

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1505	Date: May 16, 2008
	Change Request 6027

SUBJECT: Correction to Determinations of Early vs. Later Episodes Under the Home Health Prospective Payment System (HH PPS)

I. SUMMARY OF CHANGES: This instruction requires the Common Working File to exclude episodes that were fully denied by medical review from determinations of whether an episode should be paid as "early" or "later." It also makes miscellaneous corrections and clarifications to HH billing manual instructions.

New / Revised Material

Effective Date: Home health PPS episodes beginning on or after January 1, 2008

Implementation Date: October 6, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/Table of Contents
R	10/10.1.9/Composition of HIPPS Codes for HH PPS
R	10/10.1.15/Adjustments of Episode Payment - Partial Episode Payment (PEP)
R	10/10.1.19.1/Adjustments of Episode Payment - Therapy Threshold
N	10/10.1.19.3/Adjustments of Episode Payment - Early or Later Episodes
R	10/30.5/National Home Health Prospective Payment Episode History File
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/60/No Payment Billing
R	10/70.4/Decision Logic Used by the Pricer on Claims

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

Not Applicable.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6027.1.2	Medicare systems shall consider the following list of ANSI claim adjustment reason codes when associated with revenue code 0023: 16 17 22 50 56 58 107 116 150 151 173 175 185 A1 B5 B7 B8 B9 B12 B20									X	
6027.1.3	Medicare systems shall set a value of '2' in the cancel indicator of the HH episode record when the conditions defined in requirements 6027.1.1 and 6027.1.2 are met.									X	
6027.2	Medicare systems shall exclude episodes with a cancel indicator of '2' from pre-payment edits ensuring correct episode sequence.									X	
6027.3	Medicare systems shall exclude episodes with a cancel indicator of '2' from the informational unsolicited response (IUR) process used to correct episode sequence.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6027.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that					X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6027.1	HH PPS claims include any record with type of bill 32x or 33x other than requests for anticipated payment (322 or 332).
6027.1.2	Claim adjustment reason codes begin in the third position of the ANSI code field sent to CWF. The first two positions represent a Group Code. Definition of these codes are found at: www.wpc-edi.com/custom_html/claimadjustment.htm
6027.2 & 6027.3	These requirements refer to CWF edits and IURs 524P and 524Q.

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne (410) 786-6148, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC): N/A

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

Table of Contents *(Rev.1505, 05-16-08)*

10.1.19.3 - Adjustments of Episode Payment – Early or Later Episodes

10.1.9 - Composition of HIPPS Codes for HH PPS

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

For HH PPS episodes beginning on and after October 1, 2000 but before January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is a fixed letter “H” to designate home health, and does not correspond to any part of HHRG coding.
- The second, third, and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the original 2000 HH PPS final rule. HIPPS code lists are maintained on the CMS Web site. Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.
- The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper. This position does not correspond to HHRGs since these codes do not differentiate payment groups. The fifth position will allow only numeric characters and a fifth position value other than “1,” which is produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

The first position of every home health HIPPS code will be “H.” The remaining four positions discussed above can be summarized as follows:

(Clinical) Position #2	(Functional) Position #3	(Service) Position #4	Position #5	Domain Level
A (HHRG: C0)	E (HHRG: F0)	J (HHRG: S0)	1 = 2nd, 3rd & 4 th positions computed	= min
B (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	2 = 2nd position derived	= low
C (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	3 = 3rd position derived	= mod
D (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	4 = 4th position derived	= high
	I (HHRG: F4)		5 = 2nd & 3 rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4 th positions derived	

(Clinical) Position #2	(Functional) Position #3	(Service) Position #4	Position #5	Domain Level
			8 = 2nd, 3rd & 4 th positions derived	
		N thru Z	9, 0	expansion values for future use

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

Based on this coding structure:

- The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG.
- The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, the Pricer software will price all eight codes for that HHRG identically.

For HH PPS episodes beginning on and after January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is no longer a fixed value. The refined HH PPS uses a four-equation case-mix model which assigns differing scores in the clinical, functional and service domains based on whether an episode is an early or later episode in a sequence of adjacent *covered* episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores that follow.
- The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system.
- The fifth position indicates a severity group for non-routine supplies (NRS). The HH PPS grouper software will assign each episode into one of 6 NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number 1 through 6 before submitting the claim.

Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

	Position #1	Position #2	Position #3	Position #4	Position #5		
	Grouping Step	Clinical Domain	Functional Domain	Service Domain	Supply Group – supplies provided	Supply Group – supplies not provided	Domain Levels
Early Episodes (1st & 2nd)	1 (0-13 Visits)	A (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	S (Severity Level: 1)	1 (Severity Level: 1)	= min
	2 (14-19 Visits)	B (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	T (Severity Level: 2)	2 (Severity Level: 2)	= low
Late Episodes (3rd & later)	3 (0-13 visits)	C (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	U (Severity Level: 3)	3 (Severity Level: 3)	= mod
	4 (14-19 Visits)			N (HHRG: S4)	V (Severity Level: 4)	4 (Severity Level: 4)	= high
Early or Late Episodes	5 (20 + Visits)			P (HHRG: S5)	W (Severity Level: 5)	5 (Severity Level: 5)	= max
					X (Severity Level: 6)	6 (Severity Level: 6)	
	6 thru 0	D thru E	I thru J	Q thru R	Y thru Z	7 thru 0	Expansion values for future use

Examples:

- First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level and non-routine supplies were not provided = HIPPS code 1AFK1
- Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity level 4 = HIPPS code 4CHLV
- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score for all episodes over 20 therapies is the same (minimum) and supply severity level 6 = HIPPS code 5BHKX

Based on this coding structure:

- 153 case-mix groups defined in the 2007 HH PPS final rule are represented by the first four positions of the code.
- Each of these case-mix groups can be combined with any NRS severity level, resulting in 1836 HIPPS codes in all (i.e., 153 case-mix groups times 12 NRS codes (two each per NRS severity level)).
- Each HIPPS code will represent a distinct payment amount, without any duplication of payment weights across codes.
- HIPPS codes created using this structure are valid only on claim lines with revenue code 0023.

10.1.15 - Adjustments of Episode Payment - Partial Episode Payment (PEP)

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened episodes. In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called partial episode payments (PEP).

PEP adjustments occur as a result of the two following situations:

- a. When a patient has been discharged and readmitted to home care within the same 60-day episode, which will be indicated by using a Patient Discharge Status code of 06 on the final claim for the first part of the 60 day episode; or
- b. When a patient transfers to another HHA during a 60-day episode, also indicated with a Patient Discharge Status code of 06 on their final claim.

Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. **This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service to and including the day of the last billable service.**

For episodes beginning on or after January 1, 2008, the non-routine supply payment amount is also subject to this proration on a basis of days.

10.1.19.1 - Adjustments of Episode Payment - Therapy Threshold *(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)*

The number of therapy visits projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode.

For episodes beginning before January 1, 2008:

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational, or speech-language pathology combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS codes representing the same payment group; one if a beneficiary does not receive the therapy hours projected, and another if they do meet the “therapy threshold.” Therefore, when the therapy threshold is not met and the HIPPS code output by the Grouper indicated it would be, there is an automatic “fall back” HIPPS code, and Pricer software in Medicare claims processing systems will correct payment without access to the full OASIS data set.

The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare claims processing systems would pay the full episode payment based on the HIPPS code. Note that HIPPS codes may also be changed based on the medical review of claims, but Pricer software enforces the therapy threshold. Pricer will automatically change the HIPPS to the fallback code if the threshold is not met, but providers must adjust the HIPPS on their own claims if instead they originally billed the fallback code and then unexpectedly met or exceeded the threshold.

For episodes beginning on or after January 1, 2008:

The refined HH PPS adjusts Medicare payment based on whether one of three therapy thresholds (6, 14 or 20 visits) is met. As a result of these multiple thresholds and since meeting a threshold can change the payment equation that applies to a particular episode, a simple “fallback” coding structure is no longer possible. Also, additional therapy visits may change the score in the service domain of the HIPPS code.

Due to this increased complexity of the payment system regarding therapies, the Pricer software in Medicare's claims processing system will recode all claims based on the actual number of therapy services provided. This recoding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment.

Since the number of therapy visits provided can change the payment equation used under the refined four-equation case mix model, in some cases this recoding may change several positions of the HIPPS code. In these cases, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

As in the original HH PPS, the electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

10.1.19.3 - Adjustments of Episode Payment – Early or Later Episodes (Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

For episodes beginning on or after January 1, 2008:

The refined HH PPS uses a 4-equation case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early (1st or 2nd episode in a sequence of adjacent covered episodes) or later (the 3rd episode and beyond in a sequence of adjacent covered episodes) episode of care.

Early episodes include not only the initial episode in a sequence of adjacent covered episodes, but also the next adjacent covered episode, if any, that followed the initial episode. Later episodes are defined as all adjacent episodes beyond the second episode. Episodes are considered to be adjacent if they are separated by no more than a 60-day period between claims.

Any Medicare fee-for-service covered episode for a beneficiary is considered in determining adjacent covered episodes. A sequence of adjacent covered episodes is not interrupted if a beneficiary transfers between HHAs. Episodes covered by Medicare Advantage plans are not considered in determining adjacent episodes.

Example: A patient is admitted to Agency A on July 5th into a payment episode that ends on the date of Sept 2nd. The patient is then recertified on Sept 3rd, with an end of episode date of November 1st. . Agency B admits on Jan 1, 2008.

When determining if two eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one

episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1. Continue counting to, and including, the first day of the next episode.

In this example, November 1st was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent.

The episode starting January 1st would be reported by Agency B as “early”. December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “later.”

HHAs report whether an episode is “early” or “later” using OASIS item M0110. This OASIS information is then used to determine the HIPPS code used for billing. The first position of the HIPPS code shows whether an episode is “early” or “later.” Since HHAs may not always have complete information about previous episodes, the HIPPS code is validated by Medicare systems. The Common Working File reads the episode history described in section 30.5 to determine whether an episode has been coded correctly based on the most current information available to Medicare. If the HIPPS code disagrees with Medicare’s episode history, the claim will be recoded.

The receipt of any episode may change the sequence of previously paid claims. For instance, a claim may be paid as “early” because the HHA was not aware of prior episodes and the previous HHA had not billed for the prior episodes. When the earlier dated episodes are received, Medicare systems will initiate an automatic adjustment to recode the previously paid claim and correct its payment.

When claims are recoded, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

30.5 - National Home Health Prospective Payment Episode History File ***(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)***

CWF maintains a national episode history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. Only Medicare contractors, not providers, may view this file.

The episode file, populated as soon as the first HH PPS episode is opened for a beneficiary with either a RAP or a claim, contains:

- The beneficiary's Health Insurance Claim Number (HICN);
- The pertinent Contractor and Provider Numbers;
- 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;
- DOEBA and DOLBA, Dates of Earliest and Latest Billing Activity (respectively) - dates needed to attribute episode payment to the correct Medicare trust fund, drawn from the existing home health benefit period file;
- Patient Status Indicator - the patient discharge status code on an HH PPS claim, indicating the status of the HH patient at the end of the episode. This indicator will also be populated by RAPs, but the value will always be "30";
- 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);
- The HIPPS Code(s) - up to six for any episode (though only one will be used for episodes beginning on or after January 1, 2008), representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
- Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or claim;
- A LUPA Indicator - received from the shared system indicating whether or not there was a LUPA episode; and
- A RAP Cancellation Indicator - showing whether or not a RAP has been auto-canceled for this episode because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel only code "B," this indicator is a value of "1." *For episodes beginning on or after January 1, 2008, this indicator is also used when a final claim has been denied as fully non-covered by medical review. In these cases, the indicator is a value of "2."* In all other cases, the value is "0."

Separate from the episode file, CWF passes the Claims-OASIS matching key on the RAP or claim to CMS' National Claims History (NCH). This enables NCH claims data to be linked to individual OASIS assessments supporting the payment of individual claims. The LUPA indicator is also passed to NCH, in addition to routinely passed claim data.

A transfer/readmit indicator, populated by the source of admission code taken from the RAP or claim as an indicator of the type of admission, is present on the internal episode file used in CWF editing but it is not displayed on the episode history screen. If contractors need to validate this data used in CWF editing, they must research the claim record on CWF history. The episode file contains the 36 most recent episodes for any beneficiary. Episodes that precede the most recent 36 will be dropped off the file and will not be retrievable online. The date of accretion, meaning dates on which episode records are created or updated, for an episode is the date the RAP or claim is accepted or applied.

40.1 - Request for Anticipated Payment (RAP)

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit an RAP with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the next remittance advice (RA).

If care continues with the same provider for a second episode of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the next RA will be used to recoup the overpaid amount.

While an RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity.

Patient Control Number

Optional - The patient’s control number may be shown if the HHA assigns one and needs it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a “frequency” code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

NOTE: While the bill classification of “3,” defined as “Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)” may also be appropriate to an HH PPS claim depending upon a beneficiary’s eligibility, Medicare encourages HHAs to submit all RAPs with bill classification “2.” Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	Definition
2-Interim-First Claim	For HHAs, used for the submission of original or replacement RAPs.
8-Void/Cancel of a Prior Claim	Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code “2” bill (a replacement RAP) must be submitted for the episode to be paid. If an RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted.

Medicare contractors will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

Statement Covers Period (From-Through)

Required - Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the “from” and “through” date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.).

Patient Name/Identifier

Required - Patient’s last name, first name, and middle initial.

Patient Address

Required - Patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - Month, day, and year of birth of patient.

Left blank if the full correct date is not known.

Patient Sex

Required - “M” for male or “F” for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

Required - Date the patient was admitted to home health care. On the first RAP in an admission, this date should match the statement covers “from” date. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

Source of Referral for Admission or Visit

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code. For a complete list of codes, see Chapter 25.

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician’s plan of care.

Patient Discharge Status

Required - Indicates the patient’s status as of the “through” date of the billing period. Since the “through” date of the RAP will match the “from” date, the patient will never be discharged as of the “through” date. As a result only one patient status is possible on RAPs, code 30 which represents that the beneficiary is still a patient of the HHA.

Condition Codes

Conditional. The HHA enters any NUBC approved code to describe conditions that apply to the RAP.

If canceling the RAP (TOB 3X8), the agency reports one of the following:
Claim Change Reasons

Code	Title	Definition
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

Enter “Remarks” indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

For a complete list of Occurrence Codes, see Chapter 25.

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

For a complete list of value codes, see Chapter 25.

Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

NOTE: Revenue codes 058X and 059X are not accepted with covered charges on Medicare home health RAPs under HH PPS. Revenue code 0624 (investigational devices) is not accepted at all on Medicare home health RAPs under HH PPS.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Service Date

Required - On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Service Units

Optional – Service units are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports service units as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Total Charges

Required – The HHA reports zero charges on the 0023 revenue code line.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports any necessary charge amounts to meet the requirements of other payers or its billing software. Medicare claims processing systems will not make any payments based upon submitted charge amounts.

Payer Name

Required - See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

Release of Information Certification Indicator

Required - A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

Insured's Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. *Tables defining*

these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

The following represents an example of a treatment authorization code created using this format:

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

Document Control Number (DCN)

Required - If canceling an RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case.

Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-*CM* code and principle diagnosis reported on the claim must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis.

For other diagnoses, the diagnoses and ICD-9-*CM* codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-*CM* guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-*CM* guidelines.

OASIS form items M0245 or M0246, which report Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-*CM* coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.

Remarks

Conditional - Remarks are necessary when canceling the RAP, to indicate the reason for the cancellation.

40.2 - HH PPS Claims

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be

reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See Chapter 1.)

Billing Provider Name, Address, and Telephone Number

Required – The HHA’s minimum entry is the agency’s name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. Medicare contractors use this information in connection with the provider identifier to verify provider identity.

Patient Control Number and Medical/Health Record Number

Required - The patient’s control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

The HHA may enter the number assigned to the patient’s medical/health record. If this number is entered, the Medicare contractor must carry it through their system and return it on the remittance record.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to

as a “frequency” code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

NOTE: While the bill classification of 3, defined as “Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)” may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - Definition

7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or “new” bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.

8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

9 - Final Claim for an HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8.

HHAs must submit HH PPS claims with the frequency of “9.” These claims may be adjusted with frequency “7” or cancelled with frequency “8.” Medicare contractors do not accept late charge bills, submitted with frequency “5” on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

Statement Covers Period

Required - The beginning and ending dates of the period covered by this claim. The “from” date must match the date submitted on the RAP for the episode. For continuous

care episodes, the “through” date must be 59 days after the “from” date. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal discharge procedures as the “through” date. If a discharge claim is submitted due to change of Medicare contractor, see instructions for patient status code below. If the beneficiary has died, the HHA reports the date of death in the “through date.”

Any NUBC approved patient status code may be used in these cases. The HHA may submit claims for payment immediately after the claim “through” date. It is not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

Patient Name/Identifier

Required – The HHA enters the patient’s last name, first name, and middle initial.

Patient Address

Required - The HHA enters the patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The HHA enters the month, day, and year of birth of patient. If the **full** correct date is not known, leave blank.

Patient Sex

Required - “M” for male or “F” for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

Required - The HHA enters the same date of admission that was submitted on the RAP for the episode.

Source of Referral for Admission or Visit

Required - The HHA enters the same source of admission code that was submitted on the RAP for the episode.

Patient Discharge Status

Required - The HHA enters the code that most accurately describes the patient's status as of the "Through" date of the billing period. Any applicable NUBC approved code may be used.

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

In cases where an HHA is changing the Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status code 06. Billing for the beneficiary is being "transferred" to the new contractor.

In cases where the ownership of an HHA is changing which causes the Medicare certification number (known as the OSCAR number) to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. In changes of ownership which do not affect the Medicare certification number, billing for episodes is also unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date. The claim should be coded with patient status 06. Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

If HHAs require guidance on OASIS assessment procedures in these cases, they should contact the appropriate state OASIS education coordinator.

Condition Codes

Optional – The HHA enters any NUBC approved code to describe conditions that apply to the claim. For a complete list of Condition Codes see Chapter 25.

HHAs that are adjusting previously paid claims enter one of the following codes representing Claim Change Reasons:

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Codes
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter “Remarks” indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3X8), HHAs report the condition codes D5 or D6 and enter “Remarks” indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

Occurrence Codes and Dates

Optional - The HHA enters any NUBC approved code to describe occurrences that apply to the claim. For a complete list of Occurrence Codes see Chapter 25.

Occurrence Span Code and Dates

Optional - The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission during an episode.

For a complete list of Occurrence Span codes see Chapter 25.

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. For episodes in which the beneficiary’s site of service changes

from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Contractors always place condition code 61 on the claim along with this value code.)
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §18129(a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 32X, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will not change the TOB and will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by “X” in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim.

For episodes beginning before January 1, 2008, if there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more than once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day. If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change.

Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care and zero charges. See §40.1 for more detailed information on the HIPPS code.

For episodes beginning on or after January 1, 2008, HHAs enter only one 0023 revenue code per claim in all cases.

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 042X, 043X, 044X, 055X, 056X and 057X) must be reported as a separate line. Any of the following revenue codes may be used:

<p>027X (NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)</p>	<p>Medical/Surgical Supplies (Also see 062X, an extension of 027X)</p> <p>Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount.</p>
<p>042X</p>	<p>Physical Therapy</p> <p>Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>043X</p>	<p>Occupational Therapy</p> <p>Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>044X</p>	<p>Speech-Language Pathology</p> <p>Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>055X</p>	<p>Skilled Nursing</p> <p>Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

056X	<p>Medical Social Services</p> <p>Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
057X	<p>Home Health Aide (Home Health)</p> <p>Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

NOTE: FIs do not accept revenue codes 058X or 059X when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

Revenue Codes for Optional Billing of DME

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their Medicare contractor processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

029X	<p>Durable Medical Equipment (DME) (Other Than Renal)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one.</p>
060X	<p>Oxygen (Home Health)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.</p>

Revenue Code for Optional Reporting of Wound Care Supplies

062X	<p>Medical/Surgical Supplies - Extension of 027X</p> <p>Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.</p>
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HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation “surg dressings,” HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Chapter 7 of Pub. 100-02, Medicare Benefit Policy Manual defines routine vs. nonroutine supplies. HHAs will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS’ future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

Validating Required Reporting of Supply Revenue Code

With the advent of the refined HH PPS, the payment system includes a separate case-mix adjustment for non-routine supplies. Effective for HH PPS episodes beginning on or after January 1, 2008, non-routine supply severity levels will be indicated on HH PPS claims through a code value in the 5th position of the HIPPS code. The 5th position of the HIPPS code can contain two sets of values. One set of codes (the letters S through X) indicate that supplies were provided. The second set of codes (the numbers 1 through 6) indicate the HHA is intentionally reporting that they did not provide supplies during the episode. See section 10.1.9 for the complete composition of HIPPS under the refined HH PPS.

HHAs must ensure that if they are submitting a HIPPS code with a 5th position containing the letters S through X, the claim must also report a non-routine supply revenue with covered charges. This revenue code may be either revenue code 27x, excluding 274, or revenue code 623, consistent with the instructions for optional separate reporting of wound care supplies.

Medicare systems will return the claim to the HHA if the HIPPS code indicates non-routine supplies were provided and supply charges are not reported on the claim. When the HHA receives a claim returned for this reason, the HHA must review their records regarding the supplies provided to the beneficiary. The HHA may take one of the following actions, based on the review of their records:

- If non-routine supplies were provided, the supply charges must be added to the claim using the appropriate supply revenue code.
- If non-routine supplies were not provided, the HHA must indicate that on the claim by changing the 5th position of the HIPPS code to the appropriate numeric value in the range 1 through 6.

After completing one of these actions, the HHA may return the claim to the Medicare contractor for continued adjudication.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA must report the HIPPS code (see §40.1 for definition of HIPPS codes) that was reported on the RAP. *The first four positions of the code must be identical to the value reported on the RAP. The fifth position may vary from the letter value reported on the RAP to the corresponding number which represents the same non-routine supply severity level but which reports that non-routine supplies were not provided.*

On claims reflecting a SCIC *that occurred in an episode that began prior to January 1, 2008*, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

Service Units

Required - The HHA should not report service units on 0023 revenue code lines. For line items detailing all services within the episode period, the HHA reports units of

service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

Total Charges

Required - The HHA must report zero charges on the 0023 revenue code line (the field may be zero or blank).

For line items detailing all services within the episode period, the HHA reports charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). Medicare claims processing systems will not make any payments based upon submitted charge amounts.

Non-covered Charges

Required - The total noncovered charges pertaining to the related revenue code are entered here.

Payer Name

Required - See Chapter 25.

Release of Information Certification Indicator

Required - See Chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Patient's Relationship To Insured

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Unique Identifier

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Group Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Group Number

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions

11 – 18 are converted to a single alphabetic code using the same system. *Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.*

The following represents an example of a treatment authorization code created using this format:

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

In cases of billing for denial notice, using condition code 21, this code may be filled with *a placeholder value as defined in section 60.*

The investigational device (IDE) revenue code, 0624, is not allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims processing systems will match all HH PPS claims to their corresponding RAP and

populate this field on the electronic claim record automatically. Providers do not need to submit a DCN on all HH PPS claims, only on adjustments to paid claims.

Employer Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-*CM* code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

Other Diagnosis Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may **not** duplicate the principal diagnosis as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9-*CM* codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-*CM* guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-*CM* guidelines.

OASIS form items M0245 or M0246, which report Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-*CM* coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported on the claim. In other

circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician that has signed the plan of care.

Remarks

Conditional - Remarks are required only in cases where the claim is cancelled or adjusted.

60 - No Payment Billing

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

No-Payment Billing and Receipt of Denial Notices Under HH PPS

Claims for homebound Medicare beneficiaries under a physician plan of care and electing fee-for-service coverage are reimbursed under HH PPS. Under HH PPS, home health agencies may continue to seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

A - Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 3x0, and condition code 21. The statement dates on the claim should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also key in the charge for each line item on the claim as a non-covered charge.

In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code as a proxy *and a placeholder value for the OASIS Matching Key, as follows:*

- *For claims for episodes starting before January 1, 2008, use HIPPS code HAEJ1 and an 18-digit string of the number 1, "1111111111111111", for the OASIS Matching Key.*
- *For claims for episodes starting on or after January 1, 2008, use HIPPS code IAFKS and a placeholder OASIS matching Key value of "11AA11AA11AAAAAAA."*

The claim must meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems also ensure that a matching RAP has not been paid for that billing period.

B - Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on the claim are non-covered.

C - Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period

In certain cases, CMS allows the use of no payment claims in association with an HHABN involving custodial care and termination of a benefit during an episode period. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there an HHABN must be used assuming a triggering event occurs (i.e., the initiation of completely noncovered care). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a previous episode period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The HHABN for notification of the beneficiary, using Option Box 1 language, with the beneficiary selecting the third checkbox indicating both services and billing is desired, and then also the following checkbox for Medicare billing on that notice, and,
2. A condition code 21 no-payment claim to bill all subsequent services.

NOTE: Providers can never pre-select HHABN options for beneficiaries, in accordance with existing liability notice policy. In each case, the beneficiary must be consulted as to the option they want to select. The HHABN options presented relative to specific billing scenarios above, and in the rest of the document, are only illustrations and in no way authorization for pre-empting a beneficiary's right to choose a specific option.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev.1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

A. The following calculations shall apply to claims with “From” dates on or after October 1, 2000, and before January 1, 2008. For calculations which apply to claims with “From” dates on or after January 1, 2008, see subsection B below.

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H, 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in “INIT-PYMNT-INDICATOR.” If the value is 0 or 1, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.
 - a. If the “REVENUE-SUM1-6-QTY-ALL” (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six “REVENUE-QTY-COV-VISITS” fields from the revenue code table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the six products. The result is the total payment for the episode.

Return this amount in the “TOTAL-PAYMENT” field with return code 06. No further calculations are required.
 - b. If “REVENUE-SUM1-6-QTY-ALL” is greater than or equal to 5, proceed to the therapy threshold determination.

2. Therapy threshold determination.
 - a. If the “REVENUE-SUM1-3-QTY-THR” (the total of the quantities associated with therapy revenue codes, 042x, 043x, 044x, which will be passed from the shared systems sorted in this order) is less than 10, perform the following:

If the “MED-REVIEW-INDICATOR” is a Y for any HRG, do not alter the HIPPS code reported in “HRG-INPUT-CODE.” Copy that code to the “HRG-OUTPUT-CODE” field. Proceed to the next HRG occurrence.

If “MED-REVIEW-INDICATOR” is an N for any HRG, read the table of HIPPS codes for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be met for that code), copy the code from the first column to the “HRG-OUTPUT-CODE” field.

If the code in the first column does not match the code in the second column (indicating the therapy threshold is unmet for that code), place the code from the second column in the “HRG-OUTPUT-CODE” field.

- b. If “HHA-REVENUE-SUM1-3-QTY-THR” is greater than or equal to 10: Copy all “HRG-INPUT-CODE” entries to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the codes in the “HRG-OUTPUT-CODE” fields for all further calculations involving each HRG.

3. HRG payment calculations.

- a. If the “HRG-OUTPUT-CODE” occurrences are less than 2, and the “PEP-INDICATOR” is an N:

Find the weight for the “HRG-OUTPUT-CODE” from weight table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to “MSA1.” Multiply the case-mix adjusted rate by the current nonlabor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Proceed to the outlier calculation (see 4 below).

- b. If the “HRG-OUTPUT-CODE” occurrences are less than 2, and the “PEP-INDICATOR” is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the “PEP-DAYS” amount

by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (4 below).

- c. If the “HRG-OUTPUT-CODE” occurrences are greater than or equal to 2, and the “PEP-INDICATOR” is an N:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the “HRG-NO-OF-DAYS” field for that code divided by 60. Repeat this for up to six occurrences of the “HRG-OUTPUT-CODE.” These amounts will be returned in separate occurrence of the “HRG-PAY” fields, so that the shared systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is *the* total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

- d. If the “HRG-OUTPUT-CODE” occurrences are greater than or equal to 2, and the “PEP-INDICATOR” is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the “PEP -DAYS” field divided by 60. Multiply the result by the quantity in the “HRG-NO-OF-DAYS” field divided by the quantity in the “PEP-DAYS” field. Repeat this for up to six occurrences of “HRG-CODE.” These amounts will be returned separately in the corresponding “HRG-PAY” fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

4. Outlier calculation:

- a. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the “SERV-THRU-DATE” falls, using the MSA code in the “MSA1” field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.
- b. For each quantity in the six “REVENUE-QTY-COV-VISITS” fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA code in the “MSA1” field. The result is the wage index adjusted imputed cost for the episode.

- c. Subtract the outlier threshold for the episode from the imputed cost for the episode.
- d. If the result is greater than \$0.00, calculate .80 times the result. Return this amount in the “OUTLIER-PAYMENT” field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the “TOTAL-PAYMENT” field, with return code 01.
- e. If the result is less than or equal to \$0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the “OUTLIER-PAYMENT” field. Return the total of all HRG payment amounts in the “TOTAL-PAYMENT” field, with return code 00.

B. The following calculations shall apply to claims with “From” dates on or after January 1, 2008.

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H, 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in “INIT-PYMNT-INDICATOR.” If the value is 0 or 1, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

- a. If the “REVENUE-SUM1-6-QTY-ALL” (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six “REVENUE-QTY-COV-VISITS” fields from the revenue code table for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated “REVENUE-COST” field.

If the following conditions are met, calculate an additional LUPA add-on payment:

- the dates in the “SERV-FROM-DATE” and “ADMIT-DATE” fields match
- the first position of the HIPPS code is a 1 or a 2
- the value in “LUPA-SRC-ADM” is not a B or C AND

- the value in “RECODE-IND” is not a 2.

Wage index adjust the current LUPA add-on amount (published via Recurring Update Notification) and return this amount in the “LUPA-ADD-ON-PAYMENT” field.

Return the sum of all “REVENUE-COST” amounts in the “TOTAL-PAYMENT” field. If the LUPA payment includes LUPA add-on amount, return 14 in the “PAY-RTC” field. Otherwise, return 06 in the “PAY-RTC” field. These distinct return codes assist the shared systems in apportioning visit payments to claim lines. No further calculations are required.

- b. If “REVENUE-SUM1-6-QTY-ALL” is greater than or equal to 5, proceed to the recoding process in step 2.

2. Recoding of claims based on episode sequence and therapy thresholds.

- a. Read the “RECODE-IND.” If the value is 0, proceed to step c below.

If the value in “RECODE-IND” is 1, find the number of therapy services reported in “REVENUE - SUM 1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in “RECODE-IND” is 3, find the number of therapy services reported in “REVENUE - SUM 1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

- b. Read the alphabetic values in the “CLINICAL-SEV-EQ” field and “FUNCTION-SEV-EQ” field for which the number at the end of the field names corresponds to the recoded first position of the HIPPS code determined in step a. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric value. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2nd, 3rd and 4th positions of the HIPPS code *as follows*.

- *recode the 2nd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value</i>	<i>CLINICAL-SEV-EQ1 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru D</i>	<i>0-4</i>	<i>C1 (Min)</i>	<i>A</i>
<i>E thru H</i>	<i>5-8</i>	<i>C2 (Low)</i>	<i>B</i>
<i>I +</i>	<i>9+</i>	<i>C3 (Mod)</i>	<i>C</i>

- *recode the 3rd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value</i>	<i>FUNCTION-SEV-EQ1 converted point value</i>	<i>Functional Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 3rd position value</i>
<i>A thru E</i>	<i>0-5</i>	<i>F1 (Min)</i>	<i>F</i>
<i>F</i>	<i>6</i>	<i>F2 (Low)</i>	<i>G</i>
<i>G +</i>	<i>7+</i>	<i>F3 (Mod)</i>	<i>H</i>

- *change the 4th position of the HIPPS code according to the table below:*

<i>REVENUE - SUM 1-3-QTY-THR value</i>	<i>Resulting HRG - OUTPUT – CODE 4th position value</i>
<i>0-5</i>	<i>K</i>
<i>6</i>	<i>L</i>
<i>7-9</i>	<i>M</i>
<i>10</i>	<i>N</i>
<i>11-13</i>	<i>P</i>

If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2nd, 3rd and 4th positions of the HIPPS code *as follows:*

- *recode the 2nd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value</i>	<i>CLINICAL-SEV-EQ2 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru F</i>	<i>0-6</i>	<i>C1 (Min)</i>	<i>A</i>
<i>G thru N</i>	<i>7-14</i>	<i>C2 (Low)</i>	<i>B</i>
<i>O+</i>	<i>15+</i>	<i>C3 (Mod)</i>	<i>C</i>

- *recode the 3rd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value</i>	<i>FUNCTION-SEV-EQ2 converted point value</i>	<i>Functional Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 3rd position value</i>
<i>A thru F</i>	<i>0-6</i>	<i>F1 (Min)</i>	<i>F</i>
<i>G</i>	<i>7</i>	<i>F2 (Low)</i>	<i>G</i>
<i>H +</i>	<i>8+</i>	<i>F3 (Mod)</i>	<i>H</i>

- *change the 4th position of the HIPPS code according to the table below:*

<i>REVENUE - SUM 1-3-QTY-THR value</i>	<i>Resulting HRG - OUTPUT – CODE 4th position value</i>
<i>14-15</i>	<i>K</i>
<i>16-17</i>	<i>L</i>
<i>18-19</i>	<i>M</i>

If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2nd, 3rd and 4th positions of the HIPPS code *as follows:*

- *recode the 2nd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value</i>	<i>CLINICAL-SEV-EQ3 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru B</i>	<i>0-2</i>	<i>C1 (Min)</i>	<i>A</i>
<i>C thru E</i>	<i>3-5</i>	<i>C2 (Low)</i>	<i>B</i>
<i>F+</i>	<i>6+</i>	<i>C3 (Mod)</i>	<i>C</i>

- *recode the 3rd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value</i>	<i>FUNCTION-SEV-EQ3 converted point value</i>	<i>Functional Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 3rd position value</i>
<i>A thru H</i>	<i>0-8</i>	<i>F1 (Min)</i>	<i>F</i>
<i>I</i>	<i>9</i>	<i>F2 (Low)</i>	<i>G</i>
<i>J+</i>	<i>10+</i>	<i>F3 (Mod)</i>	<i>H</i>

- *change the 4th position of the HIPPS code according to the table below:*

<i>REVENUE - SUM 1-3-QTY-THR value</i>	<i>Resulting HRG - OUTPUT – CODE 4th position value</i>
<i>0-5</i>	<i>K</i>
<i>6</i>	<i>L</i>
<i>7-9</i>	<i>M</i>
<i>10</i>	<i>N</i>
<i>11-13</i>	<i>P</i>

If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2nd, 3rd and 4th positions of the HIPPS code *as follows:*

- *recode the 2nd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value</i>	<i>CLINICAL-SEV-EQ4 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru H</i>	<i>0-8</i>	<i>C1 (Min)</i>	<i>A</i>
<i>I thru P</i>	<i>9-16</i>	<i>C2 (Low)</i>	<i>B</i>
<i>Q+</i>	<i>17+</i>	<i>C3 (Mod)</i>	<i>C</i>

- *recode the 3rd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value</i>	<i>FUNCTION-SEV-EQ4 converted point value</i>	<i>Functional Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 3rd position value</i>
<i>A thru G</i>	<i>0-7</i>	<i>F1 (Min)</i>	<i>F</i>
<i>H</i>	<i>8</i>	<i>F2 (Low)</i>	<i>G</i>
<i>I+</i>	<i>9+</i>	<i>F3 (Mod)</i>	<i>H</i>

- *change the 4th position of the HIPPS code according to the table below:*

<i>REVENUE - SUM 1-3-QTY-THR value</i>	<i>Resulting HRG - OUTPUT – CODE 4th position value</i>
<i>14-15</i>	<i>K</i>
<i>16-17</i>	<i>L</i>
<i>18-19</i>	<i>M</i>

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE field for all further calculations.

- If the first position of the HIPPS code submitted in “HRG-INPUT-CODE” is a 5 and the number of therapy services in “REVENUE - SUM 1-3-QTY-THR” is less than 20, read the value in the “EPISODE-TIMING” field.

If the value in the “EPISODE-TIMING” field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS

code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in the “EPISODE-TIMING” field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

Return to step b and recode the remaining positions of the HIPPS code as described above.

- d. In all cases, read only the “REVENUE - SUM 1-3-QTY-THR” field and recode the 4th positions of the HIPPS code according to the table below, if possible:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE field for all further calculations.

If the HIPPS code begins with 1 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the “RECODE-IND” to 1. Return to step b and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the “RECODE-IND” to 3. Return to step b and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 1, and set the “RECODE-IND” to 1. Return to step b and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 3, and set the “RECODE-IND” to 3. Return to step b and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 1 or 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 *or more*:

- change the first position of the HIPPS code to 5
- recode the 2nd position of the HIPPS code according to the table below:

<i>Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value</i>	<i>CLINICAL-SEV-EQ2 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru G</i>	<i>0-7</i>	<i>C1 (Min)</i>	<i>A</i>
<i>H thru N</i>	<i>8-14</i>	<i>C2 (Low)</i>	<i>B</i>
<i>O +</i>	<i>15+</i>	<i>C3 (Mod)</i>	<i>C</i>

- *recode the 3rd position of the HIPPS code according to the table below:*

<i>Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value</i>	<i>FUNCTION-SEV-EQ2 converted point value</i>	<i>Functional Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 3rd position value</i>
<i>A thru F</i>	<i>0-6</i>	<i>F1 (Min)</i>	<i>F</i>
<i>G</i>	<i>7</i>	<i>F2 (Low)</i>	<i>G</i>
<i>H +</i>	<i>8+</i>	<i>F3 (Mod)</i>	<i>H</i>

- *change the 4th position of the HIPPS code to K.*

If the HIPPS code begins with 3 or 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 *or more*:

- change the first position of the HIPPS code to 5
- recode the 2nd position of the HIPPS code according to the table below:

<i>Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value</i>	<i>CLINICAL-SEV-EQ4 converted point value</i>	<i>Clinical Severity Level</i>	<i>Resulting HRG - OUTPUT – CODE 2nd position value</i>
<i>A thru G</i>	<i>0-7</i>	<i>C1 (Min)</i>	<i>A</i>
<i>H thru N</i>	<i>8-14</i>	<i>C2 (Low)</i>	<i>B</i>

Perform the calculation of the case-mix and wage index adjusted payment for the HRG and supply amounts, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (4 below).

4. Outlier calculation:

- a. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the MSA code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.
- b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the MSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.
- c. Subtract the outlier threshold for the episode from the imputed cost for the episode.
- d. If the result is greater than \$0.00, calculate .80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.
- e. If the result is less than or equal to \$0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.