DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1504 | **Related Change Request (CR) #: 7760**

Related CR Release Date: July 18, 2012 | **Effective Date: October 1, 2012**

Related CR Transmittal #: R2495CP | **Implementation Date: October 1, 2012**

Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments

Note: This article was revised on December 6, 2016, to add a link to MLN Matters Article MM9585 that advises home health agencies that effective April 1, 2017, MACs will automate the denial of Home Health Prospective Payment System claims when the patient assessment (OASIS) data has not been received. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Beginning on April 1, 2015, Medicare systems will compare the Health Insurance Prospective Payment System (HIPPS) code on a Medicare home health claim to the HIPPS code generated by the corresponding Outcomes and Assessment Information Set (OASIS) assessment before the claim is paid. If the HIPPS code from the OASIS assessment differs, Medicare will use the OASIS-calculated HIPPS code for payment. At this time, if no corresponding OASIS assessment is found the claim will process normally.

Background

Original Medicare determines payments of Home Health (HH) claims using case-mix groups based on the OASIS assessment of the beneficiary. OASIS assessments are entered

into software at the HHA that transmits the data to a national quality data repository. In addition, the software runs the data from each assessment through a grouping program that generates a case-mix group. The HHA submits the case-mix group on their claim as a HIPPS code. Although the Centers for Medicare & Medicaid Services (CMS) provides free grouping software, many providers create their own software to integrate these data entry and grouping functions with their own administrative systems.

Previously, the transmission of assessment data and the submission of claims were entirely separate processes. The Fiscal Intermediary Shared System (FISS), which processes all Original Medicare HH claims, did not have access to the quality data repository. As a result, FISS could not validate the submitted HIPPS code against the associated OASIS assessment. This created a payment vulnerability for the Medicare program which the Office of Inspector General (OIG) identified in several studies.

Implementing the Change

In 2012, CMS issued Change Request (CR) 7760, which required the FISS system to create a file exchange interface with the national quality data repository, the Quality Information Evaluation System (QIES). This interface provided the infrastructure to validate HIPPS codes against OASIS assessments and to also perform similar validations of Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) claims. The interface was implemented October 1, 2012.

The QIES required additional changes to perform the matching of the claim data to its corresponding assessment and to return to the FISS the HIPPS code calculated from the assessment. In order to best manage risk, CMS decided to test and implement the matching process in phases. The MACs tested the IRF matching process during 2013 and implemented it in claims processing in February 2014. The MACs successfully tested the HH matching process during the remainder of 2014. For HH PPS claims received on or after April 1, 2015, Medicare will validate the submitted HIPPS code against the OASIS-calculated HIPPS code present in QIES.

Impact on Home Health Agencies

HHAs do not need to make any changes to their billing systems. HH PPS claims will be suspended temporarily during processing to allow for the file exchange between FISS and QIES. The claims will be suspended with FISS reason code 37071 in status/locations SMFRX0-SMFRX4. This will occur during the 14 day payment floor period and should not delay payments to HHAs.

If the matching process determines that the OASIS-calculated HIPPS code is different from the one submitted on the claim, the OASIS-calculated HIPPS code will be used for payment. If the HIPPS code matches or if an OASIS assessment corresponding to the claim is not found, the claim will process normally at this time.

If the matching process changes the HIPPS code used for payment, special coding on the remittance advice will notify the HHA. Claim Adjustment Reason Code 186 (Level of care change adjustment) and Remittance Advice Remark Code N69 (PPS code changed by

claims processing system) will identify the recoded claims. These are the same codes used to identify claims recoded due to changes in therapy services. The electronic remittance advice will also return to the HHA the HIPPS code used for payment.

Understanding Changed HIPPS Codes in FISS

The FISS will display a new field in Direct Data Entry (DDE) that will contain the OASIS-calculated HIPPS code. The field will be named "RETURN-HIPPS1." When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice.

It is also possible that an OASIS-calculated HIPPS code may be re-coded further by Medicare systems. The OASIS-calculated HIPPS code will be sent to the HH PPS Pricer program which may change the code based on changes in therapy services or whether the claim is for an early or later episode. In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field. HHAs will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE:

Field in DDE	DDE Map	Represents
HCPC	MAP171E	HHA-submitted HIPPS code
RETURN-HIPPS1	MAP171E	OASIS-calculated HIPPS code
APC-HIPPS	MAP171A	Pricer re-coded HIPPS code

Next Steps

Per the Code of Federal Regulations (CFR) at 42 CFR 484.210(e), submission of an OASIS assessment for all HH episodes of care is a condition of payment. If the OASIS is not found during medical review of a claim, the claim is denied. At this time, if no corresponding OASIS assessment is found by the claims matching process Medicare will release the claim to process normally, unless the claim is selected for medical review. However, the OIG recommended that the Medicare program use this claims matching process to further enforce the condition of payment.

CMS plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release. At that time, Medicare will deny claims when a corresponding assessment is past due in the QIES but is not found in that system. CMS will provide notice to HHAs as soon as possible after we determine the implementation date.

Additional Information

The official instructions (CR7760 and CR8950) issued to your MAC regarding this change are available at **http://www.cms.gov/Regulations-and-**

Guidance/Guidance/Transmittals/Downloads/R2495CP.pdf and at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3151CP.pdf**, respectively.

The recommendations of the OIG regarding this project are available at **http://oig.hhs.gov/oei/reports/oei-01-10-00460.asp** on the OIG website.

If you have questions please contact your MAC at their toll-free number. The number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

Document History

Date of Change	Description
December 6, 2016	The article was revised on to add a link to MLN Matters Article MM9585 that advises home health agencies that effective April 1, 2017, MACs will automate the denial of Home Health Prospective Payment System claims when the patient assessment (OASIS) data has not been received.
January 29, 2015	Initial article released