CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4453	**Date: November 8, 2019**
	Change Request 11536

SUBJECT: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

I. SUMMARY OF CHANGES: This Change Request updates the CY 2020 60-day episode and 30-day base payment rates, the national per-visit amounts, LUPA add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS. In addition, the CR revises the initial payment percentage for both initial and subsequent 30-day periods of care under the split percentage payment approach for CY 2020. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 70.5.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.6/Split Percentage Payment
R	10/20.1.2/Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
R	10/70.2/Input/Output Record Layout
R	10/70.3/Decision Logic Used by the Pricer on RAPs

III. FUNDING:
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 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.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 4453	Date: November 8, 2019	Change Request: 11536

SUBJECT: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

EFFECTIVE DATE: January 1, 2020
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I. GENERAL INFORMATION

A. Background: The Medicare Home Health Prospective Payment System (HH PPS) rates provided to home health agencies (HHAs) for furnishing home health services are updated annually as required by section 1895(b)(3)(B) of the Social Security Act (the Act). The CY 2020 HH PPS rate update includes implementation of the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology for home health services beginning on or after January 1, 2020. The CY 2020 HH PPS rate update implements a change in the unit of payment from a 60-day episode of care to a 30-day period of care as required by section 1895(b)(2)(B) of the Act, as amended by section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018. This rate update will increase the CY 2020 60-day episode and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments, as required by section 421(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as amended by section 50208(a) of the BBA of 2018. Finally, in CY 2020, for existing HHAs (that is, HHAs certified for participation in Medicare with effective dates prior to January 1, 2019), the split-percentage payment will be reduced from the current 60/50 percent (dependent on whether the request for anticipated payment (RAP) is for a new or subsequent period of care) to 20 percent in CY 2020 for all 30-day home health periods of care (both initial and subsequent periods of care). Newly-enrolled HHAs (that is HHAs certified for participation in Medicare effective on or after January 1, 2019), will not receive split-percentage payments for CY 2020 but are required to submit "no-pay" RAPs for all 30-day home health periods of care.

B. Policy: Section 53110 of the BBA of 2018 amended section 1895(b)(3)(B) of the Act, such that for home health payments for CY 2020, the home health payment update is required to be 1.5 percent. The multifactor productivity (MFP) adjustment is not applied to the BBA of 2018 mandated 1.5 percent payment update. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2020, the home health payment update would be -0.5 percent (1.5 percent minus 2 percentage points).

National, Standardized 60-Day Episode Payment and 30-Day Period Payment Amounts

As finalized in the CY 2019 HH PPS final rule, the unit of home health payment will change from a 60-day episode to a 30-day period effective for those 30-day periods beginning on or after January 1, 2020. The standardized 60-day payment rate will apply to case-mix adjusted episodes (that is, not low utilization payment adjustments (LUPAs)) beginning on or before December 31, 2019 and ending on or after January 1, 2020. As such, the latest date such a 60-day crossover episode could end on is February 28, 2020. Those 60-day episodes that begin on or before December 31, 2019, but are LUPA episodes, will be paid the national, per-visit payment rates.

To determine the CY 2020 national, standardized 60-day episode payment rate for those 60-day episodes that span the implementation date of the PDGM and the change to a 30-day unit of payment, CMS applies a wage index budget neutrality factor of 1.0060 and the home health payment update percentage of 1.5 percent

for HHAs that submit the required quality data and by 1.5 percent minus 2 percentage points, or- 0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 1 and 2 (see attached).

To determine the CY 2020 national, standardized 30-day period payment rate beginning January 2020, CMS applies a wage index budget neutrality factor of 1.0063 and the home health payment update percentage of 1.5 percent for HHAs that submit the required quality data and by 1.5 percent minus 2 percentage points, or -0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 7 and 8 (see attached).

The payments for both the CY 2020 national, standardized 60-day episode payment rate and the CY 2020 national, standardized 30-day period payment rate are further adjusted by the individual episode's case-mix weight and by the applicable wage index.

National Per-Visit Rates

In order to calculate the CY 2020 national per-visit payment rates, CMS starts with the CY 2019 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0066 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2020 wage index. The per-visit rates are then updated by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data. The per-visit rates are shown in Tables 9 and 10.

Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2020 NRS conversion factors, CMS updates the CY 2019 NRS conversion factor by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2020 payments for HHAs that do submit the required quality data is shown in Table 3. The payment amounts for the various NRS severity levels are shown in Table 4. The NRS conversion factor for CY 2020 payments for HHAs that do not submit quality data is shown in Table 5 and the payment amounts for the various NRS severity levels are shown in Table 6.

Rural Add-On Provision

In the CY 2019 HH PPS final rule (83 FR 56443), CMS finalized policies for the rural add-on payments for CY 2019 through CY 2022, in accordance with section 50208 of the BBA of 2018. The CY 2019 HH PPS proposed rule (83 FR 32373) described the provisions of the rural add-on payments, the methodology for applying the new payments, and outlined how CMS categorized rural counties (or equivalent areas) based on claims data, the Medicare Beneficiary Summary File and Census data.

CY 2020 HH PPS payments will be increased by 0.5 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "High utilization" category. CY 2020 HH PPS payments will be increased by 3.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "Low population density" category. CY 2020 HH PPS payments will be increased by 2.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "All other" category.

The HH PRICER module, located within CMS' claims processing system, will increase the final CY 2020 60-day and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments.

Outlier Payments

The fixed dollar loss (FDL) ratio and the loss-sharing ratio used to calculate outlier payments must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, CMS has used a value of 0.80 for the loss-sharing ratio which CMS believes, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes were made to the loss-sharing ratio of 0.80 for CY 2020.

For CY 2020, the FDL ratio for 60-day episodes that span the implementation date of the PDGM, will remain 0.51. The FDL ratio for 30-day periods of care in CY 2020 is 0.56. In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are shown in Table 11.

Split Percentage Payment

Medicare makes a split percentage payment for most HH PPS episodes/periods. The first payment is in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. The current split percentage payments are 60/40 (for initial episodes of care) and 50/50 (for subsequent episodes of care).

For CY 2020, the split-percentage payment for existing HHAs will be reduced to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care)

In the CY 2019 HH PPS final rule (83 FR 56628), CMS finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split-percentage payments beginning in CY 2020. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, will still be required to submit a ‘‘no pay’’ Request for Anticipated Payment (RAP) at the beginning of a period of care in order to establish the home health period of care, as well as every 30 days thereafter.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11536.1	The contractor shall install two HH PPS Pricer software modules effective January 1, 2020. NOTE: Requirements for sending claims to the existing HH Pricer and the new HH PDGM Pricer were included in CR 11081. This requirement refers to					X				HH Pricer

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	the delivery of the production modules to support those requirements.									
11536.2	The contractor shall apply the CY 2020 HH PPS 60-day payment rates for episodes with claim statement "From" dates on or before December 31, 2019.									HH Pricer
11536.3	The contractor shall apply the CY 2020 HH PPS payment rates for periods with claim statement "From" dates on or after January 1, 2020.									HH Pricer
11536.4	For RAPs (Type of Bill 322) with "From" dates on or after January 1, 2020, the contractor shall calculate a percentage payment of 20%.									HH Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
11536.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X		X		

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): Amanda Barnes, 410-786-2310 or Amanda.Barnes@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).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 2

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

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(Rev.:4453, Issued: 11-08-19)

10.1.6 - Split Percentage Payment
(Rev.: 4453, Issued: 11-08-19, Effective: 01-01-20, Implementation: 01-06-20)

Medicare makes a split percentage payment for most HH PPS episodes/periods. The first payment is in response to a RAP, and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. There are two exceptions to split payment, the No-RAP LUPA, discussed in §§10.1.18 and 40.3 in this chapter, and the RAPs paying zero percent as discussed in §10.1.12 in this chapter.

There is a difference in the percentage split of RAP and final claim payments for initial and subsequent episodes/periods for patients in continuous care. *For all episodes with "From" dates before January 1, 2020*, the percentage split for *initial episodes* is 60 percent in response to the RAP, and 40 percent in response to the claim. Initial, for the purpose of determining the RAP percentage, is identified in claims processing by an admission date that matches the RAP's "From" date. For all continuous care, each of the two percentage payments is 50 percent of the estimated casemix adjusted payment.

For all periods of care with "From" date on or after January 1, 2020, the percentage payment on RAPs is 20%.

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
(Rev.: 4453, Issued: 11-08-19, Effective: 01-01-20, Implementation: 01-06-20)

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode/period of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

Additionally, information about current home health episodes/periods of care may be available from MACs. Institutional providers (providers who bill using the institutional claim format) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists or suppliers who bill using the professional claim format also have access to a similar electronic inquiry via the HIPAA standard eligibility transaction - the 270/271 transaction. They may also, as a last resort, call their A/B MAC's (B)'s provider toll free line to request home health eligibility information available on the Common Working File. The A/B MAC's (B)'s information is based only on claims Medicare has received from home health agencies at the day of the contact.

Medicare systems maintain a data file that captures and displays the dates when Medicare paid physicians for the certification or recertification of the beneficiary's HH plan of care. Physicians submit claims for

these services to A/B MACs (B) on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for an HH episode/period of care promptly in order to receive their initial *percentage* payment.

But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that HH services will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems display, for each Medicare beneficiary, the code for certification (G0180) or recertification (G0179) and the date of service for either of the two codes.

Suppliers and providers should note that this information is supplementary to the previously existing sources of information about HH episodes. Like HH episode/period of care information maintained on CWF, certification information is only as complete and timely as billing by providers allows it to be. For many episodes, a physician certification claim may never be billed. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

If a therapy provider or a supplier learns of a home health episode/period of care from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH episode/period, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health episode and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

70.2 - Input/Output Record Layout

(Rev.: 4453, Issued: 11-08-19, Effective: 01-01-20, Implementation: 01-06-20)

The required data and format for the HH Pricer input/output record for episodes beginning before January 1, 2020 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.

File Position	Format	Title	Description
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 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.

File Position	Format	Title	Description
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. If recoded, the Medicare claims processing system stores this output item in the APC-HIPPS field on the claim record.
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 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.
258-262	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.
263-270	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
271-279	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 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.

File Position	Format	Title	Description
280-288	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.
289-297	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-visit amount multiplied by 1.6266.
298-532	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.
533-534	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

File Position	Format	Title	Description
			85 — No revenue code present on 03x9 or adjustment TOB
535-539	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.
540-544	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 covered visit quantities input with all six HH discipline revenue codes.
545-553	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.
554-562	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.
563-567	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.
568	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.
569	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
570	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

File Position	Format	Title	Description
571	X	CLINICAL-SEV-EQ1	Input item: A hexavigesimal 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.
572	X	FUNCTION-SEV-EQ1	Input item: A hexavigesimal 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.
573	X	CLINICAL-SEV-EQ2	Input item: A hexavigesimal 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.
574	X	FUNCTION-SEV-EQ2	Input item: A hexavigesimal 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.
575	X	CLINICAL-SEV-EQ3	Input item: A hexavigesimal 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.
576	X	FUNCTION-SEV-EQ3	Input item: A hexavigesimal 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.
577	X	CLINICAL-SEV-EQ4	Input item: A hexavigesimal 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.
578	X	FUNCTION-SEV-EQ4	Input item: A hexavigesimal 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.
579-588	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
589-599	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
600-604	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from field 30 of the provider specific file.

File Position	Format	Title	Description
605-613	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.
614-622	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.
623-650	X(28)	FILLER	

The required data and format for the HH Pricer input/output record for periods of care beginning on or after January 1, 2020 are shown below:

File Position	**Format**	**Title**	**Description**
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.
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	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value 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% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments).
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
46-56	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.

File Position	Format	Title	Description
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only episode in a sequence. The indicator is set to '0' in all other cases.
96	X	PEP-IND	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.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is 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.
104-109	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
110-118	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
119-122	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.
125-127	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.

File Position	Format	Title	Description	
128-132	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.	
133-140	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.	
141-149	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 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.	
150-158	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.	
159-167	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 1.8714. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6841. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6293.	
168-402	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
403-404	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, *20%*
			05	*No longer used.*
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP

File Position	Format	Title	Description	
			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 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
405-409	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 covered visit quantities input with all six HH discipline revenue codes.	
410-418	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. Added to the claim as a value code 17 amount.	
419-427	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
428-436	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.	
437-445	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.	
446-650	X(205)	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.

70.3 - Decision Logic Used by the Pricer on RAPs

(Rev.: 4453, Issued: 11-08-19, Effective: 01-01-20, Implementation: 01-06-20)

On input records with TOB 322 and "SERV-FROM-DATE" before January 1, 2020, Pricer will perform the following calculations in the numbered order:

1. Determine the applicable Federal standard episode rate to apply by reading the values 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.

   For certain dates of service when required by law, read "CBSA" and "COUNTY-CODE" to determine if a rural add-on payment applies. If yes, use the appropriate rural episode rate with or without quality data in subsequent calculations.

2. Find weight for "HRG-INPUT-CODE" from the table of weights for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times Federal standard episode rate for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and nonlabor portions of the payment. 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 "CBSA" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by the current non-labor-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 case-mix and wage index adjusted payment for this HRG.

   Find the non-routine supply weight corresponding to the fifth positions of the "HRG-INPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.

   Sum the HRG payment and non-routine supply payment.

3. a. If the "INIT-PYMNT-INDICATOR" equals 0 or 2, perform the following:

   Determine if the "SERV-FROM-DATE" of the record is equal to the "ADMITDATE." If yes, multiply the wage index and case-mix adjusted payment by .6. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 05.

   If no, multiply the wage index and case-mix adjusted payment by .5. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 04.

   b. If the "INIT-PYMNT-INDICATOR" = 1 or 3, perform the following:

   Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 03.

On input records with TOB 322 and "SERV-FROM-DATE" on or after January 1, 2020, Pricer will perform the following calculations in the numbered order:

1. Determine the applicable Federal standard episode rate to apply by reading the values in “INIT-PAY-QRP-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.

   For certain dates of service when required by law, read “CBSA” and “COUNTY-CODE” to determine if a rural add-on payment applies. If yes, use the appropriate rural episode rate with or without quality data in subsequent calculations.

2. Find weight for “HRG-INPUT-CODE” from the table of weights for the calendar year in which the “SERV-THRU-DATE” falls. Multiply the weight times Federal standard episode rate for the year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate.

   This case-mix adjusted rate must also be wage-index adjusted according to labor and nonlabor portions of the payment. Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to “CBSA.” Multiply the Federal adjusted rate by the current non-labor-related percentage) to determine the nonlabor portion.

   Sum the labor and nonlabor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

3. a. If the “INIT-PAY-QRP-INDICATOR” equals 0 or 2, perform the following:

   Multiply the wage index and case-mix adjusted payment by .*2*. Return the resulting amount as “HRG-PAY” and as “TOTAL-PAYMENT” with return code 04.

   b. If the “INIT-PYMNT-INDICATOR” = 1 or 3, perform the following:

   Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as “HRG-PAY” and as “TOTAL-PAYMENT” with return code 03.

TABLE 1: CY 2020 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2019 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 National, Standardized 60-Day Episode Payment
$3,154.27	X 1.0060	X 1.015	$3,220.79

TABLE 2: CY 2020 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2019 National, Standardized 60- Day Episode Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update Minus 2 Percentage Points	CY 2020 National, Standardized 60-Day Episode Payment
$3,154.27	X 1.0060	X 0.995	$3,157.33

TABLE 3: CY 2020 NRS CONVERSION FACTOR

CY 2019 NRS Conversion Factor	CY 2020 HH Payment Update	CY 2020 NRS Conversion Factor
$54.20	X 1.015	$55.01

TABLE 4: CY 2020 NRS PAYMENT AMOUNTS

Severity Level	Points (Scoring)	Relative Weight	CY 2020 NRS Payment Amounts
1	0	0.2698	$14.84
2	1 to 14	0.9742	$53.59
3	15 to 27	2.6712	$146.94
4	28 to 48	3.9686	$218.31
5	49 to 98	6.1198	$336.65
6	99+	10.5254	$579.00

TABLE 5: CY 2020 NRS CONVERSION FACTOR FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

CY 2019 NRS Conversion Factor	CY 2020 HH Payment Update Percentage Minus 2 Percentage Points	CY 2020 NRS Conversion Factor
$54.20	X 0.995	$53.93

TABLE 6: CY 2020 NRS PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Severity Level	Points (Scoring)	Relative Weight	CY 2020 NRS Payment Amounts
1	0	0.2698	$ 14.55
2	1 to 14	0.9742	$ 52.54
3	15 to 27	2.6712	$ 144.06
4	28 to 48	3.9686	$ 214.03
5	49 to 98	6.1198	$ 330.04
6	99+	10.5254	$ 567.63

TABLE 7: CY 2020 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2019 30-day Budget Neutral (BN) Standard Amount	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 National, Standardized 30-Day Period Payment
$1,824.99	X 1.0063	X 1.015	$1,864.03

TABLE 8: CY 2020 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2019 National, Standardized 30-Day Period Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update Minus 2 Percentage Points	CY 2020 National, Standardized 30-Day Period Payment
$1,824.99	X 1.0063	X 0.995	$1,827.30

TABLE 9: CY 2020 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS

HH Discipline	CY 2019 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 Per-Visit Payment
Home Health Aide	$66.34	X 1.0066	X 1.015	$ 67.78
Medical Social Services	$234.82	X 1.0066	X 1.015	$239.92
Occupational Therapy	$161.24	X 1.0066	X 1.015	$164.74

HH Discipline	CY 2019 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 Per-Visit Payment
Physical Therapy	$160.14	X 1.0066	X 1.015	$163.61
Skilled Nursing	$146.50	X 1.0066	X 1.015	$149.68
Speech-Language Pathology	$174.06	X 1.0066	X 1.015	$177.84

TABLE 10: CY 2020 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline	CY 2019 Per-Visit Rates	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update Minus 2 Percentage Points	CY 2020 Per-Visit Rates
Home Health Aide	$66.34	X 1.0066	X 0.995	$66.44
Medical Social Services	$234.82	X 1.0066	X 0.995	$235.19
Occupational Therapy	$161.24	X 1.0066	X 0.995	$161.49
Physical Therapy	$160.14	X 1.0066	X 0.995	$160.39
Skilled Nursing	$146.50	X 1.0066	X 0.995	$146. 73
Speech- Language Pathology	$174.06	X 1.0066	X 0.995	$174.33

TABLE 11: COST-PER-UNIT PAYMENT RATES FOR THE CALCULATION OF OUTLIER PAYMENTS

		For HHAs that DO Submit the Required Quality Data		For HHAs that DO NOT Submit the Required Quality Data	
HH Discipline	Average Minutes Per-Visit	CY 2020 Per-Visit Payment	Cost-per-unit (1 unit= 15 minutes)	CY 2020 Per-Visit Payment	Cost-per-unit (1 unit= 15 minutes)
Home Health Aide	63.0	$ 67.78	$16.14	$66.44	$15.82
Medical Social Services	56.5	$239.92	$63.70	$235.19	$62.44
Occupational Therapy	47.1	$164.74	$52.46	$161.49	$51.43
Physical Therapy	46.6	$163.61	$52.66	$160.39	$51.63
Skilled Nursing	44.8	$149.68	$50.12	$146.73	$49.13
Speech- Language Pathology	48.1	$177.84	$55.46	$174.33	$54.36