CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2209	**Date: May 6, 2011**
	Change Request 7395

NOTE: This instruction is being re-issued to include implementation dates in the manual instructions. Implementation dates are October 3, 2011, for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements; and January 3, 2012, for Business Requirements 7395.4, 7395.6, and their associated sub-requirements. The transmittal number, date issued and all other information remains the same. We apologize for any inconvenience this may have caused. The attached instructions may be communicated to the public and posted on your Web site as early as today, May 13, 2011.

SUBJECT: Corrections to Home Health Prospective Payment System (HH PPS) Outlier Limitation

I. SUMMARY OF CHANGES: This Change Request corrects errors in the calculation of the HH PPS 10 percent outlier limitation and instructs Medicare contractors to perform claim adjustments to ensure provider payments are accurate.

EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: October 3, 2011 for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements

January 3, 2012 for Business Requirements 7395.4, 7395.6, and their associated sub-requirements

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments
R	10/70.2/Input/Output Record Layout

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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
**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2209	Date: May 6, 2011	Change Request: 7395

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Implementation Date: October 3, 2011 for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements

January 3, 2012 for Business Requirements 7395.4, 7395.6, and their associated sub-requirements

I. GENERAL INFORMATION

A. Background: A limitation on outlier payments under the HH PPS was finalized in the 2010 HH PPS final rule. Under these requirements, Medicare systems accumulate during claims processing, for each home health agency (HHA), the overall total payments the HHA has received and the total of outlier payments they have received. The total payment amount includes any outlier payments. These totals are then compared to determine whether an HHA has been paid 10% of their total payments in outliers.

Error in Basic Limitation Calculation

To accumulate the overall total payment, the requirement that "Medicare systems shall apply the sum of the payment amounts in value code 64 and 65 to the HHA's total for each processed claim" assumed that the value code 64 and 65 amounts, which represent the Part A and Part B payments for each episode, included the outlier amount in their values. CMS has learned this assumption is in error.

The outlier amount shown on claims with value code 17 is not apportioned into the value code 64 and 65 amounts but is instead apportioned into separate Part A and Part B outlier amounts in a separate process on the remittance advice. As a result, the basic calculation of the outlier limitation since January 1, 2010, has been in error. All HHAs' total payment amounts have been understated and therefore certain HHAs have had payments withheld as exceeding the outlier limitation in error. These HHAs were underpaid for Medicare home health services in 2010. Requirement 7395.1 below corrects this error.

Error in Process of Accumulating Totals

CMS has also identified a problem involving the timing of when outlier totals are updated. Claims with outlier payments do not update the provider's year-to-date outlier payment and overall payment totals until all the claims in a daily processing batch are finalized in the Fiscal Intermediary Shared System (FISS). That is, the claims must have completed all editing processes and be ready to be paid. This creates a problem because in cases where more than one claim qualifying for an outlier payment are processed in the same daily batch of claims, the outlier amount

paid on the first claim is not reflected in the year-to-date totals when the next outlier claim is processed moments later in the same processing cycle.

All claims processed in the same batch of claims use the same year-to-date total amounts. As a result, when multiple outlier claims are in the same batch, claims that should be identified as exceeding the 10% outlier limitation are not. These claims are processed normally and the outlier amount is paid, resulting in an overpayment to the HHA. CMS suspects that the overpayments resulting from this timing problem have to some degree counterbalanced the underpayments resulting from the error in the basic calculation, masking both problems for much of 2010.
The timing problem regarding when outlier totals are updated cannot be entirely corrected. If Medicare systems were reprogrammed to update the year-to-date totals at the moment the outlier payments are calculated, this would create a risk that if that claim were returned or rejected at any later point in processing, the outlier amount would be added in error. There would also be a risk that when the returned or rejected claim was corrected, its outlier amount would be added to the year-to-date totals twice. This change would trade the current risk of overpayments to HHAs for a more commonly occurring risk of underpayments.

To ensure the timing of this process is perfectly accurate would require a major redesign of FISS programming that is out of proportion with the scope of the problem. The problem can be reduced considerably, though, by updating the amounts used when each paid claim is processed to completion, rather than the current process of updating the totals once in a processing cycle. Additionally, the quarterly outlier reconciliation process will be revised to identify any overpayments that still result and correct them. To make the outlier limitation more transparent to providers, a detail file of outlier payments will be created that can be viewed by each HHA. Requirements 7395.2 and 7395.4 and their sub-requirements describe these changes.

Total Outlier Payment Field Size Limitation

When the outlier limitation was initially implemented, the field that holds each provider's total year-to-date payments was created with eight positions to the left of the decimal point. This limits an HHA's total Medicare payments for the year to $99, 999,999.99. For the overwhelming majority of HHAs, this limitation does not create a problem. However, CMS has identified that there are HHAs with total payments in excess of $100 million dollars. To ensure accurate processing of the outlier limitation for such HHAs, the field will be expanded to nine positions to the left of the decimal point. Requirement 7395.5 describes this change.

Correcting Outlier Payments to Date

In order to correct the payment errors that have resulted from the problems described above, Medicare will adjust any claim paid for dates of service since January 1, 2010, for which an outlier payment was made or for which an outlier payment was calculated and withheld. Requirement 7395.6 requires these adjustments. For most HHAs, this adjustment process will result in the correction of an underpayment. For a limited number of HHAs, the adjustments will result in the collection of any overpayment not offset by other underpayment amounts.

B. Policy: This Change Request contains no new policy. It corrects the implementation of the outlier limitation as described in previous regulations and instructions.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
7395.1	Medicare systems shall apply the sum of the payment amounts in value codes 17, 64 and 65 on each processed claim to each HHA's year-to-date total HH PPS payment amount.						X				
7395.2	Medicare systems shall update each HHA's year-to-date outlier payments and year-to-date total HH PPS payment as each claim is processed in addition to at the end of each processing day.						X				
7395.2.1	When sending an HHA's PROV-OUTLIER-PAY-TOTAL and PROV-PAYMENT-TOTAL to the HH Pricer, Medicare systems shall send the amounts updated by the most recent prior claim.						X				
7395.3	Medicare systems shall contain, for each HHA provider, a detail screen of claims for which outliers are paid.						X				
7395.3.1	When a HH PPS claim is paid, Medicare systems shall add an entry to the detail screen that shows the value code 17 amount paid, if any, and the total HH PPS payment (sum of value code 17, 64 and 65) and the date the claim was paid.						X				
7395.3.2	Medicare systems shall ensure that the detail screen can be viewed and searched by HHAs for purposes of monitoring their payments accrued toward the outlier limitation.						X				
7395.4	Medicare systems will adjust outliers claims paid in excess of the 10% outlier limitation as part of quarterly HH outlier reconciliation process.						X				
7395.4.1	Medicare systems shall complete the current process of adjustments to claims with Pricer return code 02 before taking any steps to identify outlier claims paid in excess of the 10% limitation.						X				
7395.4.2	Medicare systems shall read each HHA's provider year-to-date outlier payment and total payment amount and identify any provider that has been paid more than 10% in outlier payments.						X				
7395.4.3	For each HHA identified in requirement 7395.4.2, Medicare systems shall calculate the dollar amount of outlier payments that has been paid in excess of 10%.						X				
7395.4.4	For each HHA identified in requirement 7395.4.2, Medicare systems shall create a report of outlier claims currently in paid claims history with outlier payments up to but not exceeding the dollar amount calculated in requirement 7395.4.3.						X				
7395.5	Medicare systems shall expand the HH Pricer input/output record so that the format of the PROV-PAYMENT-TOTAL field is 9(9)V99.						X				HH Pricer
7395.6	Medicare systems shall create a utility program to identify and reprocess all HH PPS claims where the outlier limitation may have been applied in error.						X				
7395.6.1	Prior to adjusting any claims, Medicare systems shall add each HHA's year-to-date outlier payments to their year-to-						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	date total HH PPS payment for calendar years 2010.										
7395.6.2	Medicare systems shall adjust all HH PPS claims and adjustments with dates of service on or after January 1, 2010 with a value code 17 amount (including zero amounts).					X	X				HH&H MACs
7395.6.3	Medicare contractors shall run this utility immediately after the changes described in requirements 7395.1 – 7395.5 are implemented, and independent of any quarterly cycle of outlier reconciliation adjustments.					X					HH&H MACs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7395.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					X					HH & H MACs

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7395.1	This requirement refers to the value that will be sent to the PROV-PAYMENT-TOTAL field in the HH Pricer input/output record.
7395.6.1	The purpose of this requirement is to correct each HHA's year-to-date total HH PPS payment amount, as if requirement 7395.1 had been implemented in January 1, 2010.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS 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.

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev.2209; Issued: 05-06-11; Effective Date: 01-01-10; Implementation Date: **October 3, 2011, for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements; and January 3, 2012, for Business Requirements for 7395.4, 7395.6, and their associated sub-requirements.)**

HH PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 60-day periods, Medicare claims processing systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations *shall* be made by comparing the **total of the products** of:

- The number of visits of each discipline on the claim **and** each wage-adjusted national standardized per visit rate for each discipline; with

- The **sum** of the episode payment **and** a wage-adjusted standard fixed loss threshold amount.

If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode.

Outlier payment amounts are wage index adjusted to reflect the CBSA in which the beneficiary was served. Outlier payments are to be made for specific episode claims. The outlier payment is a payment for an entire episode, and therefore carried only at the claim level in paid claim history; and not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment *shall* be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim in history using value code 17 with an associated dollar amount representing the outlier payment.

Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

Effective January 1, 2010, the outlier payments made to each HHA will be subject to an annual limitation. Medicare systems will ensure that outlier payments comprise no more than 10% of the HHA's total HH PPS payments for the year. Medicare systems will track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier

payments that each HHA has received. When each HH PPS claim is processed, Medicare systems will compare these two amounts and determine whether the 10% has currently been met.

If the limitation has not yet been met, any outlier amount *shall* be paid normally. (Partial outlier payments *shall* not be made. Only if the entire outlier payment on the claim does not result in the limitation being met, *shall* outlier payments be made for a particular claim.) If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the episode *shall* be paid but any outlier amount *shall* not be paid. When the calculated outlier amount is not paid, HHAs will be alerted to this by the presence of the following codes on their remittance advice:

Group code CO: "Contractual Obligation"

Claim adjustment reason code B5: "Coverage/program guidelines were not met or were exceeded."

Remittance advice remark code N523: "The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid."

Since the payment of subsequent claims may change whether an HHA has exceeded the limitation over the course of the timely filing period, Medicare systems will conduct a quarterly reconciliation process. All claims where an outlier amount was calculated but not paid when the claim was initially processed *shall* be reprocessed to determine whether the outlier has become payable. If the outlier can be paid, the claim *shall* be adjusted to increase the payment by the outlier amount. *Additionally, if any HHAs are found to have been overpaid outlier during the quarterly reconciliation process, claims shall be adjusted to recover any excess payments.*

These adjustments will appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (type of bill 3XI) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

70.2 - Input/Output Record Layout

***(Rev 2209; Issued: 05-06-11; Effective Date: 01-01-10; Implementation Date:* October 3, 2011, for Business Requirements 7395.1, 7395.2, 7395.3, 7395.5, and their associated sub-requirements; and January 3, 2012, for Business Requirements for 7395.4, 7395.6, and their associated sub-requirements.)**

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

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

File Position	Format	Title	Description
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-46	X(9)	FILLER	Blank.
47-50	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
77	X	HRG-MED - REVIEW - INDICATOR	Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code *unless the*

File Position	Format	Title	Description
			claim is recoded due to therapy thresholds or changes in episode sequence.
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is 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.
258-266	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
267-275	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.
276-400	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.

File Position	Format	Title	Description	
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	*Final payment where outlier applies, but is not payable due to limitation.*
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	*Not used.*
			08	*Not used.*
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	*Not used.*
			13	*Not used.*
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates before Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 3x9 or adjustment TOB
403-407	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.	
408-412	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	

File Position	Format	Title	Description
			discipline revenue codes.
413-421	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.
422-430	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.
431-435	9(3)V9(2)	LUPA-ADD-ON-PAYMENT	Output item: 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.
436	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.
437	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
438	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
439	X	CLINICAL-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment

File Position	Format	Title	Description
			authorization code.
440	X	FUNCTION-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.
441	X	CLINICAL-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.
442	X	FUNCTION-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.
443	X	CLINICAL-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code.
444	X	FUNCTION-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code.
445	X	CLINICAL-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.
446	X	FUNCTION-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
447-456	9(8)V99	PROV-	Input item: The total amount of outlier payments

File Position	Format	Title	Description
		OUTLIER-PAY-TOTAL	that have been made to this HHA during the current calendar year.
457 - 467	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA during the current calendar year.
468-500	X(33)	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 systems 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 systems 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.