form HCFA-1450 (UB-92) even when an episode may already be open for the same beneficiary at another HHA. In such cases, the previously open episode will be automatically closed in Medicare systems as of the date services began at the HHA the beneficiary transferred to, and the new episode for the "transfer to" agency will begin on that same date. **Payment would be pro-rated for the shortened episode of the "transferred from"agency**, adjusted to a period less than 60 days either according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency**.** Note that HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

467.23 Definition of Discharge and Readmission Situation Under HH PPS--Payment Effects.--Under HH PPS, HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days. Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period: 60 days less the number of days after the date of the delivery of last billable service until what would have been the 60th day. The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock"). As with transfers, Form Locator 20 (Source of Admission) of Form HCFA-1450 (UB-92) can be used to send "a transfer to same HHA" indicator on a RAP, so that the new episode can be opened by the HHA.

Note that beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. **When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period.** Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA.

467.24 Payment When Death Occurs During an HH PPS Episode.--If a beneficiary's death occurs during an episode, full episode payment will still be made. The "Through" date on the claim (Form Locator 6) of Form HCFA-1450 (UB-92) closing the episode in which the beneficiary died should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

467.25 Adjustments of Episode Payment--Low Utilization Payment Adjustments (LUPAs).--**If an HHA provides 4 visits or less, they will be reimbursed based on a standardized per visit payment instead of an episode payment for a 60-day period.** Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history. If the claim for the LUPA is later adjusted such that the number of visits becomes 5 or more, payments will be adjusted to an episode basis, rather than a visit basis.

467.26 Adjustments of Episode Payment--Special Submission Case: "No-RAP" LUPAs.--Normally, there will be two percentage payments (initial and final) paid for an HH PPS episode, the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which an HHA knows that an episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment. **In such cases and only in such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage payment that otherwise would later likely be largely recouped automatically against other payments.** Physician orders must be signed when these claims are submitted. If an HHA later has to adjust the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the claim must be canceled, and the entire episode re-billed with a RAP and a claim.

467.27 Adjustments of Episode Payment--Therapy Threshold.--The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode. Because the advent of 15 minute increment reporting on home health claims only recently preceded HH PPS, therapy hours will be proxied from visits at the start of HH PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent 8 hours of therapy.

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational or speech therapy combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS representing the same payment group: one if a beneficiary does not receive the therapy hours projected, and another if he or she does meet the "therapy threshold". Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and Medicare systems will correct payment without access to the full OASIS data set.

**If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case-mix for the episode with a new HIPPS code and pay the episode on the basis of the new code**. HHAs will receive the difference between full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code. The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare systems would automatically cancel the claim with the changed HIPPS code and pay the full episode payment based on the original HIPPS. Note that HIPPS code may also be changed based on of medical review of claims.

467.28 Adjustments of Episode Payment--Partial Episode Payment (PEP).--Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened episodes. In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called partial episode payments (PEPs).

When either the agency the beneficiary is transferring from is preparing the claim for the episode, or an agency that has discharged a patient knows when preparing the claim that the same patient will be readmitted in the same 60 days, the claim should contain patient status code 06 in Form Locator 22 (Patient Status) of the Form HCFA-1450 (UB-92). Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. **This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service to and including the day of the last billable service.**

467.29 Adjustments of Episode Payment--Significant Change in Condition (SCIC).--While HH PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes a change in patient condition will occur significant enough to require the patient to be re-assessed during the 60-day episode period. In such cases, the HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode, even in the rare case of two different HIPPS codes applying to services on the same day. Since a line-item date is required in every case, Pricer will then be able to calculate the number of days of care provided under each HIPPS code, and **pay proportional amounts under each HIPPS based on the number of days of service provided under each payment group** (count of days under each HIPPS from first billable service to last billable service). The total of these amounts will be the full payment for the episode, and such adjustments are referred to as significant change in condition (SCIC) adjustments. The electronic remittance advice including a claim for a SCIC-adjusted episode will show the total claim reimbursement and separate segments showing the reimbursement for each HIPPS code.

There is no limit on the number of SCIC adjustment that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode, with one exception: if the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply. This exception is not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode). Payment will be made based on six HIPPS, determined by RHHI medical review staff, if more than six HIPPS are billed.

467.30 Adjustments of Episode Payment--Outlier Payments.--HH PPS payment groups are based on averages of home care experience. **When cases "lie outside" expected experience by involving an unusually high level of services in a 60-day period, Medicare systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment**. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations will be made by comparing the total of the products of: each wage and case-mix adjusted national standardized per visit rate for each discipline and the number of visits of each discipline on the claim, with the sum of: the case-mix adjusted episode payment and a wage-adjusted standard fixed loss threshold amount. If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific HRG payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode. Outlier payment amounts are wage index adjusted to reflect the MSA in which the beneficiary was served. The outlier payment is a payment for an entire episode, and therefore only carried at the claim level in paid claim history, not allocated to specific lines of the claim. Separate outliers will not be calculated for different HIPPS codes in a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

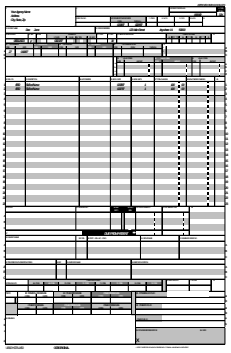
Outlier payments will be made on remittances for specific episode claims. HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total reimbursement for the episode claim on a remittance, but it will be identified separately on the claim in history with a value code, 17, in Form HCFA-1450 (UB-92) Form Locators 39-41, with an attached amount, and a condition code, 61, in Form HCFA-1450 (UB-92) Form Locators 24-30. Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

467.31 Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments.-- Episode payment adjustments as described above only apply to claims, not requests for anticipated payment (RAPs). Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment, and also will not receive outlier payments. Of other HH PPS claims, multiple adjustments may apply on the same claim, though some combinations of adjustments are unlikely (i.e., a significant change in condition (SCIC) and therapy threshold adjustment in a shortened episode (PEP adjustment)). All claims except LUPA claims will be considered for outlier payment. Payment adjustments are calculated in Pricer software (see subsequent Pricer section).

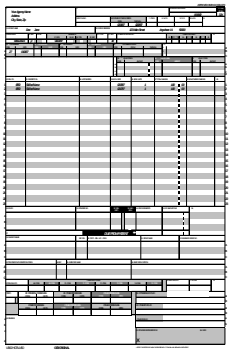
467.32 Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustments.--The next few pages illustrate Request for Anticipated Payment (RAP) and claim submission, and more common payment adjustments, under this payment system.

**1. <u>One 60-Day Episode, No Continuous Care (Patient Discharged)</u>:**

**RAP**



**Claim**



Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**

*Submitted after discharge or 60 days* with **Patient Status Code 01**

Contains same **HIPPS Code** as RAP

Does not give any **line-item detail** for Medicare use as primary payer (*can carry charges on lines not used by Medicare*)

Gives **all line-item detail** for the entire **HH Episode**

**From** and **Through Dates** match, date of first service delivered

**From Date** same as RAP, **Through Date** Discharge or Day 60

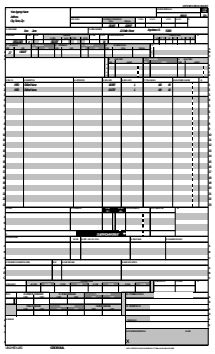
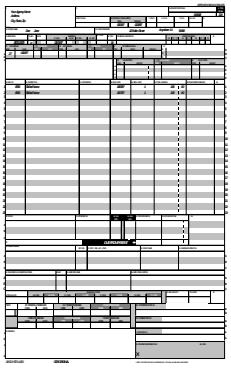
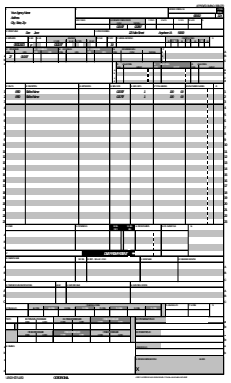
Creates **HH Episode** in **HIQH Inquiry System**

Closes **HH Episode** in **HIQH Inquiry System**

Triggers initial percentage payment for 60-day **HH Episode**

Triggers final percentage payment

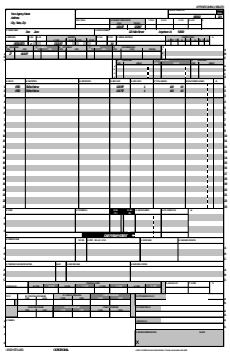
**2. Initial Episode in Period of Continuous Care:**

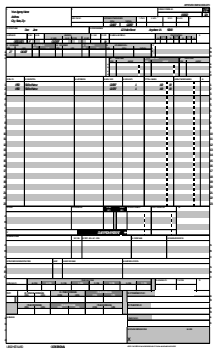
| **FIRST EPISODE:** | | **NEXT EPISODE(s)--:** |
|---|---|---|
| **RAP** | **Claim** | **RAP(s) &Claim(s)** |
|  |  |  |
| Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS** | *Submitted after 60 days* with **Patient Status Code 30** | Unlike previous RAP in period, **Admission Date** will be the same as that on the first RAP of the period, and will stay the same on RAPs and claims throughout the period of continuous care |
| Does not give any other **line-item detail** for Medicare use | Contains same **HIPPS Code** as RAP, and gives **all line-item detail** for all **HH Episode** | |
| **From** and **Through Dates** match first service delivered | **From Date** same as RAP, **Through Date**, Day 60 of **HH Episode** | **From** and **Through Dates, RAP** claims, are first day of **HH Episode**, w/ or w/o service (i.e., Day 61, 121, etc.) |
| Creates **HH Episode** in **HIQH Inquiry System** | Closes **HH Episode** in **HIQH Inquiry System** | Creates or closes **HH Episode(s)** |
| Triggers initial percentage **payment** | Triggers final percentage **payment** for 60-day **HH Episode**Triggers **payment(s)** | |

- **These two scenarios (1. and 2. above) are expected to encompass most episode billings**
- **For RAPs, Source of Admission Code “B” is used is used to receive transfers from other agencies, "C" if readmission to same agency after discharge**
- **There is no number limit on medically-necessary episodes in continuous care periods**

**3. <u>A Single LUPA Episode</u>:**

**RAP** **Claim**





Contains one **HIPPS Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**

Does not give any other **line-item detail** for use

**From** and **Through Dates** match, first service delivered

Creates **HH Episode** in **HIQH Inquiry System**

Triggers initial percentage **payment**

*Submitted after discharge or 60 days* with **Code** and **Patient Status Code 01**

Contains same **HIPPS Code** as RAP, gives **all line-item detail** for the entire **HH Episode**-- **<u>line item detail will not show</u>** Medicare **<u>more than 4 visit for the entire episode</u>**

**From Date** same as RAP, **Through Date** Discharge or Day 60

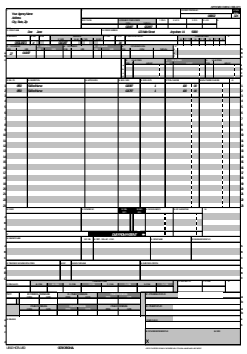
Closes **HH Episode** in **HIQH Inquiry System**

Triggers final percentage **payment** for 60-day **HH Episode**

- **Though less likely, a LUPA can also occur in a period of continuous care (*scenario not illustrated*)**
- **While also less likely, a LUPA, though never pro-rated, can also be part of a shortened episode (*see PEP Episodes, below*) or an episode in which the patient condition changes (*see SCIC Episode, below*)-- *these less likely scenarios are not illustrated***

**4. "No-RAP" LUPA Episode:**

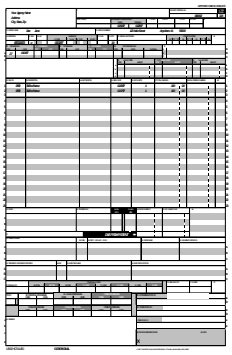
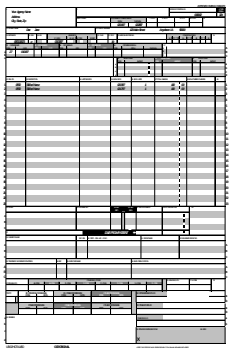
**Claim**



When a home health agency (HHA) knows from the outset that an episode will be 4 visits or less, the agency may choose to bill only a claim for the episode. (Note claims characteristics are the same as the LUPA final claim on the previous page.)

| **PROs:** | **CONs:** |
|---|---|
| **Will not get large episode percentage payment up-front** for LUPA that will be reimbursed on a visit basis (overpayment concern, but new payment system will recoup such "overpayments" automatically against future payments) | **No HH Episode record** is created in the Inquiry System, therefore beneficiary is not linked to the HHA providing services UNTIL a claim is received |
| **Less paperwork** | **No payment until claim is processed** |

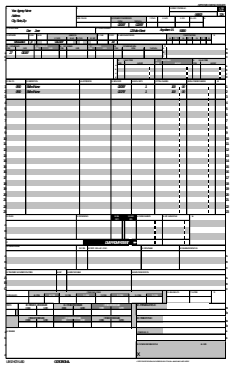
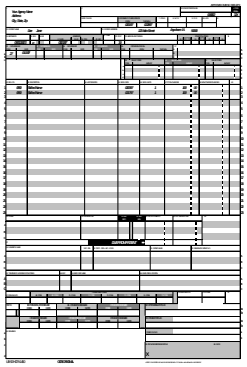
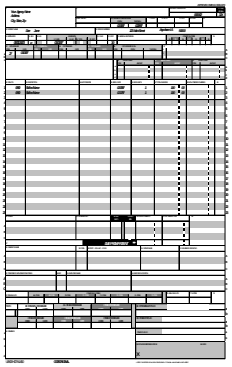
**5. <u>Episode with a PEP Adjustment</u>-- Transfer to AnotherAgency <u>OR</u> Discharge-Known Readmission to Same Agency:**

| **RAP** | **Claim** |
|---|---|
|  |  |
| Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS** | *Submitted after discharge* **w/Patient Status Code 06** |
| Does not contain other **line-item detail** for Medicare use | Contains same **HIPPS Code** as RAP, and gives **all line-item detail** for all the **HH Episode** |
| **From** and **Through Dates** match, first service delivered | **From Date** same as RAP, **Through Date** is discharge |
| Creates **HH Episode** in **HIQH Inquiry System** | Closes **HH Episode** in **HIQH Inquiry System** at date of discharge, not 60 days |
| Triggers initial percentage **payment** | Triggers final percentage **payment**, and total payment for the episode will be cut back proportionately (x/60), “x”being the number of days of the shortened **HH Episode** |

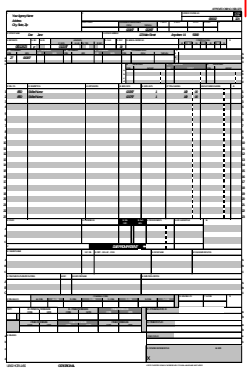
- **Known Readmission: agency has found after discharge the patient will be re-admitted in the same 60-day episode ("transfer to self"-- new episode) before final claim submitted**
- **The next episode presumably would be billed as either Scenario 1. or 2. above**
- **A PEP can also occur in a period of otherwise continuous care (*scenario not illustrated*)**
- **A PEP episode can contain a change in patient condition (*see SCIC Episode, below*)-- *this scenario is not illustrated***

**6. Episode with a PEP Adjustment--Discharge and "Unknown" Re-Admit, Continuous Care:**

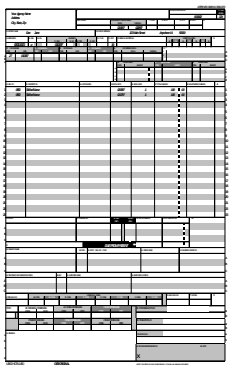
**FIRST EPISODE----------|START OF NEXT EPISODE:**

| **RAP** | **Claim** | **RAP** |
|---|---|---|
|  |  |  |
| Contains one **HIPPS Code** and **Claim-OASIS Matching** Key output | *Submitted after discharge or* 60 *days* **w/Patient Status Code 01**--agency submitted claim before the patient was re-admitted in the same 60-day episode | Unlike previous RAP in period, **Admission Date** will be the the same as that on the period, and will stay the same on RAPs and claims throughout the period of continuous care |
| Does not contain other line-item detail for Medicare use | Contains same **HIPPS Code** as RAP, and gives all line-item detail for all the **HH Episode** | Contains **Source of Admission Code "C"** to indicate patient re-admitted in same 60 days that would have been in previous episode, but now new episode will begin and previous episode automatically shortened |
| Creates **HH Episode** in **HIQH Inquiry System** | Closes **HH Episode** in **HIQH Inquiry System** 60 days initially, and then revised episode | |
| **From** and **Through Dates** match first service delivered | **From Date** same as RAP, **Through Date** Discharge or Day 60 of Episode | **From** and **Through Dates,** RAP first HH Episode day, w/ or w/o service (i.e., Day 61) |
| Triggers initial percentage payment | Triggers final percentage payment, may be total payment for the episode at first, but will be cut back proportionately (x/60) to the number of days of the shortened episode when next billing received | Opens next HH Episode in HIQH Inquiry System<br><br>Triggers initial payment for new HH Episode |

## 7. Episode with a SCIC Adjustment



**RAP Claim**



| | |
|---|---|
| Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS** | *Submitted after discharge* **with Patient Status Code** as appropriate (01, 30, etc.) |
| | Carries **Matching Key** and diagnoses consistent w/**last OASIS** assessment |
| Does not contain **other line-item** detail for Medicare use | Contains same **HIPPS Code** as RAP, additional **HIPPS** output every time patient reassessed because of change in condition, and gives **all line-item** detail for all the **HH Episode** |
| **From** and **Through Dates** match, first service delivered | **From Date** same as RAP, **Through Date** Discharge or Day 60 |
| Creates **HH Episode** in **HIQH Inquiry System** | Closes **HH Episode** in **HIQH Inquiry System** |
| Triggers initial percentage **payment** | Triggers final percentage **payment** |

467.33 Exhibit: General Guidance on Line Item Billing Under HH PPS.--The following tables are added for quick reference on billing most line-item on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first tables grouping services, and the second items and supplies:

| TYPE OF LINE ITEM | Episode | Services/Visits | Outlier |
|---|---|---|---|
| CLAIM CODING | **New 0023 revenue code** with new HIPPS code (HHRG) on HCPCS field of same line | **Current revenue codes 42x, 43x, 44x, 55x, 56x, 57x w/Gxxxx HCPCS for increment reporting**, *(NOTE revenue codes 58x and 59x not permitted for HH PPS)* | Determined by Pricer-- **NOT billed by HHAs** |
| TYPE OF BILL (TOB) | **Billed on 32x only** (have 485, patient homebound) | **Billed on 32x only if POC**; 34x* if no 485 | **Appears on remittance only for HH PPS claims** (via Pricer) |
| PAYMENT BASIS | **PPS episode rate:** (1) full episode w/ or w/out **SCIC** adjustment; (2) less than full episode w/**PEP** adjustment, (3) **LUPA** paid on visit basis (4) therapy threshold adjustment | **When LUPA on 32x**, visits paid on adjusted national standardized per visit rates; **paid as part of Outpatient PPS for 34x*** | **Addition to PPS episode rate payment only**, NOT LUPA, paid on claim basis, not line item |
| PPS CLAIM? | **Yes, RAPs and Claims** | **Yes, Claims only** [34x* no 485/non-PPS] | **Yes, Claims only** |

**NOTE: For HH PPS, HHA submitted IC TOB must be 322-- may be adjusted by 328; Claim TOB must be 329-- may be adjusted by 327, or 328.**

*** 34x claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on CWF (exceptions noted on chart below).**

| TYPE OF LINE ITEM | DME** (non-implantable, other than Oxygen & P/O) | Oxygen & P/O (non-implantable P/O) | Non-routine*** Medical Supplies | Osteoporosis Drugs | Vaccines | Other Outpt. Items (antigens, splints & casts) |
|---|---|---|---|---|---|---|
| CLAIM CODING | **Current revenue codes 29x, 294** for drugs/supplies for effective DME use w/HCPCS | **Current revenue codes 60x** (Oxygen) **and 274** (P/O) w/HCPCS | **Current revenue code 27x** or **62x** w/ or w/o HCPCS, voluntary use of 623 for wound care supplies | **Current revenue code 636 & HCPCS** | **Current revenue codes 636** (drug) and HCPCS**, 771** (administration) | **Current revenue code 550** & HCPCS |
| TYPE OF BILL (TOB) | **Billed to RHHI on 32x if 485**, 34x* if no 485 | **Billed to RHHI on 32x if 485**, 34x* if no 485 | **Billed on 32x if 485**, or 34* if no 485 | **Billed on 34x* only** | **Billed on 34x* only** | **Billed on 34x* only** |
| PAYMENT BASIS | **Fee Schedule** | **Fee Schedule** | **Bundled into PPS payment if 32x** (even LUPA); paid in cost report settlement **for 34x*** | **Cost,** and paid separately with or without open HH PPS episode | **Paid as part of Outpatient PPS,** and paid separately with or without open HH PPS episode | **Paid as part of Outpatient PPS,** and paid separately with or without open HH PPS episode |
| PPS CLAIM? | **Yes, Claim only** [34x* no 485/non-PPS] | **Yes, Claim only** [34x* no 485/non-PPS] | **Yes, Claim only** [34x* no POC/non-PPS] | **No** (34x* claims only) | **No** (34x* claims only) | **No** (34x* claims only) |

**NOTE: For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).**

*** 34x claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for same beneficiary is open on CWF.**
****Other than DME treated as routine supplies according the Medicare FI (§3629) and Home Health (§473) Manuals.**
*****Routine supplies are not separately billable or payable under Medicare home health care.**

467.34 Exhibit: Acronym Table.--The following Acronym Table is offered to help with interpretation of the two previous sections, which, due to format constraints, could not spell out all terms:

| ITEM | COMMENTS |
|---|---|
| Admission Date | For HH PPS, date of first service of episode OR first service in a period of continuous care (multiple episodes) placed in Form Locator 17 of the HCFA Form 1450 (UB-92) found in Medicare and/or NUBC (National Uniform Billing Committee) manuals. HCFA manuals can be found on its Web Site (www.hcfa.gov/pubforms/p2192toc.htm). |
| Claim | Second of two "bookends" at opening and closing of HH PPS episode to receive one of two split percentage payments. |
| DME | Durable Medical Equipment. Billed by revenue codes &/or HCPCS. Paid by HCFA according to a HCFA DME fee schedule accessible on the HCFA Web Site (www.hcfa.gov/stat/pufiles.htm). |
| DMERC | DME Regional Carrier. 4 Medicare carriers nationally processing DME on HCFA 1500 claims. |
| Episode | 60-day unit of payment for HH PPS. |
| Grouper | A software module that "groups" information for payment classification; for HH PPS, data from the OASIS assessment tool is grouped to form HHRGs and output HIPPS codes. Specifications for the HH PPS Grouper are posted on the HCFA Web Site (www.hcfa.gov/medicare/hhmain.htm), and the grouper module is also built into PPS-compatible versions of HAVEN software, software publicly available automating the OASIS assessment tool. |
| HCFA | The Health Care Financing Administration, the Federal Agency administering the Medicare program and the federal portions of Medicaid and the Child Health program. |
| HCFA Form-1450 | HCFA's version of the UB-92 (see UB-92, below). |
| HCPC(S) Code(s) | HCFA Common Procedural Coding System. Coding for services or items used on the Form HCFA-1450 (UB-92) in FL 44 or Form HCFA-1500 claim forms. A list of HCPCS is accessible on the HCFA Web Site (www.hcfa.gov/stat/pufiles.htm). |
| HH | Home Health |
| HHA(s) | Home Health Agency(ies) |
| (H)HRG | Home Health Resource Group. One of 80 HH episode payment rates. |
| HIPPS | Health Insurance Prospective Payment System. Procedural coding used in FL 44 of the Form HCFA-1450 (UB-92) in association with certain HCFA prospective payment systems (skilled nursing facility, home health). 8 HIPPS are assigned to each HHRGs for HH PPS. |
| Inquiry System (HIQH) | An on-line transaction providing information on HH PPS episodes for specific Medicare beneficiaries for HHAs and hospices. Like the current HIQA eligibility inquiry system, this system will be based on batch claim data available in the Common Working File, a component of Medicare claims processing systems, available to providers via their RHHIs. |
| Line Item | Service or item-specific detail of claim. Contains repeated entries of Form Locators 42-49 on HCFA Form-1450 (UB-92). |
| LUPA | Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of HHRGs |
| National Standard Per Visit | National rates for each 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers. |

| | |
|---|---|
| **No-RAP LUPAs** | A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less. |
| **OASIS** | Outcome ASsessment Information Set. The HH assessment instrument required by HCFA. |
| **Outlier** | An addition to a full episode payment in cases where costs of services delivered are estimated exceed a fixed loss threshold. HH PPS outliers are computed as part of Medicare claims payment by Pricer for all non-LUPA episodes. |
| **Patient Status Code** | Form Locator 22 of the Form HCFA-1450 (UB-92) describing patient status at discharge/end of period; of note for HH PPS in the code list filling this location: "01"= "discharge to home/self care", "06" = "discharged/transferred home/HHA care" and "30" = "still a patient". |
| **PEP** | Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharges with readmissions). |
| **POC** | Plan of care. Medicare HH services for homebound beneficiaries must have a physician-established plan (see 485 below). |
| **P/O(S)** | Prosthetics and orthotics |
| **PPS** | Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition. |
| **Pricer** | Software modules in Medicare claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems. |
| **RAP** | Request for Anticipated Payment. First of two "bookends" at opening and closing of HH PPS episode to receive one of two split percentage payments. Note although the RAP uses a Form HCFA-1450 (UB-92), it is not a claim according to Medicare statutes, and in not subject to the payment floor, among other differences from claims. |
| **Revenue Code** | Payment codes for services or items place in Form Locator 42 of the Form HCFA-1450 (UB-92. Note that a new revenue code 0023 will be used on a distinct line item when billing episode payments (HIPPS in HCPCS field, separate line items for visits and supplies follow on claim); an "x" in the last digit of three digit revenue codes means that value can vary from 0-9. |
| **RHHI** | Regional Home Health Intermediary. 5 fiscal intermediaries nationally designated to process Medicare home health and hospice claims. |
| **SCIC** | Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under that HHRG, and all pro-rated amounts added for the final episode payment. |
| **Source of Ad- mission Code** | Form Locator 20 of the Form HCFA-1450 (UB-92); of note are new codes for HH PPS: "B" = "transfer from another home health facility", and "C" = "readmission to the same HHA". |
| **TOB** | Type of Bill (i.e., 32x, 34x). Coding representing the nature of each Form HCFA-1450 (UB-92) claim (i.e., type of benefit, such as homebound home health; payment source, such as specific Medicare trust fund; and frequency of bill , such as initial or cancellation)-- an "x" in the last digit of numeric three digit type of bill means that value can be from 0-9. |
| **UB-92** | The claim or bill form, in either paper or electronic version, used by most institutional health care providers. Published by HCFA as the Form HCFA-1450, but the standard itself is maintained by a non-governmental body: the National Uniform Billing Committee. |
| **10/01/00** | Legislated effective date for HH PPS. |
| **1500** | The claim form, in either paper or electronic version (NSF), used by most non-institutional health care providers and suppliers to bill Medicare. Published as Form HCFA-1500. |
| **485** | HCFA form number for Plan of Care (see POC above). |

467.35 HH PPS Consolidated Billing and Primary HHAs.--The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services is to be made to a single home health agency (HHA) overseeing that plan, and this HHA is known as the primary agency or HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

The HHA that submits the first RAP or No-RAP LUPA claim successfully processed by Medicare systems will be recorded as the primary HHA for a given episode in the CWF-based HIQH inquiry system for HH PPS. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Fiscal and regional home health intermediaries and carriers will reject any claims from other than the primary HHA that contain billing for the services and items above when billed for dates of service within an established 60-day home health episode. This applies to provider types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers). HHAs and hospices will be able to access information on existing episodes from the HIQH Inquiry system, other institutional providers from the HIQA/HUQA system. Both these inquiry systems, though based on information contained in the CWF, are available to Medicare providers through their intermediaries.

DME is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DME Regional Carrier or billed by a HHA to a RHHI, even HHAs other than the primary HHA. Medicare systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the intermediary and the carrier at the same time for the same beneficiary.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis, in addition to episodes payments, and are billed on a claim with a bill-type not specific to HH PPS (TOB 34x). When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them.

## 468. NEW COMMON WORKING FILE (CWF) REQUIREMENTS FOR THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

468.1 Creation of the Health Insurance Query for Home Health Agencies (HIQH).--In the past, the Health Insurance Query Access system, or HIQA, within the CWF, allowed different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility. HIQA has been available to home health agencies (HHAs) and hospices through their Medicare contractor, a Regional Home Health Intermediary (RHHI).

With the advent of the home health prospective payment system (HH PPS) and home health consolidated billing, HHAs similarly needed to determine if beneficiaries were already being served by other HHAs, because only one HHA is able to bill during a given episode period, though other agencies may obtain reimbursement under arrangement with the primary agency. In such cases, HHAs already providing services would be considered the primary agency for billing purposes. If the beneficiary is not already under care at another HHA, he or she can be admitted to a new HHA, and that agency would become primary. Beneficiaries can also be admitted to a second agency as primary, even if an episode is already open at another HHA, if a transfer situation exists.

With the implementation of HH PPS in 2000, CWF was expanded so that information pertinent to determining primary HHA status could be obtained through an on-line inquiry transaction in CWF--**HIQH: Health Insurance Query for HHAs**. This transaction is also available to hospices. The agency's primary status, or change of primary status from one agency to another in a transfer situation, is reflected in HIQH following submission of Requests for Anticipated Payment (RAPs) or claims by HHAs. Since HIQH includes information provided in HIQA, and since beneficiaries often move from home health to hospice care, both HHAs and hospices can employ HIQH as their single CWF inquiry transaction as of October 1, 2000. Unlike HIQA, which is paired with HUQA, HIQH does not have a parallel transaction system.

HIQA/HUQA will continue to exist and be used routinely by other Medicare institutional providers. HIQA will also be expanded so that these providers will be able to know if a HH PPS episode is open, since HH PPS consolidated billing may affect the processing of their claims.

468.2 HIQH Inquiry and Response.--HIQH is also available through RHHIs like HIQA. HIQH shows whether or not the beneficiary is currently in a home health episode of care (being served by a primary HHA), along with other information. To inquire, an HHA or hospice would enter data matching what was previously entered for HIQA, though under the new transaction identifier HIQH, including:

- The beneficiary's **Health Insurance Claim Number (HICN)**, name and sex;
- The pertinent **Contractor and Provider Numbers**;
- **CWF Host**, *and one new item:*
- **Date the HHA Expects to Serve the Beneficiary**.

CWF will immediately return information on the two episode periods in the CWF Episode File closest to the date the HHA submitted in the new item. If a date is not specified, information on the two most recent episode periods in the File will be returned. The HIQH response will display the following information for the specific beneficiary in response to the inquiry:

- The beneficiary's **Health Insurance Claim Number (HICN)**;
- The pertinent **Contractor and Provider Numbers**;
- **Episode Start and End Dates--** these dates make apparent if a primary HHA is already billing for a beneficiary and for how long;

o Period Status Indicator--the patient status codes either on a RAP, if the episode has not yet been closed by a claim, or the claim for the episode: these codes reveal whether a beneficiary has been discharged (01), has transferred or discharged and readmitted (06), has died (20) or is expected to remain in the care of the HHA currently providing services (30);

o HH Benefit Periods--the two most recent home health benefit periods, which Medicare uses to pay claims from either the Part A or Part B trust funds;

o **Medicare Secondary Payer (MSP) Information or HMO Entitlement Information**--if it exists for the beneficiary, this information will be returned;

o **Hospice Periods**--the two most recent hospice periods for the patient, if any; and

o **HIQA Header Information**--all that pertains to home health and hospice from the basic entitlement information from page 1 of the HIQA inquiry.

HIQH will provide a specific response message in cases when no episodes exist for a given beneficiary. This message will make clear that for the date(s) requested, no home health episode information is available.

468.3 Timeliness and Limitations of HIQH Responses.--Though inquirers get a response back from HIQH within a very short time frame, these responses are not truly “real time.” The CWF auxiliary file that retains episode information is updated by, and is only as current as, each RAP or claim batch run in CWF. All processed RAPs and claims will update the episode file, even if RAPs have zero reimbursement, or if claims or RAPs are ultimately denied. Episodes are only removed from the file when HHAs cancel their own RAPs, for episode not yet closed, or claims, for closed episodes, or when an RHHI cancels a claim or a RAP for specific reasons (i.e., fraud).

In general, HIQH responses will be as current as the previous day. Therefore, even when a response indicates a beneficiary is not currently in an episode, the possibility exists that a RAP or claim could be in process, and the inquiring agency would still not be the primary HHA for a beneficiary for whom a 'clear’ inquiry was received. In such cases, the inquiring agency would not learn that they were not the primary HHA immediately, waiting until they either looked again in HIQH after new batch updates were reflected, or possibly only once the RAP or claim submitted was rejected. While this situation should occur infrequently, since one beneficiary would have to be going to two different agencies virtually simultaneously, it cannot be avoided given the limitations of current batch-processing systems.

Also possible but even rarer, claims or RAPs from two different HHAs for the same beneficiary for the same date may be in the same batch of claims or RAPs sent to CWF. In such cases, the arbitrary claim process will still result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

468.4 Inquiries to RHHIs Based on HIQH Responses.--HHAs and hospices may want to follow-up on information they view in HIQH. In such cases, usually to contact the primary agency already on file to bill under arrangement, the provider’s RHHI should be contacted through existing provider inquiry channels. HCFA has confirmed that each RHHI may provide information on either the provider or contractor numbers HHAs may request given the HIQH responses they receive. Information released will be determined by each RHHI, such as name and address, but must be enough for the inquiring HHA to contact either the primary HHA, if under that RHHI’s jurisdiction, or another RHHI (contractor number), if the provider number from the HIQH response is attached to another RHHI. If an instance ever exists where an HHA is an individual, such as a provider doing business using a Social Security Number as a tax identification number, information cannot be released, since it would violate the individual’s right to privacy.

468.5 National Home Health Prospective Payment Episode History File.--HIQH, the new CWF inquiry system for HH PPS, relays information including that contained in the HH PPS episode history file of each beneficiary. CWF was amended for HH PPS to create a national episode history file for each beneficiary, in order to enforce consolidated billing and perform HH PPS processing. Accompanying episode period response trailers were also created, and are to be updated daily in response to HH PPS Requests for Anticipated Payment (RAPs) and claims, both transactions employ the Form HCFA-1450 (UB-92) form with distinct bill types that are effective October 1, 2000.

The episode file, populated as soon as the first HH PPS episode is opened for a beneficiary with either a RAP or a claim, contains:

- The beneficiary's **Health Insurance Claim Number (HICN)**;
- The pertinent **Regional Home Health Intermediary, RHHI, (Contractor) and Provider Numbers**;
- **Period Start and End Dates**--the start date is received on a RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized;
- **DOEBA and DOLBA, Dates of Earliest and Latest Billing Activity (respectively)**--dates needed to attribute episode payment to the correct Medicare trust fund, drawn from the existing home health benefit period file;
- **Period Status Indicator**--the patient status code on an HH PPS claim, indicating whether a beneficiary has been discharged (01), has transferred or discharged and readmitted (06), has (20) or is expected to remain in the care of the HHA currently providing services (30);
- **Transfer/Readmit Indicator**--Source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge, etc.);
- **The HIPPS Code(s)**--up to six for any episode, and two for any line item, representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
- **Principle and Secondary Diagnosis Codes**--from the RAP or overlaying claim;
- **A LUPA Indicator**--received from the standard system indicating whether or not there was a LUPA episode; and
- **A RAP Cancellation Indicator**--showing whether or not a RAP has been canceled for this episode because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel-only code indicator "B", this indicator is a value of "1", in all other cases, the value is "0".

Separate from the episode file, CWF passes the Claim-OASIS matching key on the RAP or claim to HCFA's National Claims History (NCH). This enables NCH claim data to be linked to individual OASIS assessments supporting the payment of individual claims. The LUPA indicator is also passed to NCH, in addition to routinely passed claim data.

The episode file contains the 36 most recent episodes for any beneficiary. Episodes preceding the most recent 36 will be dropped off the file and will not be retrievable on-line. The date of accretion for an episode is the date the RAP or claim is accepted or applied.

468.6 Opening and Length of HH PPS Episodes.--Within CWF, the episode history auxiliary file is separate from the home health benefit period auxiliary file, which existed prior to HH PPS. All HH PPS claims will update both these files, in particular the DOEBA, DOLBA and visit counts. In most cases, an HH PPS episode in an episode file will be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement.

Note that claims, as opposed to RAPs, will only open episodes in one special circumstance: when a provider knows from the outset that four or fewer visits will be provided for the entire episode, which always results in a LUPA, and therefore decides to forego the RAP as to avoid recoupment of the difference of the large initial percentage episode payment and visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

Multiple episodes can be open for the same beneficiary at the same time. The same HHA may require multiple episodes be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. CWF will post RAPs received with appropriate transfer and re-admit indicators to facilitate the creation of multiple episodes. Same day transfers are permitted, such that an episode for one agency, based on the claim submitted by that agency, can end on the same date as an episode was opened by another agency for the same beneficiary.

When episodes are created from RAPs, CWF calculates a period end date that does not exceed the start date plus 59 days. CWF will assure no episode exceeds this length under any circumstance, and will auto-adjust the period end date to shorten the episode if needed based on activity at the end of the episode (i.e., shortened by transfer).

468.7 Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAPs and HHA Claim Activity.--CWF will reject RAPs and claims with statement dates overlapping existing episodes using a trailer and a distinct error code, including No-RAP LUPA claims, unless a transfer of discharge and re-admit situation is indicated. CWF will also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. 60-day episodes, starting on the original period start date, will remain on record in these cases.

CWF will auto-cancel claims, and adjust episode lengths, when episodes are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode will default to end the day before the first date of service of the new RAP or claim causing the adjustment, though the episode length may change once claims finalizing episodes are received. When claims are auto-canceled, CWF will send an unsolicited response to the standard system component of claims processing so that payment for the episode is automatically adjusted, a partial episode payment or PEP adjustment-- without necessitating re-billing by the HHA. If when performing such adjustments there is no claim in paid status for the previous episode that will receive the PEP adjustment, CWF will just adjust the period end date, but if the previous claim is in paid status both the claim, via the standard system, and the episode will be adjusted.

In PEP situations, if the first episode claim contains visits with dates in the subsequent episode period, the claim of the first episode will be rejected by CWF with UR reject code that indicates the date of the first overlapping visit. The claim rejected by CWF will then be returned to the HHA by the RHHI for correction. If the situation is also a transfer, when the first HHA with the adjusted episode subsequently receives a rejected claim, the agency can either re-bill by correcting the dates, or seek payment under arrangement from the subsequent HHA. For readmission and discharge, the agency may correct the erroneously billed dates for its own previously-submitted episode, but corrections and adjustments in payment will be made automatically as appropriate whether the agency submits corrections or not.

If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, CWF will reject the later received RAP or claim with a trailer and a new error code, even if the later received RAP started with an earlier date of service, unless there is a transfer or readmit indicator. In such cases, RHHIs will return the claims rejected by CWF to providers. CWF will create an internal message in addition to setting appropriate indicators in these circumstances.

If a claim is canceled by an HHA, CWF will cancel the episode. If an HHA cancels a RAP, CWF will also cancel the episode. When claims are denied, auto-canceled or canceled by the system, CWF will not cancel the episode. An RHHI may also take an action that results in cancellation of an episode, usually in cases of fraudulent billing. Other than cancellation, episodes are closed by final processing of the claim for that episode.

468.8 Other Editing and Changes for HH PPS Episodes.--CWF will assure that the final from date on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary will remain in the care of the same HHA (patient status code 30). If the patient dies, represented by a patient status code of 20, the episode will be fully paid, but the through date on the claim will indicate the date of death instead of the episode end date. When the status of a claim is 06, the episode period end date will be adjusted to reflect the through date of that claim, and payment is also adjusted. CWF will permit a "transfer from" and a "transfer to" agency to bill for the same day when that is the date of transfer. When the status of the claim is 01, no change is made in the episode length or claim payment unless a separate RAP/claim is received overlapping that 60-day period and containing either a transfer/discharge-readmit indicator. CWF will also act on source of admission codes on RAPs: for example, "B", indicating transfer, and "C", indicating readmission after discharge by the same agency in the same 60-day period will open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone will not trigger creation of a new episode. CWF will also recognize the following internal action codes sent by the standard systems, not submitted by providers on claims, for HH PPS: "01" for RAPs, bill type 3XG claims and No-RAP LUPA claims, "03" on claims except No-RAP claims, and "04" for cancel only claims. Different types of actions will follow 04 cancellations. When the HUHH record is received from the RHHI, based on the cancel-only code also placed on the claim by the standard systems, the following actions will occur based on the code: "A", the episode will not be removed from the episode file, the cancellation indicator will not be set, and the DOEBA and DOLBA dates will be removed; "B", the episode record is not removed and the cancellation indicator is set, and "E" the episode is removed. Cancel only code "F" will be used when either the RAP or claim (HUHH record) is canceled by the provider, and consequently the attached episode will be removed from the episode file.

468.9 Priority Among Other Claim Types and HH PPS Consolidating Billing for Episodes.--Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. So that, if an HH PPS claim is received, and CWF finds either an inpatient or skilled nursing facility (SNF) claim with services within the episode dates for the HH PPS claim, CWF will reject the HH claim, since the episode would fall within the range of the dates of service of those other inpatient claims. This would still be the case even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later, but contained dates of service within the HH PPS episode period.

A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment is likely to apply. Occurrence span code 74, previously used in such situations, should not be employed on HH PPS claims. However, if an agency chooses to discharge and a beneficiary still returns to the agency, or another agency, in the same 60-day period, there would be one shortened HH PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period.

CWF developed A-B crossover edits for Medicare systems to prevent duplicate billing among RHHIs and DME regional carriers. Consequently, CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS coding, though HH consolidated billing does not apply to DME by law.

By law, consolidated billing is required for home health services, to be implemented along with HH PPS. In short, consolidated billing requires that only the HHA responsible for a given HH PPS episode, the primary HHA, bill services under the home health benefit, with the exception of DME, for the period of that episode. The type of service most affected are non-routine supplies and outpatient therapies, since these service are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

For home health consolidated billing, non-routine medical supplies are identified as 178 discrete items by HCPCS code in the final rule for HH PPS. If an HH PPS episode is open, only the primary HHA should bill for these items. CWF will reject claims not billed by the primary HHA, submitted to either RHHIs or DME Regional Carriers, for these items when an episode is open, or even if such claims are billed before or after the episode the episode itself, but overlap with the episode period. Such claims will be returned to Part A, Part B, or DMERC standard systems as appropriate. CWF will also return an unsolicited trailer 20 to the Part A standard system as needed in these situations, and develop a new reject response code to return to the Part B or DME standard systems if warranted. In such cases, both regional home health and fiscal intermediaries will return the claims rejected by CWF to providers. Routine supplies remain unreimbursed by Medicare.

CWF will develop edits to enforce consolidated billing for outpatient therapies, recognized under revenue codes 42x, 43x, 44x, so that only those therapy services billed by the primary HHA will be paid and posted. These revenue codes have been cross-reference to 54 HCPCS codes listed in the HH PPS final rule approximating the same services. Subsequent services billed after the posting of a HH episode will be rejected back to the appropriate standard system as described above relative to routine supplies.

If revenue code 636 and the HCPCS code for osteoporosis drug is billed on a 34x bill type claim during an open HH episode, CWF must edit to ensure that the provider of the 34x bill is the same as the primary provider of the open episode, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the episode payment. HH PPS will not cause any changes in the billing of outpatient services by HHAs (i.e., vaccines, splints, antigens and casts) or home health visits not under a plan of care on 34x bill type claims.

468.10 Medicare Secondary Payment (MSP) and the HH PPS Episodes File.--CWF will apply existing MSP edits (auxiliary file) to both RAPs and HH PPS claims, editing all RAPs, whether a HUSP record is present or not, to see if the episode period service date falls within an MSP period. A HUSP record will be created for all RAPs containing MSP information, and this record will create or update the CWF MSP auxiliary file as appropriate. Though both RAPs and claims will create episode records, only claim, not RAP, payment will be affected by primary payer contributions in MSP situations. Therefore, RAPs are marked in Medicare standard systems with a non-payment code if MSP applies, and ultimately sent to a paid status in Medicare systems without processing through post-payment locations, thereby processing with zero payment. First claim development is performed only on claims, not RAPs.

468.11 Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File.--The following chart summarizes basic effects of HH PPS claims processing on the episode record:

| Transaction | How CWF Is Impacted | How Other Providers Are Impacted |
|---|---|---|
| **Initial RAP (Percentage Payments 0-60)** | Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a transfer source code is present |
| **Subsequent Episode RAP** | Opens another subsequent 60-day episode using RAP's "from" date; "through" date is automatically calculated to extend through next 60 days | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a transfer source code is present |
| **Initial RAP with Transfer Source Code of B** | Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day | • The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from can not bill for services past the date of transfer.<br>• Another HHA cannot bill during this episode unless another transfer situation occurs |
| **RAP Cancellation by Provider or RHHI** | 60-day episode record is deleted from CWF | • No episode exits to prevent RAP submission or No-RAP LUPA claim submission |
| **RAP Cancellation by System** | 60-day episode record remains open on CWF | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a transfer source code is present |

| Transaction | How CWF Is Impacted | How Other Providers Are Impacted |
|---|---|---|
| **Claim (full episode)** | 60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a transfer source code is present |
| **Claim (discharge with goals met prior to Day 60)** | 60-day episode record completed; episode "thorough" date remains at the 60th day; DOLBA updates with date of last service | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a transfer source code is present |
| **Claim (transfer)** | 60-day episode completed; episode period end date reflects transfer; DOLBA updates with date of last service | • A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date |
| **No-RAP LUPA Claim** | Opens a 60-day episode record using RAP's "from" date; "through"date is automatically calculated to extend through 60th day; DOLBA updates with date of last service | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• Other No-RAP LUPA claims will be rejected unless a transfer source code is present<br>• Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open a 60-day episode by submitting a RAP or by submitting a No-RAP LUPA Claim |
| **Claim (adjustment)** | No impact on 60-day episode unless adjustment changes patient status to transfer | • No impact |
| **Claim Cancellation by Provider or RHHI** | 60-day episode is deleted from CWF | • No episode exists to prevent RAP submission or No-RAP LUPA claim submission |
| **Claim Cancellation by System** | 60-day episode record remains open on CWF | • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present<br>• No-RAP LUPA claims will be rejected unless a tansfer source code is present |

## 473. BILLING FOR PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS, AND HEPATITIS B VACCINES

A. Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B. Coverage Requirements.--Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and its administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law by any provider of service or any entity or individual with a supplier number. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

C. General Billing Requirements.--Follow §219 for general billing instructions.

Bill your intermediary for the vaccines on Form HCFA-1450, using bill type 34X. The vaccine and its administration may be on the same claim form. There is no requirement for a separate bill. However, you may have to submit a separate bill if your intermediary requires it.

D. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;
90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

These codes are for the vaccines only. Bill for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV, and G0010 for the hepatitis B vaccine.

E. Applicable Revenue Codes.--Bill for the vaccines using revenue code 636. Bill for the administration of the vaccines using revenue code 771.

F. Other Coding Requirements.--You must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive the vaccines or if the vaccines are the only service billed on a claim. Report code V04.8 for the influenza virus vaccine, code V03.82 for PPV, and code V05.3 for the hepatitis B vaccine. In addition, for the influenza virus vaccine, report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy.

G. Special Billing Instructions for Home Health Agencies (HHAs).--The following provides billing instructions for HHAs in various situations:

o Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B), Medicare will not pay for a skilled nursing visit by you under the HHA benefit. However, the vaccine and its administration is covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. Do not charge for travel time or other expenses (i.e., gasoline). In this situation, bill under bill type 34X and use revenue code 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

**NOTE:** A separate bill is not allowed for the visit.

o If a vaccine (influenza, PPV, or hepatitis B) is administered during the course of an otherwise covered home health visit, (e.g., to perform wound care), the visit would be covered as normal but you must not include the vaccine or its administration in your visit charge. In this case, you would still be entitled to payment for the vaccine and its administration under the vaccine benefit. In this situation, you bill under bill type 34X and use revenue code 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

**NOTE:** A separate bill is required for the visit.

o Where a beneficiary does not meet the eligibility criteria for coverage, a home health nurse may be paid for the vaccine (influenza, PPV, or hepatitis B) and its administration. No skilled nursing visit charge is billable. The administration should include charges only for the supplies being used and the cost of the injection. Do not charge for travel time or other expenses (i.e., gasoline). In this situation, you bill under bill type 34X and use revenue code 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, and their spouse does not, and the spouse wants an injection the same time as a nursing visit, bill in accordance with the above bullet point.

H. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.--Some potential "mass immunizers" have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. A mass immunizer is defined as any entity that gives the influenza virus vaccine to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required.

The simplified process involves use of the Form HCFA-1450. When conducting mass immunizations, attach a standard roster to a single pre-printed Form HCFA-1450 which will contain the variable claim information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

o Provider name and number;

- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file".

**NOTE:** A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The modified Form HCFA-1450 shows the following preprinted information in the specific FLs:

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code); (See NOTE: below)
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0008 FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number);
- UPIN SLF000 in FL 82; and
- Diagnosis code V04.8 in FL 67 (Principal Diagnosis Code).

If you conduct mass immunizations, you are required to complete the following FLs on the preprinted Form HCFA-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

**NOTE:** Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer However, if you know that a particular group health plan covers the influenza virus vaccine and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

When you provide the influenza virus vaccine in a mass immunization setting, you do not have the option to pick and choose who to roster bill for this service. If you are using employees from your certified portion, and as a result will be reflecting these costs on your cost report, you must bill your Regional Home Health Intermediary (RHHI) on the Form HCFA-1450.

If you are using employees from your non-certified portions (employees of another entity that is not certified as part of your HHA), and as a result, payment will not be made on the cost report for these costs, you must obtain a provider number and bill your carrier on the Form HCFA-1500.

If employees from both certified and non-certified portions of your facility are used to furnish the vaccine at a single mass immunization site, you must prepare two separate rosters, i.e., one for employees of the certified portion of your facility to be submitted to your RHHI, and one for employees of the non-certified portion of your facility to be submitted to your carrier.

If you do not mass immunize, continue to bill for influenza virus vaccine using the normal billing method i.e., submission of a Form HCFA-1450 of electronic billing for each beneficiary.

I. Simplified Billing of Pneumococcal Pneumonia Vaccine (PPV) by Mass Immunizers.--The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the PPV to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required.

The simplified process involves use of the Form HCFA-1450 with preprinted standardized information relative to the provider and the benefit. Attach a standard roster to a single pre-printed Form HCFA-1450 which will contain the variable claims information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file".

**NOTE:** A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The roster should contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the PPV.

**WARNING:** The beneficiary's vaccination status must be verified before administering the PPV. It is acceptable to rely on the patient's memory to determine prior vaccination status. If the patient is uncertain whether they have been vaccinated within the past 5 years, administer the vaccine. If patients are certain that they have been vaccinated within the past 5 years, do not revaccinate.

The modified Form HCFA-1450 shows the following preprinted information in the specific form locators (FLs):

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code).

Providers conducting mass immunizations are required to complete the following FLs on the preprinted HCFA-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

**NOTE:** Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

When you provide the PPV in a mass immunization setting, you do not have the option to pick and choose who to roster bill for this service. If you are using employees from your certified portion, and as a result will be reflecting these costs on your cost report, you must bill your Regional Home Health Intermediary (RHHI) on the Form HCFA-1450.

If you are using employees from your non-certified portions (employees of another entity that are not certified as part of your HHA), and as a result, payment will not be made on the cost report for these costs, you must obtain a provider number and bill your carrier on the Form HCFA-1500.

If employees from both certified and non-certified portions of your facility are used to furnish the vaccine at a single mass immunization site, you must prepare two separate rosters, i.e., one for employees of the certified portion of your facility to be submitted to your RHHI, and one for employees of the non-certified portion of your facility to be submitted to your carrier.

If you do not mass immunize, continue to bill for the PPV using normal billing procedures; i.e., submission of a Form HCFA-1450 or electronic billing for each beneficiary.

Uniform Billing

## 475. COMPLETION OF FORM HCFA-1450 FOR HOME HEALTH AGENCY BILLING

The Form HCFA-l450 (also known as the UB-92) is a uniform institutional provider bill suitable for use in billing multiple third party payers. Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Lists of approved coding for the form are maintained by the National Uniform Billing Committee (NUBC). Detailed information is given below only for the items that are required to bill Medicare for home health services under a plan of care under the home health prospective payment system (HH PPS). Follow these instructions to bill for dates of service on or after October 1, 2000. For guidance regarding billing for dates of service on or before September 30, 2000, refer to the Medicare Intermediary Manual §§3638.1 through 3638.11. Bills for home health services must not include service dates in both September and October 2000.

Items not listed do not need to be completed, although you may complete them when billing multiple payers.

475.1 Request for Aticipated Payment.--The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, submit a request for anticipated payment (RAP) with coding as described below.

Each RAP must be based on a current OASIS-based case-mix. In general, a RAP and a claim will be submitted for each episode period. Each claim, usually following a RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims systems. The full recoupment of the RAP payment will be reflected on the next remittance advice.

If care continues with the same provider for a second episode of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the next remittance advice (RA) will be used to recoup the overpaid amount. These recoupments will be reflected on remittance advices relative to specific episodes in order for providers to clearly understand Medicare payments.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Untitled
Not required.

FL 3. Patient Control Number
Optional. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

**NOTE:** While the bill classification of 3, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to a HH PPS claim depending upon a beneficiary's eligibility, HAs are encouraged to submit all RAPs with bill classification 2. Medicare claims systems determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

| 3rd Digit-Frequency | Definition |
|---|---|
| 2-Interim-First Claim | Use this code for the first of an expected series of bills for which utilization is chargeable. Use this code for the submission of original or replacement RAPs. |
| 8-Void/Cancel of a Prior Claim | Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If a RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), use this code to cancel it so that a corrected RAP can be submitted. |

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. Submit the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.). Submit all dates in the format MM-DD-YYYY.

FL 7. Covered Days
Not Required.

FL 8. Noncovered Days
Not Required.

FL 9. Coinsurance Days
Not Required.

FL 10. Lifetime Reserve Days
Not Required.

FL l2. Patient's Name
Required. Enter the patient's last name, first name, and middle initial.

FL l3 Patient's Address
Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate
Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, leave blank.

FL l5. Patient's Sex
Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL l6. Patient's Marital Status
Not Required.

FL l7. Admission Date
Required. Enter the date the patient was admitted to home health care (MM-DD-YYYY). On the first RAP in an admission, this date should match the statement covers "from" date in FL 6. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episode should, therefore, match the date submitted on the first RAP in the admission.

FL l8. Admission Hour
Not Required.

FL l9. Type of Admission
Not Required.

FL 20. Source of Admission
Required. Enter a code indicating the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

| Code | Definition |
|---|---|
| 1 | Physician Referral |
| 2 | Clinic Referral |

FL 20. Source of Admission (Cont.)
Code Structure:

| Code | Definition |
|---|---|
| 3 | HMO Referral |
| 4 | Transfer from a Hospital |
| 5 | Transfer from a SNF |
| 6 | Transfer from Another Health Care Facility |
| 7 | Emergency Room |
| 8 | Court/Law Enforcement |
| 9 | Information Not Available |
| A | Transfer from a Critical Access Hospital (CAH) |
| B | Transfer from Another HHA |
| C | Readmission to Same HHA |

On the first RAP in an admission, this code should reflect the actual source of admission to your agency. On RAPs for subsequent episodes of continuous care report code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. Enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6). Since the "through" date of the RAP will match the "from" date, the patient will never be discharged as of the "through"date. As a result only one patient status is possible on RAPs.

Code structure:

| Code | Definition |
|---|---|
| 30 | Still patient |

FL 23. Medical Record Number
Optional. Enter the number assigned to the patient's medical/health record. The intermediary must carry the number you enter through their system and return it to you.

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes
Optional. Enter any NUBC approved code to describe conditions that apply to the RAP.

If canceling the RAP (TOB 3x8), report the following:

Claim Change Reasons

| Code | Title | Definition |
|---|---|---|
| D5 | Cancel to Correct HICN or Provider ID | Cancel only to correct an HICN or Provider Identification Number. |
| D6 | Cancel Only to Repay a Duplicate or OIG Overpayment | Cancel only to repay a duplicate payment or OIG overpayment. |

FL 31. Untitled
Not Required.

FL 32, 33, 34, and 35. Occurrence Codes and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27, which indicated the date of the current plan of care certification period, is not required on HH PPS RAPs.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the bill if convenient.

FL 36. Occurrence Span Code and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the RAP. Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Not Required.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required.

Fls 39-41. Value Codes and Amounts

Required. Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

| Code | Title | Definition |
|---|---|---|
| 61 | Location Where Service is Furnished (HHA and Hospice) | MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. |

Optional. Enter any NUBC approved code to describe other values that apply to the RAP.

Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

FL 42 and 43 Revenue Code and Revenue Description

Required. One revenue code line is required on the RAP. This line will be used to report the Health HIPPS code (defined below) which will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs are as follows:

| REV. CD. | DESCRIPTION |
|---|---|
| 0023 | Home Health Services |

Optional. Additional revenue code lines may be submitted if you choose to do so, reporting any revenue codes which are accepted on HH PPS claims except 0023 (see §475.2 below). Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment. The 0023 revenue code line must not be submitted with a charge amount.

**NOTE:** Revenue codes 58X, 59X and 624 will no longer be accepted on Medicare home health RAPs under HH PPS.

You may continue to report a “Total” line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of the charges billed. However, Medicare claims systems will overlay this amount with the total reimbursement for the RAP.

FL 44. HCPCS/Rates

Required. On the 0023 revenue code line, report the HIPPS code for which anticipated payment is being requested.

Definition. HIPPS rate codes represent specific patient characteristics (or case-mix) on which Medicare payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on UB-92 claims forms for institutional providers. One revenue code is defined for each prospective payment system that calls for HIPPS codes. HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") on the form itself. The associated revenue code is placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alpha-numeric codes of five digits.

Under the home health prospective payment system, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRG). These HHRGs are determined based on assessments made using the Outcome and Assessment Information Set (OASIS). Grouper software run at your site will use specific data elements from the OASIS data set and assign beneficiaries to an HHRG. On Medicare claims these HHRGs will be represented as HIPPS codes. The Grouper will output the HIPPS code which must be entered in FL 44 on the claim. The HHRG will not be output.

HHA HIPPS codes are five position alpha-numeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respectively to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS code were either calculated from complete OASIS data or derived from incomplete OASIS data. A value of “1" in the fifth position indicates a complete data set which should be accepted for the State repository for this OASIS data. Both RAPs and claims must reflect the HIPPS code ultimately accepted by the State agency for an episode. A table in §467.13 further demonstrates how HIPPS codes are determined. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in Medicare Program Memoranda. Contact your RHHI for the current list of codes.

Optional. If additional revenue code lines are submitted on the RAP, report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §475.2.

FL 45. Service Date

Required. On the 0023 revenue code line, report the date of the first billable service provided under the HIPPS code reported on that line.

Optional. If additional revenue codes are submitted on the RAP, report service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §475.2.

FL 46. Units of Service

Optional. Units of service are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, report units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §475.2.

FL 47. Total Charges

Required. Zero charges must be reported on the 0023 revenue code line. Medicare claims systems will place the reimbursement amount for the RAP in this field on the electronic claim record.

Optional. If additional revenue codes are submitted on the RAP, report any necessary charge amounts to meet the requirements of other payers or your billing software. Medicare claims systems will not make any payment determinations based upon submitted charge amounts.

FL 48. Non-Covered Charges

Not Required. Report non-covered charges only on HH PPS claims.

Examples of completed FLs 42 through 48. The following provides examples of revenue code lines as they should be completed based on the reporting requirements above.

For the UB-92 Flat File:
Report the required 0023 line as follows:

| Record Type | Revenue Code | HCPCS | Date of Service | Units | Total Charges | Non-covered Charges |
|---|---|---|---|---|---|---|
| 61 | 0023 | HAEJ1 | 20001001 | | 0.00 | |

Report additional revenue code lines as follows:

| Record Type | Revenue Code | HCPCS | Date of Service | Units | Total Charges | Non-covered Charges |
|---|---|---|---|---|---|---|
| 61 | 0550 | G0154 | 20001001 | 1 | 150.00 | |

For the hard copy Form HCFA-1450 (UB-92):
Report the required 0023 line as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 | FL 48 |
|---|---|---|---|---|---|
| 0023 | HAEJ1 | 10012000 | | 0.00 | |

Report optional additional revenue code lines as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 | FL 48 |
|---|---|---|---|---|---|
| 550 | G0154 | 10012000 | 1 | 150.00 | |

FL 49. Untitled

Not Required.

FLs 50A, B, and C. Payer Identification
Required. If Medicare is the primary payer, enter "Medicare" on line A. When Medicare is entered on line 50A, this indicates that you have developed for other insurance coverage and have determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. See §§248, 250, 25l, 252, and 253 to determine when Medicare is not the primary payer. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on the RAP.

FL 51. Medicare Provider Number
Required. Enter the six position alphanumeric "number" assigned by Medicare. It must be entered on the same line (A, B, or C) as "Medicare" in FL 50.

If the Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. (See §432) In this case, report the new provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Not Required.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56. (Untitled)
Not Required.

FL 57. (Untitled)
Not Required.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his HI card or other Medicare notice.

FLs 59A, B, and C. Patient's Relationship to Insured
Not Required.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

FLs 61A, B, and C. Group Name
Not Required.

FLs 62A, B, and C. Insurance Group Number
Not Required.

FL 63. Treatment Authorization Code
Required. Enter the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen position code, containing the start of care date (eight positions, from OASIS item M0030 in format MM-DD-YYYY), the date the assessment was completed (eight positions, from OASIS item M0090 in format MM-DD-YYYY), and the reason for assessment (two positions, from OASIS item M0100).

Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment. Do not change any item from what is required by OASIS reporting rules for purposes of submitting the RAP to Medicare.

The investigational device (IDE) revenue code, 624, will not be allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Not Required.

FL 65. Employer Name
Not Required.

FL 66. Employer Location
Not Required.

FL 67. Principal Diagnosis Code
Required. Enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill with zeros.

The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis), and on the Form HCFA-485, form item 11 (ICD-9-CM/Principle Diagnosis).

FLs 68-75. Other Diagnoses Codes
Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form HCFA-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the Form HCFA-485, form item 13, may be reported in FLs 68-75 on the RAP if they are reported in the narrative form item 21 of the Form HCFA-485.

FL 76. Admitting Diagnosis
Not Required.

FL 77. E-Code
Not Required.

FL 78. Untitled
Not Required.

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Not Required.

FL 81. Other Procedure Codes and Dates
Not Required.

FL 82. Attending/Requesting Physician I.D.
Required. Enter the UPIN and name of the attending physician that has established the plan of care with verbal orders.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks
Not Required.

FL 85. Provider Representative Signature
Not Required.

FL 86. Date
Not Required.

475.2 HH PPS Claims.--The following data elements are required to submit a claim under home health PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After a RAP has been paid and a 60 day episode has been completed, or the patient has been discharged, submit a claim to receive the balance of payment due for the episode.

HHAs should be aware that HH PPS claims will be processed in Medicare claims systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §475.3). As the claim is processed the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net reimbursement on the claim can be easily understood. Detailed remittance advice information is contained in §485.

Coding required for a HH PPS claim is as follows:

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Untitled
Not required.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility
3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

While the bill classification of 3, defined as “Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)” may also be appropriate to a HH PPS claim depending upon a beneficiary’s eligibility, HHAs are encouraged to submit all claims with bill classification 2. Medicare claims system determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

| 3rd Digit-Frequency | Definition |
|---|---|
| 7-Replacement of Prior Claim | Use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. |
| 8-Void/Cancel of a Prior Claim | Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "9" bill (a replacement Claim) must be submitted for the episode to be paid. |

FL 4. Type of Bill (Cont.)

| 3rd Digit-Frequency | Definition |
|---|---|
| 9-Final claim for a HH PPS episode | This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8. |

HH PPS claims are submitted with the frequency of "9." These claims may be adjusted with frequencies "7" or "8." Late charge bills, submitted with frequency "5" are not accepted under HH PPS.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period covered by this claim. The "From" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "Through" date must be 60 days later than the "From" date. The patient status code in FL 22 must be 30 in these cases. In cases where the beneficiary has been discharged or transferred within the 60-day episode period, report the date of the last service prior to this event as the "Through" date. If the beneficiary has died, report the date of death in the through date. Any NUBC approved patient status code may be used in these cases. You may submit claims for payment immediately after the claim "Through" date. You are not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

Submit all dates in the format MM-DD-YYYY.

FL 7. Covered Days
Not Required.

FL 8. Noncovered Days
Not Required.

FL 9. Coinsurance Days
Not Required.

FL 10. Lifetime Reserve Days
Not Required.

FL l2. Patient's Name
Required. Enter the patient's last name, first name, and middle initial.

FL l3 Patient's Address
Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate
Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, leave blank.

FL l5. Patient's Sex
Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL l6. Patient's Marital Status
Not Required.

FL l7. Admission Date
Required. Enter the same date of admission that was submitted on the RAP for the episode (MM-DD-YYYY).

FL l8. Admission Hour
Not Required.

FL l9. Type of Admission
Not Required.

FL 20. Source of Admission
Required. Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. Enter the code that most accurately describes the patient's status as of the "Through" date of the billing period (FL 6).

Code Structure:

| Code | Definition |
|---|---|
| 01 | Discharged to home or self-care (routine discharge) |
| 02 | Discharged/transferred to a short-term general hospital |
| 03 | Discharged/transferred to SNF |
| 04 | Discharged/transferred to an ICF |
| 05 | Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution |
| 06 | Discharged/transferred to home under care of another organized home health service organization, OR<br>Discharged and readmitted to the same home health agency within a 60-day episode period |
| 07 | Left against medical advice or discontinued care |
| 20 | Expired (or did not recover - Christian Science Patient) |
| 30 | Still patient or expected to return for outpatient services |
| 50 | Discharged/transferred to hospice--home |
| 51 | Discharged/transferred to hospice--medical facility |

FL 22. Patient Status (Cont.)
Patient Status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a Partial Episode Payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which a HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claim record to 06.

FL 23. Medical Record Number
Required. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes
Optional. Enter any NUBC approved code to describe conditions that apply to the claim.

If adjusting a HH PPS claim (TOB 3x7), report the following:

Claim Change Reasons

| Code | Definition |
|---|---|
| D0 | Changes to Service Dates |
| D1 | Changes to Charges |
| D2 | Changes to Revenue Codes/HCPCS |
| D7 | Change to Make Medicare the Secondary Payer |
| D8 | Change to Make Medicare the Primary Payer |
| D9 | Any Other Change |
| E0 | Change in Patient Status |

If adjusting the claim to correct a HIPPS code, report condition code D9.

If canceling the claim (TOB 3x8), report the following:

| Code | Definition |
|---|---|
| D5 | Cancel to Correct HICN or Provider ID |
| D6 | Cancel Only to Repay a Duplicate or OIG Overpayment |

FL 32, 33, 34, and 35. Occurrence Codes and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HH PPS claims.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the “From” and “Through” dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span “From” dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span “Through” date is in the date field.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the bill if convenient.

FL 36. Occurrence Span Code and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the claim. Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY. Reporting of occurrence span code 74 to show the dates of an inpatient admission within an episode is not required.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. If submitting an adjustment (type of bill 3x7) to a previously paid HH PPS claim, enter the control number assigned to the original HH PPS claim here. Insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims systems will match all HH PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically. Providers do not need to submit an ICN/DCN on all HH PPS claims, only on adjustments to paid claims.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLs 39-41. Value Codes and Amounts
Required. Home health episode payments must be based upon the site at which the beneficiary is served. Claims will not be processed without the following value code:

| Code | Title | Definition |
|---|---|---|
| 61 | Location Where Service is Furnished (HHA and Hospice) | MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. |

FLs 39-41. Value Codes and Amounts (Cont.)
For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.

Optional. Enter any NUBC approved code to describe other values that apply to the claim. Code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use FLs 39a through 41a before FLs 39b through 41b (i.e., the first line is used before the second line).

FL 42 and 43 Revenue Code and Revenue Description
Required. Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims systems will reject the claim.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), report one or more additional 0023 revenue code lines to reflect each change. Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary which changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero charges in FL 46. See Section 475.1, FL 44, for more detailed information on the HIPPS code.

Claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 42X, 43X, 44X, 55X, 56X and 57X) must be reported as a separate line. Any of the following revenue codes may be used:

27X Medical/Surgical Supplies. (Also see 62X, an extension of 27X.)

Code indicates the charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | MED-SUR SUPPLIES |
| 1 - Nonsterile Supply | NONSTER SUPPLY |
| 2 - Sterile Supply | STERILE SUPPLY |
| 3 - Take Home Supplies | TAKEHOME SUPPLY |
| 4 - Prosthetic/Orthotic Devices | PROSTH/ORTH DEV |
| 5 - Pace maker | PACE MAKER |
| 6 - Intraocular Lens | INTR OC LENS |
| 7 - Oxygen-Take Home | 02/TAKEHOME |
| 8 - Other Implants | SUPPLY/IMPLANTS |
| 9 - Other Supplies/Devices | SUPPLY/OTHER |

Required detail: With the exception of revenue code 274, only service units and a charge must be

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

reported with this revenue code. If also reporting revenue code 623 to separately and specifically identify wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for the 623 revenue code line and other supply revenue codes are mutually exclusive. Revenue code 274 requires a HCPCS code, the date of service, service units and a charge amount

42X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Rationale: Permits identification of particular services.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | PHYSICAL THERP |
| 1 - Visit Charge | PHYS THERP/VISIT |
| 2 - Hourly Charge | PHYS THERP/HOUR |
| 3 - Group Rate | PHYS THERP/GROUP |
| 4 - Evaluation or Re-evaluation | PHYS THERP/EVAL |
| 9 - Other Physical Therapy | OTHER PHYS THERP |

Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

43X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | OCCUPATION THER |
| 1 - Visit Charge | OCCUP THERP/VISIT |
| 2 - Hourly Charge | OCCUP THERP/HOUR |
| 3 - Group Rate | OCCUP THERP/GROUP |
| 4 - Evaluation or Re-evaluation | OCCUP THERP/EVAL |
| 9 - Other Occupational Therapy (may include restorative therapy) | OTHER OCCUP THER |

Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | SPEECH PATHOL |
| 1 - Visit Charge | SPEECH PATH/VISIT |
| 2 - Hourly Charge | SPEECH PATH/HOUR |
| 3 - Group Rate | SPEECH PATH/GROUP |
| 4 - Evaluation or Re-evaluation | SPEECH PATH/EVAL |
| 9 - Other Speech-Language Pathology | OTHER SPEECH PAT |

Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | SKILLED NURSING |
| 1 - Visit Charge | SKILLED NURS/VISIT |
| 2 - Hourly Charge | SKILLED NURS/HOUR |
| 9 - Other Skilled Nursing | SKILLED NURS/OTHER |

Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | MED SOCIAL SVS |
| 1 - Visit Charge | MED SOC SERV/VISIT |
| 2 - Hourly Charge | MED SOC SERV/HOUR |
| 9 - Other Med. Soc. Services | MED SOC SERV/OTHER |

Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

57X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | AIDE/HOME HEALTH |
| 1 - Visit Charge | AIDE/HOME HLTH/VISIT |
| 2 - Hourly Charge | AIDE/HOME HLTH/HOUR |
| 9 - Other Home Health Aide | AIDE/HOME HLTH/OTHER |

Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

**NOTE:** Revenue codes 58X and 59X may no longer be reported as covered on Medicare home health claims under HH PPS. If reporting these codes, report all charges as non-covered. Revenue code 624 may no longer be reported on Medicare home health claims under HH PPS.

Optional:

Revenue codes for optional billing of DME:

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see §463.

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

29X Durable Medical Equipment (DME) (Other Than Renal)

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | MED EQUIP/DURAB |
| 1 - Rental | MED EQUIP/RENT |
| 2 - Purchase of New DME | MED EQUIP/NEW |
| 3 - Purchase of Used DME | MED EQUIP/USED |
| 4 - Supplies/Drugs for DME Effectiveness (HHAs Only) | MED EQUIP/SUPPLIES/DRUGS |
| 9 - Other Equipment | MED EQUIP/OTHER |

Required detail: the applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one.

60X Oxygen (Home Health)

Code indicates charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292, or 293.

Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | 02/HOME HEALTH |
| 1 - Oxygen - State/Equip/Suppl or Cont | 02/EQUIP/SUPPL/CONT |
| 2 - Oxygen - Stat/Equip/Suppl Under 1 LPM | 02/STAT EQUIP/UNDER 1 LPM |
| 3 - Oxygen - Stat/Equip/Over 4 LPM | 02/STAT EQUIP/OVER 4 LPM |
| 4 - Oxygen - Portable Add-on | 02/STAT EQUIP/PORT ADD-ON |

Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

FL 42 and 43 Revenue Code and Revenue Description (Cont.)

Revenue code for optional reporting of wound care supplies:

62X Medical/Surgical Supplies - Extension of 27X

Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed.

| Subcategory | Standard Abbreviation |
|---|---|
| 3 - Surgical Dressings | SURG DRESSING |

Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, ensure that the charge amounts for the two revenue code lines are mutually exclusive.

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 623. Notwithstanding the standard abbreviation "surg dressings", use this line item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Section 206.4 defines routine vs. nonroutine supplies. Continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist HCFA's future refinement work if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

You may continue to report a “Total” line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum of charges billed. Medicare claims systems will assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates
Required. On the earliest dated 0023 revenue code line, report the HIPPS code (See §475.1 for definition of HIPPS codes) which was reported on the RAP. On claims reflecting a significant change in condition (SCIC), report on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43.

FL 45. Service Date
Required. On each 0023 revenue code line, report the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, report service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43 above.

FL 46. Units of Service
Required. Do not report units of service on 0023 revenue code lines. For line items detailing all services within the episode period, report units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. For the revenue codes that represent home health visits (42x, 43x, 44x, 55x, 56x, and 57x) report as units of service a number of fifteen minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15 minute increment.

FL 47. Total Charges
Required. Zero charges must be reported on the 0023 revenue code line. Medicare claims systems will place the reimbursement amount for the claim in this field on the electronic claim record.

For other line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. Medicare claims systems will not make any payment determinations based upon submitted charge amounts.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. Report all non-covered charges, including no-payment claims.

Claims with Both Covered and Non-Covered Charges.-- Report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. On the UB-92 flat file, use record type 61, Field No. 10 (total charges) and Field No. 11 (non-covered charges).

HHA Bills with All Non-Covered Charges-- Submit claims when all of the charges on the claim are non-covered (no-payment claim). Complete all items on a no-payment claim in accordance with instructions for completing payment claims with the exception that all charges are reported as non-covered.

Examples of Completed FLs 42 through 48.--The following provides examples of revenue code lines should be completed based on the reporting requirements above.

For the UB-92 Flat File:
Report the multiple 0023 lines in a SCIC situation as follows:

| Record Type | Revenue Code | HCPCS | Date of Service | Units | Total Charges | Non-Covered Charges |
|---|---|---|---|---|---|---|
| 61 | 0023 | HAEJ1 | 20001001 | | 0.00 | |
| 61 | 0023 | HAFM1 | 20001025 | | 0.00 | |

Report service revenue code lines as follows:

| Record Type | Revenue Code | HCPCS | Date of Service | Units | Total Charges | Non-Covered Charges |
|---|---|---|---|---|---|---|
| 61 | 0270 | | | 8 | 84.73 | |
| 61 | 0291 | K0006 | 20001001 | 1 | 120.00 | |
| 61 | 0420 | G0151 | 20001005 | 3 | 155.00 | |
| 61 | 0430 | G0152 | 20001007 | 4 | 160.00 | |
| 61 | 0440 | G0153 | 20001009 | 4 | 175.00 | |

| Record Type | Revenue Code | HCPCS | Date of Service | Units | Total Charges | Non-Covered Charges |
|---|---|---|---|---|---|---|
| 61 | 0550 | G0154 | 20001012 | 1 | 140.00 | |
| 61 | 0560 | G0155 | 20001014 | 8 | 200.00 | |
| 61 | 0570 | G0156 | 20001016 | 3 | 65.00 | |
| 61 | 0580 | | 20001018 | 3 | 0.00 | 75.00 |
| 61 | 0623 | | | 5 | 47.75 | |

For the Hard Copy Form HCFA-1450 (UB-92):
Report the multiple 0023 lines in a SCIC situation as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 | FL48 |
|---|---|---|---|---|---|
| 0023 | HAEJ1 | 10012000 | | 0.00 | |
| 0023 | HAFM1 | 10012000 | | 0.00 | |

Report additional revenue code lines as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 | FL48 |
|---|---|---|---|---|---|
| 270 | | | 8 | 84.73 | |
| 291 | K0006 | 10012000 | 1 | 120.00 | |
| 420 | G0151 | 10052000 | 3 | 155.00 | |
| 430 | G0152 | 10072000 | 4 | 160.00 | |
| 440 | G0153 | 10092000 | 4 | 175.00 | |
| 550 | G0154 | 10122000 | 1 | 140.00 | |
| 560 | G0155 | 10142000 | 8 | 200.00 | |
| 570 | G0156 | 10162000 | 3 | 65.00 | |
| 580 | | 10182000 | 3 | 0.00 | 75.00 |
| 623 | | | 5 | 47.75 | |

FL 49. Untitled
Not Required.

FLs 50A, B, and C. Payer Identification
Required. If Medicare is the primary payer, enter "Medicare" on line A. When Medicare is entered on line 50A, this indicates that you have developed for other insurance coverage and have determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. See §§248, 250, 25l, 252, and 253 to determine when Medicare is not the primary payer. Conditional and other payments for Medicare Secondary Payer (MSP) situations will be made based on the HH PPS claim.

FL 51. Medicare Provider Number
Required. Enter the six position alphanumeric “number” assigned by Medicare. It must be entered on the same line as “Medicare” in FL 50.

FL 51. Medicare Provider Number (Cont.)
If the Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. (See §432.) In this case, report the original provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Not Required.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56. (Untitled)
Not Required
.

FL 57. (Untitled)
Not Required.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his HI card or other Medicare notice.

Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and you are requesting payment because:

- Another payer paid some of the charges and Medicare is secondarily liable for the remainder;
- Another payer denied the claim; or
- You are requesting conditional payment as described in §§494G, 495F, 496F, or 497F.

If that person is the patient, enter "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and their spouses (see §497);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a Medicare Coordination Period (see §252);
- An auto-medical, no-fault, or liability insurer (see §251);
- LGHPs for disabled beneficiaries; or
- WC including BL (see §250).

Fls 59A, B, and C. Patient's Relationship To Insured
Required. If claiming payment under any of the circumstances described under FLs 58A, B, or C, enter the code indicating the relationship of the patient to the identified insured.

Code Structure:

| Code | Title | Definition |
|---|---|---|
| 0l | Patient is the Insured | Self-explanatory |
| 02 | Spouse | Self-explanatory |
| 03 | Natural Child/Insured Financial Responsibility | Self-explanatory |
| 04 | Natural Child/Insured Does Not Have Financial Responsibility | Self-explanatory |
| 05 | Step Child | Self-explanatory |
| 06 | Foster Child | Self-explanatory |
| 08 | Employee | Patient is employed by the insured. |
| 09 | Unknown | Patient's relationship to the insured is unknown. |
| l5 | Injured Plaintiff | Patient is claiming insurance as a result of injury covered by insured. |

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

If claiming a conditional payment under any of the circumstances described under FLs 58A, B, or C, enter the involved claim number for that coverage on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where you are claiming a payment under the circumstances described in FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

FLs 62A, B, and C. Insurance Group Number
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

FL 63. Treatment Authorization Code
Required. Enter the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

Copy these OASIS items exactly as they appear on the OASIS assessment, matching the date formats used on the assessment. Do not change any item from what is required by OASIS reporting rules for purposes of submitting the claim to Medicare.

The investigational device (IDE) revenue code, 624, will not be allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Required. Where you are claiming a payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

Code Structure:

| Code | Title | Definition |
|---|---|---|
| 1 | Employed Full Time | Individual claimed full time employment. |
| 2 | Employed Part Time | Individual claimed part time employment. |
| 3 | Not Employed | Individual states that he or she is not employed full time or part time. |
| 4 | Self-employed | Self-explanatory. |
| 5 | Retired | Self-explanatory. |
| 6 | On Active Military Duty | Self-explanatory. |
| 7-8 | | Reserved for national assignment. |
| 9 | Unknown | Individual’s employment status is unknown. |

FL 65. Employer Name
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc. in which the employer is located.

FL 67. Principal Diagnosis Code
Required. Enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, do not fill with zeros.

The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis), and on the Form HCFA- 485, form item 11 (ICD-9-CM/Principle Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FLs 68-75. Other Diagnoses Codes
Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form HCFA-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the Form HCFA-485, form item 13, may be reported in FLs 68-75 on the claim if they are reported in the narrative form item 21 of the Form HCFA-485.

In most cases the other diagnoses codes on the claim will match those submitted on the RAP. In SCIC cases, however, the other diagnoses codes reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FL 76. Admitting Diagnosis
Not Required.

FL 77. E-Code
Not Required.

FL 78. Untitled
Not Required.

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Not Required.

FL 81. Other Procedure Codes and Dates
Not Required.

FL 82. Attending/Requesting Physician I.D.
Required. Enter the UPIN and name of the attending physician that has signed the plan of care.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks
Not Required.

FL 85. Provider Representative Signature
Not Required.

FL 86. Date
Not Required.

475.3 HH PPPS Claims When No RAP is Submitted - "No-RAP" LUPAs.--All episodes for which payment based on HIPPS codes will be made, a RAP and a claim must be submitted. However, there may be circumstances in which an HHA is aware prior to billing Medicare that four or fewer visits will be supplied in the episode. In these cases, since the HHA is aware that the episode will be paid a low utilization payment adjustment (LUPA) based on national standardized per visit rates, only a claim may be submitted for the episode. These claims will be referred to as "No-RAP LUPA" claims.

HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in a recoupment of funds for the episode since the payment for a RAP will exceed payment for four or fewer visits. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim causes the creation of an episode record in CWF and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk of not being established as the primary HHA for that period.

If the agency chooses to submit this "No-RAP LUPA" claim, the claim form should be coded like other claims as described in §475.2.

475.4 HH PPS Pricer Program.--

A. General.--Effective for dates of service on or after October 1, 2000, all home health services billed on type of bill 32x or 33x will be reimbursed based on calculations made by the HH Pricer. The HH Pricer operates as a module within HCFA's standard systems. The HH Pricer makes all reimbursement calculations applicable under HH PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, therapy threshold adjustments, significant change in condition (SCIC) adjustments and outlier payments. (See §§467.22-467.30) Standard systems must send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the standard systems.

The following describes the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make reimbursement determinations. No part of the Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare. The following is presented informationally, in order to help HHAs understand their HH PPS payments and how they are determined.

B. Input/Output Record Layout.--The HH Pricer input/output file will be 450 bytes in length. The required data and format are shown below:

| File Position | Format | Title | Description |
|---|---|---|---|
| 1-10 | X(10) | NPI | This field will be used for the National Provider Identifier when it is implemented. |
| 11-22 | X(12) | HIC | Input item: The Health Insurance Claim number of the beneficiary, copied from FL 60 of the claim form. |
| 23-28 | X(6) | PROV-NO | Input item: The six digit OSCAR system provider number, copied from FL 51 of the claim form. |
| 29-31 | X(3) | TOB | Input item: The type of bill code, copied from FL 4 of the claim form. |
| 32 | X | PEP-INDICATOR | Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Standard systems must set a Y if the patient status code in FL 22 of the claim is 06. An N is set in all other cases. |
| 33-35 | 9(3) | PEP-DAYS | Input item: The number of days to be used for PEP payment calculation. Standard systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim. |
| 36 | X | INIT-PAY-INDICATOR | Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the standard systems from field 19 of the provider specific file. Valid values: |

| File Position | Format | Title | Description |
|---|---|---|---|
| | | | 0 = Make normal percentage payment<br>1 = Pay 0% |
| 37-43 | X(7) | FILLER | Blank. |
| 44-46 | X(3) | FILLER | Blank. |
| 47-50 | X(4) | MSA | Input item: The metropolitan statistical area (MSA) code, copied from the value code 61 amount in FLs 39-41 of the claim form. |
| 51-52 | X(2) | FILLER | Blank. |
| 53-60 | X(8) | SERV-FROM-DATE | Input item: The statement covers period "From" date, copied from FL 6 of the claim form. Date format must be CCYYMMDD. |
| 61-68 | X(8) | SERV-THRU DATE | Input item: The statement covers period “Through” date, copied from FL 6 of the claim form. Date format must be CCYYMMDD. |
| 69-76 | X(8) | ADMIT-DATE | Input item: The admission date, copied from FL 17 of the claim form. Date format must be CCYYMMDD. |
| 77 | X | HRG-MED-REVIEW-INDICATOR | Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Standard systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases. |
| 78-82 | X(5) | HRG-INPUT-CODE | Input item: Standard systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, standard systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer. |
| 83-87 | X(5) | HRG-OUTPUT-CODE | Output item: The HIPPS code used by the Pricer to determine the reimbursement amount on the claim. This code will match the input code in all cases except when the therapy threshold for the claim was not met. |
| 88-90 | 9(3) | HRG-NO-OF-DAYS | Input item: A number of days calculated by the standard systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and includingthe last line item service date provided under that HIPPS code. |

| File Position | Format | Title | Description |
|---|---|---|---|
| 91-96 | 9(2)V9(4) | HRG-WGTS | Output item: The weight used by the Pricer to determine the reimbursement amount on the claim. |
| 97-105 | 9(7)V9(2) | HRG-PAY | Output item: The reimbursement amount calculated by the Pricer for each HIPPS code on the claim. |
| 106-250 | Defined above | Additional HRG data | Five more occurences of all HRG/HIPPS code related fields defined above, since up to 6 HIPPS codes can be automatically processed for payment in any one episode. |
| 251-254 | X(4) | REVENUE-CODE | Input item: One of the six home health discipline revenue codes (42x, 43x, 44x, 55x, 56x, 57x). All six revenue codes must be passed by the standard systems even if the revenue codes are not present on the claim. |
| 255-257 | 9(3) | REVENUE-QTY-COV-VISITS | Input item: A quantity of covered visits corresponding to each of the six revenue codes. Standard systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code. |
| 258-266 | 9(7)V9(2) | REVENUE-DOLL-RATE | Output item: The dollar rates used by the Pricer to calculate the reimbursement for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any. |
| 267-275 | 9(7)V9(2) | REVENUE-COST | Output item: The dollar amount determined by the Pricer to be the reimbursement for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any. |
| 276-400 | Defined above | Additional REVENUE data | Five more occurrences of all REVENUE related data defined above. |

| File Position | Format | Title | Description |
|---|---|---|---|
| 401-402 | 9(2) | PAY-RTC | Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.<br><br>Payment return codes:<br><br>00 = Final payment where no outlier applies<br>01 = Final payment where outlier applies<br>03 = Initial percentage payment, 0%<br>04 = Initial percentage payment, 50%<br>05 = Initial percentage payment, 60%<br>06 = LUPA payment only<br><br>Error return codes:<br><br>10 = Invalid TOB<br>15 = Invalid PEP Days<br>20 = PEP indicator invalid<br>25 = Med review indicator invalid<br>30 = Invalid MSA code<br>35 = Invalid Initial Pymnt Indicator<br>40 = Dates < Oct 1, 2000 or invalid<br>70 = Invalid HRG code<br>75 = No HRG present in 1st occurrence<br>80 = Invalid revenue code<br>85 = No revenue code present on 3x9 or adjustment TOB |
| 403-407 | 9(5) | REVENUE-SUM 1-3-QTY-THR | Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 42x, 43x, and 44x. |
| 408-412 | 9(5) | REVENUE-SUM 1-6- QTY-ALL | Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a low utilization payment adjustment (LUPA). This amount will be the total of all the covered visit quantities input will all six HH discipline revenue codes. |
| 413-421 | 9(7)V9(2) | OUTLIER-PAYMENT | Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. |
| 422-430 | 9(7)V9(2) | TOTAL-PAYMENT | Output item: The total reimbursement determined by the Pricer to be due on the RAP or claim. |
| 431-450 | X(20) | FILLER | Blank. |

Input records on RAPs will include all input items except for “REVENUE” related items, and input records on RAPs will never report more than one occurrence of “HRG” related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The standard systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for each HIPPS code will be placed in the total charges and the covered charges field of the appropriate revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount. If the return code is 06 (indicating a low utilization payment adjustment), the standard systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice.

C. Decision Logic Used By The Pricer On RAPs.--On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

1. Find weight for "HRG-INPUT-CODE" from the table of weights for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply the weight times Federal standard episode rate for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and non-labor portions of the payment established by HCFA. Multiply the case-mix adjusted rate by .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by .22332 to determine the non-labor portion.

Sum the labor and non-labor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

2. a. If the "INIT-PYMNT-INDICATOR" equals 0, perform the following:

Determine if the “SERV-FROM-DATE" of the record is equal to the "ADMIT-DATE." If yes, multiply the wage index and case-mix adjusted payment by .6 Return the resulting amount as “HRG-PAY” and as “TOTAL-PAYMENT" with return code 05.

If no, multiply the wage index and case-mix adjusted payment by .5 Return the resulting amount as “HRG-PAY” and as "TOTAL-PAYMENT" with return code 04.

b. If the "INIT-PYMNT-INDICATOR" = 1, perform the following:

Multiply the wage index and case-mix adjusted payment by .0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 03.

D. Decision Logic Used By The Pricer On Claims.--On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P or 33P (that is, all provider submitted claims and provider or intermediary initiated adjustments) Pricer will perform the following calculations in the numbered order:

1. Low Utilization Payment Adjustment (LUPA) calculation.

a. If the "REVENUE-SUM1-6-QTY-ALL" (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue

code table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the six products. The result is the total payment for the episode. Return this amount in the "TOTAL-PAYMENT" field with return code 06. No further calculations are required.

b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

2. Therapy threshold determination.

a. If the "REVENUE-SUM1-3-QTY-THR" (the total of the quantities associated with therapy revenue codes, 42x, 43x, 44x, which will be passed from the standard systems sorted in this order) is less than 10, perform the following:

If the "MED-REVIEW-INDICATOR" is a Y for any HRG, do not alter the HIPPS code reported in “HRG-INPUT-CODE.” Copy that code to the "HRG-OUTPUT-CODE" field. Proceed to the next HRG occurrence.

If "MED-REVIEW-INDICATOR" is an N for any HRG, read the table of HIPPS codes for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be meet for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

If the code in the first column does not match the code in the second column (indicating the therapy threshold is unmet for that code), place the code from the second column in the "HRG-OUTPUT-CODE" field.

b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the codes in the “HRG-OUTPUT-CODE fields for all further calculations involving each HRG.

3. HRG payment calculations.

a. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is an N:

Find the weight for the "HRG-OUTPUT-CODE" from weight table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by .22332 to determine the non-labor portion. Sum the labor and non-labor portions. The sum is the wage index and case-mix adjusted payment for this HRG.
Proceed to the outlier calculation (see 4 below).

b. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (see 4 below).

c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is an N:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the "HRG-NO-OF-DAYS" field for that code divided by sixty. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will returned in separate occurrence of the “HRG-PAY" fields, so that the standard systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the "PEP -DAYS" field divided by 60. Multiply the result by the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field. Repeat this for up to six occurrences of "HRG-CODE." These amounts will returned separately in the corresponding "HRG-PAY" fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

4. Outlier calculation:

a. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the “SERV-THRU-DATE” falls, using the MSA code in the “MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA code in the “MSA1" field. The result is the wage index adjusted imputed cost for the episode.

c. Subtract the outlier threshold for the episode from the imputed cost for the episode.

d. If the result is greater than $0.00, calculate .80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the “TOTAL-PAYMENT” field, with return code 01.

e. If the result is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the “TOTAL-PAYMENT” field, with return code 00.

E. Annual Updates to the HH Pricer.--Rate and weight information used by the HH Pricer is updated annually. Updates occur each October, to reflect the Federal fiscal year. The following update items will be published annually in the ***Federal Register***:

- The Federal standard episode amount;
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights to be used for each HRG;
- A table of national standardized per visit rates;
- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and non-labor percentages.

## 476. BILLING FOR ORAL CANCER DRUGS

Section 13553 of OBRA 1993 provides coverage of self-administrable oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic agent furnished beginning January 1, 1994. To be covered, an oral cancer drug must:

- Be prescribed by a physician or practitioner as an anti-cancer chemotherapeutic agent;
- Be a drug or biological approved by the Food and Drug Administration (FDA);
- Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service. The oral anti-cancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug and Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium;
- Be used for the same indications (including off-label uses) as the non-self-administrable version of the drug; and
- Be reasonable and necessary for the individual patient.

| Generic/Chemical Name | How Supplied | HCPCs |
|---|---|---|
| Cyclophosphamide | 25 mg/ORAL | J8530 |
| | 50 mg/ORAL | J8530* |
| Etoposide | 50 mg/ORAL | J8560 |
| Methotrexate | 2.5 mg/ORAL | J8610 |
| Melphalan | 2 mg/ORAL | J8600 |
| Prescription Drug, Chemotherapeutic, NOS | Oral | J8999 |

* Treat 50 mg. as 2 units of 25 mg. for billing purposes.

Part B of Medicare pays 80 percent of the reasonable cost of oral cancer drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on the Form HCFA-1450, type of bill, or FL 4, 34x only for homebound beneficiaries as of October 1, 2000, or its electronic equivalent. Enter revenue code 636 in FL 42, the name and HCPCS of the oral drug in FLs 43 and 44, and the number of tablets or capsules in FL 46 of the UB-92. An exception is made for 50mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units. Complete the remaining items in accordance with regular billing instructions. A cancer diagnosis must be entered in FLs 67-75 of the UB-92 for coverage of an oral cancer drug. Medicare does not pay for a visit solely for administration of oral cancer drugs.

476.1 Self-Administered Antiemetic Drugs.--Effective with dates of service on or after January 24, 1996, Medicare pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists. The self-administered antiemetic drug is covered as a necessary means for the administration of the oral anticancer drug (similar to a syringe and needle necessary for injectable administration). Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anticancer drug in high doses for longer periods are not covered. In addition, self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption.

Part B of Medicare pays 80 percent of the reasonable cost of self-administered antiemetic drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on Form HCFA-1450, type of bill, or FL 4, 34x only for homebound beneficiaries as of October 1, 2000, or its electronic equivalent. Enter revenue code 636 in FL 42. For claims with dates of service on or after January 24, 1996 through March 31, 1996, enter HCPCS code J3490 in FL 44. For dates of service on or after April 1, 1996, enter one of the following HCPCS codes in FL 44, as appropriate:

K0415 Prescription antiemetic drug, oral, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified; or

K0416 Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anticancer drug, not otherwise specified.

Enter the name of the self-administered antiemetic drug in FL43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit. Complete the remaining items in accordance with regular billing instructions. Medicare does not pay for a visit solely for administration of self-administered antiemetic drugs in conjunction with oral anticancer drugs.

Claims are edited to assure that the beneficiary is receiving the self-administered antiemetic drug in conjunction with a Medicare covered oral anticancer drug.

## 477. BILLING FOR AMBULANCE SERVICES

Your intermediary processes claims for ambulance services provided under arrangement between you and an ambulance company or ambulance services furnished directly by you.

Furnish the following data when needed by your intermediary. Your intermediary will make arrangement with you about the method and media for submitting the data, i.e., with the claim or upon your intermediary's written request, paper or the electronic record, Addendums A and B, record type 75.

- A detailed statement of the condition necessitating the ambulance service;
- Your statement indicating whether or not the patient was admitted as an inpatient. If applicable, show the name and address of the facility;
- Name and address of certifying physician;

- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General.--Section 4531(a)(1) of the Balanced Budget Act (BBA) of 1997 provides that in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor equal to the consumer price index for all urban consumers (CPI-U) minus 1 percent, effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997 and September 30, 1998), FFY 1999, and as much of FFY 2000 as precedes January 1, 2000.

The following provides billing instructions for implementing the above provision and is needed to determine the reasonable cost per ambulance trip. You are to bill for ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

B. Applicable Bill Types.--The appropriate bill type is only 34x for home health claims as of October 1, 2000.

C. Revenue Code/HCPCS Reporting.--You must report revenue code 54X and one of the following HCFA Common Procedure Coding System (HCPCS) codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period: A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330. In addition, report one of the following mileage HCPCS codes: A0380 or A0390. No other HCPCS codes are acceptable for reporting ambulance services and mileage. For purposes of revenue code reporting, report one of the following codes: 540, 542, 543, 545, 546, or 548. Do not report revenue codes 541, 544, 547, and 549.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, you must report revenue code 54X (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is onboard) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are NOT reported.

However, in the case where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. In this situation, report the appropriate HCPCS code of either A0322 (if a basic life support (BLS) vehicle is used) or A0328 (if an advanced life support (ALS) vehicle is used.) Report the mileage HCPCS code A0380 (BLS) or A0390 (ALS) from the point of dispatch to the point of pickup. No further mileage is billed (e.g., the mileage after the ambulance arrives at the point of pickup is neither billed nor covered.) (See §221.3.G for a more detailed explanation.)

D. Modifier Reporting.--You must report an origin and destination modifier for each ambulance trip provided in FL 44 "HCPCS/Rates". Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

- o D: Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes;
- o E: Residential, Domiciliary, Custodial facility (other than an 1819 facility);
- o G: Hospital based dialysis facility (hospital or hospital related);
- o H: Hospital;
- o I: Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- o J: Non-hospital based dialysis facility;
- o N: Skilled Nursing Facility (SNF) (1819 facility);
- o P: Physician's office (Includes HMO non-hospital facility, clinic, etc.);
- o R: Residence;
- o S: Scene of accident or acute event; or
- o X: (Destination Code Only) intermediate stop at physician's office en route to the hospital. (Includes HMO non-hospital facility, clinic, etc.)

In addition, you must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

- o QM: Ambulance service provided under arrangement by a provider of services; or
- o QN: Ambulance service furnished directly by a provider of services.

E. Line-Item Dates of Service Reporting.--You are required to report line-item dates of service per revenue code line. This means that you must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in FL 45 "Service Date" (MMDDYY). (See examples below.)

F. Service Units Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 46 "Service Units" each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, you must also report the number of loaded miles. (See examples below.) (For an exception to the rule for loaded miles see §221.3.G.)

G. Total Charges Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0380 or A0390, report the actual charge for mileage.

**NOTE:** There are cases where you do not incur any cost for mileage (e.g., you receive a subsidy from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity.) In these situations, report the ambulance trip in accordance with Subsections C through G above. In addition, for purposes of reporting mileage, report on a separate line item the appropriate HCPCS code, modifiers, and units. For the related charges, report $1.00 in FL 48 "Non-covered Charges." Prior to submitting the claim to CWF, your intermediary will remove the entire revenue code line containing the mileage amount reported in FL 48 "Non-covered Charges" to avoid nonacceptance of the claim.

Examples.--The following provides examples of how bills for ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by you. Ambulance services provided under arrangement between you and an ambulance company are reported in the same manner except you report a QM modifier instead of a QN modifier.

Example 1: Claim containing only one ambulance trip.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | Modifier #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 540 | A0320 | RH | QN | 082797 | 1 (trip) | 100.00 |
| 61 | 540 | A0380 | RH | QN | 082797 | 4 (mileage) | 8.00 |

For the hard copy UB-92 (HCFA-1450), report as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|
| 540 | A0320RHQN | 082797 | 1 (trip) | 100.00 |
| 540 | A0380RHQN | 082797 | 4 (mileage) | 8.00 |

Example 2: Claim containing multiple ambulance trips.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | Modifier #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 540 | A0322 | RH | QN | 082897 | 1 (trip) | 100.00 |
| 61 | 540 | A0380 | RH | QN | 082897 | 2 (mileage) | 4.00 |
| 61 | 540 | A0324 | RH | QN | 082997 | 1 (trip) | 400.00 |
| 61 | 540 | A0390 | RH | QN | 082997 | 3 (mileage) | 6.00 |
| 61 | 540 | A0326 | RH | QN | 083097 | 1 (trip) | 500.00 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 61 | 540 | | A0390 | RH | QN | 083097 | 5 (mileage) | 10.00 |

Rev. 296 74.1

For the hard copy UB-92 (Form HCFA-1450), report as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|
| 540 | A0322RHQN | 082897 | 1 (trip) | 100.00 |
| 540 | A0380RHQN | 082897 | 2 (mileage) | 4.00 |
| 540 | A0324RHQN | 082997 | 1 (trip) | 400.00 |
| 540 | A0390RHQN | 082997 | 3 (mileage) | 6.00 |
| 540 | A0326RHQN | 083097 | 1 (trip) | 500.00 |
| 540 | A0390RHQN | 083097 | 5 (mileage) | 10.00 |

Example 3: Claim containing more than one ambulance trip provided on the same day.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | Modifier #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 540 | A0322 | RH | QN | 090297 | 1 (trip) | 100.00 |
| 61 | 540 | A0380 | RH | QN | 090297 | 2 (mileage) | 4.00 |
| 61 | 540 | A0322 | HR | QN | 090297 | 1 (trip) | 100.00 |
| 61 | 540 | A0380 | HR | QN | 090297 | 2 (mileage) | 4.00 |

For the hard copy UB-92 (HCFA-1450), report as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|
| 540 | A0322RHQN | 090297 | 1 (trip) | 100.00 |
| 540 | A0380RHQN | 090297 | 2 (mileage) | 4.00 |
| 540 | A0322HRQN | 090297 | 1 (trip) | 100.00 |
| 540 | A0380HRQN | 090297 | 2 (mileage) | 4.00 |

H. Edits.--Your intermediary will edit to assure proper reporting as follows:

o Each pair of revenue codes 54X must have one of the following ambulance HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330 and one of the following mileage HCPCS codes A0380 or A0390;

o The presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 54X;

o The units field is completed for every line item containing revenue code 54X; and

o Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 and A0330 always equal “1”.

Retention and Destruction of Health Insurance Records

## 480. RETENTION OF HEALTH INSURANCE RECORDS

Maintain health insurance materials related to services rendered under title XVIII for the prescribed retention periods outlined below unless State law stipulates a longer period. They must be available for review by HCFA, intermediary, DHHS Audit or other specially designated components for bill review, audit, and other references during the retention period.

A. Categories of Health Insurance Records to Be Retained.--If these records are microfilmed, also see subsection C below.

o Billing Material.--Your copies of forms HCFA-1450 and any other supporting documents, charge slips, and other business and accounting records referring to specific claims.

o Cost Report Material.--All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, canceled checks, copies of material used in preparing annual cost reports and other similar cost reports of dealings with outside sources of medical supplies and services or with related organizations.

o Medical Record Material.--Physicians' certifications and recertifications, clinical and other medical records relating to health insurance claims.

o HHA Physician Material.--Your physician agreements on which Part A-Part B allocations are based.

B. Retention Period.--Retain clinical records for 5 years after the month the cost report to which the records apply is filed with your intermediary, unless State law stipulates a longer period of time.

After payment of the bill, you need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in subsection A. These records, punch cards, adding machine tapes, internal controls, or other similar material are not required for period retention.

C. Microfilming Health Insurance Records.--You may at your option microfilm all health insurance records.

o Billing material (Form HCFA-1450) with any attachments that you have furnished your intermediary may be destroyed providing the microfilm accurately reproduces all original documents.

o Retain copies of all other categories of health insurance records listed in subsection A in their original form. If you microfilm these records, store them in a low cost facility for the retention period.

480.l Destruction of Health Insurance Records.--When material no longer needs to be retained for title XVIII purposes, it may be destroyed unless State law stipulates a longer period of retention.

To insure the confidentially of the records, destroy them by shredding, mutilation or other protective measures. Their final disposition of the records may provide for their sale or salvage. Report monies as an adjustment to expense in the cost report for the year sold.

## Time Limitation for Medical Information Requests

483. REQUEST FOR ADDITIONAL MEDICAL INFORMATION

A. Requests for Additional Medical Documentation.--When a determination of Medicare coverage cannot be made based upon the information on the claim and any attachments submitted with it:

- The intermediary will request additional documentation; and
- The claim will be pended for 30 days.

B. Failure to Submit Documentation.--

- The intermediary will deny the claim for lack of medical necessity if the information is not received within 35 days after the date of the request. This allows 5 days mail time.

- You will be held liable for the denied services. Do not charge the beneficiary for coinsurance and deductible amounts. The beneficiary is responsible only for charges for services not covered by Medicare.

- The intermediary will send a denial letter to the beneficiary with a copy to you. The denial letter will include limitation of liability and appeals information.

- Once the claim has been denied, you must submit a formal request for reconsideration if you submit the requested information.

## 485. HH PPS REMITTANCE ADVICE INSTRUCTIONS

485.1 Scope of Remittance Changes for HH PPS.--Section 3752 of the Medicare Intermediary Manual contains instructions for HCFA use of the ANSI ASC X12 835 (835) electronic remittance advice for the implementation of the outpatient prospective payment system (OPPS), and lays the foundation for changes in the remittance format necessitated by HH PPS. Additional HH PPS changes in specific versions of the electronic remittance format are presented in the next few subsections of this manual, and are additions to current requirements for the remittance for OPPS. However, HCFA will not make additional paper remittance format changes, 835 version 3051.4A.01 implementation guide changes, or PC-Print changes for HH PPS.

All the statements below on home health billing apply only to types of bill 32x or 33x. HHAs are encouraged to submit all RAPs and claims with type of bill 32x. While the bill classification of 3, as in type of bill 33x, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to a HH PPS claim depending upon a beneficiary's eligibility, Medicare claims systems determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this. Type of bill is reported on form locator 4 on the Form HCFA-1450 (UB-92) claim form.

As with OPPS, detailed service line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data is not reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported by the Fiscal Intermediary Standard System (FISS). The standard paper remittance advice (SPR), and the FISS version 3051.3A and 3030M 835 transactions continue to report claim level summary data. Home health agencies on FISS that wish to receive service line level data must upgrade to version 3051.4A.01 of the 835. Parallel changes have been made to the Arkansas Part A Standard System to support electronic transmission.

485.2 Payment Methodology of the HH PPS Remittance: HIPPS Codes.--HH PPS episode payment is represented by a Health Insurance Prospective Payment System (HIPPS) code on a claim or a Request for Anticipated Payment (RAP). As a general rule, the amount of the first payment for a 60-day HH PPS episode, made in response to a RAP submitted on a claim form and processed like a claim, will be reversed and withheld from the full payment made for the episode, in response to a claim, at the end of the 60 days. Episodes of 4 or fewer visits will be paid using standard per visit rates, rather than on an episode basis.

Due to the expansion of the claim in 2000, two HIPPS codes can appear on a single line item. This new feature is used for HH PPS when, during processing, Medicare finds payment should have been made on a HIPPS other than the one submitted by the provider. In such cases, payment is made on the HIPPS for the line item not previous submitted (the corrected HIPPS). Standard systems carry the corrected HIPPS in the panel code field of the line item. As noted below, the remittance carries both the submitted and paid HIPPS.

485.3 DME and Other Items Not Included in HH PPS Episode Payment.--By law, durable medical equipment (DME) is not included in payment of home health PPS episodes, though episodes are global payment for most other home health services and items. DME must be reported in a separate line/loop for the claim closing an episode. DME may not be included in the Request for Anticipated Payment (RAP) for an episode. DME will continue to be paid under the DME fee schedule as at present. Continue to pay osteoporosis drug, flu injection, vaccines or outpatient benefits delivered by home health agencies, such as splints or casts, separately from home health PPS as 34x type of bill claims.

485.4 835 Version 3051.4A.01 Line Level Reporting Requirements for RAP Payments.--

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-- this number should be 1, representing the from and through dates being the same on the RAP.

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. The only line item receiving Medicare payment on the RAP should be the single 0023 revenue code line.

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, and should not be reported for either the first or the final remittance advice for a HIPPS 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 percentage episode payments.

485.5 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (More than 4 Visits).--

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in §485.4, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

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 1-11 from §485.4 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 27x, 29x, 62x and 623 services, and other services outside the home health benefit that may 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 or other 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 step 2 above, 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.

485.6 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (4 or Fewer Visits).--

1. Follow §485.5 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 or other line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in §485.5 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.

485.7 Instructions for Versions Subsequent to Electronic 835 Version 3051.4A.01.--Unless new specific instructions are released in either new manual instructions or a program memorandum, apply the steps in the three subsection above to future versions of the 835 subsequent to Version 3051.4A.01.

## 489. CREDIT BALANCE REPORTING REQUIREMENT - GENERAL

The Paperwork Burden Reduction Act of 1980 was enacted to inform you about why the Government collects information and how it uses this information. In accordance with §§1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, §1866(a)(1()(C) of the Act requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. In accordance with these provisions, complete a Medicare Credit Balance Report (HCFA-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The HCFA-838 is specifically used to monitor identification and recovery of "credit balances" due to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;

- Paid for services planned but not performed or for non-covered services;

- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or

- A hospital which bills and is paid for outpatient services included in a beneficiary's inpatient claim. Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the HCFA-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to §§300, 302, and 341 that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

489.1 Submitting the HCFA-838.--Submit a completed HCFA-838 to your intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program.

489.2 Completing the HCFA-838.--The HCFA-838 consists of a certification page and a detail page. An officer or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the officer or Administrator sign the form and submit it to attest to this fact.

The detail page requires specific information on each credit balance on a claim-by-claim basis. The detail page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you report. Submit the detail page(s) on a computer diskette, which is available from your FI. Submit the certification page in hard copy.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

**NOTE:** Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Complete the HCFA-838 providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;

- The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;

- The month, day and year of the reporting quarter, e.g., 6/30/92;

- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;

- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and

- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1- The last name and first initial of the Medicare beneficiary, (e.g., Doe, J).

Column 2 - The Medicare Health Insurance Claim Number (HICN) of the Medicare beneficiary.

Column 3 - The 10-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

Column 4 - The 3-digit number explaining the type of bill, e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions in §§473-475.)

Columns 5/6 - The month, day and year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 01/01/93).

Column 7 - The month, day and year (e.g., 01/01/93) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and ICN number correspond to the most recent payment.

Column 8 - An "O" if the claim is for an open Medicare cost reporting period or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)

Column 9 - The amount of the Medicare credit balance that was determined from your patient/accounting records.

Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the HCFA-838 to your intermediary.)

Column 11 - A "C" when you submit a check with the HCFA-838 to repay the credit balance amount shown in column 9, or an "A" if you submit an adjustment request.

Column 12 - The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if you make full payment.

Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons".

Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability. For code description, see §475.)

12 - Working Aged
13 - End Stage Renal Disease
14 - Auto No Fault/Liability
15 - Workers' Compensation
16 - Other Government Program
41 - Black Lung
42 - Department of Veterans Affairs (VA)
43 - Disability

Column 15 - The name and address of the primary insurer identified in column 14.

**NOTE:** Once a credit balance is reported on the HCFA-838, it is not to be reported on a subsequent period report.

489.3 Payment of Amounts Owed Medicare.--Pay all amounts owed Medicare as shown in column 9 of the credit balance report at the time you submit the HCFA-838. (See §489.7.) Make payment by check or by submission of adjustment requests. Submit adjustment requests in hard copy or electronic format.

If you use a check to pay credit balances, submit adjustment requests for the individual credit balances that pertain to open cost reporting periods. Your FI will assure that monies are not collected twice.

If the amount owed Medicare is so large that immediate repayment would cause financial hardship, contact your FI regarding an extended repayment schedule.

Interest is assessed on Medicare credit balances not timely repaid applying 42 CFR 405.376. In part this means:

o Interest accrues on outstanding amounts beginning from the due date of a timely-filed Medicare credit balance report if the report is not accompanied by payment in full.

o Interest is charged on the entire amount shown on a Medicare credit balance report beginning from the day after the report was due if the report is not timely-filed.

o Interest is charged on outstanding amounts beginning from the date a credit balance occurred, in those instances where a credit balance(s) was omitted from a Medicare credit balance report or was not accurately reported.

o Interest will not be charged on Medicare credit balances resulting from MSP provisions until they are past due in accordance with the 60-day repayment provision of 42 CFR 489.20. Once due, interest is assessed on outstanding Medicare credit balances resulting from MSP provisions in the same manner as any other outstanding Medicare credit balance, as discussed above.

489.4 Records Supporting HCFA-838 Data.--You must develop and maintain documentation that shows that each patient record with a credit balance (transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for preparation of the HCFA-838. At a minimum, your procedures should:

- o Identify whether or not the patient is an eligible Medicare beneficiary;
- o Identify other liable insurers and the primary payer; and
- o Adhere to applicable Medicare payment rules.

**NOTE:** A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the HCFA-838 or for not maintaining documentation that adequately supports the credit balance data reported to HCFA. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

489.5 Provider-Based Home Health Agencies (HHAs).--Provider-based HHAs are to submit their HCFA-838 to their Regional Home Health Intermediary even though it may be different from the FI servicing the parent facility.

489.6 Exception for Low Utilization Providers.--Providers with extremely low Medicare utilization do not have to submit a HCFA-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-1, §2414.B, or files less than 25 Medicare claims per year.

489.7 Compliance with MSP Regulations.--MSP regulations at 42 CFR 489.20 require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a HCFA-838 and adherence to HCFA's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the HCFA-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it in the HCFA-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the HCFA-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the HCFA-838, but within the 60 days allowed.

**NEXT PAGE IS 74.15**

EXHIBIT I

**Medicare Credit Balance Report Certification**

The Medicare Credit Balance Report is required under the authority of §§1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

**ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS, OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.**

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by _____(Provider Name(s) and Number(s)) for the calendar quarter ended_____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations, and instructions.

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Public reporting burden for this collection of information is estimated to average 6 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

and to:

Office of Information and Regulatory Affairs
Office of Management and Budget
Washington D.C. 20503.

Paperwork Reduction Project (0938-0600)

EXHIBIT II

This Page is Reserved for
the Medicare Credit Balance Report
(HCFA-838)