CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13089	**Date: February 21, 2025**
	Change Request 13955

SUBJECT: Manual Updates Regarding Home Health Adjustments and Skilled Nursing Facility, Home Health and Hospice Pricer Information

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update instructions regarding adjustments to home health claims when a beneficiary is unexpectedly discharged after a 'Still Patient' claim has been submitted. It also revises and deletes sections of the Medicare Claims Processing Manual that contain Pricer information to reflect the conversion of these programs from mainframe COBOL to Java in the Cloud.

EFFECTIVE DATE: May 22, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 22, 2025

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	1/Table of Contents
R	1/130.5/Home Health Adjustments
D	1/130.5.1/Submitting Adjustment Requests
R	6/Table of Contents
R	6/30.4/SNF PPS Pricer Software
D	6/30.4.1/ Input and Output Data
D	6/30.4.2/SNF PPS Rate Components
D	6/30.4.3/Decision Logic Used by the Pricer on Claims
R	10/Table of Contents
R	10/10.1.11/Payment, Claim Adjustments and Cancellations
R	10/70/HH PPS Pricer Program
D	10/70.1/General
D	10/70.2/Input and Output Data
D	10/70.3/RESERVED
D	10/70.4/Decision Logic Used by the Pricer on Claims
D	10/70.5 /Annual Updates to the HH Pricer
R	11/Table of Contents
R	11/130/Hospice Pricer Program
D	11/130.1/Input/Output Record Layout
D	11/130.2/Decision Logic Used by the Pricer on Claims

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13089	Date: February 21, 2025	Change Request: 13955

SUBJECT: Manual Updates Regarding Home Health Adjustments and Skilled Nursing Facility, Home Health and Hospice Pricer Information

EFFECTIVE DATE: May 22, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 22, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update instructions regarding adjustments to home health claims when a beneficiary is unexpectedly discharged after a 'Still Patient' claim has been submitted. It also revises and deletes sections of the Medicare Claims Processing Manual that contain Pricer information to reflect the conversion of these programs from mainframe COBOL to Java in the Cloud.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update instructions regarding adjustments to home health claims when a beneficiary is unexpectedly discharged after a 'Still Patient' claim has been submitted. A Home Health Agency (HHA) may submit a claim with patient status code 30 (still patient) at the end of a period of care on the expectation that additional HH visits will be provided in the next period of care. Some intervening event may prevent the delivery of additional visits and the beneficiary is subsequently discharged. In this situation, the HHA shall submit an adjustment claim to correct the patient status code to reflect the discharge on their claim, since patient status code 30 may prevent billing of services subject to HH consolidated billing during the last days of the period of care.

This CR also revises sections of the Medicare Claims Processing Manual that contain Pricer layouts or logic to reflect the conversion of these programs from COBOL to Java. Manual sections that previously included the COBOL record layouts of the Pricer input/output records are deleted to reflect the conversion of these programs from mainframe COBOL to Java in the Cloud and to refer to the appropriate websites for additional documentation and software.

B. Policy: This CR contains no new policy. The update to Pub. 100-04, Chapter 1 is consistent with longstanding policy. The other changes provide technical information describing Original Medicare claims processing.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13955.1	The contractors shall be aware of the manual changes to publication 100-04:	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• chapter 1, revision to section 130.5, deletion of section 130.5.1 • chapter 6, revision to section 30.4, deletion of sections 30.4.1, 30.4.2 and 30.4.3 • chapter 10, revision to sections 10.1.11 and 70, deletion of sections 70.1, 70.2, 70.3, 70.4 and 70.5 • chapter 11, revision to section 130, deletion of sections 130.1 and 130.2.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. 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: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 13089; Issued: 02-21-25)

130.5 - Home Health Adjustments

(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

Several conditions can cause the claim for a HH period of care (Type of Bill 032x) to be adjusted. Claims may be cancelled (TOB 0328) by HHAs if a mistake is made in billing. In these cases, the period of care will be cancelled in CWF as well. Adjustment claims (TOB 0327) may also be used to change information on a previously submitted claim, which may also change payment.

A home health agency submits a corrected claim if any of the following apply (the list is not exhaustive):

- *A change in provider number;*
- *A change in visits (decrease or increase);*
- *A change in diagnosis code or other claim elements affecting the determination of the HIPPS code used for payment; or*
- *A change in the patient status code affecting payment of the claim or the ability of other providers subject to HH consolidated billing to be paid for covered services.*

Diagnosis codes on HH claims reflect the patient's condition as of the start of a period of care (the claim From date). Errors in diagnosis codes which applied on the From date of a given period of care may be corrected with an adjustment claim. The HHA reports condition code D4 on the adjustment claim. Diagnosis codes that reflect a change in the patient's condition during a period of care should be reflected on the claim for the next period.

An HHA may submit a claim with patient status code 30 (still patient) at the end of a period of care on the expectation that additional HH visits will be provided in the next period of care. Some intervening event may prevent the delivery of additional visits and the beneficiary is subsequently discharged. In this situation, the HHA shall submit an adjustment claim to correct the patient status code to reflect the discharge on their claim, since patient status code 30 may prevent billing of services subject to HH consolidated billing during the last days of the period of care. The HHA reports condition code E0 (zero) on the adjustment claim.

Medicare Claims Processing Manual
Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Table of Contents
(Rev. 13089: Issued: 02-21-25)

30.4 - SNF PPS Pricer Software

(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

The Balanced Budget Act (BBA) of 1997 (Public Law 105-33) mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs), covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program.

Effective for cost reporting periods beginning on or after July 1, 1998, all skilled nursing services billed on TOB 21x will be paid based on calculations made by the SNF Pricer. The SNF Pricer operates as a module within CMS' claims processing systems. The SNF Pricer makes all payment calculations applicable under SNF PPS.

Medicare claims processing systems maintain a client that communicates with the SNF Pricer application programming interface (API). The Pricer is made available electronically to the shared systems and is updated at least annually.

The API describing the elements of SNF PPS claims that are used and the source code that calculates payments in the SNF Pricer are available to SNFs and their software vendors at: https://www.cms.gov/pricersourcecodesoftware. This is code is shared informationally. No part of the SNF Pricer logic is required to be incorporated into a SNF's billing system in order to bill Medicare.

A web-based version of the SNF Pricer Program that may be used to estimate SNF PPS payments can be found at: https://webpricer.cms.gov/ .

Annual Updates to the SNF Pricer

Rate and weight information used by the SNF Pricer is updated periodically, usually annually. Updates occur each October, to reflect the fact that SNF PPS rates are effective for a Federal fiscal year. Updates may also occur at other points in the year when required by legislation.

As of October 1, 2019, SNF PPS payments are made using the Patient-Driven Payment Model (PDPM). The rate components under the PDPM are described in Section 120. Whenever these components are updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the SNF Pricer.

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 13089; Issued: 02-21-25)

10.1.11 - Payment, Claim Adjustments and Cancellations

(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

HHAs may cancel or adjust claims. Type of bill 0328 is used to cancel an HH PPS claim. A cancellation is needed to change the beneficiary identifier or the HHA's provider number, if originally submitted incorrectly. Type of bill 0327 is used to adjust an HH PPS claim. Adjustments are used to correct information that may change payment. *For additional information regarding HH adjustments, see Chapter 1, section 130.5.*

70 - HH PPS Pricer Program

(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

Home health services billed on TOB 032x are reimbursed based on calculations made by the HH Pricer. The HH Pricer is a module within Medicare claims processing systems. The HH Pricer makes all payment calculations applicable under HH PPS, including claim payments for full periods of care, and all payment adjustments.

Medicare claims processing systems maintain a client that communicates with the HH Pricer application programming interface (API). The Pricer is made available electronically to the shared systems and is updated at least annually.

The API describing the elements of HH PPS claims that are used and the source code that calculates payments in the HH Pricer are available to HHAs and their software vendors at: https://www.cms.gov/pricersourcecodesoftware. This is code is shared informationally. No part of the HH Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare.

A web-based version of the HH Pricer Program that may be used to estimate HH PPS payments can be found at: https://webpricer.cms.gov/ .

Annual Updates to the HH Pricer

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the Federal Register:

- *The Federal standard period of care amount;*
- *The fixed loss amount to be used for outlier calculations;*
- *A table of case-mix weights and LUPA thresholds to be used for each HHRG;*
- *A table of national standardized per visit rates and per unit rates;*
- *The pre-floor, pre-reclassified hospital wage index; and*
- *Changes, if any, to the outlier loss-sharing percentage and the labor and nonlabor percentages.*

Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the HH Pricer.

Medicare Claims Processing Manual
Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev. 13089; Issued: 02-21-25)

130 *Hospice* Pricer Program

(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

Hospice services billed on TOB 081x and 082x are reimbursed based on calculations made by the Hospice Pricer. The Hospice Pricer is a module within Medicare claims processing systems. The Hospice Pricer makes all payment calculations applicable under Hospice claims, including all levels of care (Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care).

Medicare claims processing systems maintain a client that communicates with the Hospice Pricer application programming interface (API). The Pricer is made available electronically to the shared systems and is updated at least annually.

The API describing the elements of hospice claims that are used and the source code that calculates payments in the Hospice Pricer are available to hospices and their software vendors at: https://www.cms.gov/pricersourcecodesoftware. This is code is shared informationally. No part of the Hospice Pricer logic is required to be incorporated into a hospice's billing system in order to bill Medicare.

A web-based version of the Hospice Pricer Program that may be used to estimate hospice payments can be found at: https://webpricer.cms.gov/.

Annual Updates to the Hospice Pricer

Rate information used by the Hospice Pricer is updated periodically, usually annually. Updates occur each October, to reflect the fact that hospice payment rates are effective for a Federal fiscal year. Updates may also occur at other points in the year when required by legislation.

The following components are used by the Hospice Pricer to determine the Hospice payment rate:

- Wage Index
- Labor and Non-Labor Amounts for each level of care rate
  - Routine Home Care (RHC) rates days 1 thru 60
  - Routine Home Care (RHC) rates days 60+
  - Continuous Home Care (CHC) rates
  - Inpatient Respite Care (IRC) rates
  - General Inpatient Care (GIP) rates
- Service Intensity Add-on (SIA) rates

Whenever the Hospice Pricer is updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes. *These Recurring Update Notifications also describe how the changes will be implemented through the Hospice Pricer.*