CareCentrix®

HIPPS Requirement
Provider Frequently Asked Questions
July 2014

Q1: What are the new billing requirements for home health care providers with regards to Health Insurance Prospective Pay System (HIPPS) codes?

A1: The Centers for Medicare and Medicaid Services (CMS) require home health providers to submit HIPPS codes in the HIPAA 5010 / 837i format for home health care services provided to Medicare Advantage members. Consistent with this requirement, CareCentrix will require both contracted and non-contracted home health care providers to submit HIPPS codes for home health care services provided to Medicare Advantage members.

Q2: When is this requirement effective?

A2: This new CMS requirement went into effect on July 1, 2014.

Q3: Is the requirement effective date based on date of service or the date of claim submission?

A3: The requirement is based on date of service. Home health claims for services provided to Medicare Advantage members on or after July 1, 2014 must follow the new HIPPS requirement.

Q4: With the implementation of this new requirement, is there a specific claim format that must be used when submitting home health claims for Medicare Advantage members?

A4: Home health care providers must use the 837i (institutional format) or, for paper claims, the standard UB-04 (CMS-1450) claim form. The CMS-1500 claim form does not include a field for the HIPPS code and should not be utilized.

Q5: Where on the claim should the HIPPS code be included?

A5: Insert the HIPPS code in Box 44 on the 837 institutional format or UB04.

Q6: What additional information should be included on the claim with the HIPPS code?

A6: In addition to billing with the HIPPS code, the following information should be included on the claim:

1. The HIPPS code should be billed in a separate claim line in conjunction with a revenue code of '0022', '0023' or '0024' which will indicate use of a HIPPS code.
2. The HIPPS code should be billed indicating a quantity of one $0.00 charge and a date of service equal to the date of the earliest billable service on the claim.

Q7: Does this new HIPPS requirement impact other claims submission requirements?

A7: This new HIPPS requirement will not impact the current clean claim elements or other claim submission requirements as specified in the CareCentrix Provider Manual. The CareCentrix Provider Manual can be found at www.carecentrixportal.com.

Q8: What will happen to the claim if any of the HIPPS required information is left off of the claim?

A8: Any claims for dates of service on or after 07/1/2014 that do not follow the CMS HIPPS requirement may be rejected. ***Please note:*** Front end rejections are not proof of timely filing. All incomplete claims must be resubmitted by the provider with all clean claim elements and

HIPPS elements present within the original timely filing timeframe as specified in your contract and our Provider Manual.

Q9: Does this new requirement change CareCentrix's payment methodology; i.e. episodic versus per visit payments?

A9: No, this HIPPS code requirement does not affect your current payment arrangement.

Q10: Will the HIPPS code determine reimbursement rate?

A10: No, the HIPPS code does not affect your reimbursement rate.

Q11: Is the Provider required to hold all billing and submit all visits with the final claim submitted to CareCentrix?

A11: No, all providers should continue to submit their claims within the timely filing timeframe as specified in your contract and our Provider Manual. The new HIPPS requirement will not change timely filing guidelines.

Q12: In which locator do you want to see the authorization code since the UB does not have a specific location for it as the HCFA-1500 does?

A12: The Authorization Code (TAC) should be populated in field 63 on the 837i or UB04 (CMS 1450) claim form.

Q13: Will this mandate only apply to patients with an actual start of care of July 1st or after? In other words, if a patient is started on 6/1/14 and the patient is still being seen in July, can we finish billing without the HIPPS code since the start of care was prior to July?

A13: No, a HIPPS code is required for home health service provided on or after 7/1/14.

Q14: Do all claims need to be submitted with the appropriate HIPPS code or just claims for Medicare Advantage members?

A14: The appropriate HIPPS code only needs to be included for home health care claims for Medicare Advantage members.

Q15: What happens if the HIPPS code changes throughout the Medicare Advantage member's episode? Do we need to contact CareCentrix to notify you of this update?

A15: If the HIPPS code changes during the member's episode, you are not required to telephonically contact CareCentrix. However, please ensure that the most accurate HIPPS code is included on your claim.

Q16: Are HIPPS codes required on all Medicare Advantage claims or just the claims for the first and last visit?

A16: The appropriate HIPPS code must be included on all home health claims for services provided to Medicare Advantage Members.