PUBLICATION

Beginning April 1, HHA Payment Will Be Determined By CMS Generated Code Using OASIS Data [Ober|Kaler]

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Payment for a particular home health agency (HHA) beneficiary's episode of care is based on a Health Insurance Prospective Payment System (HIPPS) code. There are three sources for the HIPPS code and they do not always agree: (1) the HHA submits a HIPPS code as one of the data elements in the Outcomes and Assessment Information Set (OASIS) submitted to CMS ; (2) CMS uses software to determine the proper HIPPS code based on all the OASIS data; and (3) the HHA includes a HIPPS code on each HHA claim for Medicare payment.

As explained in a November 10, 2009 Federal Register, effective January 1, 2010, CMS would notify an HHA if the HIPPS code generated by the CMS system was inconsistent with the code the HHA included in its OASIS data. 74 Fed. Reg. 58078, 58109-58111. That could occur if an HHA used its own grouper software to determine the code, rather than using CMS's software. While HHAs are permitted to use their own software, the CMS software is the official version and any discrepancy in the HIPPS code must result in adoption of the CMS code and use of this code on the HHA claim form:

In the case where the Final Validation Report returns to the HHA a HIPPS code which is different than the HIPPS code submitted to CMS by the HHA on the OASIS, the HHA must ensure that the HIPPS code from the Final Validation report is the HIPPS code reported on the bill.

74 Fed. Reg. at 58109, 58210.

Thus, pursuant to this current methodology, the HIPPS code on the claim form drives the specific payment for the beneficiary episode of care, but HHAs should be using the HIPPS code as determined by CMS based on the HHA-submitted OASIS data.

Beginning April 1, 2015, CMS is adopting changes that will ensure that the CMS determined code will determine payment. For claims received on or after April 1, 2015, Medicare will compare the submitted HIPPS code on the claim against the CMS OASIS-calculated HIPPS code. If the matching process identifies a discrepancy between the two codes, then the CMS code will be used to determine payment. This change in methodology is described in MLN Matters No. SE1504. In this document, CMS identifies the submission of an OASIS assessment for all home health episodes of care as a condition of payment. CMS has stated, however, that for the time being, Medicare will make payment during the normal claims process, even if an OASIS is not timely submitted. If, however, the claim is subject to medical review by a CMS contractor, and no OASIS is found, the claim will be denied:

If the OASIS is not found during medical review of a claim, the claim is denied. At this time, if no corresponding OASIS assessment is found by the claims matching process Medicare will release the claim to process normally, unless the claim is selected for medical review. However, the OIG recommended that the Medicare program use this claims matching process to further enforce the condition of payment.

CMS plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release. At that time, Medicare will deny claims when a corresponding assessment is past

due in the QIES [the Quality Evaluation Information System which allows validation of HIPPS codes against OASIS assessments] but is not found in that system. CMS will provide notice to HHAs as soon as possible after we determine the implementation date.

Ober|Kaler's Comments

Submission of the OASIS data has been considered a condition of payment since January 1, 2010. Although CMS has not rigorously enforced this requirement to date, it has made clear in the recent MLN Matters that this is going to change. HHAs should use this opportunity to make sure they are submitting complete and accurate OASIS data, to ensure that future HHA claims payment are properly paid.