CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3553	Date: June 28, 2016
	Change Request 9474

Transmittal 3457, dated February 5, 2016, is being rescinded and replaced by Transmittal 3553, dated June 28, 2016, to delete business requirement 9474.10 and the corresponding manual language in section 20.2.5. All other information remains the same.

SUBJECT: New Condition Code for Reporting Home Health Episodes With No Skilled Visits

I. SUMMARY OF CHANGES: This Change Request revises Medicare billing instructions for home health claims to allow the use of a new condition code. The code indicates the home health agency (HHA) provided no skilled services during the billing period, but the HHA has documentation on file of an allowable circumstance.

EFFECTIVE DATE: July 1, 2016 - Claims received on or after 7/1/2016
Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: July 5, 2016

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/Adjustments of Episode Payment - Confirming OASIS Assessment Items
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments
R	10/20.2/Home health Consolidated Billing Edits in Medicare Systems
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	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/70.4/Decision Logic Used by the Pricer on Claims

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined

in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3553	Date: June 28, 2016	Change Request: 9474

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SUBJECT: New Condition Code for Reporting Home Health Episodes With No Skilled Visits

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I.   GENERAL INFORMATION

A.   Background: Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act require that in order to be eligible to receive Medicare home health (HH) services the beneficiary must have a skilled need (i.e., require intermittent skilled nursing (SN) services, physical therapy (PT), and/or speech-language pathology (SLP) services or have a continuing need for occupational therapy (OT) services). In order to better enforce this requirement, Transmittal 3176, Change Request 9027, issued January 30, 2015 revised Original Medicare systems to return to the provider any claims for episodes that are the first episode in a sequence of episodes or are the only episode of care received by a beneficiary for which patient eligibility for the Medicare home health benefit has not been established (i.e., no SN, PT, or SLP visits reported on the claim).

Enforcing this requirement on claims for subsequent episodes of HH care could not be automated using previously existing codes. There may be circumstances which prevent the home health agency (HHA) from delivering the skilled services planned for an episode, such as an unexpected inpatient admission. Determining whether payment is allowable requires development of the claim. Section 40.1.3 in Chapter 7 of the Medicare Benefits Policy Manual, Pub. 100-02 states that: "Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services."

Medicare requested the National Uniform Billing Committee to create a new code that would allow the HHA to indicate upon submission that such documentation exists. A new condition code 54 is effective on July 1, 2016 and is defined "No skilled HH visits in billing period. Policy exception documented at the HHA." Submission of this code will streamline claims processing for both the payer and provider. Claims without skilled visits that are submitted without the new condition code will be returned to the provider. This will allow the HHA to either:

- Add any accidentally omitted skilled services to the claim

- Submit the claim as non-covered, if appropriate or

- Append the new condition code.

These actions will prevent unnecessary reviews and denials for the HHA and allow Medicare to better target medical review resources. Requirements 1 and 2 below, implement the new condition code 54.

Additionally, the requirements below address unintended consequences of the implementation of new Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing visits. Transmittal 3378,

CR 9369, issued October 16, 2015 terminated HCPCS code G0154, replacing it with two new codes, G0299 and G0300. During the implementation of CR 9369, CMS discovered several other processes are affected by this coding change:

- G0299 and G0300 were previously used to describe defibrillator services. An edit in Medicare systems requires certain diagnosis codes appropriate to support the need for a defibrillator. This edit would set inappropriately on all home health and hospice claims with dates of service on or after January 1, 2016.

- Another edit in Medicare systems currently requires that revenue code 055x is always reported with HCPCS G0154 on hospice claims. This edit would set inappropriately on all hospice claims with dates of service on or after January 1, 2016.

CMS directed contractors to temporarily deactivate these two edits to prevent Medicare from returning claims in error. Requirements 3 through 6 below revise these edits so contractors can reactivate them without any adverse impact.

Medicare systems also use HCPCS code G0154 in the criteria for identifying the earliest visit date when calculating low utilization payment adjustments (LUPA) add-on amounts. When home health agencies can no longer report G0154, the earliest visit date for skilled nursing visits reported with G0299 or G0300 will not be used in the calculation. This will result in some claims not receiving LUPA add-on amounts or receiving a payment based on the wrong service discipline. Requirements 7 and 8 below correct this error and instruct contractors to adjust home health claims to correct payments.

Finally, this CR contains a number of routine maintenance revisions to home health billing instructions, Pub. 100-04, chapter 10. The revisions include reformatting the presentation of remittance advice codes and ensuring code pairs are compliant with industry standards. They also include an update to the Pricer logic section to reflect case-mix scoring changes for calendar year 2016 and to correctly reflect LUPA add-on calculations which were effective January 1, 2014.

B. Policy: For claims submitted on or after July 1, 2016, Medicare HHAs shall indicate HH claims submitted with no skilled services that meet Medicare coverage requirements by appending condition code 54.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E MAC	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9474.1	The contractor shall accept condition code 54 on home health claims, Type of Bill (TOB) 032x other than 0322.			X		X				
9474.1.1	The contractor shall return claims to the provider claims if the TOB is 0322 or any TOB other than 032x and condition code 54 is present.	X		X		X				
9474.2	The contractor shall return claims to the provider if the			X		X				

Number	Requirement	Responsibility								Other
		A/B MAC			DME MAC	Shared-System Maintainers				
		A	B	HHH		FISS	MCS	VMS	CWF	
	following conditions are met: • Type of Bill (TOB) 032x other than 0322, • The From Date is not equal to the Admission Date, • No revenue code 042x, 043x, 044x or 055x line with covered charges is present, AND • Condition code 20, 21 or 54 is not present.									
9474.3	The contractor shall revise editing that enforces the presence of appropriate diagnosis codes on defibrillator claims to exclude HCPCS G0299 and G0300 if the dates of service are on or after January 1, 2016.					X				
9474.4	The contractor shall reactivate reason code 31157 as of the implementation date of this CR.	X		X						
9474.5	The contractor shall revise editing that requires pairing of revenue codes and HCPCS codes on hospice claims (Types of Bill 081x and 082x) to ensure that: • For claims with dates of service on or after 1/1/2010 and before 1/1/2016, line items reporting revenue code 055x must report HCPCS code G0154, and • For claims with dates of service on or after 1/1/2016, line items reporting revenue code 055x must report HCPCS code G0299 or G0300. NOTE: This editing was created by business requirement 6440.2					X				
9474.6	The contractor shall reactivate reason code 31428 as of the implementation date of this CR.	X		X						
9474.7	The contractor shall send the earliest line item date for a skilled nursing visit to the HH Pricer based on the date of service, as follows: • For dates of service before January 1, 2016, when revenue code 055x is present on the					X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	earliest date and the HCPCS code is G0154, G0162, G0163, or G0164. • For dates of service on or after January 1, 2016, when revenue code 055x is present on the earliest date and the HCPCS code is G0299, G0300, G0162, G0163, or G0164.									
9474.8	The contractor shall adjust home health claims that meet the following criteria: • The claim statement covers "Through" date is between January 1, 2016 and the implementation date of this CR, • The claim admission date and statement covers "From" date match, • The HIPPS code on the claim begins with 1 or 2, • Condition code 47 is not present, and • Pricer return code 06 or 14 is present.				X					
9474.8.1	The contractor shall complete claim adjustments within 60 days of the implementation date of this CR.				X					
9474.9	The contractor shall use the following remittance advice codes when rejecting/denying claims due to home health consolidated billing: Group Code: CO CARC: 97 RARC: N390	X	X	X	X					
9474.10	This requirement deleted.									
9474.11	When the hospice Pricer is called multiple times in the course of processing a claim, the contractor shall apply the return code with the highest numeric value unless return code 75 is highest value and return code 74 is also present.					X				
9474.11.1	When the hospice Pricer is called multiple times in the course of processing a claim, return code 75 is highest					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	value and return code 74 is also present, the contractor shall apply return code 77. NOTE: This requirement is to address the unlikely circumstance that the sequence of processing causes information about high RHC payment (code 75) and the end of life SIA adjustment (code 74) to be returned separately when both apply to the claim.									

III.   PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9474.12	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X		

IV.   SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Charles Nixon, charles.nixon@cms.hhs.gov (for hospice claims) , Wil Gehne, wilfried.gehne@cms.hhs.gov (for home health claims)

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

10.1.19 - Adjustments of Episode Payment - Confirming OASIS Assessment Items
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

The total case-mix adjusted episode payment is based on the OASIS assessment. Medicare claims systems may confirm certain OASIS assessment items in the course of processing a claim and adjust the HH PPS payment accordingly.

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

Group Code: CO
CARC: 186
RARC: N69
MSN: N/A

10.1.21 - Adjustments of Episode Payment - Outlier Payments
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

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.

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 Three.

Group Code: CO
CARC: B5
RARC: N523
MSN: N/A

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 (TOB 032I) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

20.2 - Home health Consolidated Billing Edits in Medicare Systems
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

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. 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 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 or not.

If the patient was discharged or transferred, the edits apply to dates of service between the episode start date and the last billable service date for the episode. 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 start date and the episode end date. The episode start date is excluded but the episode 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.

20.2.4 - Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

If only a RAP for the episode 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, 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.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

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 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.

40.1 - Request for Anticipated Payment (RAP)
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

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. 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.

Each RAP must report a payment group represented by a HIPPS code. In general, a RAP and a claim will be submitted for each episode period. Each claim must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode 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 of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been submitted. If a prior episode 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 (day 61, 121, etc.).

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. RAPs will not be processed without the following value code:

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.

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.

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 - 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.*

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 International Classification of Diseases (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.

The principle diagnosis reported on the claim must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis). Diagnosis codes in OASIS form M1024, which reports payment diagnoses, are not directly reported in any field of the claim form.

Other Diagnoses Codes

Required - The HHA enters the full ICD codes for additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis.

Other diagnoses reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). 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. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD coding guidelines the codes reported in these OASIS items must

be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

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.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

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. Payment for this episode will usually be made in two parts. After a RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

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. Medicare contractors 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 Medicare contractor 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 requests for anticipated payment 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." Medicare contractors 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

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. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode 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."

Any NUBC approved patient status code may be used in these cases. 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 60-day episode 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 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 60-day episode. 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 Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor 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 contractor.

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

Conditional - The HHA enters any 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 episodes in which the beneficiary's site of service changes from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in the Medicare contractor's online claim history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Contractors 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 -	The dollar amounts determined to be associated

Code	Title	Definition
	Part A	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. 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. 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: Contractors 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 Medicare contractor 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

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 5th position of the HIPPS code. The 5th 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 5th 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 5th 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 Medicare contractor 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. 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.

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 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:

Physical Therapy (revenue code 042x)

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.

Occupational Therapy (revenue code 043x)

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)

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.

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).

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.

Medical Social Services (revenue code 056x)

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

<u>Home Health Aide (revenue code 057x)</u>

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

<u>Regarding all skilled nursing and skilled therapy visits</u>

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. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

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 - *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.*

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.

The ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

The principal diagnosis code on the claim will match that submitted on the RAP.

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.

For other diagnoses, the diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). 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. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician who has signed the plan of care.

Remarks

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

70.4 - Decision Logic Used by the Pricer on Claims
(Rev.3553, Issued; 06-28-16; Effective: 07-01-16; Implementation: 07-05-16)

The following calculations shall apply to claims with "From" dates on or after January 1, 2008.

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 contractor initiated adjustments), Pricer will perform the following calculations in the numbered order.

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% 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 *step 3.1, 4.1 or 5.1* below *(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.

3. *If the claim "Through" date is* before January 1, 2015, use the following translation. *Otherwise, proceed to step 4.*

   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 D	0-4	C1 (Min)	A
E thru H	5-8	C2 (Low)	B
I +	9+	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 E	0-5	F1 (Min)	F
F	6	F2 (Low)	G
G +	7+	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 F	0-6	C1 (Min)	A
G thru N	7-14	C2 (Low)	B
O+	15+	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 F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	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

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	0-2	C1 (Min)	A
C thru E	3-5	C2 (Low)	B
F+	6+	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 H	0-8	F1 (Min)	F
I	9	F2 (Low)	G
J +	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
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 H	0-8	C1 (Min)	A
I thru P	9-16	C2 (Low)	B
Q+	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 G	0-7	F1 (Min)	F
H	8	F2 (Low)	G
I +	9+	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.

3.1. 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 step 3* and recode the remaining positions of the HIPPS code as described above.

3.2. 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 G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	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 F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	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 G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	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 F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	F3 (Mod)	H

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

4. For claims with "Through" dates on or after January 1, 2015 *and before January 1, 2016*, use the following translation. *Otherwise, proceed to step 5.*

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 O	0 - 14	F1 (Min)	F
P	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
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 D	0 - 3	F1 (Min)	F
E thru N	4 - 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	0	C1 (Min)	A
B	1	C2 (Low)	B
C+	2+	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 J	0 - 9	F1 (Min)	F
K	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 F	0 - 5	C1 (Min)	A
G thru M	6 - 12	C2 (Low)	B
N +	13+	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	0	F1 (Min)	F
B thru H	1 - 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.

4.1. 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 step 4* and recode the remaining positions of the HIPPS code as described above.

4.2 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 F	3 - 5	F2 (Low)	G
G+	6+	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 F	3 - 5	F2 (Low)	G
G+	6+	F3 (Mod)	H

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

5. For claims with "Through" dates on or after January 1, 2016, 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 O	0 - 14	F1 (Min)	F
P	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
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	0	C1 (Min)	A
B	1	C2 (Low)	B
C+	2+	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 D	0 - 3	C1 (Min)	A
E thru M	4 - 12	C2 (Low)	B
N +	13+	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	0	F1 (Min)	F
B thru H	1 - 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.

5.1. 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 step 5 and recode the remaining positions of the HIPPS code as described above.

5.2. 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.

6. HRG payment calculations.

6.1. 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. Multiply the weight times the Federal standard 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 "MSA1." 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 7* below).

6.2. 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 7* below).

7. Outlier calculation:

7.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the MSA code in the "MSA1" 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.

7.2. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal 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 MSA code in the "MSA1" field. The result is the wage index adjusted imputed cost for the episode.

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

7.4. If the result determined in *step 7.3* is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

7.5. 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% 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 7.4*, 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 7.4*, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

7.6. If the result determined in *step 7.3* 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.