CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3829	**Date: August 4, 2017**
	Change Request 10167

SUBJECT: Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization

I. SUMMARY OF CHANGES: This Change Request revises the record layout for the home health Pricer interface to support new payment and data initiatives. It also adds consistency editing to ensure the accurate reporting of site of service G-codes on home health visit line items.

EFFECTIVE DATE: January 1, 2018 - For requirements 10167.1 through 10167.8, claim "Through" dates on or after this date. For requirements 10167.9 through 10167.14, claim "From" date on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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	1/190/Payer Only Codes Utilized by Medicare
R	10/70.2/ Input/Output Record Layout

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: 3829	Date: August 4, 2017	Change Request: 10167

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I. GENERAL INFORMATION

A. Background: In the CY 2016 Home Health Prospective Payment System final rule, CMS finalized its proposal to implement the Home Health Value-Based Purchasing (HHVBP) Model in nine states representing each geographic area in the nation. For all Medicare-certified home health agencies (HHAs) that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA's total performance score on a set of measures already reported via OASIS and HHCAHPS for all patients serviced by the HHA, or determined by claims data, plus three new measures where performance points are achieved for reporting data. The HHVBP Model, as finalized, will be tested by CMS's Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Act. The requirements below make the revisions needed to HH Pricer program to accept the necessary adjustment factor to apply HHVBP adjustment and to capture the adjusted amount on the claim record. Instructions for entering the HHVBP adjustment factor in provider files are in CR 9939.

Additionally, as part of many of its quality and program improvement initiatives, CMS utilizes standardized allowed amounts for HH claims. Standardized allowed amounts are Medicare allowed amounts adjusted to remove sources of variation not directly related to decisions to utilize care, such as variation due to the application of hospital wage indexes and geographic practice cost indexes (GPCIs). Incentive payment and penalty adjustments are also not included in the standardized allowed amount. In other words, standardized amounts reflect a standard Medicare allowed amount as though the incentive programs were not in effect. To facilitate accurate calculation of standardized allowed amounts for HHAs and to facilitate their use by multiple CMS components, this CR requires that standardized allowed amounts be calculated by Medicare systems and passed on to claims history databases using the field created for hospital standardized payment amounts in CR 8746.

Finally, this CR requires system changes to make HH and hospice claims processing more consistent. CR 6440 created edits on hospice claims to ensure that G-codes for service visits are reported with the corresponding revenue code for the service discipline. Similar editing does not exist for HH claims, even though the same G-codes and revenue codes are required. The requirements below create these edits for HH claims.

B. Policy: The HHAs in the nine HHVBP states will have their payments adjusted (upward or downward) in the following manner: a maximum payment adjustment of three percent in CY 2018; a maximum payment adjustment of five percent in CY 2019; a maximum payment adjustment of six percent in CY 2020; a maximum payment adjustment of seven percent in CY 2021; and a maximum payment adjustment of eight percent in CY 2022.

Medicare systems will produce a standardized allowed amount for each home health claim. The standardized amount will be sent to the Integrated Data Repository (IDR) and the National Claims History

(NCH) and will be displayed for informational use only.

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	
10167.1	The contractor shall modify the input/output record to HH Pricer to reflect the revised record layout in the Medicare Claims Processing Manual, chapter 10, section 70.2.					X				
10167.2	The contractor shall multiply the HH PPS payments otherwise due, after all other payment adjustments are applied, by the HH VBP adjustment factor.									HH PPS Pricer
10167.3	The contractor shall return a HH VBP adjusted payment amounts and an HH VBP adjusted claim total payment amount in existing output record payment fields.									HH PPS Pricer
10167.4	The contractor shall subtract the total HH PPS payment amount before HH VBP adjustment from the total HH VBP adjusted amount and return the result in the HH VBP adjustment amount field of the output record.									HH PPS Pricer
10167.5	The contractor shall place the HH VBP adjustment amount on the claim as a value code QV amount. Note: This may be a positive or a negative amount.					X				
10167.6	The contractor shall calculate an interim standardized allowed amount for all records according to the logic described in Attachment 1 and return the amount in the Pricer output field PPS-STD-VALUE.									HH PPS Pricer
10167.7	The contractor shall calculate a final standardized amount for all HH PPS RAPs, claims and adjustments that meet all the following criteria: 1. Type of bill (TOB) = 032x, 2. Through date on or after January 1, 2018, and 3. Nonpayment code = blank.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10167.7.1	The contractor shall add any positive Medicare payment amounts reported with revenue center codes 029x, 060x, and 0274 to the standardized amount returned by the HH Pricer in the PPS-STD-VALUE field. NOTE: The payment amount shall not include coinsurance.					X				
10167.7.2	The contractor shall reduce the amount calculated in requirement 7.1 by the current amount of sequestration, if sequestration applies.					X				
10167.7.3	The contractor shall add any coinsurance amounts (value codes A2 or B2) and third party primary payer payments (line item primary amounts used by MSPPAY) reported with revenue center codes 029x, 060x, and 0274 to the amount calculated in requirement 7.2 and report this amount as the final standardized amount.					X				
10167.8	The contractor shall record the final standardized amount calculated in requirement 7.3 on the claim in record in the PPS-STNDRD-VALUE field.					X				IDR, NCH
10167.9	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 042x if the HCPCS code is other than Q5001, Q5002, Q5009, G0151, G0157 or G0159.			X		X				
10167.10	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 043x if the HCPCS code is other than Q5001, Q5002, Q5009, G0152, G0158 or G0160.			X		X				
10167.11	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 044x if the HCPCS code is other than Q5001, Q5002, Q5009, G0153 or G0161.			X		X				
10167.12	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 055x if the HCPCS code is other than Q5001, Q5002, Q5009, G0162, G0299, G0300, G0493, G0494, G0495 or G0496.			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10167.13	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 056x if the HCPCS code is other than Q5001, Q5002, Q5009 or G0155.			X		X				
10167.14	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 057x if the HCPCS code is other than Q5001, Q5002, Q5009 or G0156.			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10167.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10167.3	The individual payment amounts that can be affected by HH VBP adjustment are the HRG-PAY, REVENUE-COST, REVENUE-ADD-ON-VISIT-AMT and OUTLIER-PAYMENT fields.

X-Ref Requirement Number	Recommendations or other supporting information:
10167.9 thru .13	The site of service Q-codes can be reported on any service line, so these are included with the discipline specific G-codes in all the new edits.

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 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: 1

190 – Payer Only Codes Utilized by Medicare

(Rev.3829, Issued: 08-04-17, Effective: 01-01-18, Implementation: 01-02-18)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – M9 Not used by Medicare.

MA – GI Bleed.

MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MT – Not currently used by Medicare.

MZ – IOCE error code bypass

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48-49 – Not currently used by Medicare.

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 –HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Accountable Care Organization reduction.

Q1 – Pioneer payment reduction

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – Reserved for future use

Q5 – EHR

Q6 – PQRS

Q7 – Q9 – Not used by Medicare.

QD – Device Credit

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU –Device credit with device offset

QV – Value-based purchasing adjustment amount

QW – Placeholder reserved for future use

70.2 - Input/Output Record Layout

(Rev.3829, Issued: 08-04-17, Effective: 01-01-18, Implementation: 01-02-18)

The required data and format for the HH Pricer input/output record 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 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.

File Position	Format	Title	Description
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. 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.

File Position	Format	Title	Description	
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.	
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 1.8714. 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.	
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

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 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 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.	

File Position	Format	Title	Description
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
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.

File Position	Format	Title	Description
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.*
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*	

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.