CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4312	**Date: May 23, 2019**
	Change Request 11272

Transmittal 4294, dated May 3, 2019, is being rescinded and replaced by Transmittal 4312, dated, May 23, 2019 to correct an oversight in the manual section. New diagnosis instructions added to section 40.2 (HH claims) also apply to section 40.1 (RAPs) and are added to that section. All other information remains the same.

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Additional Manual Instructions

I. SUMMARY OF CHANGES: This Change Request revises additional sections of Pub. 100-04, chapter 10, to support the implementation of the HH PDGM.

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 16, 2019

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	10/10.1.19.3/Adjustments of Episode Payment – Validation of HIPPS
R	10/20/Home Health Prospective Payment System (HH PPS) Consolidated Billing
R	10/20.1.1/Responsibilities of Home Health Agencies
R	10/20.1.2/Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
R	10/20.2/Home health Consolidated Billing Edits in Medicare Systems
R	10/20.2.2/Therapy Editing
R	10/20.2.3/Other Editing Related to Home Health Consolidated Billing
R	10/20.2.4/Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date
R	10/20.2.5/No RAP Received and Therapy Services Rendered in the Home
R	10/30.1/Eligibility Query to Determine Status
R	10/30.2/CWF Response to Inquiry
R	10/30.3/Timeliness and Limitations of CWF Responses
R	10/30.5/National Home Health Prospective Payment Episode History File
R	10/30.6/Opening and Length of HH PPS Episodes/Periods of Care
R	10/30.7/Closing, Adjusting and Prioritizing HH PPS Episodes/Periods of Care Based on RAPs and HHA Claim Activity
R	10/30.8/Other Editing for HH PPS Episodes
R	10/30.9/Coordination of HH PPS Claims With Inpatient Claim Types
D	10/30.10/Medicare Secondary Payment (MSP) and the HH PPS Episodes File
R	10/30.11/Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/40.3/HH PPS Claims When No RAP is Submitted - “No-RAP” LUPAs
D	10/40.5/Billing for Nonvisit Charges
R	10/70.2/Input/Output Record Layout
R	10/70.3/Decision Logic Used by the Pricer on RAPs
R	10/70.4/Decision Logic Used by the Pricer on Claims
R	10/70.5/Annual Updates to the HH Pricer

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: 4312	Date: May 23, 2019	Change Request: 11272

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SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Additional Manual Instructions

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 16, 2019

I. GENERAL INFORMATION

A. Background: In the CY 2019 final Home Health Prospective Payment System Rate Update final rule, CMS finalized an alternative case-mix methodology now called the Patient-Driven Groupings Model (PDGM) which includes the payment reform requirements as set forth in the BBA of 2018 and will be implemented in CY 2020. The manual instructions in this Change Request are revised to conform to the final policies of the PDGM.

B. Policy: This CR further implements the policies of the PDGM, as described in the CY 2019 home health final rule and as required by section 51001 of the BBA of 2018. For the complete policy, see the final rule and CR 11081.

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	
11272.1	The contractor shall be aware of the manual changes to Pub. 100-04, chapter 10, Home Health Agency Billing.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11272.2	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		

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): 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: 0

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 4312, Issued: 05-23-19)

10.1.19.3 - Adjustments of Episode Payment – Validation of HIPPS

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Recoding Based on OASIS-calculated HIPPS Codes

The HIPPS code calculated based on the OASIS assessment for an episode is reported on the HH RAP and claim. HHAs may calculate the HIPPS code using CMS-provided Grouper software or with their own software that recreates CMS grouping logic. When the OASIS assessment is submitted to the Medicare quality system, the HIPPS code is independently calculated using the CMS-provided Grouper program.

When processing the claim for an episode, Medicare systems compare the provider-submitted HIPPS code with the HIPPS code calculated based on the assessment information in the quality system. If the codes do not match, the OASIS-calculated HIPPS code is used for payment.

Medicare systems display the OASIS-calculated HIPPS code in Direct Data Entry (DDE) in a field named "RETURN-HIPPS1." When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice. In other cases, the HIPPS code in this field will match what the HHA submitted on their claim.

The OASIS-calculated HIPPS code may be re-coded further by Medicare systems. The OASIS-calculated HIPPS code will be sent to the HH PPS Pricer program which may change the code based on changes in therapy services (see section 10.1.19.1) or whether the claim is for an early or later episode (see section 10.1.19.2). In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice. HHAs will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE:

Field in DDE	DDE Map	Represents
HCPC	MAP171E	HHA-submitted HIPPS code
RETURN-HIPPS1	MAP171E	OASIS-calculated HIPPS code
APC-HIPPS	MAP171A	Pricer re-coded HIPPS code

The OASIS-calculated HIPPS code may also be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the HIPPS code determined by medical review will be used for payment and will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

This recoding process applies only to episodes beginning before January 1, 2020. Under the Patient-Driven Grouping Model, payment groups are determined by Medicare systems using OASIS data and the provider-submitted HIPPS code is not used.

When an OASIS Assessment Has Not Been Submitted

Submission of an OASIS assessment is a condition of payment for HH episodes/periods of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30 day period will have elapsed by the time an episode/period of HH services is completed and the final claim for that episode/period is submitted to Medicare. If the OASIS assessment is not found in the quality system upon receipt of a final claim and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will *return or* deny the HH claim.

If the claim is denied, the contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N/A
MSN: 41.17

If the claim is returned, the HHA may correct any errors in the OASIS or claim information to ensure a match and then re-submit the claim. If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:

- *Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,*
- *Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period, and*
- *Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.*

Condition code 21 must not be used in these instances, since it would result in inappropriate beneficiary liability.

The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N211
MSN: 41.17

20 - Home Health Prospective Payment System (HH PPS) Consolidated Billing

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare makes payment for all such items and services to a single HHA overseeing that plan. This HHA is known as the primary HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise." Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;

- Medical social services;
- Routine and nonroutine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Exception: Therapy services are not subject to the home health consolidated billing methodology when performed by a physician.

Medicare periodically publishes Recurring Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. Medicare updates the lists annually, effective January 1, as a result of annual changes in HCPCS codes, unless the HCPCS changes do not affect home health services. The lists may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

The HHA that submits a RAP or No-RAP LUPA claim successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given episode in the CWF. If a beneficiary transfers during a 60-day episode*/30-day period of care*, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. A/B MACs (HHH) will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within an episode*/period of care* (see §20.2 for details).

A/B MACs (HHH) will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under an HH plan of care (using TOB 034x) when the primary HHA has already billed other services under an HH plan of care (TOB 032x) for the beneficiary. Institutional providers may access information on existing episodes*/periods of care* through the home health CWF inquiry process. See §30.1.

Durable medical equipment is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier or an HHA (including HHAs other than the primary HHA). Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted by multiple providers for the same dates of service for the same beneficiary. In the event of duplicate billing, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent payment for the purchase and the rental of the same item for the same dates of service. In this event, the first claim received, regardless of whether for purchase or rental, will be processed and paid.

The exception to the above, however, is competitive bidding for certain DME. HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program, must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP Codes where beneficiaries receiving these items maintain their permanent residence. Home health agency claims submitted for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs, who will have jurisdiction over all claims for competitively bid items.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis in addition to *the HH unit of payment*. For more detailed information, refer to §20.2.3 and §90.1.

20.1.1 - Responsibilities of Home Health Agencies

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made. The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services that the physician has ordered on the beneficiary's home health plan of care.

However, providing services either directly or under arrangement requires knowledge of the services provided during the episode*/period of care*. An HHA would not be responsible for payment to another provider in the situation in which they have no prior knowledge (e.g., they are unaware of physicians orders) of the services provided by that provider to a patient who is under their home health plan of care.

In certain circumstances where the primary HHA is unaware of services provided during the episode*/period of care* and the beneficiary is properly notified, the beneficiary may be liable for payment for these services. In order to protect the beneficiary from unexpected liability in these cases, and in order to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a home health patient notify the beneficiary of the possibility that they will be responsible for payment.

Notification about home health consolidated billing must begin with the beneficiary's admission to home health care. Under the Medicare Home Health Services Conditions of Participation: Patient rights, (42 CFR, §484.10 (c) (i)), the HHA must advise the patient, in advance, of the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will furnish care, and the frequency of visits proposed to be furnished. It is, therefore, the responsibility of the HHA to fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by his/her primary HHA.

In addition, under the Conditions of Participation: Patient liability for payment, (42 CFR, §484.10(e)), HHAs are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient. Information regarding patient liability for payment must be provided by the HHA both orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA.

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

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.

Beginning October 2010, another source of information is available via the CWF. Medicare systems will 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 60% or 50% 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.

20.2 - Home health Consolidated Billing Edits in Medicare Systems

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

In short, consolidated billing requires that only the primary HHA bill services under the home health benefit, with the exception of DME and therapy services provided by physicians, for the period of that episode*/period of care*. The types of service most affected are nonroutine supplies and outpatient therapies, since these services are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

Home health consolidated billing edits are applied when the episode*/period* claim has been received and processed in CWF. Edits are applied differently depending on whether the HH patient was discharged/transferred at the end of the HH episode*/period* or not.

If the patient was discharged or transferred, the edits apply to dates of service between the episode*/period* start date and the last billable service date for the episode*/period*. The start date and last service date are excluded.

If the patient is not discharged or transferred (patient status 30, “Still Patient”), the edits apply to dates of service between the episode*/period* start date and the episode*/period* date. The start date is excluded but the end date is included.

If any line item services subject to consolidated billing are identified within these dates, CWF sends information to the contractors that enables them to reject or deny those line items.

Claims subject to consolidated billing may be identified in one of two ways. Claims may be edited when the HH PPS claim had been received before the claim for services subject to consolidated billing. In these cases, the line items subject to consolidated billing are rejected or denied prior to payment. Claims may also be identified when the HH PPS claim is received after the other claims subject to consolidated billing. In these cases, the claim for services subject to consolidated billing has already been paid. CWF then notifies the contractor to make a post-payment rejection or denial.

For post-payment rejections of claims billed on institutional claims, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed on professional claims, those contractors will follow their routine overpayment identification and recovery procedures. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

The contractor shall use the following remittance advice messages and associated codes when not paying outlier amounts under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO
CARC: 97
RARC: N390
MSN: N/A

Since home health consolidated billing is not an ABN situation, coding on incoming claims cannot allow Medicare systems to fully identify the payment liability for any denial. As described in §20.1, whether the denial is the liability of the primary HHA or the beneficiary is determined by whether the services are provided under arrangement and whether the beneficiary received notice of their potential liability. These denials are shown as provider liability on remittance advices (group code CO) to ensure therapy providers or suppliers explore whether a payment arrangement exists or can be made for the services. Despite this coding limitation, Medicare recognizes that ultimately beneficiaries may be liable for these services.

20.2.2 - Therapy Editing

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. These revenue codes are subject to consolidated billing when submitted on types of bill 013x, 023x, 034x, 074x, 075x or 085x. Consolidated billing edits do not apply on TOB 034x when the HHA is billing for disposable negative pressure wound therapy services during a HH episode*/period of care*.

On claims submitted by practitioners using the professional claim format, CWF enforces consolidated billing for outpatient therapies using a list of HCPCS codes which represent therapy services.

Therapy services on professional claims are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.

The following specialty codes indicate a physician for purposes of this edit:

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology

Code	Physician Specialty
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

20.2.3 - Other Editing Related to Home Health Consolidated Billing

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

CWF edits to prevent duplicate billing across two providers. Consequently, CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though HH consolidated billing does not apply to DME by law.

If revenue code 0636 and the HCPCS code for an osteoporosis drug is billed on a TOB 034x claim during an open HH episode*/period of care*, CWF must edit to ensure that the provider of the 034x claim is the same as the primary provider of the open episode*/period*, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the *unit of* payment. HH consolidated billing will not affect billing of DME or services outside the home health benefit, even when these services are billed by HHAs.

20.2.4 - Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

If only a RAP for the episode*/period of care* has been received and the incoming claim with services subject to consolidated billing contains dates of service within the full 60-day home health episode period *or 30-day period of care*, CWF returns an alert to the Medicare contractor to notify them that the claim may be subject to consolidated billing. The Medicare contractor processes the claim to payment, but passes on the alert to the provider on the remittance advice at the line level.

The contractor shall use the following remittance advice messages and associated codes when making payment under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: CO
CARC: N/A
RARC: N88
MSN: N/A

This indicates to providers that the services may be denied and claim payment may be recouped if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing.

20.2.5 - No RAP Received and Therapy Services Rendered in the Home

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

There may be situations in which a beneficiary is under a home health plan of care, but CWF does not yet have a record of either a RAP or a home health claim for the episode/ */period* of care. To help inform independent therapy providers billing professional claims to Medicare contractors that the services they rendered in the home setting may be subject to consolidated billing, providers will receive notification on the remittance advice when Medicare pays them for the service.

Medicare systems processing professional claims will provide this notification when the place of service on the claim is "12 home," the HCPCS code is a therapy code subject to home health consolidated billing and CWF has not returned a message indicating the presence of a RAP.

30.1 - Eligibility Query to Determine Status

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Under the HH PPS and home health consolidated billing (described elsewhere in this chapter), one HHA is considered the "primary" home health agency in billing situations. This primary agency is the only agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. When a homebound beneficiary seeks care from an HHA or from an institutional therapy provider subject to home health consolidated billing, the provider needs to determine if the beneficiary is already being served by an HHA - an agency that then would be considered primary.

Providers may send an inquiry to determine the beneficiary's entitlement and eligibility status into the Common Working File or CWF, through their A/B MAC (A) or (HHH). They must send the ASC X12 270 Health Care Eligibility Inquiry transaction set and will receive the ASC X12 271 Health Care Eligibility Response transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

A/B MACs (A) or (HHH) processing institutional claims will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The A/B MAC (A) or (HHH) will create the 271 response or DDE screen from the ELGA transaction record.

The response shows whether or not the beneficiary is currently in a home health episode*/period* of care. If the beneficiary is not already under care at another HHA, he/she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode*/period* is already open at another HHA if the beneficiary has chosen to transfer.

See chapter 31 for a description of the data elements and related requirements.

30.2 - CWF Response to Inquiry

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

CWF will return information on the two *episodes/periods of care* in the CWF episode file (the File) closest to the date the HHA or other provider entered in the "applicable date" field. If a date is not specified,

information on the two most recent *episodes/periods* in the File will be returned. See Chapter 31 for complete data sets returned to specific provider types.

30.3 - Timeliness and Limitations of CWF Responses

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Inquirers receive a response within a very short time frame. However, these responses are not truly "real time." The CWF auxiliary file that retains episode*/period* information is updated by, and is only as current as, each RAP or claim batch run in CWF. All processed RAPs and claims will update the file, even if RAPs have zero payment, or if claims or RAPs are ultimately denied. The CWF removes episodes*/periods* from the file only when:

- HHAs cancel their own RAPs for episodes*/periods* not yet closed;
- HHAs cancel their own claims, for closed episodes*/periods*; or
- When a A/B MAC (HHH) processing HH claims cancels a claim or a RAP for specific reasons (i.e., fraud).

In general, responses will be as current as the previous day. Therefore, even when a response indicates a beneficiary is not currently in an episode*/period*, the possibility exists that a RAP or claim could be in process, and the inquiring agency would still not be the primary HHA for a beneficiary for whom a "clear" inquiry was received. In such cases, the inquiring agency will not learn that it is not the primary HHA immediately.

Also possible but even more rare, claims or RAPs from two different HHAs for the same beneficiary for the same date may be in the same batch of claims or RAPs sent to CWF. In such cases, the arbitrary claim process will still result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

30.5 - National Home Health Prospective Payment Episode History File

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

CWF maintains a national episode history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. *Even though under the PDGM, the HH unit of payment is a 30-day period of care, this file continues to be named 'the episode file' in CWF.* Only MACs, not providers, may view this file.

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

- The beneficiary *identifier*;
- The pertinent A/B MAC (HHH) and CMS Certification Number;
- Period Start and End Dates - the start date is received on a RAP or claim, and the end date is initially calculated to be the 60th *or 30th* day after the start date, changed as necessary when the claim for the episode*/period* is finalized;
- DOEBA and DOLBA - line item dates of service of the first and last HH visits reported on the final claim for the episode*/period*;

- Patient Status Indicator - the patient discharge status code on an HH PPS claim, indicating the status of the HH patient at the end of the episode/*period*. This indicator will also be populated by RAPs, but the value will always be "30";

- Transfer/Readmit Indicator - code values in this field indicate the reason this record was allowed to overlap the *end date* of the previous episode:

    - 'B' indicates the record was a transfer from another HHA (i.e., condition code 47 was on the RAP or claim;

    - 'C' indicates the record was a discharge and admission from the same HHA (i.e., CCNs on the two episodes/*periods* are the same).

  This transfer/readmit indicator is present on the internal episode file used in CWF editing but it is not displayed on the episode history screen. If A/B MACs (HHH) need to validate this data, they must research the claim record on CWF history.

- The HIPPS Code - the code representing the basis of payment for episodes/*periods* other than those receiving a low utilization payment adjustment (LUPA);

- Principal Diagnosis Code and First Other Diagnosis Code - diagnosis codes reported on the RAP or claim;

- A LUPA Indicator - received from the shared system indicating whether or not a LUPA *applied*; and

- A RAP Cancellation Indicator - showing whether or not a RAP has been auto-canceled for this episode/*period* because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel only code "B," this indicator is a value of "1." For episodes beginning on or after January 1, 2008, this indicator is also used when a final claim has been denied as fully non-covered by medical review. In these cases, the indicator is a value of "2." In all other cases, the value is "0."

The episode file contains the 36 most recent episodes/*periods* for any beneficiary. Episodes/*periods* that precede the most recent 36 will be dropped off the file and will not be retrievable online. The date of accretion for an episode/*period* is the date the RAP or claim is accepted or applied.

30.6 - Opening and Length of HH PPS Episodes/*Periods of Care*

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Within CWF, the episode history auxiliary file is separate from the home health benefit period auxiliary file, which existed prior to HH PPS. All HH PPS claims will update both these files. In most cases, receipt and processing of a RAP will open an HH PPS episode/*period* in *the* episode file, even if the RAP or claim has zero payment.

Claims open episodes in only one special circumstance. This is when a provider knows from the outset that *the LUPA threshold* for the entire episode/*period will not be exceeded*, and therefore decides to forego the RAP so as to avoid recoupment of the difference of the initial percentage episode payment and LUPA visit-based payment. This particular billing situation is *called* a No-RAP LUPA.

Multiple episodes/*periods* can be open for the same beneficiary at the same time. The same HHA may require multiple episodes/*periods* be opened for the same beneficiary because of an unexpected readmission after discharge, or if a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes/*periods* may also occur between different providers if a transfer situation exists. CWF will post RAPs received with appropriate transfer and readmit indicators to facilitate the creation of multiple episodes/*periods*.

Same day transfers are permitted, such that an episode/*period* for one agency can end on the same date as an episode/*period* was opened by another agency for the same beneficiary. Both HHA's services for this date will be approved for payment, without regard for whether the same HH disciplines (e.g. skilled nursing, physical therapy, etc.) from both HHAs provided services.

When episodes/*periods* are created from RAPs, CWF calculates a period end date that does not exceed the start date plus 59 days *or plus 29 days*. CWF will assure no episode exceeds *the maximum* length under any circumstance, and will auto-adjust the period end date to shorten the episode/*period* if needed based on activity at the end of the episode/*period* (i.e., shortened by transfer).

30.7 - Closing, Adjusting and Prioritizing HH PPS Episodes/*Periods of Care* Based on RAPs and HHA Claim Activity

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

A/B MACs (HHH) that process HH claims reject RAPs and claims with statement dates overlapping existing episodes/*periods* unless a transfer or discharge and readmit situation is indicated. These A/B MACs (HHH) also reject claims in which the dates of the covered visits reported do not fall within the episode/*period* established by the same agency.

Episode/*period* lengths are shortened when another RAP or claim indicating transfer or discharge/readmission is received. The episode *end date* defaults to the day of the first date of service of the new RAP or claim. If a full payment has been made for the now shortened episode/*period*, the A/B MAC (HHH) will adjust the episode to reflect a PEP payment. Any line items that fall after the beginning of the new episode/*period* are then noncovered.

If a RAP or claim is canceled by an HHA, CWF cancels the episode/*period*. If a RAP is canceled and payment is recouped and the RAP when a corresponding final bill has not been received, the episode/*period* remains open at CWF.

30.8 - Other Editing for HH PPS Episodes

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

CWF assures that the final "through date" on the claim equals the calculated period end date for the episode/*period* if the patient status code for the claim indicates the beneficiary remains in the care of the same HHA (patient status code 30). If the patient dies, represented with a patient status code of 20, the episode/*period* does not receive a PEP adjustment, though other adjustments may apply, but the through date on the claim indicates the date of death instead of the end of the episode/*period*. When the patient status of a claim is 06, indicating transfer, the episode/*period* end date is adjusted to reflect the "through date" of that claim, and payment is also adjusted. When the status of the claim is 01, no change is made in the episode/*period* length or payment unless a separate RAP or claim is received which overlaps that 60-day period and contains either a transfer or discharge and readmit indicator.

CWF *opens a new episode/period when* condition code 47 *is present*, indicating transfer to another HHA. CWF also opens a new episode/*period* when the CMS certification number (CCN) for the provider on the incoming RAP matches the CCN on the episode/*period* the RAP overlaps. This indicates a discharge and readmission situation.

30.9 - Coordination of HH PPS Claims With Inpatient Claim Types

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Beneficiaries cannot be institutionalized and receive home health care simultaneously. Therefore claims for institutional inpatient services (inpatient hospital, skilled nursing facility (SNF) and swing bed claims), have priority in Medicare claims editing over claims for home health services.

If an HH PPS claim is received, and CWF finds dates of service on the HH claim that falls within the dates of an inpatient, SNF or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence), Medicare systems will reject the HH claim. The HHA may submit a new claim removing any dates of service within the inpatient stay that were billed in error.

If the HH PPS claim is received first and the inpatient hospital, SNF or swing bed claim comes in later, but contains dates of service duplicating dates of service *on* the HH PPS *claim*, Medicare systems will adjust the previously paid HH PPS claim to non-cover the duplicated dates of service.

30.10 – RESERVED

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

30.11 - Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

The following chart summarizes basic effects of HH PPS claims processing on the episode record. *Even though under the PDGM, the HH unit of payment is a 30-day period of care, this file continues to be named 'the episode file' in CWF and references to 'episode record' below refer to episodes or periods of care.*

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP	• Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Subsequent Episode RAP	• Opens another subsequent episode using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through next 60 days • DOEBA and DOLBA are left blank	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP with condition code 47	• Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank • The Period End Date is automatically changed to reflect the RAP's "from" date.	• The Period End Date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the "from" date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider or A/B MAC (HHH)	• The episode record is deleted from CWF	• No episode record is present to prevent RAP submission or No-RAP LUPA claim submission by another provider, making that provider the primary HHA for the dates of the episode
RAP Cancellation by System	• The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • In order to receive payment for this episode, the original RAP must be resubmitted before the final claim is submitted • To correct information on this RAP, the original RAP must be cancelled by the HHA and then re-submitted once more with the correct information
Claim (full episode)	• 60-day episode record is completed; • Period End Date remains at the 60th day • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Claim (discharge with goals met prior to Day 60)	• Episode record completed • Period End Date remains at the 60th day; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Claim (transfer)	• Episode record completed • Period End Date reflects claim "Through" date; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date
No-RAP LUPA Claim	• Opens an episode record using claim's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • Other No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim
Claim Adjustment	• No impact on the episode unless adjustment changes patient status to transfer or service lines are added or removed to change the DOEBA or DOLBA date.	• No impact
Claim Cancellation by Provider or A/B MAC (HHH)	• The episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP LUPA claim submission by another provider, making that provider the primary HHA for the dates of the episode

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Claim Cancellation by System	• The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

40.1 - Request for Anticipated Payment (RAP)

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

The following data elements are required to submit a RAP under HH PPS. Home health services under a plan of care are paid based on a 60-day episode of care (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit a RAP using the coding described below.

In general, a RAP and a claim will be submitted for each episode or period of care. Each claim must represent the actual utilization over the episode period. If the claim is not received 60 days after the calculated end date of the episode (day 120) or period (day 90) or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the HHA's next remittance advice (RA).

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

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

Provider Name, Address, and Telephone Number

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

Patient Control Number

Required - The patient's control number assigned by the HHA for association and reference purposes.

Type of Bill

Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this particular episode of care. The type of bill accepted for HH PPS requests for anticipated payment is:

032x - Home Health Services under a Plan of Treatment

4th Digit	Definition

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

Medicare contractors will allow only provider-submitted cancellations of RAPs or provider-submitted final claims to process as adjustments against original RAPs. Provider may not submit adjustments (frequency code '7') to RAPs.

NOTE: Type of bill 033x is no longer valid, effective October 1, 2013.

Statement Covers Period (From-Through)

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

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior RAP submission instructions for RAPs with "From" dates before January 1, 2020. The HHA should follow PDGM instructions for RAPs with "From" dates on or after January 1, 2020.

Patient Name/Identifier

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

Patient Address

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

Patient Birth Date

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

Left blank if the full correct date is not known.

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

Required - Indicates the patient's point of origin for the admission.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code.

Patient Discharge Status

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

Condition Codes

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

If the RAP is for an episode in which the patient has transferred from another HHA, the HHA enters condition code 47.

If canceling the RAP (TOB 0328), the agency reports a condition code indicating the appropriate claim change reason.

Enter "Remarks" indicating the reason for cancellation.

Occurrence Codes and Dates

Conditional – The HHA enters any NUBC approved code to describe occurrences that apply to the RAP. Occurrence code values are two alphanumeric digits, and the corresponding dates are shown as eight numeric digits.

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

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. To ensure these payment adjusts are applied accurately, the HHA reports the following codes:

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

Code	Title	Definition
		the place of residence where the home health service is delivered.

Conditional - Any NUBC approved Value code to describe other values that apply to the RAP. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

Revenue Code and Revenue Description

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

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

For RAPs with "From" dates on or after January 1, 2020, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code in order to meet this requirement. *The percentage payment for the RAP is based on the HIPPS code as submitted. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems.*

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

Service Date

Required - For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.

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

Service Units

Required – Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the RAP. If additional revenue codes are submitted on the RAP, the HHA reports service units as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Total Charges

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

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

Payer Name

Required - See Chapter 25.

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

Release of Information Certification Indicator

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

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

Insured's Name

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

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - On RAPs with "From" dates before January 1, 2020, the HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99

7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2015	15
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2016	16
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	H
12	Functional severity points – under Equation 1	2	C
13	Clinical severity points – under Equation 2	13	N
14	Functional severity points – under Equation 2	4	E
15	Clinical severity points – under Equation 3	3	D
16	Functional severity points – under Equation 3	4	E
17	Clinical severity points – under Equation 4	12	M
18	Functional severity points – under Equation 4	7	H

This is an example of a treatment authorization code created using this format:

The treatment authorization code that would appear on the claim would be, in this example: 15JK16AA41HCNEDEMH.

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format. If the format is incorrect, the contractor returns the claim to the provider.

On RAPs with “From” dates on of after January 1, 2020, treatment authorization codes are no longer required on RAPs.

Document Control Number (DCN)

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

Principal Diagnosis Code

Required - The HHA enters the ICD code for the principal diagnosis. The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by the HIPAA. The code must be the full

diagnosis code, including all five digits for ICD-9-CM or all seven digits for ICD-10 CM where applicable. Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For claim "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

Other Diagnosis Codes

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

In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Attending Provider Name and Identifiers

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

Remarks

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

40.2 - HH PPS Claims

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Home health services under a

plan of care are paid based on a 60-day episode of care (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode or period will usually be made in two parts. After a RAP has been paid and an episode or period has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the RA so the net payment on the claim can be easily understood. Detailed RA information is contained in chapter 22 of this manual.

Billing Provider Name, Address, and Telephone Number

Required – The HHA's minimum entry is the agency's name, city, state, and ZIP Code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. A/B MACs (HHH) use this information in connection with the provider identifier to verify provider identity.

Patient Control Number and Medical/Health Record Number

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

The HHA may enter the number assigned to the patient's medical/health record. If this number is entered, the A/B MAC (HHH) must carry it through their system and return it on the remittance record.

Type of Bill

Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this particular episode of care. The types of bill accepted for HH PPS claims are:

032x - Home Health Services under a Plan of Treatment

4th Digit - Definition

> 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.
>
> 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.
>
> 9 - Final Claim for an HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace codes 7, or 8.

HHAs must submit HH PPS claims with the 4th digit of "9." These claims may be adjusted with code "7" or cancelled with code "8." A/B MACs (HHH) do not accept late charge bills, submitted with code "5," on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

NOTE: Type of bill 033x is no longer valid, effective October 1, 2013.

Statement Covers Period

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior claims submission instructions for claims with "From" dates before January 1, 2020, including episodes that span into 2020. The HHA should follow PDGM instructions for claims with "From" dates on or after January 1, 2020.

Required - The beginning and ending dates of the period covered by this claim. The "from" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "through" date must be 59 days after the "from" date for a 60-day episode or 29 days after the "From" date for a 30-day period of care

In cases where the beneficiary has been discharged or transferred within the episode or period, HHAs will report the date of discharge in accordance with internal discharge procedures as the "through" date. If the beneficiary has died, the HHA reports the date of death in the "through date."

The HHA may submit claims for payment immediately after the claim "through" date. It is not required to hold claims until the end of the episode or period unless the beneficiary continues under care.

Patient Name/Identifier

Required - The HHA enters the patient's last name, first name, and middle initial.

Patient Address

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

Patient Birth Date

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

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

Patient Discharge Status

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

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a PEP adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode or 30-day period, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the episode or period. Situations may occur in which the HHA is unaware at the time of billing the discharge that these

circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

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

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

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

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

Condition Codes

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

If the RAP is for an episode in which the patient has transferred from another HHA, the HHA enters condition code 47.

If the claim is for an episode in which there are no skilled HH visits in billing period, but a policy exception that allows billing for covered services is documented at the HHA, the HHA enters condition code 54.

HHAs that are adjusting previously paid claims enter one of the condition codes representing Claim Change Reasons (code values D0 through E0). If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" indicating the reason for the HIPPS code change. HHAs use D9 if multiple changes are necessary.

When submitting an HH PPS claim as a demand bill, HHAs use condition code 20. See §50 for more detailed instructions regarding demand billing.

When submitting an HH PPS claim for a denial notice, HHAs use condition code 21. See §60 for more detailed instructions regarding no-payment billing.

Required - If canceling the claim (TOB 0328), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

Required – On claims with "From" dates on or after January 1, 2020, the HHA enters occurrence code 50 and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090). If occurrence code 50 is not reported on a claim or adjustment, the claim will be returned to the provider for correction.

On claims for initial periods of care (i.e. when the From and Admission dates match), the HHA reports an inpatient admission that ended within 14 days of the "From" date by using one of the following codes.

Code	Short Descriptor	Long Descriptor
61	Hospital Discharge Date	The Through date of a hospital stay that ended within 14 days prior to the From date this HHA claim.
62	Other Institutional Discharge Date	The Through date of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days prior to this HHA admission.

On claims for continuing periods of care, the HHA reports an inpatient hospital admission that ended within 14 days of the "From" date by using occurrence code 61.

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent discharge date. Claims reporting more than one of any combination of occurrence codes 61 and 62 will be returned to the provider for correction.

Conditional - The HHA enters any other NUBC approved code to describe occurrences that apply to the claim.

Occurrence Span Code and Dates

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

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. For episodes in which the beneficiary's site of service changes from one CBSA or county to another within the episode period, HHAs should submit the CBSA code or State and County code corresponding to the site of service at the end of the episode on the claim.

Provider-submitted codes:

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

Code	Title	Definition
		State and County Code of the place of residence where the home health service is delivered.

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the HHA.

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

If information returned from the CWF indicates all visits on the claim are Part A, the shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code V.

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

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. *This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.*

For claims with "From" dates before January 1, 2020, the fifth position of the code represents the NRS severity level. This fifth position may differ to allow the HHA to change a code that represents that supplies were provided to a code that represents that supplies were not provided, or vice versa. However, the fifth position may only change between the two values that represent the same NRS severity level. Section 10.1.9 of this chapter contains the pairs of corresponding values. If these criteria are not met, Medicare claims processing systems will return the claim.

HHAs enter only one 0023 revenue code per claim in all cases.

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode*/period*. *All services must be billed on one claim for the entire episode/period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.*

Each service must be reported in line item detail. Each service visit (revenue codes 042x, 043x, 044x, 055x, 056x and 057x) must be reported as a separate line. Any of the following revenue codes may be used:

027x	Medical/Surgical Supplies (Also see 062x, an extension of 027x) Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills
042x	Physical Therapy Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

043x	Occupational Therapy Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
044x	Speech-Language Pathology Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
055x	Skilled Nursing Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
056x	Medical Social Services Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
057x	Home Health Aide (Home Health) Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: A/B MACs (HHH) do not accept revenue codes 058x or 059x when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

Revenue Codes for Optional Billing of DME

Billing of DME provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their A/B MAC (HHH) processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20 of this manual.

0274	Prosthetic/Orthotic Devices Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

029x	Durable Medical Equipment (DME) (Other Than Renal) Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.
060x	Oxygen (Home Health) Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

0623	Medical/Surgical Supplies - Extension of 027x Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation "surg dressings," HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

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

HHAs can assist Medicare's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027x for nonroutine supplies are also complete and accurate.

Validating Required Reporting of Supply Revenue Code

For claims with "From" dates before January 1, 2020, the HH PPS includes a separate case-mix adjustment for non-routine supplies. Non-routine supply severity levels are indicated on HH PPS claims through a code value in the fifth position of the HIPPS code. The fifth position of the HIPPS code can contain two sets of values. One set of codes (the letters S through X) indicate that supplies were provided. The second set of codes (the numbers 1 through 6) indicate the HHA is intentionally reporting that they did not provide supplies during the episode. See section 10.1.9 for the complete composition of HIPPS under the HH PPS.

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

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

- If non-routine supplies were provided, the supply charges must be added to the claim using the appropriate supply revenue code.

- If non-routine supplies were not provided, the HHA must indicate that on the claim by changing the fifth position of the HIPPS code to the appropriate numeric value in the range 1 through 6.

After completing one of these actions, the HHA may return the claim to the A/B MAC (HHH) for continued adjudication.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA must report the HIPPS code that was reported on the RAP. The first four positions of the code must be identical to the value reported on the RAP. For claims with "From" dates before January 1, 2020, the fifth position may vary from the letter value reported on the RAP to the corresponding number which represents the same non-routine supply severity level but which reports that non-routine supplies were not provided.

HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.

For episodes with "From" dates before January 1, 2020, Medicare may change the HIPPS used for payment of the claim in the course of claims processing, but the HIPPS code submitted by the provider in this field is never changed or replaced. If the HIPPS code is changed, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

For episodes with "From" dates on or after January 1, 2020, Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changed based on medical review or other processes, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code.

To report HH visits, the HHA reports one of the following HCPCS codes to represent a visit by each HH care discipline:

<u>Physical Therapy (revenue code 042x)</u>

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.

G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.

G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

<u>Occupational Therapy (revenue code 043x)</u>

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.

G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.

G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Note that modifiers indicating services delivered under a therapy plan of care (modifiers GN, GO or GP) are not required on HH PPS claims.

Skilled Nursing (revenue code 055x)

General skilled nursing:

For dates of service before January 1, 2016: G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

For dates of service on or after January 1, 2016: Visits previously reported with G0154 are reported with one of the following codes:

> G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
>
> G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.

Care plan oversight:

For dates of service before January 1, 2017:

G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

G0163 Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0163 with one of the following codes:

> G0493 Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).
>
> G0494 Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing

personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

Training:

For dates of service before January 1, 2017: G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0164 with one of the following codes:

G0495 Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

G0496 Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Medical Social Services (revenue code 056x)

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (revenue code 057x)

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding all skilled nursing and skilled therapy visits

In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, Medicare would expect the HHA to report the G-code which reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code that reflects the service for which most of the time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

For episodes beginning on or after July 1, 2013, HHAs must report where home health services were provided. The following codes are used for this reporting:

Q5001: Hospice or home health care provided in patient's home/residence

Q5002: Hospice or home health care provided in assisted living facility

Q5009: Hospice or home health care provided in place not otherwise specified

The location where services were provided must always be reported along with the first visit reported on the claim. In addition to reporting a visit line using the G codes as described above, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit and a nominal covered charge (e.g., a penny). If the location where

services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Service Date

Required - For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.

For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

When the claim Admission Date matches the Statement Covers "From" Date, Medicare systems ensure that the Service Date on the 0023 revenue code line also matches these dates.

Service Units

Required - Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the claim. For line items detailing all services within the episode period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes.

For the revenue codes that represent home health visits (042x, 043x, 044x, 055x, 056x, and 057x), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported.

Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. If any visits report over 96 units (over 24 hours) on a single line item, Medicare systems return the claim returned to the provider.

Effective January 1, 2017, covered and noncovered increments of the same visit must be reported on separate lines. This is to ensure that only covered increments are included in the per-unit based calculation of outlier payments.

Total Charges

Required - The HHA must report zero charges on the 0023 revenue code line (the field must contain zero).

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

Non-covered Charges

Required – The HHA reports the total non-covered charges pertaining to the related revenue code here. Examples of non-covered charges on HH PPS claims may include:

- Visits provided exclusively to perform OASIS assessments

- Visits provided exclusively for supervisory or administrative purposes
- Therapy visits provided prior to the required re-assessments

Payer Name

Required - See chapter 25.

Release of Information Certification Indicator

Required - See chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

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

Patient's Relationship To Insured

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

Insured's Unique Identifier

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

Insured's Group Name

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

Insured's Group Number

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

Treatment Authorization Code

Required - On claims with "From" dates before January 1, 2020, the code on the claim will match that submitted on the RAP.

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

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

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format. If the format is incorrect, the contractor returns the claim to the provider.

On claims with "From" dates on of after January 1, 2020, treatment authorization codes are no longer required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 0327) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims processing systems will match all HH PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically. Providers do not need to submit a DCN on all HH PPS claims, only on adjustments to paid claims.

Employer Name

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

Principal Diagnosis Code

Required - The HHA enters the ICD code for the principal diagnosis. The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by the HIPAA. The code must be the full diagnosis code, including all five digits for ICD-9-CM or all seven digits for ICD-10 CM where applicable. Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For claim "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

Other Diagnosis Codes

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

In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Attending Provider Name and Identifiers

Required - The HHA enters the name and national provider identifier (NPI) of the attending physician who signed the plan of care.

Other Provider (Individual) Names and Identifiers

Required - The HHA enters the name and NPI of the physician who certified/re-certified the patient's eligibility for home health services.

NOTE: Both the attending physician and other provider fields should be completed unless the patient's designated attending physician is the same as the physician who certified/re-certified the patient's eligibility. When the attending physician is also the certifying/re-certifying physician, only the attending physician is required to be reported.

Remarks

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

40.3 - HH PPS Claims When No RAP is Submitted - "No-RAP" LUPAs

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

A RAP and a claim must be submitted for all episodes*/periods of care* for which Medicare makes payment based on HIPPS codes. However, if the HHA is aware prior to billing Medicare that it will supply fewer visits *than the LUPA threshold* in the episode*/period*, it may submit only a claim. In these cases, the claim is called a "No-RAP LUPA," since the HHA is aware the claim will be paid a LUPA payment adjustment based on national standard visit rates. HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in a recoupment of funds since the payment for a RAP will exceed payment for four or fewer visits. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim causes the creation of an episode*/period* record in CWF and establishes an agency as the primary HHA. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk of not being established as the primary HHA for that period.

If the agency chooses to submit this "No-RAP LUPA" claim, the claim form should be coded like other claim as described in §40.2.

40.5 - *RESERVED*

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

70.2 - Input/Output Record Layout

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

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.

File Position	Format	Title	Description
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.
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.

File Position	Format	Title	Description
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.
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.

File Position	Format	Title	Description	
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 1.8451. 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

File Position	Format	Title	Description	
			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.	
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	

File Position	Format	Title	Description
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.
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.

File Position	Format	Title	Description
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	

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.

File Position	Format	Title	Description
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.
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.
105-110	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
111-119	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
120-123	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.

File Position	Format	Title	Description	
124-126	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.	
127-131	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.	
132-139	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.	
140-148	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.	
149-157	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.	
158-166	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.	
167-401	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
402-403	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.

File Position	Format	Title	Description	
			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 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
404-408	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.	
409-417	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.	
418-426	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
427-435	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.	
436-444	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.	
445-650	X(206)	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. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

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:*

   Determine if the "SERV-FROM-DATE" of the record is equal to the "ADMIT-DATE." 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.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

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

If the "SERV-FROM-DATE" is before January 1, 2020, the Pricer shall perform the following:

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PYMNT-INDICATOR." If the value is 0 or 1, use the full standard episode rate in

subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2 percent due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

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

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

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

    Compare the earliest line item dates for revenue codes 042x, 044x and 055x and select the revenue code with the earliest date.

    If the earliest date for revenue codes 042x or 044x match the revenue code 055x date, select revenue code 055x.

    If the earliest date for revenue codes 042x and 044x match and revenue code 055x is not present, select revenue code 042x.

    1.3 Apply the appropriate LUPA add-on factor to the selected earliest dated line.

    - If revenue code 055x, multiply the national per-visit amount by 1.8451.
    - If revenue code 042x, multiply the national per-visit amount by 1.6700.
    - If revenue code 044x, multiply the national per-visit amount by 1.6266.

    Return the resulting payment amount in the "REVENUE-ADD-ON-VISIT-AMT" field.

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

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

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

    2.1. Read the "RECODE-IND." If the value is 0, proceed to the applicable section below labeled Therapy Visit Recoding, based on the claim "Through" date.

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

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

2.2. Read the alphabetic values in the "CLINICAL-SEV-EQ" field and "FUNCTION-SEV-EQ" field for which the number at the end of the field names corresponds to the recoded first position of the HIPPS code determined in step 2.1. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric value. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

Proceed to the applicable section below labeled Episode Sequence Recoding, based on the claim "Through" date.

Episode Sequence Recoding for claims with "Through" dates on or after January 1, 2017 and before January 1, 2018:

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

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

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

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

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	F3 (Mod)	H

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

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th position value
0-5	K
6	L
7-9	M

10	N
11-13	P

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru G	0 - 6	F1 (Min)	F
H thru N	7 - 13	F2 (Low)	G
O +	14+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A

C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

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

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

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

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru B	0 - 1	F1 (Min)	F
C thru J	2 - 9	F2 (Low)	G
K+	10+	F3 (Mod)	H

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

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

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

Therapy Visit Recoding for claims with "Through" dates on or after January 1, 2017 and before January 1, 2018:

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

If the value in the "EPISODE-TIMING" field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

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

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

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

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

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

If the HIPPS code begins with 1 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B

R +	17+	C3 (Mod)	C

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

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

Episode Sequence Recoding for claims with "Through" dates on or after January 1, 2018 and before January 1, 2019, use the following translation:

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

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

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

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

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	F3 (Mod)	H

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

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th position value
0-5	K
6	L

7-9	M
10	N
11-13	P

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru H	0 - 7	F1 (Min)	F
I thru P	8 - 15	F2 (Low)	G
Q+	16+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value

A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

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

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

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

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru H	3 - 7	F2 (Low)	G

I+	8+	F3 (Mod)	H

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

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

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

Therapy Visit Recoding for claims with "Through" dates on or after January 1, 2018 and before January 1, 2019:

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

If the value in the "EPISODE-TIMING" field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

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

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

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

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

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

If the HIPPS code begins with 1 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A

E thru Q	4 - 16	C2 (Low)	B
R +	17+	C3 (Mod)	C

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

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

Episode Sequence Recoding for claims with "Through" dates on or after January 1, 2019, use the following translation:

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

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

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

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

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru M	0 - 12	F1 (Min)	F
N	13	F2 (Low)	G
O+	14+	F3 (Mod)	H

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

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th position value
0-5	K

6	L
7-9	M
10	N
11-13	P

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru H	0 - 7	F1 (Min)	F
I thru M	8 - 12	F2 (Low)	G
N+	13+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 15 –	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value

CLINICAL-SEV-EQ3 value			
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

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

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

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

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

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

Treatment Authorization Code position 18 –	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value

FUNCTION-SEV-EQ4 value			
A thru C	0 - 2	F1 (Min)	F
D thru H	3 - 7	F2 (Low)	G
I+	8+	F3 (Mod)	H

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

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

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

Therapy Visit Recoding for claims with "Through" dates on or after before January 1, 2019:

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

If the value in the "EPISODE-TIMING" field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

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

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

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

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

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

If the HIPPS code begins with 1 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in "REVENUE - SUM 1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-IND" to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in "REVENUE - SUM 1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

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

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

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

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

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

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

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

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2nd position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R +	17+	C3 (Mod)	C

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

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

3. HRG payment calculations.

3.1. If the "PEP-INDICATOR" is an N:

Find the weight for the first four positions of the "HRG-OUTPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Determine the applicable episode rate using step 1 of the RAP calculation. Multiply the weight times the applicable episode rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate.
Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to the "CBSA" field. Multiply the case-mix adjusted rate by the current nonlabor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Find the non-routine supply weight corresponding to the fifth positions of the "HRG-OUTPUT-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 payment results for both portions of the "HRG-OUTPUT-CODE" and proceed to the outlier calculation (see step 4 below).

3.2. If the "PEP-INDICATOR" is a Y:

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

4. Outlier calculation:

4.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the CBSA code in the "CBSA" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from the HRG payment calculation. This is the outlier threshold for the episode.

4.2. Claims with "Through" dates before January 1, 2017: For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the "CBSA" field. The result is the wage index adjusted imputed cost for the episode.

Claims with "Through" dates on or after January 1, 2017: For each quantity in the six "REVENUE-QTY- OUTLIER-UNITS" fields, read the national standard per unit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the "CBSA" field. The result is the wage index adjusted imputed cost for the episode.

4.3. Subtract the outlier threshold for the episode from the imputed cost for the episode.

4.4. If the result determined in step 4.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

4.5. Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:

- Multiply the amount in the "PROV-PAYMENT-TOTAL" field by 10 percent to determine the HHA's outlier limitation amount.

- Deduct the amount in the "PROV-OUTLIER-PAY-TOTAL" from the outlier limitation amount. This result is the available outlier pool for the HHA.

- If the available outlier pool is greater than or equal to the outlier payment amount calculated in step 4.4, return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.

- If the available outlier pool is less than the outlier payment amount calculated in step 4.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

4.6. If the result determined in step 4.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

5. Value-Based Purchasing Adjustment:

Multiply all payment amounts by adjustment factor in "PROV-VBP-ADJ-FAC." Return the results as the final Medicare payment amounts in all appropriate output fields.

Subtract the total payments calculated in steps 3 and 4 from the total VBP-adjusted payments calculated in step 5. Return the difference in the "VBP-ADJ-AMT" field.

If the "SERV-FROM-DATE" is on or after January 1, 2020, the Pricer shall perform the following: Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value 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 percent due to the failure of the provider to report required quality data.

1. *Low Utilization Payment Adjustment (LUPA) calculation.*

1.1 If the "REVENUE-SUM1-6-QTY-ALL" is less than the LUPA threshold associated with the "HRG-INPUT-CODE" (e.g. threshold is 6, sum is 5 or less), read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

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

- *the dates in the "SERV-FROM-DATE" and "ADMIT-DATE" fields match*
- *the first position of the HIPPS code is a 1 or a 2*
- *the value in "LUPA-SRC-ADM" is not a B AND*
- *the value in "RECODE-IND" is not a 2.*

Compare the earliest line item dates for revenue codes 042x, 044x and 055x and select the revenue code with the earliest date.
If the earliest date for revenue codes 042x or 044x match the revenue code 055x date, select revenue code 055x.
If the earliest date for revenue codes 042x and 044x match and revenue code 055x is not present, select revenue code 042x.

1.3 Apply the appropriate LUPA add-on factor to the selected earliest dated line.

- *If revenue code 055x, multiply the national per-visit amount by 1.8451.*
- *If revenue code 042x, multiply the national per-visit amount by 1.6700.*
- *If revenue code 044x, multiply the national per-visit amount by 1.6266.*

Return the resulting payment amount in the "REVENUE-ADD-ON-VISIT-AMT" field.

1.4 Return the sum of all "REVENUE-COST" amounts and the "REVENUE-ADD-ON-VISIT-AMT" amount, if applicable, in the "TOTAL-PAYMENT" field. If the LUPA payment includes LUPA add-on amount, return 14 in the "PAY-RTC" field. Otherwise, return 06 in the "PAY-RTC" field. No further calculations are required.

1.5 If "REVENUE-SUM1-6-QTY-ALL" is greater than the LUPA threshold associated with the "HRG-INPUT-CODE", proceed to the HRG payment calculation in step 2.

2. *HRG payment calculations.*

2.1. If the "PEP-IND" is an N:

Find the weight for the "HRG-INPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the applicable episode rate

for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate.
Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to the "CBSA" field. Multiply the case-mix adjusted rate by the current nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.
Proceed to the outlier calculation in step 3.

3.2. If the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG amount, as in 3.1. Determine the proportion to be used to calculate this PEP by dividing the "PEP-DAYS" amount by 30. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation in step 3.

3. Outlier calculation:

3.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the CBSA code in the "CBSA" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from the HRG payment calculation. This is the outlier threshold for the episode.

3.2. For each quantity in the six "REVENUE-QTY- OUTLIER-UNITS" fields, read the national standard per unit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the "CBSA" field. The result is the wage index adjusted imputed cost for the episode.

3.3. Subtract the outlier threshold for the episode from the imputed cost for the episode.

3.4. If the result determined in step 3.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

3.5. Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:

- *Multiply the amount in the "PROV-PAYMENT-TOTAL" field by 10 percent to determine the HHA's outlier limitation amount.*

- *Deduct the amount in the "PROV-OUTLIER-PAY-TOTAL" from the outlier limitation amount. This result is the available outlier pool for the HHA.*

- *If the available outlier pool is greater than or equal to the outlier payment amount calculated in step 3.4, return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.*

- *If the available outlier pool is less than the outlier payment amount calculated in step 3.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.*

3.6. If the result determined in step 3.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return

zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

4. Value-Based Purchasing Adjustment:

Multiply all payment amounts by adjustment factor in "PROV-VBP-ADJ-FAC." Return the results as the final Medicare payment amounts in all appropriate output fields.

Subtract the total payments calculated in steps 2 and 3 from the total VBP-adjusted payments calculated in step 4. Return the difference in the "VBP-ADJ-AMT" field.

70.5 - Annual Updates to the HH Pricer

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

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 episode/period amount;
- The Federal conversion factor for non-routine supplies *(for episodes beginning before January 1, 2020);*
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights *and LUPA thresholds* to be used for each HRG;
- A table of supply weights to be used to adjust the non-routine supply conversion factor *(for episodes beginning before January 1, 2020)*;
- 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 RAP payment percentages, 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.