Chapter 12   Section 7

Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic

Issue Date:
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1.0   APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0   ISSUE

To describe the Pricer requirements for reimbursement of home health services for 60-day episodes of care under the Home Health Prospective Payment System (HHA PPS).

3.0   POLICY

3.1   HHA PPS Pricer Requirements

All home health services billed on Type Of Bill (TOB) 32X shall be reimbursed based on calculations made by the Home Health (HH) Pricer. The HH Pricer operates as a call module within contractors' systems. The HH Pricer makes all reimbursement calculations applicable under HHA PPS, including percentage payments on Requests for Anticipated Payment (RAPs), claim payments for full Episodes Of Care (EOCs), and all payment adjustments, including Low Utilization Payments (LUPAs), Partial Episode Payment (PEP) adjustments, therapy threshold adjustments, and outlier payments. Contractors' systems must send an input record to Pricer for all claims with covered visits, and Pricer will send the output record back to the contractors' system. The following sections describe the elements of HHA PPS claims that are used in the HHA PPS Pricer and the logic that is used to make payment determinations.

3.1.1   General Requirements

3.1.1.1   Pricer will return the following information on all claims: Output Health Insurance Prospective Payment System (HIPPS) codes, weight used to price each HIPPS code, payment per HIPPS code, total payment, outlier payment and return code. If any element does not apply to the claim, Pricer will return zeros.

3.1.1.2   Pricer will wage index adjust all PPS payments based on the Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) reported in value code **61** on the claim.

3.1.1.3   Pricer will return the reimbursement amount for the HIPPS code in the 023 line of the claim for the RAPs and paid claims.

3.1.1.4   If input is invalid, Pricer will return one of a set of error return codes to indicate the invalid element.

3.1.1.5   Pricer must apply the fiscal year rate changes to through date on claim.

3.1.2   Pricing of RAPs

3.1.2.1   Pricer will employ RAP logic for TOB 322 only.

3.1.2.2   On the RAP, Pricer will multiply the wage index adjusted rate by 0.60 if the claim from date and admission date match and the initial payment indicator is = 0.

3.1.2.3   On the RAP, Pricer will multiply the wage index adjusted rate by 0.50 if the claim from date and admission date do not match and the initial payment indicator is = 0.

3.1.2.4   On the RAP, Pricer will multiply the wage index adjusted rate by 0.00 if the initial payment indicator equals 1.

3.1.2.5   Pricer will return the payment amount on RAP with return code **03** for 0%, **04** for 50% payment and **05** for 60% payment.

3.1.3   Pricing of Claims

3.1.3.1   Pricer will employ claim logic for TOB 329, 327, 32G, 32I, 32J, 32M, 32P, 32Q, and 33Q only.

3.1.3.2   Pricer will make payment determinations for claims in the following sequence:

- LUPA
- Recoding of claims based on episode sequence and therapy thresholds
- Home Health Resource Group (HHRG) payments [including PEP]
- Outlier, in accordance with logic in the Pricer

3.1.3.3   Pricer will pay claims as LUPAs when there are less than 5 occurrences of all HH visit revenue codes: 42X, 43X, 44X, 55X, 56X, and 57X.

3.1.3.4   Pricer will pay visits on LUPA claims at national standardized rates, and the total visit amounts will be final payment for the episode.

3.1.3.5   If Pricer determines the claim to be a LUPA, all other payment calculations will be bypassed.

3.1.3.6   Pricer will return claim LUPA payments, with return code **06**.

3.1.3.7 DHA will supply Pricer with a table of "fall back" HIPPS codes so HIPPS can be downcoded when thresholds are not met.

3.1.3.8 If one of the HIPPS codes that indicate therapy is present, Pricer will check for the presence of 10 therapy visits by revenue code (42X, 43X, 44X). Ten therapies in total for an episode is the threshold.

3.1.3.9 If 10 occurrences of therapy revenue codes are not found when HIPPS code indicates therapies, Pricer will reprice the claim based on the table of "fall back" HIPPS codes.

3.1.3.10 Pricer will return both the input HIPPS code and an output HIPPS code. The output code will be different from the input code only if the therapy threshold is not met.

3.1.3.11 If the PEP indicator is **Y**, Pricer will multiply the wage index adjusted rate by the number of HHRG days over 60 (days divided by 60).

3.1.3.12 If the PEP indicator is **Y** and there are two or more HIPPS codes on the claim, Pricer will multiply each HHRG payment by the number of PEP days/60. Each result will then be multiplied by the number of HHRG days/the number of PEP days. The sum of these amounts is the total HHRG payment for the episode.

3.1.3.13 Pricer will perform the outlier calculations on all claims unless the claim is a LUPA.

3.1.3.14 Pricer passes back to the system a single outlier amount, no matter how many HIPPS codes are on the claim.

3.1.3.15 Pricer will perform an outlier calculation that requires total number of visits per discipline to be multiplied by national standard per visit rates. Effective January 1, 2017, the methodology to calculate the outlier payment will utilize a cost-per-unit approach rather than a cost-per-visit approach. The national per-visit rates are converted into per 15 minute unit rates. The per-unit rate by discipline will be used along with the visit length data reported on the home health claim to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an EOC. The amount of time per day used to estimate the cost of an episode for the outlier calculation is limited to eight hours or 32 units per day (care is not limited, only the number of hours/units eligible for inclusion in the outlier calculation). For rare instances when more than one discipline of care is provided and there is more than eight hours of care provided in one day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of episode cost in order to cap the estimation of an episode's cost at eight hours of care per day. The total result is compared to an outlier threshold which is determined by adding the rate for the HIPPS code to a standard fixed-loss amount. If the total result is greater than the threshold, Pricer will pay 80% of the difference between the two amounts in addition to the episode rate determined by the HIPPS code.

3.1.3.16 Pricer will return claim payment with no outlier payment with return code **00**.

3.1.3.17 Pricer will return claim payments with outlier payment with return code **01**.

3.1.3.18   Pricer will return the following additional information on claims:

- The dollar rate used to calculate revenue code costs, and
- The costs calculated for each revenue code.

3.1.3.19   If any revenue code is submitted with zeros, Pricer will return zeros in these fields.

3.1.3.20   Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Following are the annual updated items:

- The Federal standard episode amount;

- The Federal conversion factor for non-routine supplies;

- The fixed loss amount to be used for outlier calculations;

- A table of case-mix weights to be used for each Health Resource Group (HRG);

- A table of supply weights to be used to adjust the non-routine supply conversion factor;

- A table of national standardized per visit rates and per unit rates;

- The pre-floor, pre-reclassified hospital wage index; and

- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and non-labor percentages.

3.1.4   **Interface with Pricer**

3.1.4.1   Provide specification for a 650-byte Pricer input record layout.

3.1.4.2   Contractor's claims processing system shall pass the following claim elements to Pricer for all claims:

- National Provider Identifier (NPI)
- Health Insurance Claim (HIC) number
- Provider number
- TOB
- Statement from and through dates
- Admission date and HIPPS codes

3.1.4.3   The system shall place the return code passed back from Pricer on the header of all claims.

3.1.4.4   If the claim is a LUPA, the system shall apportion the payment amounts returned from Pricer to the visit lines.

3.1.4.5 The system shall pass a **Y** medical review indicator to Pricer if a HIPPS code is present in the panel field on a line, and the line item pricing indicator shows that the change came from medical review (MR). In all other cases an **N** indicator shall be passed.

3.1.4.6 The system shall assure all claims with covered visits shall flow to Pricer, but only covered visits shall be passed to Pricer.

3.1.4.7 The system shall pass Pricer all six home health visit revenue codes sorted in ascending order, with a count of how many times each code appears on the claim, and those that do not appear on claims shall be passed with a quantity of zero.

3.1.4.8 If there is one HIPPS code on the claim and the patient status is **06**, the standard systems will pass 60 days of service for the HIPPS code, regardless of visit dates on the claim.

3.1.4.9 If the claim is a PEP, the standard systems will calculate the number of days between the first service date and the last service date and pass that number of days for the HIPPS code.

3.1.4.10 If the claim is a SCIC, the standard systems will calculate the number of days for all HIPPS codes from the inclusive span of days between first and last service dates under the HIPPS code.

3.1.4.11 The system shall pass a **Y/N** medical review indicator to Pricer for each HIPPS code on the claim.

3.1.4.12 The system shall pass Pricer a **Y** PEP indicator if the claim shows a patient status of **06**. Otherwise, the indicator shall be **N**.

3.1.4.13 The system shall place the payment amount returned by Pricer in the total charge and the covered charge field on the 023 line.

3.1.4.14 The system shall place any outlier amount on the claim as value code **17** amount and plug condition code **61** on the claim.

3.1.4.15 When Pricer returns an 06 return code (LUPA payment), the system shall place it on the claim header in the return code field and create a new **L** indicator in the header of the record.

3.1.4.16 Pricer shall be integrated into the system for customer service and create a new on-line screen to do it.

3.1.5 **Input/Output Record Layout**

The HH Pricer input/output file will be 650 bytes in length. The required data and format are described in the CMS Internet-Only Manuals Publication #100-04, Medicare Claims Processing Manual, Chapter 10, Sections 70.2, 70.3, and 70.4.

3.1.6 **Home Health Value-Based Purchasing (HH VBP) Model**

3.1.6.1 In the Calendar Year (CY) 2016 HHA PPS Final Rule, CMS finalized its proposal to implement the HH VBP Model in nine states representing each geographic area in the nation. For all Medicare-certified HHAs that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska,

North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA's total performance score on a set of measures already reported via Outcome and Assessment Information Set (OASIS) and Hospital Consumer Assessment of Healthcare Providers and Systems (HHCHAHPS) for all patients serviced by the HHA, or determined by claims data, plus three new measures where performance points are achieved for reporting data.

3.1.6.2   Revisions have been made to the HH Pricer program to accept the necessary adjustment factor to apply the HH VBP adjustment and to capture the adjusted amount on the claim record. The HH VBP adjustment amount shall be placed on the claim as a value code **QV** amount.

- Effective January 1, 2018, the HH VBP adjustment factor shall be reported in the "PROV-VBP-ADJ-FAC" field.

- If no factor is provided, enter 1.00000.

3.1.6.3   The HHAs in the nine HH VBP states shall have their payments adjusted (upward or downward) in the following manner:

- A maximum payment adjustment of 3% in CY 2018;
- A maximum payment adjustment of 5% in CY 2019;
- A maximum payment adjustment of 6% in CY 2020;
- A maximum payment adjustment of 7% in CY 2021; and
- A maximum payment adjustment of 8% in CY 2022.

Note: Since the TRICARE Program is not following Medicare's payment performance adjustment process (HH VBP Model), 1.00000 will be reported in field "PROV-VBP-ADJ-FAC" for all HH claims resulting in full payment of standard episode rates.

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