MLN Matters®
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The revised Home Health Prospective Payment System Fact Sheet (January 2010), which provides information about coverage of home health services and elements of the Home Health Prospective Payment System, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHlthProsPaymt.pdf on the CMS website.

MLN Matters® Number: MM6757 Revised | Related Change Request (CR) #: 6757

Related CR Release Date: February 5, 2010 | Effective Date: July 1, 2010

Related CR Transmittal #: R1904CP | Implementation Date: July 6, 2010

Coding Patient Transfers under the Home Health Prospective Payment System (HH PPS)

Note: This article was updated on November 20, 2012, to reflect current Web addresses. This article was previously revised on August 8, 2011, to add a reference to MLN Matters® article MM7338 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7338.pdf to alert HH providers to recent manual updates related to HH PPS patient transfers. All other information remains unchanged.

Provider Types Affected

Home Health Agencies (HHAs) submitting claims to Medicare Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6757 which revises Medicare processing of Home Health Prospective Payment System (HH PPS) claims to account for recent changes to the UB-04 code set by the National Uniform Billing Committee (NUBC).

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CAUTION – What You Need to Know

CR 6757 implements changes to Medicare systems in response to NUBC code changes. Point of origin codes B and C are deleted, effective with claims for dates of service on or after July 1, 2010, and a new condition code 47 is created. Medicare system editing of HH episodes is also revised to accommodate these changes.

GO – What You Need to Do

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

Background

When the National Uniform Billing Committee (NUBC) replaced the UB-92 institutional claim form with the UB-04, they made several changes to the names and definitions of claim fields. These changes included:

- Redefining the 'Source of Admission' field as 'Point of Origin for Admission or Visit'; and
- Specifying that codes in **this field must represent a place** rather than a referral source.

The NUBC has continued to review the code values that are valid for this field to ensure they are consistent with the current definition, and it has found the following are not consistent with the definition:

- Point of origin code B (defined as 'transfer from another home health agency'); and
- Point of origin code C (defined as 'readmission to the same home health agency').

Therefore, NUBC will retire these two codes effective for dates of service on or after July 1, 2010.

These two codes are significant in Medicare claims processing of home health (HH) claims under the HH PPS, because both codes are used as indicators to alert Medicare systems that a partial episode payment (PEP) adjustment will apply to a HH episode. When these codes are present, the Medicare system is programmed to allow a request for anticipated payment (RAP) which overlaps a previously established episode. The previously established episode is shortened and a new episode is created, allowing the overlapping RAP to be paid.

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The NUBC **is replacing point of origin code B with new condition code 47.** The title of condition code 47 is "Transfer from another Home Health Agency," and the definition is "The patient was admitted to this home health agency as a transfer from another home health agency." The NUBC **will not replace point of origin code C.**

CR 6757 ensures Medicare systems can continue to implement existing policies appropriately despite changes in coding. Specifically, Medicare will take the following steps for claims with dates of service on or after July 1, 2010:

- Medicare will allow an HH RAP on institutional claims (type of bill (TOB) 322 or 332) or a no-RAP Low Utilization Payment Adjustment (LUPA) claim to overlap an existing HH episode if condition code 47 is present on the RAP.
- Medicare will allow an HH RAP (TOB 322 or 332) or a no-RAP LUPA claim to overlap an existing HH episode record if the CMS Certification Number on the RAP and the episode match.
- Medicare will calculate an add-on payment to LUPAs on institutional HH claims when the following conditions are met:
  - The dates in the claim "From" date and admission dates match;
  - The first position of the Health Insurance Prospective Payment System (**HIPPS**) code is 1 or 2;
  - Condition code 47 is not present; and
  - The recoding indicator of 2 is not set.

Additional Information

The official instruction, CR 6757, issued to your RHHI regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1904CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your RHHI at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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