mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Home Health Patient-Driven Groupings Model: Operational Issues

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

Acronyms in this Presentation

- **CY: Calendar Year**
- **CARC:** Claim Adjustment Reason Code
- **HH:** Home Health
- **HHAs:** Home Health Agencies
- **HH PPS:** Home Health Prospective Payment System
- **HIPPS:** Health Insurance Prospective Payment System
- **IPF:** Inpatient Pschiatric Facility
- **IRF:** Inpatient Rehabilitation Facility
- **LTCH:** Long Term Care Hospital
- **LUPA:** Low utilization payment adjustment
- **MA:** Medicare Advantage
- **MAC:** Medicare Administrative Contractor
- **MSP:** Medicare Secondary Payer
- **OASIS:** Outcome and Assessment Information Set
- **QIES:** Quality Improvement and Evaluation System
- **PDGM:** Patient-Driven Groupings Model
- **RAP:** Request for Anticipated Payment
- **RARC:** Remittance Advice Remark Code
- **RFA:** Reason for Assessment
- **SOC:** Start of Care
- **SNF:** Skilled Nursing Facility
- **TOB:** Type of Bill

Agenda

1. Billing and claims processing overview **
2. Requests for Anticipated Payment (RAPs)
3. How OASIS data will be used in the claims system
4. Reporting new occurrence codes
5. Period timing scenarios
6. Admission source scenarios
7. Transition scenarios

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Billing and Claims Processing Overview

- Refer to the February 12, 2019, Home Health PDGM National Provider Call slides for an overview of the payment model for 30-day periods of care and details on how it contrasts with the current HH PPS based on 60-day episodes.
- Today's presentation looks at how HHA claims submission and Medicare claims processing will change as a result of the new policies.
  - Many basic elements of HH claims submission remain the same
  - Some important billing changes for HHAs
  - Changes in Medicare processing that will be helpful for HHAs to understand.

Billing and Claims Processing Overview

- Current HH PPS claim submission process:
  - HHA completes Outcomes and Assessment Information Set (OASIS) and submits to Quality Improvement and Evaluation System (QIES) system
  - HHA runs OASIS data through Grouper program in their billing system to determine the payment group
    - Health Insurance Prospective Payment System (HIPPS) code
  - HHA submits HIPPS code on their Request for Anticipated Payment (RAP) and receives split percentage payment
  - HHA provides services for up to 60 days, then submits claim with HIPPS code matching the RAP and detailed service information.

Billing and Claims Processing Overview

- Current HH PPS claims process:
  - Medicare systems make split percentage payment on the RAP based on the submitted HIPPS code
  - When the claim is received, Medicare systems query the OASIS in QIES
    - If an assessment is not found, the claim is returned to the provider
    - Compare the submitted HIPPS code with the code calculated by the Grouper in QIES
    - If the OASIS-calculated HIPPS code is different, it is used for payment.
    - Calculated HIPPS code stored on the claim in RETURN-HIPPS1 field
  - If the number of therapy services or episode sequence information require it, the HIPPS code is revised further in Medicare's Pricer program and shown in APC-HIPPS field.

Billing and Claims Processing Overview

- PDGM claim submission process:
  - HHA completes OASIS assessment and submits to **iQIES system**
  - HHA **has option to** run OASIS **and claim** data through Grouper program in their billing system to create HIPPS code **or submit any valid HIPPS code**
  - HHA submits HIPPS code on their Request for Anticipated Payment (RAP) and receives split percentage payment
  - HHA provides services for up to **30 days**, then submits claim with HIPPS code matching the RAP and detailed service information.
    - Reporting of service lines remains the same
    - Matching HIPPS remains important to pair the claim with the correct RAP
    - **New coding requirements**

Bold items = new for PDGM

Billing and Claims Processing Overview

- PDGM claims process:
  - Medicare systems make split percentage payment on the RAP based on the submitted HIPPS code
  - When the claim is received, Medicare systems query the OASIS in **iQIES**
    - If an assessment is not found, the claim is returned to the provider
    - **If found, answers to 8 OASIS items used in PDGM case-mix scoring are returned to the claims system and stored on the claim record.**
  - **Medicare systems combine OASIS items and claims data (period timing, inpatient discharge, diagnoses) and send to Grouper program.**
  - **Grouper-produced HIPPS code replaces the submitted HIPPS code and is used for payment.**

Billing and Claims Processing Overview

- PDGM claims process (continued)
  - **If Medicare claims history indicates period sequence is incorrect or HHA was not aware of inpatient discharge information, the corrected information is sent back to the Grouper and the HIPPS code is recalculated**
    - Recoded HIPPS code is still stored in APC-HIPPS field
    - **RETURN-HIPPS1 field no longer holds a code used for payment**
    - **Number of therapy services no longer results in recoding.**
  - Claim processes to payment in manner similar to today
  - For flow charts summarizing this comparison, see Change Request (CR) 11081, attachment 2.

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Requests for Anticipated Payment (RAPs)

- All HHAs will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period
  - Data fields and billing instructions required on a RAP are not changing
  - HIPPS may be produced by Grouper software or be any valid HIPPS code
  - New occurrence codes for PDGM are NOT reported on RAPs
  - Low utilization payment adjustment (LUPA) claims remain an exception (no-RAP LUPAs)

Requests for Anticipated Payment (RAPs)

- HHAs newly enrolled in Medicare on or after January 1, 2019 will not receive split percentage payments beginning CY 2020
  - Still need to submit a RAP normally at the beginning of each 30-day period to establish the home health period of care
  - These RAPs will be processed but not paid
  - No special coding is required on no-pay RAPs
    - The provider record at the HHA's MAC will note that no RAP payments apply
  - Full payment for each period of care will be made on the final claim

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How OASIS data will be used in the claims system

- OASIS assessment used in determining the HIPPS code is the most recent time point:
  - The system will look back from the claim's "From Date" for the most recent OASIS assessment
  - Start of Care (SOC) assessment (RFA 01) used for determining the functional impairment level for both the first and second 30-day periods of a new home health admission
  - Follow-up Recertification assessment (RFA 04) used for third and fourth 30-day periods
  - Resumption of Care (ROC – RFA 03) or Other Follow-up (RFA 05) assessments may be used for the second (or later) 30-day period.

How OASIS data will be used in the claims system

- OASIS items used to determine the PDGM payment group are returned from iQIES and recorded on the claim record:
  - Items M1033 (Hospitalization Risk), M1800, M1810, M1820, M1830, M1840, M1850, M1860 (current functional levels)
  - 8 items but 17 fields of data in all
- This information will be displayed on a new screen in the Fiscal Intermediary Shared System (FISS)

How OASIS data will be used in the claims system

- New Claim Page 43 (MAP103O) will look similar to this:

```
                              QIES/OASIS INFORMATION
                                        USERID XXXXXX__ DT ENTERD XX/XX/XX
M1033-HSTRY-FALL     OA  0 MR 01    M1033-WEIGHT-LOSS     OA  0 MR 01
M1033-MLTPL-HOSPZTN  OA  0 MR 01    M1033-MLTPL-ED-VISIT  OA  0 MR 01
M1033-MNTL-BHV-DCLN  OA  X MR XX    M1033-COMPLIANCE      OA  X MR XX
M1033-5PLUS-MDCTN    OA  X MR XX    M1033-CRNT-EXHSTN     OA  X MR XX
M1033-OTHER-RISK     OA  X MR XX    M1033-NONE-ABOVE      OA  X MR XX
M1800-CRNT-GROOMING  OA  X MR XX    M1810-DRESS-UPPER     OA  X MR XX
M1820-DRESS-LOWER    OA  X MR XX    M1830-CRNT-BATHG      OA  X MR XX
M1840-CRNT-TOILTG    OA  X MR XX    M1850-CRNT-TRNSFRNG   OA  X MR XX
M1860-CRNT-AMBLTN    OA  X MR XX
```

How OASIS data will be used in the claims system

- Advantages of this new display:
  - Easy reference to the data used to calculate payment groups
    - No need to look up corresponding assessment
    - iQIES provided data in the OA column will not be changed by Medicare Administrative Contractors (MACs)
  - Easier to understand what items changed as a result of review
  - Relevant OASIS items flow with the claim data into Medicare claims history databases
    - Information will be more easily accessible to researchers

How OASIS data will be used in the claims system

- OASIS corrections and claims adjustments
  - OASIS information may be corrected by an HHA after they have submitted their claim to Medicare
  - No need to adjust claims every time a correction is made
  - Only the 8 functional items are used by the claims system, so claims only need to be adjusted if these items are corrected and the HHA believes the changes will have an impact on payment

How OASIS data will be used in the claims system

- Under the PDGM, claims are the source of record for payment diagnosis codes, not OASIS
- If diagnosis codes change during a period of care (before the “From” date of the next period), the coding changes should be reflected on the claim on the next period
  - Complete an ‘other follow-up’ (RFA 05) assessment when a change would be considered a major decline or improvement in the patient’s health status
  - No edits in Medicare systems comparing claim and OASIS diagnosis codes
  - No need to complete an RFA 05 just to ensure claim and OASIS coding match

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Reporting new occurrence codes

- Occurrence code 50 – “Assessment Date”
  - Required on all final claims, not on RAPs
  - If this code is missing, the claim will be returned
  - Report the assessment completion date (OASIS item M0090) for the start of care, resumption of care, recertification or other follow-up OASIS that occurred most recently before the claim “From” date
  - This date will be used to match to the OASIS record in iQIES
- Treatment authorization codes are no longer required on all HH final claims

Reporting new occurrence codes

- Two new occurrence codes to support the admission source category of the PDGM (Community vs. Institutional)
- Occurrence code 61 – “Hospital Discharge Date”
  - Reported, but not required, on final claims. Not reported on RAPs
  - Reported on admission claims AND continuing claims, if applicable
  - Report the discharge date (“Through” date) of an inpatient hospital admission that ended within 14 days of the “From” date of the HH period of care.
  - Claims with hospital discharges within 14 days are grouped into “Institutional” payment groups

Reporting new occurrence codes

- Occurrence code 62 – “Other Institutional Discharge Date”
  - Reported, but not required, on final claims. Not reported on RAPs
  - Reported ONLY on admission claims, if applicable
    - Claim “From” and “Admission” date match
  - Report the discharge date (“Through” date) of a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days of the “From” date of the HH period of care.
  - Admission claims with other institutional discharges within 14 days are grouped into “Institutional” payment groups

Reporting new occurrence codes

- Determining “within 14 days of the ‘From’ date” of the HH claim
  - Include the ‘From’ date, then count back using the day before the ‘From’ date as day 1
  - If ‘From’ date = 1/20/2020, then 1/19/2020 is day 1
  - Counting back from 1/19/2020, the 14 day period is 1/6/2020 – 1/19/2020
- Use occurrence codes to report discharge dates in this period
  - LTCH discharge date of 1/6/2020 would be reported on an admission HH claim with occurrence code 62.
  - An acute hospital discharge date of 1/20/2020 would be reported with occurrence code 61

Reporting new occurrence codes

- Report only one occurrence code 61 or 62 on a claim. If two inpatient discharges occur during the 14 day window, report the later discharge date. Example:
  - HH claim “From” date – 1/20/2020
  - Inpatient hospital discharge date – 1/10/2020 (10 days prior)
  - SNF discharge date – 1/18/2020 (2 days prior)
  - Report occurrence code 62 and 1/18/2020.
- Claims with both occurrence code 61 and 62 will be returned
- Claims with more than one occurrence code 61 or more than one occurrence code 62 will be returned

Reporting new occurrence codes

- What happens if an HHA is not aware of an institutional discharge when they submit the claim?
  - If the inpatient claim has been processed by Medicare before the HH claim is received, Medicare systems will identify it and group the HH claim into an institutional payment group automatically
  - If the inpatient claim has not been processed yet when the HH claim is received, Medicare systems will group the HH claim into a community payment group
  - When the inpatient claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using an institutional payment group instead

Reporting new occurrence codes

- Automatic adjustments to change community payment groups to institutional will be identified on the remittance advice:
  - Type of Bill (TOB) 032G
  - Claim adjustment reason code (CARC) 186
  - Remittance advice remark code (RARC) N69

- Institutional payment groups will not be automatically adjusted to community if no inpatient claim is found after the timely filing period closes
  - inpatient stay may have been in a non-Medicare facility (e.g., Veteran's Administration)
  - Non-Medicare facilities can ONLY be identified through occurrence codes

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Period timing scenarios

- HIPPS codes show the payment group for a given claim.
- Each character of the HIPPS code is associated with the PDGM variables
  - **Position #1:** Timing and Admission Source
  - **Position #2:** Clinical Grouping
  - **Position #3:** Functional Impairment Level
  - **Position #4:** Comorbidity Adjustment
  - **Position #5:** Placeholder

- Example HIPPS Code: **2DC21** = Early-Institutional/Complex Nursing/High Functional Impairment/ Low Comorbidity Adjustment

Period timing scenarios

- Period timing reflected by two pairs of values in the first position of the HIPPS code
- Early
  - 1 – Community Early
  - 2 - Institutional Early
- Late
  - 3 – Community Late
  - 4 – Institutional Late

- A number of factors can affect whether a HIPPS code beginning with 1 or 2 is used for payment

Period timing scenarios

- “Early” periods of care under PDGM are limited to the first 30-day period in a sequence of HH periods of care
  - ‘Sequence’ - periods with no more than 60 days between the end of one period and the start of the next period (no change from current definition)

- Basic criterion of “Early” payment grouping – claim “From” date and “Admission” date match
  - Initial processing will group all admission claims as “Early”
  - Then Medicare systems will validate this using claims history data

Period timing scenarios

- If a HH claim from the same HHA or another HHA is found within the 60 days before the “From” date and the HIPPS code begins with 1 or 2, Medicare systems will automatically regroup the claim and pay using the corresponding HIPPS code that begins with 3 or 4 instead.
- If the prior HH claim has not been yet been processed by Medicare, the claim will initially pay as an “Early” period of care
  - When the prior HH claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using a “Late” payment group instead
  - Same remittance advice coding (CARC 168, RARC N86) as other recoding adjustments.
- “Late” periods will also be recoded to “Early” if no prior claims are found.

Period timing scenarios

- Example 1, Beneficiary is:
  - Admitted to HHA1: 01/15/2020
  - Discharged by HHA1: 02/10/2020
  - 1/15 to 2/10 claim processed: 03/05/2020
  - Re-admitted by HHA1: 04/05/2020
    - Claim for 01/15 period paid as “Early”
    - Claim “From” and “Admission” dates match (04/05) but the period of care starts within 60 days of the last HH discharge
    - Period starting 04/05/2020 is grouped as a “Late” period of care

Period timing scenarios

- Example 2, Beneficiary is:
  - Admitted to HHA1: 01/15/2020
  - Discharged by HHA1: 02/10/2020
  - 2/10 claim processed: 03/05/2020
  - Admitted to HHA2: 04/05/2020
    - Claim “From” and “Admission” dates match (04/05) but the period of care starts within 60 days of the last HH discharge
    - First claim for HHA2, period starting 04/05/2020, is grouped as a “Late” period of care

Period timing scenarios

- Medicare Secondary Payer (MSP). Example 3, Beneficiary is:
  - Admitted to HHA1 as MSP: 03/01/2020
  - MSP claim for period 1: 03/01/2020 – 03/30/2020
  - Payer changes to Medicare Primary: 03/31/2020
  - Medicare primary claim, period 2: 03/31/2020 – 04/29/2020
    - MSP periods are counted to determine Early or Late
    - 03/01 period uses “Early” HIPPS code when calculating MSP payment
    - 03/31 period uses “Late” HIPPS code when calculating Medicare primary payment

Period timing scenarios

- Medicare Advantage (MA). Example 4, Beneficiary is:
  - Admitted to HHA1 under MA: 03/01/2020
  - HHA1 bills MA plan for period 1: 03/01/2020 – 03/30/2020
  - Payer changes to Original Medicare: 03/31/2020
  - Original Medicare claim, period 2: 03/31/2020 – 04/29/2020
    - MA periods are NOT counted to determine Early or Late
    - HHA1 should use 03/31 as the Admission date on period 2 claim
    - 03/31 period grouped as “Early” HIPPS code

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Admission source scenarios

- HHAs will report institutional admission sources using occurrence codes 61 or 62.
  - HHAs should report only one of these occurrence codes per claim

- OASIS item M1000 (inpatient facilities in last 14 days) is not used by Medicare systems
  - Not necessary to correct a submitted OASIS if the HHA learns of a discharge after the OASIS is submitted.

Admission source scenarios

- Example 5, Admission to HH after two inpatient stays.
- The beneficiary:
  - Has inpatient hospital stay 02/01/2020 – 02/04/2020
  - Has SNF stay 02/05/2020 – 02/12/2020
  - Is admitted to HH period of care 02/14/2020
- Report occurrence code 62, both discharges are within 14 days of the HH admission date, but the SNF is most recent institutional discharge
- 02/14 period is grouped as Early/Institutional (HIPPS code starts with 2)

Admission source scenarios

- Example 6, Resumption of HH after Inpatient Stays.
- The beneficiary :
  - Is admitted to HH period of care 01/15/2020
  - Has inpatient hospital stay 02/01/2020 – 02/04/2020
  - Has SNF stay 02/05/2020 – 02/10/2020
  - Resumes care at HH 02/11/2020
  - Second period of care starts 02/14/2020
- Report occurrence code 61, hospital stay is within 14 days of 2nd period
- SNF is most recent institutional discharge, but occurrence code 62 is only reported on admission claims
- 02/14 period is grouped as Late/Institutional (HIPPS code starts with 4)

Admission source scenarios

- Example 7, Discharge and Readmission with Other Institutional Stay:
- The beneficiary:
  - Is discharged from a HH period of care 03/20/2020
  - Is discharged from an IPF stay 03/27/2020
  - Is readmitted by the HHA 03/31/2020
- The readmission is a Late period since no 60 day gap in services occurred
- Occurrence code 62 should be reported on this Late period of care
  - The 3/31 period of care is an admission (“From” and “Admission” dates will match), so reporting other institutional discharge dates applies
  - The 3/31 period will be grouped as Late/Institutional (HIPPS code starts with 4)

Admission source scenarios

- Example 8, Other Institutional Stay during Period.
- The beneficiary:
  - Is admitted to a HH period of care 03/20/2020
  - Has an IRF stay 03/27/2020 – 04/09/2020
  - Resumes care at the HHA 04/10/2020
  - Second period of care starts 04/19/2020
- Occurrence code 62 does not apply to the 04/19 period, because it is not an admission period of care
- Only acute hospital discharges are grouped as institutional for continuing periods of care
- The 04/19 period would be grouped as Late/Community (HIPPS code starts with 3)

Admission source scenarios

- Example 9, the beneficiary:
  - Is under observation in hospital 02/01/2020 – 02/03/2020
  - Is admitted to HH period of care 02/04/2020
- Occurrence code 61 does not apply, since the patient was not admitted to the inpatient hospital
- 02/04 period is grouped as Early/Community (HIPPS code starts with 1)

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Transition Scenarios

- For 60-day episodes that begin on or before December 31, 2019 and end on or after January 1, 2020 (i.e., episodes that span the January 1, 2020 PDGM implementation date), payment will be the CY 2020 national, standardized 60-day episode payment amount
- For HH periods of care that begin on or after January 1, 2020, the unit of payment will be the CY 2020 national, standardized 30-day payment amount
- Under the PDGM, recertification for home health services, updates to the comprehensive assessment and updates to the HH plan of care will continue on a 60-day basis

Transition Scenarios

- Transition and period timing
- Example 10, the beneficiary is:
  - In a HH PPS 60-day episode of care 12/15/2019-02/12/2020
  - Starts first PDGM period of care 02/13/2020
- 12/15 episode is paid under HH PPS
- 02/13/2020 is grouped as a Late period of care
  - "From" and "Admission" dates on the claim would not match

Transition Scenarios

- Transition and OASIS matching
- Example 11, the beneficiary is:
  - In a HH PPS episode of care 11/02/2019-12/31/2019
  - Has recertification assessment 12/30/2019
  - Starts first PDGM period of care 01/01/2020
- The OASIS assessment completion date (M0090) is before the PDGM implementation date
- HH submits 12/30/2019 as the occurrence code 50 date on the PDGM claim
- Medicare systems will use this date to match to the 2019 assessment and use its functional information to group the claim.

Transition Scenarios

- PDGM is effective for claim “From” dates on or after 01/01/2020, but the implementation date in Medicare instructions is 01/06/2020
  - What will happen if a RAP or claim with a PDGM HIPPS code is submitted between 01/01 and 01/05?
  - RAPs and claims with “From” dates on or after 01/01/2020 will be held by the MAC then released for processing after the implementation date
  - Typical quarterly release process, since Medicare implements changes on the first Monday of each quarter.

Resources

PDGM Resources

- PDGM Webpage
  - Interactive Grouper tool
  - Case mix weights, LUPA thresholds, and agency-level impacts
  - February 2020 National Provider Call materials
- HomeHealthPolicy@cms.hhs.gov
- CY 2019 Home Health Final Rule on Federal Register
- MLN Matters articles MM11081 and MM11272

Question & Answer Session

Questions?

- For questions or comments about today's presentation, please e-mail wilfried.gehne@cms.hhs.gov

- Please be as specific as possible with your questions

Thank you!

Thank You – Please Evaluate Your Experience

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