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

News Flash – Physicians and non-physician practitioners in all States and Washington, D.C. can now use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet. CMS will make Internet-based PECOS available next year to organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers). For information about Internet-based PECOS, including important information that physicians and non-physician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* on the CMS website.

MLN Matters® Number: MM6393

Related Change Request (CR) #: 6393

Related CR Release Date: April 24, 2009

Effective Date: Episodes beginning on or after January 1, 2008

Related CR Transmittal #: R1714CP

Implementation Date: October 5, 2009

Correction to the Editing of Health Insurance Prospective Payment System (HIPPS) Codes on Home Health Prospective Payment System (HH PPS) Claims

Provider Types Affected

Home health agencies (HHAs) submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services/supplies provided to Medicare beneficiaries during a home health episode.

Provider Action Needed

This article is based on Change Request (CR) 6393 which creates a payment safeguard that ensures home health agencies (HHAs) can no longer incorrectly change the supply severity level reflected in the 5th position of Home Health Prospective Payment System (HH PPS) Health Insurance Prospective Payment System (HIPPS) codes. The fifth position of the HIPPS on the final claim can only differ from the fifth position of that code on the Request for Anticipated Payment (RAP) in cases where supplies were initially expected to be required, but were not

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supplied. Then, the code can only change from the S-X letter code on the RAP to its corresponding number (1-6) code on the final claim.

Background

The Centers for Medicare & Medicaid Services (CMS) changed the format of the Health Insurance Prospective Payment System (HIPPS) codes that carry the case-mix group on HH PPS claims with the implementation of case-mix refinements to the home health prospective payment system (HH PPS). One of the changes required the fifth position of the code to carry a value that represents the non-routine supply (NRS) severity level.

The six letters in the range S - X in the fifth position of the HIPPS code represent each of the six NRS severity levels in the payment system.

In an effort to improve the quality of supply data reporting, CMS issued Change Request (CR) 5776 which established editing of an alternate set of values to represent episodes in which supplies were not actually provided to the beneficiary. The MLN Matters® article related to CR 5776 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5776.pdf* on the CMS website.

The six numbers in the range one through six in the fifth position of the HIPPS code represent the same six NRS severity levels (S-X) but also allow the HHA to attest that the absence of supply revenue codes on the claim is not an error or omission.

Because it is not certain at the beginning of an HH episode whether supplies will or will not be provided, Medicare grouping software always produces the HIPPS code with a letter value to show that supplies will be provided. This code is typically used on the RAP for the episode.

If at the end of the episode it is determined that supplies were not provided, the fifth position of the HIPPS code is changed on the final claim for the episode. In order to allow this, Medicare systems were revised to relax an edit that required the HIPPS code on the final claim to always match the one that had been submitted on the RAP. The edit now allows the fifth position of the code to change, with the expectation that the only change will be to replace a letter value with its corresponding number.

CMS has found that, in some cases, HHAs are instead incorrectly billing a different NRS severity level on the final claim. CR 6393 instructs that HHAs should change the fifth position of the HIPPS code on HH PPS claims only in order to report cases where supplies were or were not provided during the episode. Medicare systems will ensure that the only changes allowed are those which replace a letter

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with the number that corresponds to the same NRS severity level or which replace a number with the corresponding letter.

Additional Information

The official instruction, CR 6393, issued to your A/B MAC and RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1714CP.pdf* on the CMS website.

If you have any questions, please contact your A/B MAC or RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS web

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