

SPECIAL BILLING SITUATIONS UNDER HH PPS

Beneficiary Elected Transfers

- A patient may decide to transfer from one HHA to another at any time and as many times as they wish. When this occurs within an established HH PPS episode, the **HHA the patient is transferring from** (first HHA) should discharge the patient from their care.
- The **HHA that the patient is transferring to** (receiving HHA) will need to establish a new start of care date and plan of care (POC). The original start of care date and POC established by the first HHA **may not** be used by the receiving HHA.
- In addition, the receiving HHA **must document** that the patient has been informed they will no longer receive home health services from the first HHA after the transfer date **and** the first HHA will no longer receive Medicare payment on their behalf. CGS also advises HHAs to review the beneficiary's HH PPS episode history on the Common Working File (CWF) and print a copy showing this information **before** accepting the patient for care. See the CGS Web page, "Checking Beneficiary Eligibility" at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html for more information.
- The receiving HHA **must also** document their contact with the first HHA informing them of the transfer. Additional information and a listing of resources regarding beneficiary elected transfers is available at http://www.cgsmedicare.com/hhh/education/materials/hh_transfer.html
- When a patient transfer situation occurs between HHAs within an HH PPS episode, the first HHA will receive a Partial Episode Payment (PEP), in which payment for HH PPS services is based on a proportion of the episode (first billable visit through last billable visit).
- If the first HHA is aware of the transfer prior to submitting their final claim, the "Statement Covers Through" date (FL 6) should be recorded as the date of transfer. The "Patient Discharge Status" code (FL 17) should be recorded as "06". These fields are found on Page 01 of FISS. Complete all other fields as usual.
- The receiving HHA should record the first Medicare billable service as the "Statement Covers From" date (FL 6), "Admission Date" (FL 12), and earliest "Service Date" (FL 45) billed with revenue code 0023 when billing a beneficiary elected transfer OR if the patient was discharged from another HHA and readmitted to their HHA within the same 60 day episode.
- To report a beneficiary elected transfer to Medicare, the receiving HHA needs to report condition code "47" in FL 18-28 on the CMS-1450 claim form. A valid "Point of Origin" code must also be reported in FL 15. See the CGS "Home Health Medicare Billing Codes Sheet" for a listing of the most common point of origin codes used in home health billing. Complete all other fields as usual.

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Additional information on home health beneficiary elected transfers is accessible in the Medicare Claims Processing Manual (Pub. 100-04, Ch. 10) (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf>).

Beneficiary Discharge/Readmission

- Cases may occur where an HHA discharges a beneficiary prior to the end of a 60-day episode because they have met the goals of the plan of care, and the beneficiary is later readmitted to the **same** HHA during the **same** 60-day episode.
- The second admission prior to the end of the episode will generate a new OASIS, plan of care (POC), Request for Anticipated Payment (RAP), final claim (or No-RAP-LUPA instead of a RAP and claim) and a new 60-day episode.
- The HHA receives a **Partial Episode Payment (PEP)** for the home health services provided prior to the patient's second admission to the agency. PEPs are a proportion of the episode payment and are based on the span of days (first billable visit to last billable visit) care was provided prior to the second admission within the 60-day episode.
- When billing the discharge final claim to Medicare in this situation, the "Patient Discharge Status" code (FL 17) should be recorded as "06" if the HHA knows that it is a discharge/readmission situation. Otherwise, the HHA should record the appropriate discharge status code. This field is the "STAT" field found on FISS Page 01. Complete all other fields as usual.
- When billing the readmission RAP/claim, the first Medicare billable service date after the readmission is recorded as the "Statement Covers From" date (FL 6), "Admission Date" (FL 12), and the earliest "Service Date" (FL 45) billed with revenue code 0023. Complete all other fields as usual.
- The "Point of Origin for Admission or Visit" (FL 15) code is a required field for home health billing transactions. See the CGS "Home Health Medicare Billing Codes Sheet" for a listing of the most common point of origin codes used in home health billing.
- HHAs should be aware that a PEP will be generated automatically for dates of service on/after July 1, 2010, that fall within the HH PPS episodes established for the beneficiary by their HHA. Therefore, it is very important for HHAs to ensure they are verifying the beneficiary's episode history on CWF prior to admission or readmission AND submitting their RAPs/claims to Medicare. See the CGS Web page, "Checking Beneficiary Eligibility" at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html for more information.

- More information and a listing of resources regarding discharging and readmitting a beneficiary during the same HH PPS episode to the same HHA is available at: http://www.cgsmedicare.com/hhh/education/materials/discharge_and_remit.html

Additional information on home health discharge and readmission is accessible in the Medicare Claims Processing Manual (Pub. 100-04, Ch. 10) (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf>).

Low Utilization Payment Adjustment (LUPA)

- A LUPA occurs when **4 or fewer visits** are provided in a 60-day episode. Instead of payment being based on the HIPPS code, payment is made based on a national average per-visit payment by discipline (skilled nursing, therapy, aide, etc.) for the visits provided during the episode.
- If the HHA determines at the beginning of the episode that 4 or fewer visits will be provided to a patient during that 60-day episode, the HHA has the choice to submit a No-RAP-LUPA claim. This means that the HHA may submit the final claim for the episode to Medicare without first submitting a RAP.
- Like all final claims under HH PPS, physician's orders must be signed and dated prior to submitting No-RAP-LUPA claims to Medicare for payment.
- When billing No-RAP-LUPA claims, all required claim data should be entered as usual for a home health final claim, including the "Statement Covers Through" date (FL 6) which should reflect the 60th day of the episode or the date the patient transfers to another HHA, is discharged or dies. The claim data requirements are not different for LUPAs. The payment is different due to the 4 or fewer visits billed on the claim.
- An "add-on" payment is made to the first billable visit on LUPA claims when it is the first or only episode in a series of adjacent episodes.