

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - PRIMARY PROVIDER STATUS AND EPISODES OF CARE

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I. 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 TMA and specifically included in the network provider agreement.

II. ISSUE

This policy describes the methods used in designating the primary provider of home health services and for tracking the episodes of care for payment under the HHA PPS.

III. POLICY

A. Background.

1. With the advent of the home health agency prospective payment system (HHA PPS) and home health consolidated billing, Medicare had to establish a means of identifying a "primary" home health agency for payment purposes (i.e., a HHA that would receive payment for all services during a designated episode of care). 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 of care. This on-line query system required the establishment of a HHA PPS episode 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 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 iterations displayed two at a time.

2. The implementation and maintenance of such an on-line transactional query system would be administratively burdensome and costly for the 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 contracts. In other words, the contractors would no longer be able to assess and direct home health care within their region(s). Designation of primary HHA status (i.e., the only HHA allowed to receive payment for services rendered during an episode of care) would be dependent on the first RAP or claim submitted and processed for a particular episode of care. The determination of where and by whom the services are provided would be dependent on the provider instead of the MCSC.

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 will determine "primary status" of the HHA. Authorization screens (part of the automated authorization file) will be used to house pertinent episode data. This alternative will necessitate contractor preauthorization for all home health care (i.e., home health care delivered under both Prime and Standard). Expansion of the existing authorization requirements is a viable option given the fact that one of the managed care support contractors (MCSCs) is already authorizing home health care for standard beneficiaries under its contract. 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 files. However, adoption of this alternative process does not preclude the prescribed conventions currently in place for establishing episodes of care; e.g., transfers, discharges and readmissions to the same facility within 60-day episodes, significant changes in condition (SCICs), LUPAs, and continuous episodes of care will all be monitored and authorized as part of the authorization process. Contractors will maintain and update episode data on expanded authorization screens.

B. Designation of Primary Provider.

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 consolidated billing provisions for home health services provided under a plan of care.

a. The contractor, using PCMs, is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries (both Prime and Standard) seeking home health care. In other words, home health care can only be accessed by TRICARE beneficiaries upon referral by the PCM and with preauthorization by the contractor. The contractor shall establish and maintain these functions to facilitate referrals of beneficiaries to home health agencies. For example, a beneficiary in need of home health services will request preauthorization and placement by the Managed Care Support Contractor or other contractor designee. The MCSC will search its network for a HHA which will meet the needs of the requesting beneficiary. The beneficiary will be granted preauthorization approval for

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home health services provided by the selected HHA. The selected HHA will in turn be notified of its primary provider status under TRICARE (i.e., the selected HHA will be notified that it will be the only HHA authorized for payment for services provided to the referred TRICARE beneficiary) and must submit a request for anticipated payment after the first service has been rendered. The RAP will initiate the episode of care under the preauthorization process.

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

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

C. Opening and Length of HHA PPS Episode. While the authorization process will take the place of the HIQH in designation of primary provider status and maintenance and updating of pertinent episode data, it will not preclude the following conventions for reporting and payment of HHA episodes of care:

1. In most cases, an HHA PPS episode will be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement. The MCSC will 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 will be keenly aware of this requirement for primary status under TRICARE. In other words, if an HHA has not received prior notification from the MCSC of its selection for treatment of a TRICARE beneficiary, it does not have primary provider status under the Program.

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

3. Multiple episodes can be opened for the same beneficiary at the same time. The same HHA may require multiple episodes to be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. Again, however, the MCSCs will 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 of care) due to ongoing utilization review and preauthorization requirements under contractors' managed care

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systems. The MCSC will 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 of care. The contractors' system will post RAPs received with appropriate transfer and re-admit indicators to facilitate the creation of multiple episodes. Same-day transfers are permitted, such that an episode for one agency, based on the claim submitted by the agency, can end the same date as an episode was opened by another agency for the same beneficiary, assuming preauthorization has been initiated and granted by the MCSC.

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

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

6. The system will auto-cancel claims, and adjust episode lengths, when episodes are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode will default to end the day before the first date of service of the new RAP or claim causing the adjustment, even though the episode length may change once claims finalizing episodes are received. Payment for the episode is automatically adjusted (a partial episode payment or 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 that will receive the PEP adjustment, the system will adjust the period end date; however, if the previous claim is in paid status, both the claim and the episode will be adjusted.

7. In a PEP situation, if the first episode claim contains visits with dates in the subsequent episode period, the claim of the first episode will be rejected by the system with a reject code that indicates the date of the first overlapping visit. The claim rejected by the system will 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 subsequently receives a rejected claim, the agency can 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, but corrections and adjustments in payment will be made automatically as appropriate whether the HHA submits corrections or not.

8. If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, the system will 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 MCSC). In such cases, contractors will return the claims rejected by the system to providers.

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

D. Other Editing and Changes for HHA PPS Episodes.

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

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

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

4. The system will 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 period containing either a transfer or a discharge-readmit indicator.

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

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

7. Claims for institutional inpatient services (i.e., inpatient hospital and skilled nursing facility services) will 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 skilled nursing facility (SNF) claim (not including the dates of admission and discharge), the system will reject the HH claim.

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 continues, although a SCIC adjustment

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is likely to apply. Occurrence span code 74, previously used in such situations, should not be employed on HHA PPS claims.

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 would be one shortened HHA PPS episode 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 would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall. The agency should cancel the PEP claim and the readmission RAP in these cases and re-bill a continuous episode of care.

10. The system will edit to prevent duplicate billing of DME. Consequently, the system must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS coding, though home health consolidated billing does not apply to DME by law.

E. Chart Summarizing the Effects of RAP/Claim Actions on the HHA PPS Episode.

TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Initial RAP (Percentage Payments 0-60)	Open an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60 th day.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next episode.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60 th day.	<ul style="list-style-type: none"> • The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of the transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs.

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TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
RAP Cancellation by Provider or Contractor	The episode record is deleted from system.	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim submission.
RAP Cancellation by System	The episode record remains open on system	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present. • To correct information on this RAP, the original RAP must be replaced, canceled by the HHA and then re-submitted once more with the correct information.
Claim (full)	60-day episode record completed; episode "through" date remains at the 60 th day; Date of Latest Billing Action (DOLBA) updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (discharge with goals met prior to Day 60)	Episode record complete; episode "through" date remains at the 60 th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	<ul style="list-style-type: none"> • A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date.
No-RAP LUPA Claim	Opens an episode record using claim's "from" date; the "through" date automatically calculated to extend through 60 th day; DOLBA updates with date of last service.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • Other No-RAP LUPA claims will be rejected unless a transfer source is present. • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim.
Claim (adjustment)	No impact on the episode unless adjustment changes patient status to transfer.	<ul style="list-style-type: none"> • No impact

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TRANSACTION	HOW SYSTEM IS IMPACTED	HOW OTHER PROVIDERS ARE IMPACTED
Claim Cancellation by Provider or Contractor	The episode is deleted from system.	<ul style="list-style-type: none"> • No episode exists to prevent RAP submission or No-RAP LUPA claim submission.
Claim Cancellation by System	The episode record remains open on system.	<ul style="list-style-type: none"> • Other RAPs submitted during this open episode will be rejected unless a transfer source code is present. • No-RAP LUPA claims will be rejected unless a transfer source code is present.

F. Episode Data Requirement. The contractor's authorization screen (part of its automated authorization file) will show whether or not the beneficiary is currently in a home health episode of care (being served by a primary HHA), along with the following information:

1. The beneficiary's name and sex;
2. Pertinent contractor and provider number;
3. 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 day after the start date, changed as necessary when the claim for the episode is finalized;
4. DOEBA and DOBLA, dates of earliest and latest billing activity.
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;
6. Transfer/Readmit Indicator - Source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge);
7. The HIPPs Code(s)- up to six for any episode, representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
8. Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or overlaying claim;
9. A LUPA Indicator - received from the system indicating whether or not there was a LUPA episode; and
10. At least 6 of the most recent episodes for any beneficiary.

- END -