

## Chapter 12

## Section 5

# Home Health Benefit Coverage And Reimbursement - Primary Provider Status And Episodes/**Periods** Of Care

Issue Date:

Authority: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers, **and shall apply to home health services subject to both the original 2008 case-mix system for 60-day episodes of care and the new case-mix system now called the Patient-Driven Grouping Model (PDGM) for 30-day periods of care. Therefore, this section applies to services provided both before and after January 1, 2020. Additionally,** 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

This policy describes the methods used in designating the primary provider of home health services and for tracking the **episodes/periods of care** for payment under the Home Health Agency Prospective Payment System (HHA PPS).

### 3.0 POLICY

#### 3.1 Background

**3.1.1** With the advent of the HHA PPS and home health Consolidated Billing (CB), Medicare had to establish a means of identifying a "primary" HHA for payment purposes (i.e., a HHA that would receive payment for all services during a designated **episode/period**). Medicare addressed this problem through the establishment of an administratively complex on-line inquiry transaction system [i.e., a Health Insurance Query for Health Agencies (HIQH)] whereby other home health providers could determine whether or not the beneficiary was currently in a home health **episode/period of care**. This on-line query system required the establishment of a HHA PPS episode/**period** auxiliary file which is continually updated as Requests for Anticipated Payments (RAPs) and claims are processed through the Regional Home Health Intermediary's (RHHI) claims processing systems. The HIQH system must be able to immediately return the following information to providers querying the system: 1) contractor and provider numbers; 2) episode/**period** start and end dates; 3) period status indicator; 4) HHA benefit periods; 5) secondary payer information; 6) hospice periods; and 7) HIQH header information. The HIQH transaction system must also be able to access 36 episode/**period** iterations displayed two at a time.

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**3.1.2** The implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly for the TRICARE Program. It would have to be maintained by one of the claims processing subcontractors since it is a national system requiring continual on-line updating. Determining “primary” provider status from the query system (i.e., the first RAP or, under special circumstances, the first claim submitted and processed by the RHHI) would circumvent the contractors’ utilization management responsibilities/requirements under their existing Managed Care Support (MCS) contracts. In other words, the contractors would no longer be able to assess and direct Home Health Care (HHC) within their region(s). Designation of primary HHA status (i.e., the only HHA allowed to receive payment for services rendered during an **episode/period of care**) would be dependent on the first RAP or claim submitted and processed for a particular **episode/period of care**. The determination of where and by whom the services are provided would be dependent on the provider instead of the contractor.

**3.1.3** An alternative approach is being adopted that will meet the primary goals of ensuring Medicare PPS payment rates and benefit coverage while retaining utilization management. Under this alternative approach, the preauthorization process shall determine “primary status” of the HHA. Authorization screens (part of the automated authorization file) shall be used to house pertinent **episode/period of care** data. This alternative shall necessitate contractor preauthorization for all HHC (i.e., all beneficiary categories). The alternative authorization process is preferable to the development and maintenance of a national on-line transactional query system, given its enormous implementing and maintenance costs. Adoption of the above alternative will preclude implementation of Medicare’s on-line transactional system and maintenance of complex auxiliary **episode/period** files. However, adoption of this alternative process does not preclude the prescribed conventions currently in place for establishing **episodes/periods of care**; e.g., transfers, discharges and readmissions to the same facility within 60-day episodes **or 30-day periods**, Significant Changes In Condition (SCICs), Low Utilization Payment Adjustments (LUPAs), and continuous **care shall** all be monitored and authorized as part of the authorization process. Contractors shall maintain and update **episode/period** data on expanded authorization screens.

## **3.2 Designation of Primary Provider**

### **3.2.1 Preauthorization Process**

The preauthorization process is critical to establishment of primary provider status under the HHA PPS; i.e., designating that HHA which may receive payment under the CB provisions for home health services provided under a Plan of Care (POC).

**3.2.1.1** The contractor is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries seeking HHC. In other words, HHC can only be accessed by TRICARE Program beneficiaries upon referral by the PCM, or attending physician, and with preauthorization by the contractor. The contractor shall establish and maintain these functions to facilitate referrals of beneficiaries to HHAs. For example, a beneficiary in need of home health services **shall** request preauthorization and placement by the contractor or other contractor designee. The contractor shall search its network for a HHA which will meet the needs of the requesting beneficiary. The beneficiary **shall** be granted preauthorization approval for home health services provided by the selected HHA. The selected HHA **shall** in turn be notified of its primary provider status under the TRICARE Program (i.e., the selected HHA shall be notified that it **is** the only HHA authorized for payment for services provided to

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the referred TRICARE Program beneficiary) and **shall** submit a request for anticipated payment after the first service has been rendered. The RAP **shall** initiate the **episode/period of care** under the preauthorization process.

**3.2.1.2** The preauthorization process shall extend to all intervening events occurring during the episode period (e.g., preauthorization is required for transfers to another HHA and readmission to the same HHA within 60 days **or 30 days** of previous discharge). In each case, the contractor shall maintain responsibility for designating primary provider status under the HHA PPS.

**3.2.2 Data Requirement/Maintenance**

The tax identification number (9-18 positions) of the designated primary provider (HHA) shall be maintained and updated on the automated authorization file (i.e., the authorization screen).

**3.3 Opening and Length of HHA PPS Episode/**Period****

While the authorization process will take the place of the HIQH in designation of primary provider status and maintenance and updating of pertinent episode/**period** data, it will not preclude the following conventions for reporting and payment of HHA **episodes/periods of care**:

**3.3.1** In most cases, an HHA PPS episode/**period shall** be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement. The contractor **shall** have already notified the selected HHA of its primary status for billing under the consolidated standards prior to submission of the RAP. The preauthorization requirement will negate the need for a query system (i.e., the need for keeping other home health providers informed of whether a beneficiary is already under the care of another HHA), since providers shall be keenly aware of this requirement for primary status under the TRICARE Program. In other words, if an HHA has not received prior notification from the contractor of its selection for treatment of a TRICARE Program beneficiary, it does not have primary provider status under the Program.

**3.3.2** Claims, as opposed to RAPs, **shall** only open episodes/**periods** in one special circumstance: when a provider knows from the outset that four or fewer visits **shall** be provided for the entire episode/**period**, which always results in a LUPA, and therefore decides to forego the RAP so as to avoid recoupment of the difference of the large initial percentage episode/**period** payment and the visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

**3.3.3** Multiple episodes/**periods may** be opened for the same beneficiary at the same time. The same HHA may require multiple episodes/**periods** to be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode/**period** RAP is received prior to the claim for the previous episode/**period**. Multiple episodes/**periods** may also occur between different providers if a transfer situation exists. Again, however, the contractors shall always be aware of the intervening events (e.g., transfers to another HHAs or discharge and readmission to the same facility during the same 60-day **episode or 30-day period of care**) due to ongoing utilization review and preauthorization requirements under contractors' managed care systems. The contractor shall be responsible for designating primary provider status whether it be for a new provider, in the case of transfer, or readmission to the same provider during a 60-day **episode or 30-day period of care**. The contractors' system shall post RAPs received with appropriate transfer and re-admit indicators to

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facilitate the creation of multiple episodes/**periods**. Same-day transfers are permitted, such that an episode/**period** for one agency, based on the claim submitted by the agency, **may** end the same date as an episode/**period** was opened by another agency for the same beneficiary, assuming preauthorization has been initiated and granted by the contractor.

**3.3.4** When episodes/**periods** are created from RAPs, the system calculates a period end date that does not exceed the start plus 59 days. The system shall assure no episode/**period** exceeds this length under any circumstance, and **shall** auto-adjust the period end date to shorten the episode/**period** if needed based on activity at the end of the episode/**period** (i.e., shortened by transfer).

**3.3.5** The system shall reject RAPs and claims with statement dates overlapping existing episodes/**periods**, including No-RAP LUPA claims, unless a transfer or discharge and re-admit situation is indicated. The system shall also reject claims in which the dates of the visits reported for the episode/**period** do not fall within the episode period established by the same agency. Sixty-day episodes **or 30-day periods of care**, starting on the original period start date, shall remain on record in these cases.

**3.3.6** The system shall auto-cancel claims, and adjust episode/**period** lengths, when episodes/**periods** are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode/**period** shall default to end the day before the first date of service of the new RAP or claim causing the adjustment, even though the episode/**period** length may change once claims finalizing episodes/**periods** are received. Payment for the episode/**period** is automatically adjusted [a Partial Episode Payment (PEP) adjustment] without necessitating re-billing by the HHA. If, when performing such adjustments, there is no claim in paid status for the previous episode/**period** that **shall** receive the PEP adjustment, the system shall adjust the period end date; however, if the previous claim is in paid status, both the claim and the episode/**period** **shall** be adjusted.

**3.3.7** In a PEP situation, if the first episode/**period** claim contains visits with dates in the subsequent episode period, the claim of the first episode/**period** shall be rejected by the system with a reject code that indicates the date of the first overlapping visit. The claim rejected by the system shall then be returned to the HHA by the contractor for correction. If the situation is also a transfer, when the first HHA with the adjusted episode/**period** subsequently receives a rejected claim, the agency **may** either re-bill by correcting the dates, or seek payment under arrangement from the subsequent HHA. For readmission and discharge, the agency may correct the erroneously billed dates for its own previously-submitted episode/**period**, but corrections and adjustments in payment shall be made automatically as appropriate whether the HHA submits corrections or not.

**3.3.8** If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, the system shall reject the one for which there is no prior authorization (i.e., the RAP from the HHA for which there was no designated primary provider status by the contractor). In such cases, contractors **shall** return the claims rejected by the system to providers.

**3.3.9** If a claim is canceled by an HHA, the system shall cancel the episode/**period**. If an HHA cancels a RAP, the system shall also cancel the episode/**period**. When RAPs or claims are auto-canceled or canceled by the system, the system shall not cancel the episode/**period**. A contractor may also take an action that results in cancellation of an episode/**period**, usually in cases of fraudulent billing. Other than cancellation, episodes/**periods** are closed by final processing of the claim for that episode/**period**.

### 3.4 Other Editing And Changes For HHA PPS Episodes/**Periods**

**3.4.1** The system shall assure that the final from date on the episode/**period** claim equals the calculated period end date for the episode/**period** if the patient status code for the claim indicates the beneficiary will remain in the care of the same HHA (patient status code 30).

**3.4.2** If the patient dies, represented by a patient status code of 20, the episode/**period** shall not receive a PEP adjustment (i.e., the full payment episode/**period** amount shall be allotted), but the through date on the claim shall indicate the date of death instead of the episode/**period** end date.

**3.4.3** When the patient status of a claim is 06, indicating transfer, the episode period end date shall be adjusted to reflect the through date of that claim, and payment is also adjusted.

**3.4.4** The system shall permit a "transfer from" and a "transfer to" agency to bill for the same day when it is the date of transfer and a separate RAP/claim is received overlapping that 60-day **episode or 30-day** period containing either a transfer or a discharge-readmit indicator.

**3.4.5** When the status of the claim is 01, no change is made in the episode/**period** length or claim payment unless a separate RAP/Claim is received overlapping that 60-day **episode or 30-day** period and containing either a transfer or a discharge-readmit indicator.

**3.4.6** The system shall also act on point of origin codes on RAPs; for example, "B" (indicating transfer) and "C" (indicating readmission after discharge by the same agency in the same 60-day period) shall open new episodes/**periods**. In addition to these two codes, though, any approved point of origin code may appear, and these other codes alone shall not trigger creation of a new episode/**period**.

**3.4.7** Claims for institutional inpatient services [i.e., inpatient hospital and Skilled Nursing Facility (SNF) services] shall continue to have priority over claims for home health services under HHA PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. Therefore, if an HHA PPS claim is received, and the system finds dates of service on the HH claims that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the system shall reject the HH claim.

**3.4.8** A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode/**period** continues, although a SCIC adjustment is likely to apply. Occurrence span code 74, previously used in such situations, shall not be employed on HHA PPS claims.

**3.4.9** If an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there shall be one shortened HHA PPS episode/**period** completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode/**period** shall receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day **episode or 30-day** period. This shall likely reduce the agency's payment overall. The agency shall cancel the PEP claim and the readmission RAP in these cases and re-bill a continuous **episode/period of care**.

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**3.4.10** The system shall edit to prevent duplicate billing of Durable Equipment (DE) and Durable Medical Equipment (DME). Consequently, the system **shall** edit to ensure that all DME items billed by HHAs have a line-item date of service and Healthcare Common Procedure Coding System (HCPCS) coding, though home health CB does not apply to DME by law.

**3.5 Episode/**Period** Data Requirement**

The contractor's authorization screen (part of its automated authorization file) shall show whether or not the beneficiary is currently in a home health **episode/period of care** (being served by a primary HHA), along with the following information:

**3.5.1** The beneficiary's name and sex.

**3.5.2** Pertinent contractor and provider number.

**3.5.3** **Episode/Period** Start and End Dates. The start date is received on a RAP or claim, and the end date is initially calculated to be the 60th **or 30th** day after the start date, changed as necessary when the claim for the **episode/period** is finalized.

**3.5.4** Date of Earliest Billing Action (DOEBA) and DOLBA. Dates of earliest and latest billing activity.

**3.5.5** Period Status Indicator. The patient status code on HHA PPS claim, indicating the status of the HH patient at the end of the period.

**3.5.6** Transfer/Readmit Indicator. Point of origin codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge).

**3.5.7** The Health Insurance PPS (HIPPS) Code(s). Up to six for any **episode/period**, representing the basis of payment for **episodes/periods** other than those receiving a LUPA.

**3.5.8** Principle Diagnosis Code and First Other Diagnosis Code. From the RAP or overlaying claim.

**3.5.9** A LUPA Indicator. Received from the system indicating whether or not there was a LUPA **episode/period**; and

**3.5.10** At least six of the most recent **episodes/periods** for any beneficiary.

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