

# Homecare Q&A™

*No-nonsense Solutions that Clear the Medicare Fog*

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## PPS Reform

**Q** *If the Home Health Resource Group (HHRG) for supplies indicates that there are no supplies, severity level 1, must we still complete a line on the claim? If so, would that be zero units and no charges?*

**A** Severity level 1 in the nonroutine supplies case-mix model equates to zero points. The patient did not have any of the selected skin conditions or clinical factors in the case-mix table. In most cases, a patient with this score will not need supplies; however, there can be times when the OASIS data elements in the case-mix table do not pick up on the patient's need. **Example:** *A patient has pleural effusion and needs a chest drainage system.* The case-mix system for nonroutine supplies has no indicators to identify this condition. If this patient does not have any other skin conditions or clinical factors in the supply HHRG, his or her score would be severity level 1, zero points. An agency must provide the supplies but it will receive the minimum payment — \$14.12 per episode. The claim would report the supplies the agency provided.

If the patient's severity level is 1 and he or she does not receive supplies, someone in the agency must manually change the last position of the Health Insurance Prospective Payment System (HIPPS) code from the letter "S" to the number "1." The number indicates the agency is not providing supplies.

**Q** *If the patient was admitted to our agency two years ago, would we treat this recertification as an early or later episode for M0110, episode timing?*

**A** Even though the revised Prospective Payment System (PPS) took effect on January 1, 2008, the patient's history comes into play for M0110. If the patient has been on service continuously (with no discharge/start of care) for 121 days or longer, the

episodes would be sequential and the recertification would be considered later — the third or beyond.

**Q** *If the answer to M0110, episode timing, is incorrect, will intermediaries make the changes and pay us accordingly, or will there not be any edit of this field?*

**A** The Centers for Medicare and Medicaid Services (CMS), in its comments with the final PPS rule, said that its system will automatically correct this answer based on information available at the time. It even went so far to say that if an agency did not want to answer this question, it could let the system answer it (if the agency trusted the system to do this right). The system will also correct the answer at any time over the next 27 months based on information that might become available.

**Q** *If other agencies are not timely in submitting requests for anticipated payment (RAPs) or claims, how can we answer M0110?*

**A** An agency should determine the answer to M0110, episode timing, to the best of its ability. If the information used is incomplete, the answer may be wrong, which can have an impact on payment. However, the CMS has said that its system will correct the answer. So, hopefully, the agency will receive the correct payment.

**Q** *Regarding M0826, therapy need, does the frequency and duration of therapy visits have to be on the plan of care, or can that come from the therapist's evaluation and plan?*

**A** This is one of the most discussed topics on home health list serves in recent weeks. And information from the CMS does little to provide a solid answer.