CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2828	**Date: November 27, 2013**
	Change Request 8380

Transmittal 2796, dated September 27, 2013, is being rescinded and replaced by Transmittal 2828 to update the LUPA Add-on factors throughout this Change Request. Also, the CR is no longer sensitive/controversial. All other information remains the same.

SUBJECT: Home Health Prospective Payment System (PPS) Low Utilization Payment Adjustment (LUPA) Add-On Factors

I. SUMMARY OF CHANGES: For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA. Currently, LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences. The Calendar Year (CY) 2013 LUPA add-on amount is $95.85.

Based on updated analysis, Medicare has determined a more accurate and equitable method to apply the LUPA add-on payment amount. Using a factor equal to the excess minutes spent in the first skilled visit to perform the initial assessment expressed as a proportion of the average minutes for all non-first visits in non-LUPA episodes of 84.51 percent for skilled nursing, 67.00 percent for physical therapy, and 62.66 percent for speech-language pathology. Per the Medicare Conditions of Participation at 42 CFR §484.55(a)(1) and (a)(2), only skilled nursing, physical therapy, and speech-language pathologists are allowed to conduct the initial assessment visit.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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	10/10.1.17/Adjustments of Episode Payment – Low Utilization Payment Adjustments (LUPAs)
R	10/70.2/Input/Output Record Layout

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2828	Date: November 27, 2013	Change Request: 8380

Transmittal 2796, dated September 27, 2013, is being rescinded and replaced by Transmittal 2828 to update the LUPA Add-on factors throughout this Change Request. Also, the CR is no longer sensitive/controversial. All other information remains the same.

SUBJECT: Home Health Prospective Payment System (PPS) Low Utilization Payment Adjustment (LUPA) Add-On Factors

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA. Currently, LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences. The Calendar Year (CY) 2013 LUPA add-on amount is $95.85.

Based on updated analysis, Medicare has determined a more accurate and equitable method to apply the LUPA add-on payment amount. Using a factor equal to the excess minutes spent in the first skilled visit to perform the initial assessment expressed as a proportion of the average minutes for all non-first visits in non-LUPA episodes of 84.51 percent for skilled nursing, 67.00 percent for physical therapy, and 62.66 percent for speech-language pathology. Per the Medicare Conditions of Participation at 42 CFR §484.55(a)(1) and (a)(2), only skilled nursing, physical therapy, and speech-language pathologists are allowed to conduct the initial assessment visit.

B. Policy: In lieu of a single LUPA add-on payment, to ensure that the LUPA add-on amount equitably reflects the excess cost for an initial visit for each of the three disciplines (skilled nursing, physical therapy, and speech-language pathology), Medicare will multiply the per-visit payment amount for the first skilled nursing, physical therapy, or speech-language pathology visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the proportional increase in minutes for an initial visit over non-initial visits. The LUPA add-on factors are: 1.8451 for skilled nursing; 1.6700 for physical therapy; and 1.6266 for speech-language pathology. For example, for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is skilled nursing, the amount for that visit would be $223.44 (1.8451 multiplied by the CY 2014 skilled nursing national per-visit payment amount of $121.10).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8380.1	For HH PPS claims (types of bill 32x other than 322) subject to LUPA payments that occur as the only episode or an initial episode in a sequence of adjacent episodes, Medicare contractors shall apply an add-on factor to the per-visit payment for the first skilled visit.								X				HH PPS Pricer
8380.1.1	Medicare contractors shall send the earliest line item date to the HH Pricer in the field shown in the record layout in the Medicare Claims Processing Manual, chapter 10, section 70.2 if: 1. Revenue code 042x is present on the earliest date and HCPCS code is G0151 or G0159 2. Revenue code 044x is present on the earliest date and HCPCS code is G0153 or G0161 3. Revenue code 055x is present on the earliest date and HCPCS code is G0154, G0162, G0163, or G0164.								X				HH PPS Pricer
8380.1.2	When the Pricer return code is 14, Medicare contractors shall apply the add-on visit amount returned by the HH Pricer in the field shown in the record layout to the earliest line item with the corresponding revenue code.								X				HH PPS Pricer
8380.2	Medicare contractors shall apply per-visit add-on factors when: 1. the claim “Through” date is on or after January 1, 2014, 2. the claim has four or fewer visits, 3. the HIPPS code on the claim begins with												HH PPS Pricer

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	a 1 or 2, 4. the claim admission date and statement covers “From” date match, AND 5. the source of admission code on the claim is not B or C.												
8380.2.1	Medicare contractors shall compare the earliest line item dates for revenue codes 042x, 044x and 055x and select the revenue code with the earliest date to apply an add-on factor.												HH PPS Pricer
8380.2.1.1	If the earliest date for revenue codes 042x or 044x match the revenue code 055x date, Medicare contractors shall select revenue code 055x.												HH PPS Pricer
8380.2.1.2	If the earliest date for revenue codes 042x and 044x match and revenue code 055x is not present, Medicare contractors shall select revenue code 042x.												HH PPS Pricer
8380.2.2	If the selected revenue code is 042x, then the LUPA add-on visit amount shall be the national per-visit amount for that visit multiplied by 1.6700.												HH PPS Pricer
8380.2.3	If the selected revenue code is 044x, then the LUPA add-on visit amount shall be the national per-visit amount for that visit multiplied by 1.6266.												HH PPS Pricer
8380.2.4	If the selected revenue code is 055x, then the LUPA add-on visit amount shall be the national per-visit amount for that visit multiplied by 1.8451.												HH PPS Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Hillary Loeffler, 410-786-0456 or Hillary.Loeffler@cms.hhs.gov, Wil Gehne, 410-786-6148 or Wilfried.Gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev. 2828, Issued: 11-27-13, Effective: 01-01-14, Implementation: 01-06-14)

If an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history. If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an episode basis, rather than a visit basis.

If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only episode of care the beneficiary received, Medicare will make an additional add-on payment. For LUPA episodes beginning on or after *January 1, 2014, Medicare will add to these claims an amount calculated from a factor established in regulation.* This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit *for skilled nursing, physical therapy or speech-language pathology.*

70.2 - Input/Output Record Layout

(Rev. 2828, Issued: 11-27-13, Effective: 01-01-14, Implementation: 01-06-14)

The HH Pricer input/output file is 500 bytes in length. The required data and format are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	This field will be used for the National Provider Identifier if it is sent to the HH Pricer in the future.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29-31	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
33-35	9(3)	PEP-DAYS	Input item: The number of days to be used for PEP payment calculation. Medicare claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service

File Position	Format	Title	Description
			date on the claim.
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-46	X(9)	FILLER	Blank.
47-50	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
77	X	HRG-MED - REVIEW - INDICATOR	Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code unless the claim is recoded due to therapy thresholds or changes in episode sequence.
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is

File Position	Format	Title	Description
			determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Fields for five more occurrences of all HRG/HIPPS code related fields defined above. Not used.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X, 057X). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-*265*	9*(8)*	REVENUE-EARLIEST-DATE	*Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.*
266-274	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
275-283	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
284-292	*9(7)V9(2)*	*REVENUE-ADD-ON-VISIT-AMT*	*Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code.* *If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451.* *If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700.* *If revenue code 044x, then this is the national per-*

File Position	Format	Title	Description	
			visit amount multiplied by 1.6266.	
293-502	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
503-504	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates before Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 3x9 or adjustment TOB
505-509	9(5)	REVENUE - SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.	
510-514	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the	

File Position	Format	Title	Description
			covered visit quantities input with all six HH discipline revenue codes.
515-523	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.
524-532	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.
533-537	9(3)V9(2)	LUPA-ADD-ON-PAYMENT	Output item: *For claim "Through" dates before January 1, 2014,* the add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim. *For claim "Through" dates on or after January 1, 2014, zero filled.*
538	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the RAP or claim. The indicator is set to '1' in all other cases.
539	X	RECODE-IND	Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0 = default value 1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 3 = HIPPS code shows early episode, should be later episode
540	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values: 1 = early episode 2 = late episode
541	X	CLINICAL-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment authorization code.

File Position	Format	Title	Description
542	X	FUNCTION-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.
543	X	CLINICAL-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.
544	X	FUNCTION-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.
545	X	CLINICAL-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code.
546	X	FUNCTION-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code.
547	X	CLINICAL-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.
548	X	FUNCTION-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
549-558	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA during the current calendar year.
559-569	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA during the current calendar year.
570-600	*X(31)*	FILLER	

Input records on RAPs will include all input items except for “REVENUE” related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The Medicare claims processing system will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for the HIPPS code will be placed in the total charges and the covered charges field of the revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount. If the return code is 06 (indicating a low utilization payment adjustment), the Medicare claims processing system will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice. *If the return code is 14, the Medicare claims processing system will apply the H-HHA-REVENUE-ADD-ON-VISIT-AMT to the earliest line item with the corresponding revenue code.*

Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code.

If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451.

If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700.

If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.