OASIS Alert

Reimbursement: Brace Yourself for HIPPS Code Assessment Data Validation Edit

Is your agency missing vital claim error data?

Your OASIS data is about to get another layer of scrutiny once a new edit goes into effect. Will your claims suffer as a result?

The **Centers for Medicare & Medicaid Services** is implementing edits to validate HIPPS codes against assessment data for three post-acute providers: home health agencies, inpatient rehab facilities, and skilled nursing facilities.

First up are IRFs, whose validation edits went into place Oct. 1. CMS plans to implement HHA and SNF edits on future dates "to be determined," it notes in MLN Matters Article No. MM7760.

"Luckily home health is not going to be the guinea pig," says consultant **M. Aaron Little** with **BKD** in Springfield, Mo. "Hopefully CMS will work out the bugs with IRFs and get the process working well before applying it to HHAs and SNFs."

Why the change? "Currently, the [Fiscal Intermediary Shared System] does not have access to the assessment databases," CMS notes in the article. "This inability to validate the submitted Health Insurance Prospective Payment System (HIPPS) code(s) against the associated assessment creates significant payment vulnerability for the Medicare program."

How it will work: If the HIPPS codes on the claim and in the assessment database agree, Medicare will release the claim for processing, CMS explains. If not, the MAC will use the assessment to generate a new HIPPS code. The edits are currently being set up, but will be turned off for HHAs and SNFs for the time being.

Watching how the edits work with IRFs will answer some questions, Little says. One thing to keep an eye out for is whether the edit will add days to the payment process. It looks like FISS creates the validation file and sends it to the state system, he explains. The state then runs the validation process and sends the file back in, attached to the claim. All of these steps could add up to a three-day process, he estimates.

HHAs are used to a 14-day payment floor, Little says. "It is my understanding that the three days required to validate the HIPPS code will be built into the 14 day payment floor, rather than extending the payment process to 17 days."

"This is another level of review that will need to be done prior to Final Claim submission," says **Sue Gold**, senior consultant with Northampton, Mass.-based **Fazzi Associates**.

Agencies will need to ensure that the OASIS was submitted and accepted prior to billing, Gold says. They will also need to make certain that the HHRG on the submitted OASIS equates to the Final Claim HIPPS.

Initially, this will be a significant change in process, Gold maintains. Electronic medical records are able to determine when an OASIS has been extracted and submitted, but currently most EMRs can't determine if the OASIS was rejected, she says.

To be successful with this change, agencies will need to develop pre-billing edits which may unfortunately include a manual review, Gold says. This extra step will help ensure payment and prevent agencies from being identified via data mining as warranting greater scrutiny, she says.

Gear Up for this Additional Check

"Although a date has not yet been determined for implementing this process for home health claims, agencies should make certain to take necessary steps to be prepared for this," warns the **National Association for Home Care & Hospice**.

You can begin preparing by making sure you fully understand the OASIS assessment submission process you already have in place, Little advises. This includes the following, he says:

1. Make sure you have a good routine for transmitting assessments, whether daily or weekly depending on your agency's volume.

2. Understand the technology you're using, whether it's CMS' HAVEN or software from another provider. Make sure you know how the software determines when there are assessments that have been completed but not submitted yet and what triggers their submission.

3. Review the assessment confirmation response files your agency receives back from the state after submitting assessments. These files will tell you whether the assessments have been accepted or rejected as well as whether there were any errors with the data validation.

Tip: "Agencies that use outside vendors rather than HAVEN to generate HIPPS codes should verify the HIPPS codes that their software generates against HAVEN prior to submitting claims," NAHC advises.

Edit Could Help Prevent Incorrect Payment Headaches

On the plus side, the new validation edit will provide an extra check to help prevent reimbursement errors. While the state assessment response files provide similar information now, the edit will take the additional step of correcting payment.

Case study: One HHA recently learned the hard way about the importance of reviewing the state response files, Little says. The agency was getting back responses warning that the HIPPS code the state calculated wasn't the same as the HIPPS code being determined by their vendor's software logic.

The issue: The grouper logic in the software this agency uses was still giving case mix points for diagnosis code 401.9 (Essential hypertension; unspecified), even though that code was removed from the case mix list effective January 1, 2012.

The vendor knew this was a problem and had a correction plan in place, but somehow it wasn't applied to this agency's operating system. If the agency's personnel had been reviewing the state response files, they would have seen that there was an issue with the HIPPS code calculation, Little says. "But no one homed in on this or brought it to anyone's attention."

Lesson learned: It's important to read the state response files for your assessment submissions. Plus you need to be certain that you understand what the responses mean and what to do about them.

Had the new validation edit been in place, this agency's claims with the HIPPS code issue would have been sent to QIES where the HIPPS code would have been recalculated and the claims paid correctly, Little says. As it stands, this agency was overpaid on the claims they submitted and must now go through the process of determining the extent of the problem and correcting it.

For this agency, the new validation edit would have helped by giving a warning that something was off in the HIPPS calculation, Little says. Then staff could follow through to see why there was a problem. But the assessment confirmation reports do offer this opportunity currently.

Resources: The CMS transmittal regarding the edit is at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2495CP.pdf and the MLN Matters article is at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7760.pdf.

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