CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1348	**Date: OCTOBER 5, 2007**
	Change Request 5746

Subject: Billing Instructions for the Home Health Prospective Payment System (HH PPS) Case Mix Refinement

I. SUMMARY OF CHANGES: This transmittal provides the necessary instructions to home health agencies regarding submission of claims under the refined HH PPS. It also makes conforming changes to various sections to reflect contracting reform and the conversion to the UB-O4 claim form.

New / Revised Material
Effective Date: Episodes beginning on or after January 1, 2008
Implementation Date: November 5, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.1/Creation of HH PPS and Subsequent Refinements
R	10/10.1.2/Reserved
R	10/10.1.3/Configuration of the HH PPS Environment
R	10/10.1.5.1/More Than One Agency Furnished Home Health Services
R	10/10.1.7/Basis of Medicare Prospective Payment Systems and Case-Mix
R	10/10.1.8/Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes
R	10/10.1.9/Composition of HIPPS Codes for HH PPS
R	10/10.1.10.1/Grouper Links Assessment and Payment
R	10/10.1.10.2/Health Insurance Beneficiary Eligibility Inquiry for Home Health Agencies
R	10/10.1.10.3/Submission of Request for Anticipated Payment (RAP)
R	10/10.1.12/Request for Anticipated Payment (RAP)

R	10/10.1.13/Transfer Situation - Payment Effects
R	10/10.1.14/Discharge and Readmission Situation Under HH PPS - Payment Effects
R	10/10.1.15/Adjustments of Episode Payment - Partial Episode Payment (PEP)
R	10/10.1.16/Payment When Death Occurs During an HH PPS Episode
R	10/10.1.17/Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)
R	10/10.1.19/Adjustments of Episode Payment - Confirming OASIS Assessment Items
R	10/10.1.19.1/Adjustments of Episode Payment - Therapy Threshold
R	10/10.1.19.2/Adjustments of Episode Payment - Hospitalization Within 14 Days of Start of Care
R	10/10.1.20/Adjustments of Episode Payment - Significant Change in Condition (SCIC)
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments
R	10/10.1.22/Adjustments of Episode Payment - Exclusivity and Multiplicity of Adjustments
R	10/10.1.23/Exhibit: General Guidance on Line Item Billing Under HH PPS
R	10/10.1.24/Exhibit: Glossary and Acronym List
R	10/20.1.2/Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
R	10/20.2/Home Health Consolidated Billing Edits in Medicare Systems
R	10/20.2.1/Nonroutine Supply Editing
R	10/20.2.2/Therapy Editing
R	10/20.2.3/Other Editing Related to Home Health Consolidated Billing
R	10/20.2.4/Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date
R	10/20.2.5/No RAP Received and Therapy Services Rendered in the Home
R	10/30.1/Health Insurance Eligibility Query to Determine Episode Status
R	10/30.3/Timeliness and Limitations of CWF Responses
R	10/30.4/Provider/Supplier Inquiries to Medicare Contractors Based on Eligibility Responses
R	10/30.5/National Home Health Prospective Payment Episode History File
R	10/30.7/Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAPs and HHA Claim Activity
R	10/30.9/Coordination of HH PPS Claims Episodes With Inpatient Claim Types

R	10/30.11/Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File
R	10/40/Completion of Form CMS 1450 for Home Health Agency Billing
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/40.5/Billing for Nonvisit Charges
R	10/70.1/General
R	10/70.2/Input/Output Record Layout
R	10/70.3/Decision Logic Used by the Pricer on RAPs
R	10/70.4/Decision Logic Used by the Pricer on Claims
R	10/70.5/Annual Updates to the HH Pricer

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1348	Date: October 5, 2007	Change Request: 5746

SUBJECT: Billing Instructions for the Home Health Prospective Payment System (HH PPS) Case Mix Refinement

Effective Date: **Episodes beginning on or after January 1, 2008**

Implementation Date: November 5, 2007

I. GENERAL INFORMATION

A. Background: The initial requirements for the home health prospective payment system (HH PPS) were implemented on October 1, 2000. The final regulation for HH PPS indicated that many of its policies were discretionary and would be the subject of reconsideration and revision in future rulemaking. The policy analysis of how to refine the HH PPS has been going on within CMS for the last several years. The results were published in a Final Rule on August 29, 2007.

B. Policy: Final policies regarding the HH PPS case mix refinements are contained in the final rule. Revised provider billing instructions and Medicare claims processing instructions to conform with the final rule are contained in the manual sections contained in this transmittal.

Requirements 5746.1 through 5746.13.6 below describe for providers and their software vendors the changes to Medicare systems that will be made to implement the new policies of the final rule. These requirements have been communicated to Medicare contractors for implementation in Medicare systems via Transmittal 1310, Change Request 5663. They are reproduced here informationally to assist providers and vendors with their implementation of their claims submission changes. The requirements below apply only to HH PPS claim types (types of bill 32x and 33x) as of the effective date.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5746.1	Medicare systems shall install a new HH Pricer module that contains revisions reflecting case-mix refinement policies.							X				HH Pricer
5746.2	Medicare systems shall accept the new HIPPS codes described in Attachment One.							X			X	HH Pricer
5746.3	Medicare systems shall ensure that the new HIPPS codes							X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	described in Attachment One are only accepted for episodes beginning on or after January 1, 2008.											
5746.3.1	Medicare systems shall return claims to the provider if the new HIPPS codes are submitted on episodes beginning before January 1, 2008.							X				
5746.4	Medicare systems shall ensure that the current HIPPS codes (values in the range HAEJ1 – HDIM8) are only accepted for episodes beginning before January 1, 2008.							X				
5746.4.1	Medicare systems shall return claims to the provider if the current HIPPS codes are submitted on episodes beginning after January 1, 2008.							X				
5746.5	Medicare systems shall revise the provider submitted HIPPS to the correct code based on the number of therapy services billed.											HH Pricer
5746.6	Medicare systems shall ensure that the provider submitted HIPPS code on a claim or adjustment accurately reflects the position of the episode within a sequence of adjacent HH episodes.							X			X	
5746.6.1	Medicare systems shall define a sequence of adjacent episodes as episodes with no more than 60 days between each episode end date and the next episode start date.										X	
5746.6.2	Medicare systems shall ensure that claims and adjustments submitted with HIPPS containing 1 or 2 in the 1st position represent the first or							X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	second episode in a sequence.											
5746.6.2.1	Medicare systems shall identify claims and adjustments with HIPPS codes misrepresenting first or second episodes for re-coding.										X	
5746.6.2.2	Medicare systems shall re-code claims and adjustments identified in requirement 5746.6.2.1 using the last 9 positions of the treatment authorization code and the re-coding logic in Attachment Two.							X				HH Pricer
5746.6.3	Medicare systems shall ensure that claims and adjustments submitted with HIPPS containing 3 or 4 in the 1st position represent the third or later episode in a sequence.										X	
5746.6.3.1	Medicare systems shall identify claims with HIPPS codes misrepresenting third or later episodes for re-coding.										X	
5746.6.3.2	Medicare systems shall re-code claims and adjustments identified in requirement 5746.6.3.1 using the last 9 positions of the treatment authorization code and the re-coding table in Attachment Two.							X				HH Pricer
5746.6.4	Medicare systems shall return claims and adjustments re-coded in requirements 5746.6.2 and 5746.6.3 to the HH Pricer.							X				HH Pricer
5746.7	Medicare systems shall adjust previously paid episodes when the receipt of earlier dated episodes changes their position in a sequence of episodes.							X			X	
5746.7.1	Medicare systems shall read the HH episode history when a new episode is received and identify any HIPPS codes that represent										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	an incorrect position in the sequence.											
5746.7.2	Medicare systems shall initiate an automatic adjustment of any previously paid episodes identified in requirement 5746.7.1.							X			X	
5746.7.3	Medicare systems shall re-code and re-price automatic adjustments initiated in requirement 5746.7.2.							X				HH Pricer
5746.8	Medicare systems shall revise any edits that use HH HIPPS code ranges to use the HIPPS codes in Attachment One, as appropriate.							X				
5746.9	Medicare systems shall calculate a supply adjustment amount and add it to the otherwise calculated payment amount for the episode.											HH Pricer
5746.10	Medicare systems shall include an add-on amount to per visit payment calculations for low utilization payment adjustments (LUPAs) made on first episodes in a sequence.											HH Pricer
5746.10.1	Medicare systems shall add an additional payment to the first revenue code calculated on LUPA claims for first episodes in a sequence.							X				HH Pricer
5746.10.2	Medicare systems shall assign the return code '14' on LUPA claims for first episodes in a sequence.							X				HH Pricer
5746.10.3	Medicare systems shall use the source of admission code in the HH PPS Pricing interface.							X				HH Pricer
5746.11	Medicare systems shall ensure that claims for episodes beginning on or after January 1, 2008, contain only one revenue code 0023 line.							X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5746.11.1	Medicare systems shall return claims to the provider if claims for episodes beginning on or after January 1, 2008, contain more than one revenue code 0023 line.							X				
5746.12	Medicare systems shall disable any edits and unsolicited response processes that validate inpatient stays in the 14 days prior to an episode, for episodes beginning on or after January 1, 2008.							X			X	
5746.13	Medicare systems shall validate the format of the treatment authorization code.							X				
5746.13.1	Medicare systems shall ensure that the first, second, fifth, sixth and ninth positions of the treatment authorization code are numeric characters.							X				
5746.13.2	Medicare systems shall ensure that the third, fourth and seventh and eighth positions of the treatment authorization code are alphabetic characters.							X				
5746.13.3	Medicare systems shall ensure that the value in the tenth position of the treatment authorization code is a 1 or a 2.							X				
5746.13.4	Medicare systems shall ensure that the eleventh through eighteenth positions of the treatment authorization code are alphabetic characters.							X				
5746.13.5	Medicare systems shall bypass validation of the treatment authorization code if condition code 21 is present on the claim.							X				
5746.13.6	Medicare systems shall return claims to the provider if the treatment authorization code fails any of the validations in							X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	requirements 5746.13.1 through 5746.13.4.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5746.14	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.						X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5746.1	This HH Pricer module will also contain modifications for the calendar year 2008 annual update (i.e., revisions to the base rates, per visit rates, wage index, labor & non-labor portions, etc.) and an adjustment to correct for case mix creep.
5746.5	Therapy re-coding will account for three separate therapy thresholds. The HH Pricer will both downcode and upcode claims. All existing fields for changed HIPPS codes will be used. Current remittance advice coding will be applied.
5746.6.1	Sequences of episodes are determined without regard to changes in the billing home health agency. The calculated 60-day episode end date will be used to measure breaks between episodes in all cases except for episodes subject to partial episode payment (PEP) adjustments. In the case of PEP episode, the date of latest billing activity will be used.
5746.6.2.1	Claims will be identified by a CWF reject with a distinct new reject code.
5746.7	CWF shall trigger the adjustments described in this requirement and its sub-requirements by generating an informational unsolicited response (IUR).
5746.7.1	CWF shall apply the same criteria described in requirements 5746.6.2 and 5746.6.3 to identify episodes which are out of sequence.
5746.7.3	FISS shall apply the same criteria described in requirements 5746.6.2.2 and 5746.6.3.2 to re-code these automatic adjustments.
5746.9	The supply amount will be included in the total payment returned by the HH Pricer. It will not be reflected separately on the claim. Supply amounts will not be calculated on LUPA claims.
5746.10.1	The HH Pricer shall define first episodes as episodes with a 1 or 2 in the 1st position of the HIPPS code, with an admission date matching the claim "From" date and where the source of admission code is not B or C. The payment amount will be wage adjusted.
5746.10.3	A new one position field must be added to the HH Pricer input/output record to pass the claim's source of admission code into the HH Pricer. This is needed to correctly identify first episodes in a sequence for purposes of calculation the LUPA add-on.
5746.11	The new HH PPS case-mix system contains no provision for significant change in condition adjustments.
5746.12	The new HH PPS case-mix system contains no payment adjustments related to OASIS item M0175.

B. For all other recommendations and supporting information, use the space below:

N/A

V. CONTACTS

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VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**

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

B. ***For Medicare Administrative Contractors (MACs):***
N/A

2 ATTACHMENTS

ATTACHMENT ONE

The following table describes a new HIPPS code structure under HH PPS case mix refinement:

	Position #1	**Position #2**	**Position #3**	**Position #4**	**Position #5**		
	Grouping Step	**Clinical Domain**	**Functional Domain**	**Service Domain**	**Supply Group – supplies provided**	**Supply Group – supplies not provided**	**Domain Levels**
Early Episodes (1st & 2nd)	**1** (0-13 Visits)	**A** (HHRG: C1)	**F** (HHRG: F1)	**K** (HHRG: S1)	**S** (Severity Level: 1)	**1** (Severity Level: 1)	= min
	2 (14-19 Visits)	**B** (HHRG: C2)	**G** (HHRG: F2)	**L** (HHRG: S2)	**T** (Severity Level: 2)	**2** (Severity Level: 2)	= low
Late Episodes (3rd & later)	**3** (0-13 visits)	**C** (HHRG: C3)	**H** (HHRG: F3)	**M** (HHRG: S3)	**U** (Severity Level: 3)	**3** (Severity Level: 3)	= mod
	4 (14-19 Visits)			**N** (HHRG: S4)	**V** (Severity Level: 4)	**4** (Severity Level: 4)	= high
Early or Late Episodes	**5** (20 + Visits)			**P** (HHRG: S5)	**W** (Severity Level: 5)	**5** (Severity Level: 5)	= max
					X (Severity Level: 6)	**6** (Severity Level: 6)	
	6 thru 0	D thru E	I thru J	Q thru R	Y thru Z	7 thru 0	Expansion values for future use

NOTE: The two sets of possible values in position 5 of the HIPPS code will provide a basis for accurate supply reporting edits that will be defined in future instructions.

ATTACHMENT TWO

The last eight positions of the treatment authorization will contain codes representing the points for the clinical domain and the functional domain as calculated under each of the four equations of the refined HH PPS case mix system. The treatment authorization code, including these domain codes, will be calculated by the HH PPS Grouper software, so providers transfer this 18 position code to their claims.

The following is the new format of the treatment authorization code:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for Julian date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for Julian 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 Julian dates in positions 3-4 and 7-8 are converted from 3 position numeric values 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.

The following represents an example of a treatment authorization code created using this format:

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for Julian date	Julian date 245	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for Julian date	Julian date 001	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

The input/output record for the HH Pricer will be modified to convert existing filler fields into new fields to facilitate recoding. A new nine position field will be created to carry the clinical and functional severity point information. FISS will extract the last nine positions of the treatment authorization code and place it in this new field in the input/output record. This will enable the HH Pricer to recode claims using the point information.

On incoming original RAPs and claims, the HH Pricer will disregard the code in this nine position field, since the submitted HIPPS code is being priced at face value. The code in this nine position field will be used in recoding claims identified by CWF as misrepresenting the episode sequence. To enable the Pricer to distinguish these two cases, an additional one position numeric field will be added to the input/output record.

On original RAPs and claims, FISS will populate the new one position field with a zero. If a claim is identified under requirement 5561.6.2 as submitted by the provider as a 1st or 2nd episode and the claim is actually a 3rd or later episode, FISS will populate the new field with a 3 to indicate this. If a claim is identified under requirement 5561.6.3 as submitted by the provider as a 3rd or later episode and the claim is actually a 1st or 2nd episode, FISS will populate the new field with a 1 to indicate this.

When the new one position field is populated with a 1 or a 3, the HH Pricer will recode the claim using the following steps:

1. The HH Pricer will determine, from the new episode sequence and the number of therapy visits on the claim, which equation of the HH PPS case-mix model applies to the claim.

2. The HH Pricer will find the two positions in the new nine position field that correspond to the equation identified in step 1.

3. The HH Pricer will convert the alphabetic codes in these positions to numeric point values.

4. The HH Pricer will read the appropriate column on the case-mix scoring table below to find the new clinical and functional severity levels that correspond to that point value.

5. Using the severity levels identified in step 4 and the HIPPS code structure shown in Attachment One, the HH Pricer will determine the new HIPPS code that applies to the claim.

The HH Pricer will use the new HIPPS code resulting from these steps to re-price the claim and will return the new code to FISS using the existing output HIPPS code field in the input/output record.

When the first position of the HIPPS code is a 5 and the number of therapy services on the claim are less than 20, the HH Pricer will use the first position of the new nine position field to recode the first position of the HIPPS code and then complete the steps described above.

The case-mix scoring table to be used in step 4 is shown on the next page.

Table 3: Severity Group Definitions: Four-Equation Model

		1st & 2nd Episodes		3rd+ Episodes		All Episodes
		0 to 13 therapy visits	14 to 19 therapy visits	0 to 13 therapy visits	14 to 19 therapy visits	20+ therapy visits
Grouping Step:		1	2	3	4	5
Equation(s) used to calculate points: (see Table 2a)		*1*	*2*	*3*	*4*	*(2&4)*
Dimension	Severity Levels:					
Clinical	C1	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7
	C2	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14
	C3	9+	15+	6+	17+	15+
Functional	F1	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6
	F2	6	7	9	8	7
	F3	7+	8+	10+	9+	8+
Services Utilization (number of therapy visits)	S1	0 to 5	14 to 15	0 to 5	14 to 15	20+ (One Group)
	S2	6	16 to 17	6	16 to 17	
	S3	7 to 9	18 to 19	7 to 9	18 to 19	
	S4	10		10		
	S5	11 to 13		11 to 13		

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

Table of Contents

(Rev. 1348, 10-05-07)

10.1.1 - Creation of HH PPS *and Subsequent Refinements*

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The HH PPS was initially mandated by law in the Balanced Budget Act of 1997 and legislative requirements were modified in various subsequent laws. Section 1895 of the Social Security Act contains current law regarding HH PPS.

Final regulations describing the initial implementation of the HH PPS were issued in July 2000 and effective for dates of service on and after October 1, 2000. Unless specifically indicated, the instructions that follow in subsections of this section 10.1 reflect policies outlined in those regulations and which remain unchanged.

Final regulations describing refinements to the HH PPS system were issued in August 2007 and are effective for episodes of care beginning on and after January 1, 2008. Where HH PPS policies and instructions changed as a result of the refinements regulation, instructions that follow will be prefaced with a statement that indicates which instructions apply by dates of service.

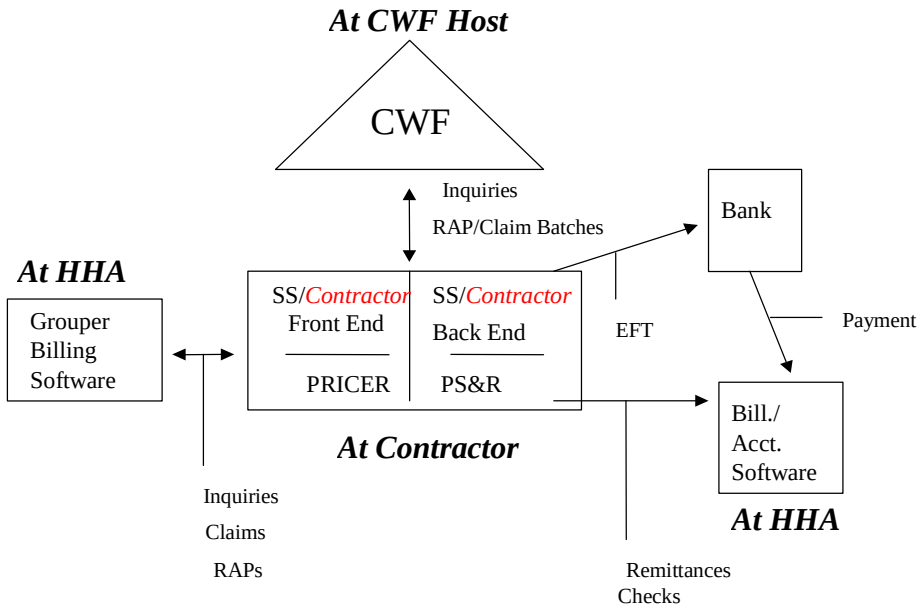
10.1.2 - *Reserved*

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

10.1.3 - Configuration of the HH PPS Environment

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The configuration of Medicare home health claim processing is similar to previous Medicare claims processing systems. The flow from the HHA at the start of billing, to the receipt or remittances and electronic funds transfer (EFT) by the agency, to the recording of payment in either billing or accounting systems (bill/acct software) can be envisioned as follows:



Subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing.

- Grouper determines HHRGs for claims at HHAs by inputting **OASIS** data. (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment.) OASIS software was updated to integrate the Grouper from the advent of HH PPS, and CMS has made Grouper specifications available on its Web site for those designing their own software.

- ELGH is an **inquiry system** in CWF available via *Medicare contractor* remote access, through which HHAs and other providers can ascertain if a home health episode has already been opened for a given beneficiary by another HHA, and track episodes of beneficiaries for whom they are the primary HHA. Refer to §§30.1 **and** 30.2 for a detailed description.

Pricer software is used to process all HH PPS claims and is integrated into the Medicare claims processing systems. In addition to pricing HIPPS codes for HHRGs, this software maintains national standard visit rate tables to be used in outlier and LUPA determinations. **Refer to** §70 **for a detailed description of the Pricer software.**

10.1.5.1 - More Than One Agency Furnished Home Health Services

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care and other HHAs serving the same beneficiary during the episode. Nonprimary HHAs can receive payment under arrangement only from the primary HHA for services on the plan of care where prior arrangement exists. The primary agency's status as primary is established through the submission of a Request for Anticipated

Payment (RAP) (see §40.1). The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies existing before the delivery of services for services called for under the plan of care. Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the Common Working File (CWF) indicates an episode of care is open for a beneficiary, the *Medicare contractor returns to the provider the* RAP of any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

Effective with HH PPS, if a patient transfers from one agency to another under HH PPS, a new plan of treatment is required in order to correspond with the new HH PPS episode period.

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types:

- Skilled nursing facilities;
- Outpatient hospital services;
- Home health agencies;
- Rehabilitation hospitals; and
- Others.

While there are commonalities among these systems, there are also variations in how each system operates and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

The term prospective payment for Medicare does not imply a system where payment is made before services are delivered, or where payment levels are determined prior to the providing of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment will be made at the beginning of the episode with as little as one visit delivered. HH PPS also means a shift of the basis of payment from payment tied to a claim or distinct revenue or procedural code, to an episode.

Case-mix is an underlying concept in prospective payment. With the creation of inpatient hospital PPS, the first Medicare PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. Other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care, use this concept of case-mix complexity, meaning that patient characteristics

affect the complexity, and therefore, cost of care. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

For individual Medicare inpatient acute care hospital bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing *contractor*. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted episode payment is based on elements of the OASIS data set including the therapy visits provided over the course of the episode. The number of therapy visits projected at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted on the claim for the episode. Though therapy visits are adjusted only with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the *Medicare contractor* processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

10.1.8 - Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Under the home health prospective payment system, a case-mix adjusted payment for a 60-day episode is made using one of 80 HHRGs (also occasionally abbreviated to HRG.) On Medicare claims, these HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes. HIPPS codes allow the HHRG code to be carried more efficiently and include additional information on how the HHRG was derived.

HIPPS code rates represent specific characteristics (or case-mix) on which Medicare payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among providers. HIPPS codes are used in association with special revenue codes used on *institutional* claims submitted to Medicare *contractors*. One revenue code is defined for every Medicare prospective payment system that uses HIPPS codes. HIPPS codes are placed in *HCPCS/ Accommodation Rates/HIPPS Rate Codes field* of the claim. The associated revenue code is placed in *the Revenue Codes field*. In certain circumstances *for episodes beginning before January 1, 2008*, multiple HIPPS codes may appear on separate lines of a single claim.

10.1.9 - Composition of HIPPS Codes for HH PPS

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

For HH PPS episodes beginning on and after October 1, 2000 but before January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

- The second, third, and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the *original 2000* HH PPS final rule. *HIPPS code lists are maintained on the CMS Web site*. Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

- The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper. This position does not correspond to HHRGs since these codes do not differentiate payment groups. The fifth position will allow only numeric characters and a fifth position value other than "1," which is produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

The first position of every home health HIPPS code will be "H." The remaining four positions discussed above can be summarized as follows:

(Clinical)Position #2	(Functional) Position #3	(Service) Position #4	Position #5	Domain Level
A (HHRG: C0)	**E** (HHRG: F0)	**J** (HHRG: S0)	**1** = 2nd, 3rd & 4th positions computed	= min
B (HHRG: C1)	**F** (HHRG: F1)	**K** (HHRG: S1)	**2** = 2nd position derived	= low
C (HHRG: C2)	**G** (HHRG: F2)	**L** (HHRG: S2)	**3** = 3rd position derived	= mod
D (HHRG: C3)	**H** (HHRG: F3)	**M** (HHRG: S3)	**4** = 4th position derived	= high
	I (HHRG: F4)		**5** = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru **Z**	**9, 0**	expansion values for future use

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

Based on this coding structure:

- The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG.

- The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, the Pricer software will price all eight codes for that HHRG identically.

For HH PPS episodes beginning on and after January 1, 2008, the distinct 5-position, alphanumeric home health HIPPS codes is created as follows:

- *The first position is no longer a fixed value. The refined HH PPS uses a four-equation case-mix model which assigns differing scores in the clinical, functional and service domains based on whether an episode is an early or later episode in a sequence of adjacent episodes. To reflect this, the first position in the HIPPS code is a numeric value that represents the grouping step that applies to the three domain scores that follow.*

- *The second, third, and fourth positions of the code remain a one-to-one crosswalk to the three domains of the HHRG coding system.*

- *The fifth position indicates a severity group for non-routine supplies (NRS). The HH PPS grouper software will assign each episode into one of 6 NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change this code to the corresponding number 1 through 6 before submitting the claim.*

Note the second through fourth positions of the HH PPS HIPPS code will allow only alphabetical characters.

	Position #1 Grouping Step	Position #2 Clinical Domain	Position #3 Functional Domain	Position #4 Service Domain	Position #5		
					Supply Group – supplies provided	Supply Group – supplies not provided	Domain Levels
Early Episodes (1st & 2nd)	**1** (0-13 Visits)	**A** (HHRG: C1)	**F** (HHRG: F1)	**K** (HHRG: S1)	**S** (Severity Level: 1)	**1** (Severity Level: 1)	= min
	2 (14-19 Visits)	**B** (HHRG: C2)	**G** (HHRG: F2)	**L** (HHRG: S2)	**T** (Severity Level: 2)	**2** (Severity Level: 2)	= low
Late Episodes (3rd & later)	**3** (0-13 visits)	**C** (HHRG: C3)	**H** (HHRG: F3)	**M** (HHRG: S3)	**U** (Severity Level: 3)	**3** (Severity Level: 3)	= mod
	4 (14-19 Visits)			**N** (HHRG: S4)	**V** (Severity Level: 4)	**4** (Severity Level: 4)	= high
Early or Late Episodes	**5** (20 + Visits)			**P** (HHRG: S5)	**W** (Severity Level: 5)	**5** (Severity Level: 5)	= max
					X (Severity Level: 6)	**6** (Severity Level: 6)	
	6 thru 0	D thru E	I thru J	Q thru R	Y thru Z	7 thru 0	Expansion values for future use

Examples:

- *First episode, 10 therapy visits, with lowest scores in the clinical, functional and service domains and lowest supply severity level and non-routine supplies were not provided = HIPPS code 1AFK1*
- *Third episode, 16 therapy visits, moderate scores in the clinical, functional and service domains and supply severity leve1 4 = HIPPS code 4CHMV*
- *Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score is high and supply severity level 6 = HIPPS code 5BHNX*

Based on this coding structure:

- *153 case-mix groups defined in the 2007 HH PPS final rule are represented by the first four positions of the code.*

- *Each of these case-mix groups can be combined with any NRS severity level, resulting in 918 HIPPS codes in all (i.e., 153 case-mix groups times 6 NRS severity levels).*

- *Each HIPPS code will represent a distinct payment amount, without any duplication of payment weights across codes.*

HIPPS codes created using this structure are valid only on claim lines with revenue code 0023.

10.1.10.1 - Grouper Links Assessment and Payment

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool. OASIS is entered, formatted and locked for electronic transmission to State agencies. HAVEN software, made publicly available by CMS, supports OASIS and its transmission. HAVEN versions were produced incorporating the Grouper module necessary for HH PPS, along with other changes needed for the new payment system, prior to the advent of that system. However, some HHAs have chosen software vendors to create their own software applications for these purposes.

Grouper software determines the appropriate *case-mix group* for payment of a HH PPS 60-day episode from the results of an OASIS submission for a beneficiary as input or "grouped" in this software. Grouper outputs *case-mix groups* as CMS HIPPS (Health Insurance Prospective Payment System) coding. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number that is not used in billing. Under HH PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims. Note that if an OASIS assessment is rejected upon transmission to a State Agency and consequently corrected resulting in a different HIPPS code, the RAP and/or claim for the episode must also be re-billed using the corrected HIPPS code.

10.1.10.2 - Health Insurance Beneficiary Eligibility Inquiry for Home Health Agencies

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

An inquiry facility is available for HHAs and other providers and suppliers to learn the beneficiary's eligibility and entitlement status, whether a home health episode has started but not ended, *and where in a sequence of adjacent episodes an episode for given dates of service will fall*. See §30 for a description.

10.1.10.3 - Submission of Request for Anticipated Payment (RAP)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met.

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the State;
- Once a physician's verbal orders for home care have been received and documented;
- A plan of care has been established and sent to the physician; and
- The first service visit under that plan has been delivered.

An episode will be opened on CWF with the receipt and processing of the RAP. RAPs, or in special cases, claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

RAPs are submitted *using Type of Bill* 322. RAPs must include the information output by Grouper for HH PPS in addition to other claim elements. While Medicare requires very limited information on RAPs (RAPs do not require charges for Medicare), HHAs have the option of reporting service lines in addition to the Medicare requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected payment amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine payment or for later data collection.

When at least one billable service has been provided in the episode, RAPs are to be submitted to *the Medicare contractor*. Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

10.1.12 - Request for Anticipated Payment (RAP)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The RAP is submitted by HHAs to their *Medicare contractor* to request the initial split percentage payment for an HH PPS episode, after receiving verbal orders and delivering at least one service to the beneficiary. Though *they are* submitted on *standard institutional claim formats* and result in Medicare payment for home services, the RAP is normally not considered a Medicare home health claim and is not subject to many of the

stipulations applied to such claims in regulations**.** (Note that RAPs may *be* considered claims for purposes of other Federal laws and regulations.) In addition to a split percentage payment (see §10.1.6), RAPs may be paid zero percent if Medicare is the secondary payer (see §30.10), or if a provider has lost the privilege of receiving RAP payment. In particular, RAPs are not subject to any type of payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode. These claims are still subject to the payment floor and payment of interest*, if applicable*.

10.1.13 - Transfer Situation - Payment Effects

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HH PPS system, beneficiaries must be able to transfer among HHAs, and episode payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs submit a RAP with a transfer indicator in the *Source of Admission field on the institutional claim* even when an episode may already be open for the same beneficiary at another HHA. In order for a receiving (new) HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). The receiving HHA must also document in its records that it accessed the *Medicare* inquiry system to determine whether or not the patient was under an established home health plan of care and contacted the initial HHA on the effective date of transfer.

In such cases, the previously open episode will be automatically closed in Medicare claims processing systems as of the date services began at the HHA the beneficiary transferred to, as reported in the RAP; and the new episode for the "transfer to" agency will begin on that same date. **Payment will be pro-rated for the shortened episode of the "transferred from" agency**, adjusted to a period less than 60 days either according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency**.** Note that HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Under HH PPS, HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days. Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period.

Payment is for 60 days less the number of days after the date of the delivery of last billable service until what would have been the 60th day (see §10.1.15). The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock"). As with transfers, *the Source of Admission field* can be used to reflect a "transfer" to the same HHA, that is, when a patient unexpectedly returns in the same 60-day period. The new episode can be opened by the HHA.

Note that beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same 60-day period. Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA, and is not expected to return for treatment under any existing plan of care.

10.1.15 - Adjustments of Episode Payment - Partial Episode Payment (PEP)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened episodes. In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called partial episode payments (PEP).

PEP adjustments occur as a result of the two following situations:

a. When a patient has been discharged and readmitted to home care within the same 60-day episode, which will be indicated by using a *Patient Discharge Status* code of 06 on the final claim for the first part of the 60 day episode; or

b. When a patient transfers to another HHA during a 60-day episode, also indicated with a *Patient Discharge Status code* of 06 on their final claim.

Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. **This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service to and including the day of the last billable service.**

10.1.16 - Payment When Death Occurs During an HH PPS Episode

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

If a beneficiary dies during an episode, full payment will be made for the episode, including payment adjustments applicable *to* given services actually delivered prior to death. However, there is one exception to this statement. Partial episode payment (PEP) adjustments will not apply to the claim, because no more home care can be delivered in the 60-day period. The *Statement Covers Period* "through" date on the claim closing the

episode in which the beneficiary died should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

If an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 60-day period. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history. If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an episode basis, rather than a visit basis.

LUPA episodes beginning on or after January 1, 2008, may be subject to an additional payment adjustment. If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only episode of care the beneficiary received, Medicare will make an additional add-on payment. Medicare will add to these claims a lump-sum established in regulation and updated annually. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit.

10.1.19 - Adjustments of Episode Payment - Confirming OASIS Assessment Items

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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

10.1.19.1 - Adjustments of Episode Payment - Therapy Threshold

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The number of therapy *visits* projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode.

For episodes beginning before January 1, 2008:

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational, or speech-language pathology combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS codes representing the same payment group; one if a beneficiary does not receive the therapy hours projected, and another if they do meet the "therapy threshold." Therefore, when the therapy threshold is not met and the HIPPS code output by the Grouper indicated it would be, there is an automatic "fall back" HIPPS code, and Pricer software in Medicare claims processing systems will correct payment without access to the full OASIS data set.

The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare claims processing systems would pay the full episode payment based on the HIPPS code. Note that HIPPS codes may also be changed based on the medical review of claims, but Pricer software enforces the therapy threshold. Pricer will automatically change the HIPPS to the fallback code if the threshold is not met, but providers must adjust the HIPPS on their own claims if instead they originally billed the fallback code and then unexpectedly met or exceeded the threshold.

For episodes beginning on or after January 1, 2008:

The refined HH PPS adjusts Medicare payment based on whether one of three therapy thresholds (6, 14 or 20 visits) is met. As a result of these multiple thresholds and since meeting a threshold can change the payment equation that applies to a particular episode, a simple "fallback" coding structure is no longer possible. Also, additional therapy visits may change the score in the service domain of the HIPPS code.

Due to this increased complexity of the payment system regarding therapies, the Pricer software in Medicare's claims processing system will recode all claims based on the actual number of therapy services provided. This recoding will be performed without regard to whether the number of therapies delivered increased or decreased compared to the number of expected therapies reported on the OASIS assessment and used to base RAP payment. As in the original HH PPS, the electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

10.1.19.2 - Adjustments of Episode Payment - Hospitalization Within 14 Days of Start of Care

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

For episodes beginning before January 1, 2008:

Whether a beneficiary was a hospital inpatient during the 14 days before the start of an HH PPS episode will be confirmed by searching Medicare claims history for a processed inpatient hospital claim during that period. Under the HH PPS case-mix system, if a

beneficiary was in a nursing facility or rehabilitation facility during the 14 days before the start of an episode but was not also a hospital inpatient during that period, the episode will receive a higher case-mix score than if a hospitalization was also present.

Certain HIPPS codes, which represent the HH PPS case-mix group, indicate the presence of a nursing facility or rehabilitation facility discharge within 14 days but no hospitalization during that period. Only when both these conditions are met do HIPPS codes result with "K" or "M" in their fourth position.

Medicare systems will compare incoming RAPs and claims with these HIPPS codes to Medicare claims history for the beneficiary and determine during processing whether an inpatient hospital claim has been received for dates of service within 14 days of the start of care. If an inpatient hospital claim is found, Medicare systems will take action on the RAP or claim. The RAPs will be returned to the provider to alert them to the hospital stay and allow them to correct the HIPPS code. The claims will be automatically adjusted to correct the HIPPS code and will be paid at the correct payment level.

When a Home Health Agency (HHA) submits an HH PPS claim on the basis of a Significant Change In Condition (SCIC), Medicare systems will bypass downcoding revenue code 0023 lines other than the earliest dated line on the HH PPS claim identified as having an inpatient claim within 14 days of the home health admission.

When this payment adjustment is made on a pre-payment basis, the electronic remittance advice (ERA) will be coded so the adjustment can be clearly identified. The ERA will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment. A distinct remark code will also be applied to the ERA and standard paper remittance for these claims.

Under Medicare timely filing guidelines, hospital claims may be received for 15-27 months from the end of the hospital stay. As a result of this lengthy timely filing period, there may also be cases where the HH PPS claim has been processed before the inpatient hospital claim is received. In these cases, absence of the inpatient claim in Medicare claims history could mean either no hospital stay occurred or the hospital claim has not yet been submitted. As a result, Medicare systems are unable to confirm the lack of hospitalization before the HH PPS claim is paid. To account for these cases, CMS will annually analyze its claims history to identify HH PPS claims with HIPPS codes with a fourth position of "K" or "M" for which an inpatient hospital claim with dates of services within 14 days was received after the HH PPS claim had already been paid. Such claims will be subject to post-payment recovery.

When the payment adjustment is made on a post-payment basis, standard demand letter overpayment procedures, compliant with §1893 of the Social Security Act, will be used to collect the overpayment.

For episodes beginning on or after January 1, 2008:

The refined HH PPS does not use the presence or absence of prior inpatient stays in assigning a patient to a case-mix group. As a result, pre-payment editing and post-payment adjustments of claims for this reason will no longer be applied to these episodes.

10.1.20 - Adjustments of Episode Payment - Significant Change in Condition (SCIC)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

For episodes beginning before January 1, 2008:

While HH PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes an unexpected change in patient condition will occur that is significant enough to require the patient to be re-assessed during the 60-day episode period and to require new physician's orders. In such cases, each new HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode upon closure.

Pricer will then use the line item dates to calculate the number of days of care provided under each HIPPS codes, and **pay proportional amounts under each HIPPS code based on the number of days of service provided under each payment group** (count of days under each HIPPS code from and including the first billable service to and including the last billable service). The total of these amounts will be the full payment for the episode.

Such adjustments are referred to as significant change in condition (SCIC) adjustments. The electronic remittance advice including a claim for a SCIC-adjusted episode will show the total claim payment and separate segments showing the payment for each HIPPS code.

There is no limit on the number of SCIC adjustments that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode, with two exceptions:

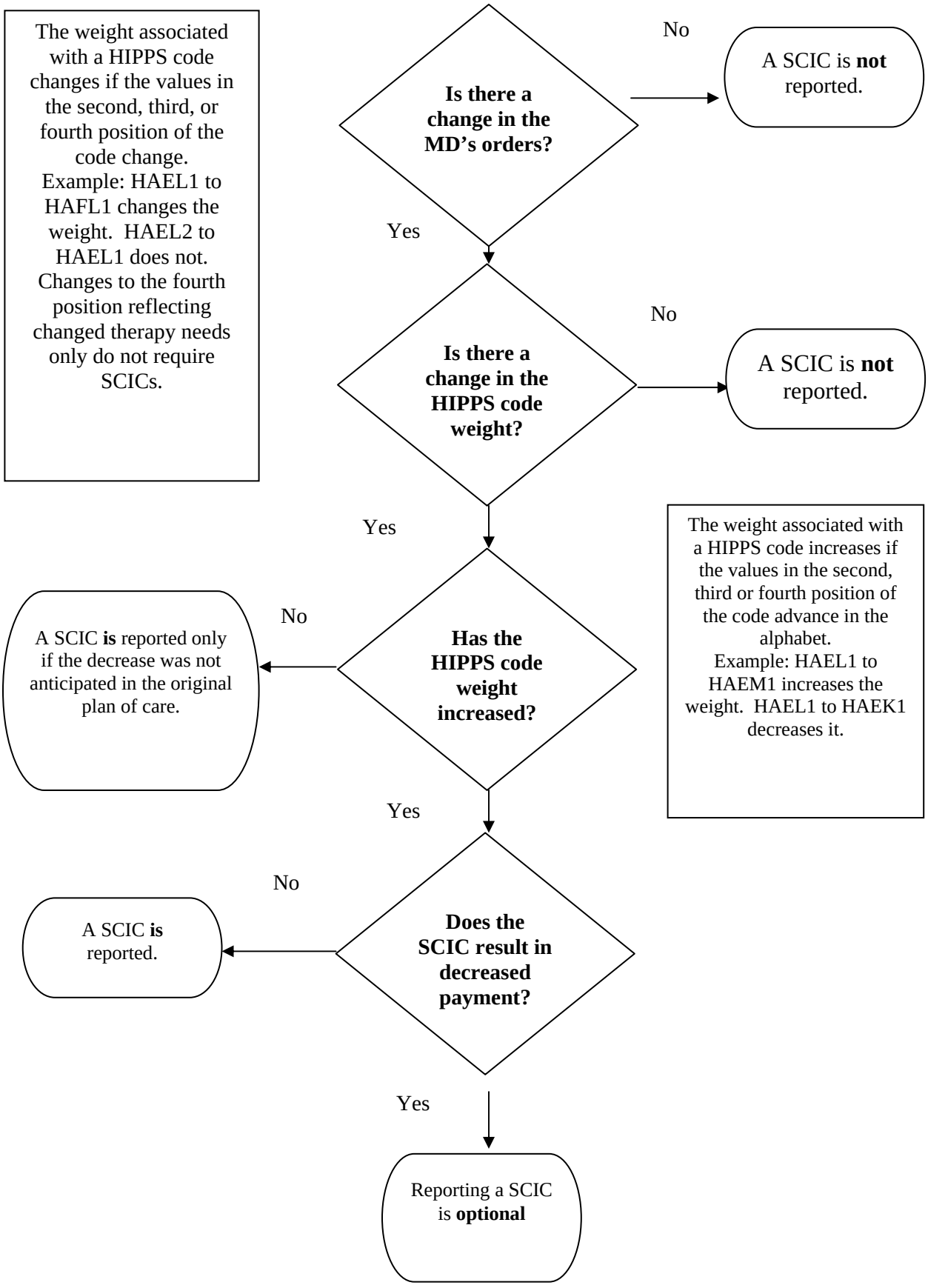
1. If the patient is re-assessed and there is no change in the HIPPS code, including a change reflecting whether or not the therapy threshold was met, the same HIPPS code does not have to be submitted twice, and no SCIC adjustment will apply. If the therapy increases, the episode should be cancelled and re-submitted under the higher payment group.

2. If the HIPPS code weight increased but the pro-ration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

The weight associated with the HIPPS code increases if the values in the second, third and fourth position in the HIPPS code advance in the alphabet, representing increasing complexity in the clinical, functional or service domain of a payment grouping for a needier patient. Exceptions are not expected to occur frequently, nor is the case of

multiple SCIC adjustments (i.e., three or more HIPPS codes for an episode). If more than six HIPPS codes are submitted, the *Medicare contractor* medical review staff determines which six will be used as the basis for payment.

The flowchart that follows outlines the decision process for billing SCIC claims. Whenever a change in condition occurs within an episode, HHAs should compare the HIPPS codes and associated payments resulting from the multiple OASIS assessments.


The weight associated with a HIPPS code changes if the values in the second, third, or fourth position of the code change. Example: HAEL1 to HAFL1 changes the weight. HAEL2 to HAEL1 does not. Changes to the fourth position reflecting changed therapy needs only do not require SCICs.
Is there a change in the MD's orders?
No
A SCIC is not reported.
Yes
Is there a change in the HIPPS code weight?
No
A SCIC is not reported.
Yes
The weight associated with a HIPPS code increases if the values in the second, third or fourth position of the code advance in the alphabet. Example: HAEL1 to HAEM1 increases the weight. HAEL1 to HAEK1 decreases it.
Has the HIPPS code weight increased?
No
A SCIC is reported only if the decrease was not anticipated in the original plan of care.
Yes
Does the SCIC result in decreased payment?
No
A SCIC is reported.
Yes
Reporting a SCIC is optional

For episodes beginning on or after January 1, 2008:

The refined HH PPS no longer contains a policy to allow for adjustments reflecting significant changes in condition. Episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Claims submitted with additional HIPPS codes reflecting SCICs will be returned to the provider.

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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 will 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. Separate outliers will not be calculated for different HIPPS codes with a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will 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.

10.1.22 - Adjustments of Episode Payment - Exclusivity and Multiplicity of Adjustments

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Episode payment adjustments as described above apply only to *claims*, not *to* requests for anticipated payment (RAPs). Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment *(if SCICs are applicable for the episode's dates of service). LUPA episodes* also will not receive outlier payments. For other HH PPS claims, multiple adjustments may apply on the same claim, though some combinations of adjustments are unlikely. All claims except LUPA claims will be considered for outlier payment. Payment adjustments are calculated in Pricer software (see subsequent Pricer section).

10.1.23 - Exhibit: General Guidance on Line Item Billing Under HH PPS

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

An Acronym List is offered in §10.1.24, to help with interpretation of this section, which, due to format constraints, could not spell out all terms.

The following tables are added for quick reference on billing most line-items on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first table groups services, and the second table groups items and supplies:

Quick Billing Reference for Services			
TYPE OF LINE ITEM	**Episode**	**Services/Visits**	**Outlier**
CLAIM CODING	**New 0023 revenue code** with new HIPPS code (HHRG) on HCPCS field of same line	**Current revenue codes 042X, 043X, 044X, 055X, 056X, 057X w/Gxxxx HCPCS for increment reporting**, (**NOTE** revenue codes 058x and 059x not permitted for HH PPS)	Determined by Pricer - **NOT billed by HHAs**
TYPE OF BILL (TOB)	**Billed on 32X only** (have HH POC, patient homebound)	**Billed on 32X only if POC**; 34X*if no HH POC	**Appears on remittance only for HH PPS claims** (via Pricer)
PAYMENT BASIS	**PPS episode rate:** (1) full episode w/ or w/out **SCIC** adjustment; (2) less than full episode w/ **PEP** adjustment, (3) **LUPA** paid on visit basis (4) therapy threshold adjustment	**When LUPA on 32X**, visits paid on adjusted national standardized per visit rates; **paid as part of Outpatient PPS for 34X***	**Addition to PPS episode rate payment only**, NOT LUPA, paid on claim basis, not line item
PPS CLAIM?	**Yes, RAPs and Claims**	**Yes, Claims only** [34X*no HH POC /non-PPS]	**Yes, Claims only**

NOTE: For HH PPS, HHA submitted RAP TOB must be 322 - may be cancelled by 328; Claim TOB must be 329 - may be adjusted by 327, or 328; 33X equivalents will also be processed.

***34X claims for HH visit/services on this chart will not be paid separately if an HH episode for same beneficiary is open on CWF (exceptions noted on chart below).**

Quick Billing Reference for Supplies						
TYPE OF LINE ITEM	**DME** (nonimplantable, other than Oxygen & P/O)**	**Oxygen & P/O (nonimplantable P/O)**	**Nonroutine*** Medical Supplies**	**Osteoporosis Drugs**	**Vaccines**	**Other Outpatient Items (antigens, splints & casts)**
CLAIM CODING	**Current revenue codes 029X, 0294** for drugs/supplies for effective DME use w/HCPCS	**Current revenue codes 060X** (Oxygen) **and 0274** (P/O) w/HCPCS	Current revenue code 027x and voluntary use of 0623 for wound care supplies	**Current revenue code 0636 & HCPCS**	**Current revenue codes 0636** (drug) and HCPCS**, 771** (administration HCPCS)	**Current revenue code 0271** & HCPCS
TOB	**Billed to RHHI/*MAC* on 32X if** HH POC, 34X* if no HH POC	**Billed to RHHI/*MAC* on 32X if** HH POC, 34X* if no HH POC	**Billed on 32X if** HH POC, or 34* if no HH POC	**Billed on 34X* only**	**Billed on 34X* only**	**Billed on 34X* only**
PAYMENT BASIS	**Fee Schedule**	**Fee Schedule**	**Bundled into PPS payment if 32X** (even LUPA); paid in cost report settlement **for 34X***	**Cost,** paid separately with open HH PPS episode, but subject to HH consolidated billing	**Paid separately based on reasonable cost with or without open HH PPS episode**	**Paid as part of Outpatient PPS,** and paid separately with or without open HH PPS episode
PPS CLAIM?	**Yes, Claim only** [34X* no HH POC/non-PPS]	**Yes, Claim only** [34X* no HH POC/non-PPS]	**Yes, Claim only** [34X* no HH POC/non-PPS]	**No** (34X* claims only)	**No** (34X* claims only)	**No** (34X* claims only)

NOTE: For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).

*** 34X claims for HH services,** except as noted for specific items above**, will not be paid separately if a HH episode for same beneficiary is open on CWF.**

**** Other than DME treated as routine supplies according to Chapter 4.**

***** Routine supplies are not separately billable or payable under Medicare home health care.** When billing on TOB 32X, catheters and ostomy supplies are considered nonroutine supplies and are billed with revenue code 027X.

10.1.24 - Exhibit: *Glossary and* Acronym List

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Admission Date - For HH PPS, date of first service of episode **or** first service in a period of continuous care (multiple episodes) placed in *the Admission/Start of Care Date field on the institutional claim.*

Claim - Second of two transactions at opening and closing of HH PPS episode to receive one of two split percentage payments.

CMS - The Center for Medicare & Medicaid Services, the Federal Agency administering the Medicare program and the Federal portions of Medicaid and the Child Health program.

DME - Durable Medical Equipment. Billed by revenue codes and/or HCPCS. Paid by CMS according to a CMS DME fee schedule accessible on the CMS Web site.

DME- *MAC* - DME *Medicare Administrative Contractor* - 4 Medicare *contractors* nationally processing DME on *professional claim formats.*

Episode - 60-day unit of payment for HH PPS.

FI – Fiscal Intermediary (intermediary)

Grouper - A software module that "groups" information for payment classification; for HH PPS, data from the OASIS assessment tool is grouped to form HHRGs and output HIPPS codes. Specifications for the HH PPS Grouper are posted on the CMS Web site, and the Grouper module is also built into PPS-compatible versions of HAVEN software, software publicly available automating the OASIS assessment tool.

HCPCS Code(s) - Healthcare Common Procedure Coding System. Coding for services or items used *in the HCPCS/ Accommodation Rates/HIPPS Rate Codes field on institutional claim formats*. A list of HCPCS is accessible on the CMS Web site.

HH - Home Health

HHA(s) - Home Health Agency(ies)

(H)HRG - Home Health Resource Group. One of HH episode payment rates.

HIPPS - Health Insurance Prospective Payment System. Procedural coding used *in the HCPCS/ Accommodation Rates/HIPPS Rate Codes field on institutional claim formats* in association with certain CMS prospective payment systems (skilled nursing facility, home health). *See 10.1.9 above for details.*

Inquiry System (HIQH/*ELGH*) - An online transaction providing information on HH PPS episodes for specific Medicare beneficiaries for HHAs and hospices. Like the HIQA/*ELGA* eligibility inquiry system, this system *is* based on batch claim data available in the Common Working File, a component of Medicare claims processing systems, available to providers via their *Medicare contractor*.

Line Item - Service or item-specific detail of claim. Contains repeated entries of *revenue code, HCPCS code, service units and charge data.*

LUPA - Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates **instead of** *case-mix groups*.

***MAC** – Medicare Administrative Contractor*

National Standard Per Visit Rates - National rates for each 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.

No-RAP LUPAs - A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.

OASIS - Outcome Assessment Information Set. The HH assessment instrument required by CMS.

Outlier - An addition to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. Pricer computes HH PPS outliers as part of Medicare claims payment for all non-LUPA episodes.

Patient Status Code – *a code in the Patient Discharge Status field on institutional claims which* describes patient status at discharge/end of period.

PEP - Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharges with readmissions).

POC - Plan of care. Medicare HH services for homebound beneficiaries must have a physician-established plan.

P/O(S) - Prosthetics and orthotics. The (S) is used to also include the supplies and other items associated with the prosthetics and orthotics.

PPS - Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

Pricer - Software modules in Medicare claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.

RAP - Request for Anticipated Payment. First of two transactions at opening and closing of HH PPS episode to receive one of two split percentage payments. Note although the RAP *is submitted on an institutional claim format*, it is not a claim according to Medicare statutes. *It* is not subject to the payment floor, among other differences from claims.

Revenue Code - *Four position* payment codes for services or items placed in the *Revenue Codes field on institutional claim formats.* Note that a new revenue code 0023 will be used on a distinct line item when billing episode payments. (HIPPS code in HCPCS field, separate line items for visits and supplies follow on claim). An "x" in the last digit of revenue codes means that value can vary from 0-9.

RHHI - Regional Home Health Intermediary. Four FIs nationally designated to process Medicare home health and hospice claims.

SCIC - Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under that HHRG, and all pro-rated amounts added for the final episode payment. *Note that SCIC adjustments apply only to episodes beginning before January 1, 2008.*

TOB - Type of Bill (i.e., 32X, 34X). Coding representing the nature of each *institutional claim* (i.e., type of benefit, such as homebound home health; payment source, such as specific Medicare trust fund; and frequency of bill, such as initial or cancellation) - an "x" in the last digit of numeric three digit TOB means that value can be from 0-9.

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

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Additionally, information about current home health episodes may be available from Medicare contractors. Institutional providers (providers who bill fiscal intermediaries) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists who bill Medicare carriers *or MACs* or suppliers who bill *DME MACs also have* access to a similar

electronic inquiry *via the HIPAA standard eligibility transaction – the 270/271 transaction*. In the interim they may, as a last resort, call their contractor's provider toll free line to request home health eligibility information available on the Common Working File. The carrier's, *MAC's* or *DME MAC's* information is based only on claims Medicare has received from home health agencies at the day of the contact. Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

If a therapy provider or a supplier learns of a home health episode from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH episode, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health episode and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

20.2 - Home health Consolidated Billing Edits in Medicare Systems

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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 editing is applied when the episode claim has been received and processed in CWF. Edits are applied if the claim subject to consolidated billing contains dates of service between and including the episode start date and the last billable service date for the episode if the patient is discharged or transferred. If the patient is not discharged or transferred, the episode end date is used for editing purposes. Any line item services within the episode start date and last billable service date or episode end date, whichever is appropriate for the patient status, will be edited. CWF sends information to *MACs,* FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing.

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 *MAC*, FI or carrier to make a post-payment rejection or denial.

For post-payment rejections of claims billed to *FIs/MACs*, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed to *carriers/MACs, 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.

Whether a claim for services subject to consolidated billing is identified pre- or post-payment, messages explaining line-item actions for home health consolidated billing appear on remittance advice for providers and Medicare Summary Notices (MSNs) for beneficiaries.

Claims subject to home health consolidated billing receive the following remittance advice codes:

- Reason Code B15: "Payment adjusted because this procedure/service is not paid separately"

- Remark Code N70: "Home health consolidated billing and payment applies"

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.

20.2.1 - Nonroutine Supply Editing

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code in the final rule for HH PPS. This list will be updated periodically by *Recurring* Update Notification. When an open HH PPS episode exists at CWF, any claim with a nonroutine supply HCPCS code that is submitted to a *DME MAC* with dates of service that overlap the episode dates will be denied.

Claims submitted to fiscal intermediaries for certain emergency, surgical, diagnostic, and end stage renal disease (ESRD) services may include a nonroutine supply HCPCS code in addition to the other services provided. Because these supplies are either bundled into

the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, these supplies do not fall within the bundling provisions of HH PPS. These claims are not subject to consolidated billing edits by CWF.

20.2.2 - Therapy Editing

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

On claims submitted to fiscal intermediaries*/MACs*, CWF enforces consolidated billing for outpatient therapies, recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes have been cross-referenced to a list of HCPCS codes which represent the same services for use in editing against *professional* claims. This list will also be updated periodically by *Recurring* Update Notification.

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

20.2.3 - Other Editing Related to Home Health Consolidated Billing

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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

If revenue code 0636 and the HCPCS code for an osteoporosis drug is billed on a 34X bill type claim during an open HH episode, CWF must edit to ensure that the provider of the 34X bill is the same as the primary provider of the open episode, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the episode payment. HH consolidated billing will not affect billing of DME or services outside the home health benefit, even when these services are billed by HHAs.

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

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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 that accompanies the payment in the form of the following remark code:

> N88 - "This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, will be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."

This remark code is applied at the line level on the electronic remittance advice. It 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. No message reflecting the alert is displayed to the beneficiary on the Medicare Summary Notice.

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

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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 the following remark code on the remittance advice when Medicare pays them for the service:

> N116 - This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

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

30.1 - Health Insurance Eligibility Query to Determine Episode Status

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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

Providers may send an inquiry to determine the beneficiary's entitlement and eligibility status into the Common Working File or CWF, through their *Medicare contractor*. Effective October 16, 2003, they must send the ANSI X12N 270 transaction set and will receive the ANSI X12N 271 transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

Medicare contractors processing institutional claims will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The *Medicare contractor* will create the 271 response or DDE screen from the ELGA transaction record.

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

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

30.3 - Timeliness and Limitations of CWF Responses

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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

- HHAs cancel their own RAPs for episodes not yet closed;
- HHAs cancel their own claims, for closed episodes; or
- When a *Medicare contractor processing HH claims* cancels a claim or a RAP for specific reasons (i.e., fraud).

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

Also possible but even more rare, claims or RAPs from two different HHAs for the same beneficiary for the same date may be in the same batch of claims or RAPs sent to CWF.

In such cases, the arbitrary claim process will still result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

30.4 - Provider/Supplier Inquiries to *Medicare Contractors* Based on Eligibility Responses

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Institutional providers and/or suppliers may want to follow-up on information they receive, usually to contact the primary agency on file to bill under arrangement. The provider or supplier may determine the HHA's *Medicare contractor* from the CMS Web site which has a list of *Medicare contractors that process HH claims* by State. *The provider or supplier also* may ask its *own Medicare contractor* through existing provider inquiry channels. *That Medicare contractor* will instruct the provider regarding which *Medicare contractor that processes HH claims* to contact to learn which HHA is involved.

Medicare contractors that process HH claims may provide information on either the provider or contractor that these providers may request. Information released will be determined by each *contractor*, such as HHA name and address, but must be enough for the inquiring provider/supplier to contact either the primary HHA, if under that *contractor*'s jurisdiction, or another *contractor*, if the provider number is attached to another *contractor*. If an instance ever exists where a provider is an individual, such as a provider doing business using a Social Security Number as a tax identification number, information cannot be released, since it would violate the individual's right to privacy.

30.5 - National Home Health Prospective Payment Episode History File

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

CWF maintains a national episode history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. Only Medicare contractors, not providers, may view this file.

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

- The beneficiary's Health Insurance Claim Number (HICN);
- The pertinent Contractor and Provider Numbers;
- Period Start and End Dates - the start date is received on a RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized;
- DOEBA and DOLBA, Dates of Earliest and Latest Billing Activity (respectively) - dates needed to attribute episode payment to the correct Medicare trust fund, drawn from the existing home health benefit period file;

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

- Transfer/Readmit Indicator - source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge);

- The HIPPS Code(s) - up to six for any episode *(though only one will be used for episodes beginning on or after January 1, 2008),* representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);

- Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or claim;

- A LUPA Indicator - received from the shared system indicating whether or not there was a LUPA episode; and

- A RAP Cancellation Indicator - showing whether or not a RAP has been auto-canceled for this episode because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel only code "B," this indicator is a value of "1," in all other cases, the value is "0."

Separate from the episode file, CWF passes the Claims-OASIS matching key on the RAP or claim to CMS' National Claims History (NCH). This enables NCH claims data to be linked to individual OASIS assessments supporting the payment of individual claims. The LUPA indicator is also passed to NCH, in additional to routinely passed claim data.

A transfer/readmit indicator, populated by the source of admission code taken from the RAP or claim as an indicator of the type of admission, is present on the internal episode file used in CWF editing but it is not displayed on the episode history screen. If contractors need to validitate this data used in CWF editing, they must research the claim record on CWF history. The episode file contains the 36 most recent episodes for any beneficiary. Episodes that precede the most recent 36 will be dropped off the file and will not be retrievable online. The date of accretion, meaning dates on which episode records are created or updated, for an episode is the date the RAP or claim is accepted or applied.

30.7 - Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAPs and HHA Claim Activity

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Medicare contractors that process HH claims reject RAPs and claims with statement dates overlapping existing episodes, including No-RAP LUPA claims, unless a transfer

or discharge and readmit situation is indicated. *These contractors* also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. Sixty-day episodes, starting on the original period start date, remain on record in these cases.

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

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

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive home care simultaneously. Thus, if an HH PPS claim is received, and CWF finds dates of service on the HH claims that fall within the dates of an inpatient or skilled nursing facility (SNF) claim (not including the dates of admission and discharge), *Medicare systems* will reject the HH claim. This would still be the case even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later, but contained dates of service duplicating dates of service within the HH PPS episode period.

A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although *for episodes beginning before January 1, 2008,* a SCIC adjustment may apply. Occurrence span code 74, previously used in such situations, should not be employed on HH PPS claims. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there would be one shortened HH PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall.

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

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The following chart summarizes basic effects of HH PPS claims processing on the episode record:

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP (Percentage Payments 0-60)	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next 60 days	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Initial RAP with Transfer Source Code of B	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider or *Contractor*	The episode record is deleted from CWF	• No episode exits to prevent RAP submission or No-RAP LUPA claim submission
RAP Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present • To correct information on this RAP, the original RAP must be replaced, cancelled by the HHA and then re-submitted once more with the correct information
Claim (full episode)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Claim	Episode record completed;	• Other RAPs submitted during this open episode

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
(discharge with goals met prior to Day 60)	episode "through" date remains at the 60th day; DOLBA updates with date of last service	will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	• A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date
No-RAP LUPA Claim	Opens an episode record using claim's "from" date; the "through" date is automatically calculated to extend through 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • Other No-RAP LUPA claims will be rejected unless a transfer source code is present • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim
Claim (adjustment)	No impact on the episode unless adjustment changes patient status to transfer	• No impact
Claim Cancellation by Provider or *Contractor*	The episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP LUPA claim submission
Claim Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP LUPA claims will be rejected unless a transfer source code is present

40 - Completion of Form CMS-1450 for Home Health Agency Billing

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data

element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

Because *claim formats serve* the needs of many payers*, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers.* In all cases, the provider is responsible for filing a timely claim for payment. (See Chapter 1.)

40.1 - Request for Anticipated Payment (RAP)

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, 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 an RAP with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, 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 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 next RA will be used to recoup the overpaid amount.

While an 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 Medicare provider number to verify provider identity.

Patient Control Number

Optional - The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

NOTE: While the bill classification of "3," defined as "Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)" may also be appropriate to an HH PPS claim depending upon a beneficiary's eligibility, Medicare encourages HHAs to submit all RAPs with bill classification "2." Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	**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 code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If an 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 and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

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.

Source of Referral for Admission or Visit

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code. For a complete list of codes, see Chapter 25.

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

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 canceling the RAP (TOB 3X8), the agency reports one of the following:
Claim Change Reasons

Code	Title	Definition
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

Enter "Remarks" indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and 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.

For a complete list of Occurrence Codes, see Chapter 25.

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.

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

For a complete list of value codes, see Chapter 25.

Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) 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 at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. 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 - On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

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

Optional – *Service units* are not required on the 0023 revenue code line. 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 links the RAP record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

Position	***Definition***	***Format***
1-2	*M0030 (Start-of-care date) – 2 digit year*	*99*
3-4	*M0030 (Start-of-care date) – alpha code for Julian date*	*XX*
5-6	*M0090 (Date assessment completed) – 2 digit year*	*99*
7-8	*M0090 (Date assessment completed) – alpha code for Julian 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 Julian dates in positions 3-4 and 7-8 are converted from 3 position numeric values 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.

The following represents an example of a treatment authorization code created using this format:

Position	*Definition*	*Actual Value*	*Resulting Code*
1-2	*M0030 (Start-of-care date) – 2 digit year*	*2007*	*07*
3-4	*M0030 (Start-of-care date) – code for Julian date*	*Julian date 245*	*JK*
5-6	*M0090 (Date assessment completed) – 2 digit year*	*2008*	*08*
7-8	*M0090 (Date assessment completed) – code for Julian date*	*Julian date 001*	*AA*
9	*M0100 (Reason for assessment)*	*04*	*4*
10	*M0110 (Episode Timing)*	*01*	*1*
11	*Clinical severity points – under Equation 1*	*7*	*G*
12	*Functional severity points – under Equation 1*	*2*	*B*
13	*Clinical severity points – under Equation 2*	*13*	*M*
14	*Functional severity points – under Equation 2*	*4*	*D*
15	*Clinical severity points – under Equation 3*	*3*	*C*
16	*Functional severity points – under Equation 3*	*4*	*D*
17	*Clinical severity points – under Equation 4*	*12*	*L*
18	*Functional severity points – under Equation 4*	*7*	*G*

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

Document Control Number (DCN)

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

Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported *on the claim* must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM 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.

For other diagnoses, the diagnoses and ICD-9 codes reported *on the claim* must match the additional diagnoses reported on the OASIS, form item M0240 (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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 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-9 guidelines.

OASIS form items M0245 *or M0426*, *which report* Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 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 a RAP, to indicate the reason for the cancellation.

40.2 - HH PPS Claims

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

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. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an 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 remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the *UB-04* (Form CMS-1450) hardcopy form. *Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names* and a table to crosswalk *UB-04* form locators to the 837 transaction is found in Chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See Chapter 1.)

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 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to

as a “frequency” code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

NOTE: While the bill classification of 3, defined as “Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)” may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims systems determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - 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 a 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 frequency codes 7, or 8.

HHAs must submit HH PPS claims with the frequency of “9.” These claims may be adjusted with frequency “7” or cancelled with frequency “8.” *Medicare contractors* do not accept late charge bills, submitted with frequency “5” on HH PPS claims. To add services within the period of a paid HH claim, *the HHA must submit* an adjustment.

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 a discharge claim is submitted due to change of *Medicare contractor, see instructions for patient status code below*. 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.

Source of Referral for Admission or Visit

Required - *The HHA enters* the same source of admission 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 partial episode payment (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 which causes the Medicare *certification* number *(known as the OSCAR number)* to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number 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 Medicare *certification* number, 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

Optional – *The HHA enters* any NUBC approved code to describe conditions that apply to the claim. For a complete list of Condition Codes see Chapter 25.

HHAs that are adjusting previously paid claims enter one of the following codes representing Claim Change Reasons:

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Codes
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

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. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3x8), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

Occurrence Codes and Dates

Optional - The HHA enters any NUBC approved code to describe occurrences that apply to the claim. *For a complete list of Occurrence Codes see Chapter 25.*

Occurrence Span Code and Dates

Optional - 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.

For a complete list of Occurrence Span codes see Chapter 25.

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 CMS online 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 §1812a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI 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, change the TOB on the claim record to 33X, 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, change the TOB on the claim record to 32X, 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 not change the TOB and will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by "X" in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim.

For episodes beginning before January 1, 2008, if there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more then once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day. If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change.

Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care and zero charges. See §40.1 for more detailed information on the HIPPS code.

For episodes beginning on or after January 1, 2008, 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 (**NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)	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.
042X	Physical Therapy Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), 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: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), 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: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), 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: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), 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: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), 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: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: FIs 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 Durable Medical Equipment (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. For additional instructions for billing DME services see Chapter 20.

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.
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

062X	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.

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

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS' 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.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a SCIC, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. 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.

Service Units

Required - The HHA should not report *service units* on 0023 revenue code lines. 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 may be zero or blank).

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. 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 total noncovered charges pertaining to the related revenue code are entered here.

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 HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

Position	***Definition***	***Format***
1-2	*M0030 (Start-of-care date) – 2 digit year*	*99*
3-4	*M0030 (Start-of-care date) – alpha code for Julian date*	*XX*
5-6	*M0090 (Date assessment completed) – 2 digit year*	*99*
7-8	*M0090 (Date assessment completed) – alpha code for Julian 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 Julian dates in positions 3-4 and 7-8 are converted from 3 position numeric values 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.*

The following represents an example of a treatment authorization code created using this format:

Position	*Definition*	*Actual Value*	*Resulting Code*
1-2	*M0030 (Start-of-care date) – 2 digit year*	*2007*	*07*
3-4	*M0030 (Start-of-care date) – code for Julian date*	*Julian date 245*	*JK*
5-6	*M0090 (Date assessment completed) – 2 digit year*	*2008*	*08*
7-8	*M0090 (Date assessment completed) – code for Julian date*	*Julian date 001*	*AA*
9	*M0100 (Reason for assessment)*	*04*	*4*
10	*M0110 (Episode Timing)*	*01*	*1*
11	*Clinical severity points – under Equation 1*	*7*	*G*
12	*Functional severity points – under Equation 1*	*2*	*B*
13	*Clinical severity points – under Equation 2*	*13*	*M*
14	*Functional severity points – under Equation 2*	*4*	*D*
15	*Clinical severity points – under Equation 3*	*3*	*C*
16	*Functional severity points – under Equation 3*	*4*	*D*
17	*Clinical severity points – under Equation 4*	*12*	*L*
18	*Functional severity points – under Equation 4*	*7*	*G*

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

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.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases *applicable for episodes beginning before January 1, 2008*, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) 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-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases *applicable for episodes beginning before January 1, 2008*, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

Other Diagnosis Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight 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-9 codes reported *on the claim* must match the additional diagnoses reported on the OASIS, form item M0240 (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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 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-9 guidelines.

OASIS form items M0245 *or M0426*, *which report* Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 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 signed the plan of care.

Remarks

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

40.5 - Billing for Nonvisit Charges

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Under HH PPS all services under a plan of care must be billed as an HH PPS episode. All services within an episode of care must be billed on one claim for the entire episode. *Medicare contractors* do not accept bill types 329 and 339 without any visit charges.

Non-visit charges incurred after termination of the plan of care are payable under Part B medical and other health services on TOB 34X.

70.1 - General

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Effective for dates of service on or after October 1, 2000, all home health services billed on TOB 32X or 33X will be reimbursed based on calculations made by the HH Pricer. The HH Pricer operates as a module within CMS' claims processing systems. The HH Pricer makes all payment calculations applicable under HH PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, therapy threshold adjustments, significant change in condition (SCIC) adjustments *(for applicable dates of service)* and outlier payments. (See §§10.1.17-10.1.22.) Medicare claims processing systems must send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the shared systems.

The following describes the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make payment determinations. No part of the Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare. The following is presented for *Medicare contractors* and as information for

the HHAs, in order to help HHAs understand their HH PPS payments and how they are determined.

70.2 - Input/Output Record Layout

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

The HH Pricer input/output file *is* 450 bytes in length. The required data and format are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	This field will be used for the National Provider Identifier when it is implemented.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit OSCAR system provider number, copied from the claim form.
29-31	X(3)	TOB	Input item: The TOB code, copied from the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient *discharge* status code of the claim is 06. An N is set in all other cases.
33-35	9(3)	PEP-DAYS	Input item: The number of days to be used for PEP payment calculation. Medicare claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim.
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0%
37-43	X(7)	FILLER	Blank.
44-46	X(2)	FILLER	Blank.
47-50	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank.

File Position	Format	Title	Description
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period “From” date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
77	X	HRG-MED - REVIEW - INDICATOR	Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code in all cases except when the therapy threshold for the claim was not met.
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Five more occurrences of all HRG/HIPPS code related fields defined above, since up to six HIPPS codes can be automatically processed for payment in any one episode.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X,

File Position	Format	Title	Description	
			057X). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.	
255-257	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.	
258-266	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
267-275	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
276-400	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Final payment, SCIC
			08	Final payment, SCIC with outlier
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Final payment, SCIC within PEP
			13	Final payment, SCIC within PEP with outlier

File Position	Format	Title	Description	
			Error return codes:	
			10	Invalid TOB
			15 16	Invalid PEP days Invalid HRG days, > 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates < Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 3x9 or adjustment TOB
403-407	9(5)	REVENUE - SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.	
408-412	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a low utilization payment adjustment (LUPA). This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
413-421	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.	
422-430	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.	
431-435	*9(3)V9(2)*	*LUPA-ADD-ON-PAYMENT*	*Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim.*	
436	*X*	*LUPA-SRC-ADM*	*Input Item: The source of admission code on the RAP or claim*	
437	*X*	*RECODE-IND*	*Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values:* *0 = default value* *1 = HIPPS code shows later episode, should be*	

File Position	Format	Title	Description
			early episode *3 = HIPPS code shows early episode, should be later episode*
438	*9*	*EPISODE-TIMING*	*Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values:* *1 = early episode* *2 = late episode*
439	*X*	*CLINICAL-SEV-EQ1*	*Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment authorization code.*
440	*X*	*FUNCTION-SEV-EQ1*	*Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.*
441	*X*	*CLINICAL-SEV-EQ2*	*Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.*
442	*X*	*FUNCTION-SEV-EQ2*	*Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.*
443	*X*	*CLINICAL-SEV-EQ3*	*Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code.*
444	*X*	*FUNCTION-SEV-EQ3*	*Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization*

File Position	Format	Title	Description
			code.
445	*X*	*CLINICAL-SEV-EQ4*	*Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.*
446	*X*	*FUNCTION-SEV-EQ4*	*Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.*
447-450	*X(4)*	*FILLER*	

Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HRG" related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for each HIPPS code will be placed in the total charges and the covered charges field of the appropriate revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17, Amount. If the return code is 06 (indicating a low utilization payment adjustment), the Medicare claims processing systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice.

70.3 - Decision Logic Used by the Pricer on RAPs

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

1. *Determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PYMNT-INDICATOR." If the value is 0, use the full standard episode rate in subsequent calculations. If the value is 1, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.*

2. Find weight for "HRG-INPUT-CODE" from the table of weights for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times

Federal standard episode rate for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and nonlabor portions of the payment established by CMS. Multiply the case-mix adjusted rate *by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below)* to determine the labor portion. Multiply the labor portion by the wage index corresponding to "*CBSA*" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by *the current non-labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below)* to determine the nonlabor portion.

Sum the labor and nonlabor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

3. a. If the "INIT-PYMNT-INDICATOR" equals 0 *or 2*, perform the following:

Determine if the "SERV-FROM-DATE" of the record is equal to the "ADMITDATE." If yes, multiply the wage index and case-mix adjusted payment by .6 Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 05.

If no, multiply the wage index and case-mix adjusted payment by .5. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 04.

b. If the "INIT-PYMNT-INDICATOR" = 1 *or 3*, perform the following:

Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 03.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

A. The following calculations shall apply to claims with "From" dates on or after October 1, 2000, and before January 1, 2008. For calculations which apply to claims with "From" dates on or after January 1, 2008, see subsection B below.

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI 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 2, use

the full standard episode rate in subsequent calculations. If the value is 1 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.

    a. 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 Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the six products. The result is the total payment for the episode.

    Return this amount in the "TOTAL-PAYMENT" field with return code 06. No further calculations are required.

    b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

2. Therapy threshold determination.

    a. If the "REVENUE-SUM1-3-QTY-THR" (the total of the quantities associated with therapy revenue codes, 042x, 043x, 044x, which will be passed from the shared systems sorted in this order) is less than 10, perform the following:

    If the "MED-REVIEW-INDICATOR" is a Y for any HRG, do not alter the HIPPS code reported in "HRG-INPUT-CODE." Copy that code to the "HRG-OUTPUT-CODE" field. Proceed to the next HRG occurrence.

    If "MED-REVIEW-INDICATOR" is an N for any HRG, read the table of HIPPS codes for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be met for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

    If the code in the first column does not match the code in the second column (indicating the therapy threshold is unmet for that code), place the code from the second column in the "HRG-OUTPUT-CODE" field.

b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the codes in the "HRG-OUTPUT-CODE fields for all further calculations involving each HRG.

3. HRG payment calculations.

a. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is an N:

Find the weight for the "HRG-OUTPUT-CODE" from weight table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal standard episode rate for the Federal fiscal 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.

Proceed to the outlier calculation (see 4 below).

b. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (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 (4 below).

c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is an N:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the "HRG-NO-OF-DAYS" field for that code divided by 60. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will be returned in separate occurrence of the "HRG-PAY" fields, so that the shared systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore

each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the "PEP -DAYS" field divided by 60. Multiply the result by the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field. Repeat this for up to six occurrences of "HRG-CODE." These amounts will returned separately in the corresponding "HRG-PAY" fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

4. Outlier calculation:

a. 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 all HRG payment calculations. This is the outlier threshold for the episode.

b. 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.

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

d. If the result is greater than $0.00, calculate .80 times the result. Return this 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.

e. If the result 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.

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

On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P, or 33P (that is, all provider submitted claims and provider or FI 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 2, use the full standard episode rate in subsequent calculations. If the value is 1 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.*

    a. *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 Federal fiscal 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.*

    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 AND*
    - *the value in "LUPA-SRC-ADM" is not a B or C.*

    Wage index adjust the current LUPA add-on amount (published via Recurring Update Notification) and return this amount in the "LUPA-ADD-ON-PAYMENT" field.

    Return the sum of all "REVENUE-COST" amounts 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.

    b. *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.*

   a. *Read the "RECODE-IND." If the value is 0, proceed to step c below.*

      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.

   b. *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 a. 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.*

      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 according to the table below:

CLINICAL-SEV-EQ1 numeric value	*Resulting HRG - OUTPUT – CODE 2nd position value*	*FUNCTION-SEV-EQ1 numeric value*	*Resulting HRG - OUTPUT – CODE 3rd position value*	*REVENUE - SUM 1-3-QTY-THR value*	*Resulting HRG - OUTPUT – CODE 4th position value*
0-4	*A*	*0-3*	*F*	*0-5*	*K*
5-9	*B*	*4-5*	*G*	*6*	*L*
10+	*C*	*6+*	*H*	*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 according to the table below:

CLINICAL-SEV-EQ2 numeric value	*Resulting HRG - OUTPUT – CODE 2nd position value*	*FUNCTION-SEV-EQ2 numeric value*	*Resulting HRG - OUTPUT – CODE 3rd position value*	*REVENUE - SUM 1-3-QTY-THR value*	*Resulting HRG - OUTPUT – CODE 4th position value*
0-4	*A*	*0-5*	*F*	*14-15*	*K*
5-12	*B*	*6-8*	*G*	*16-17*	*L*
13+	*C*	*9+*	*H*	*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 according to the table below:

CLINICAL-SEV-EQ3 numeric value	*Resulting HRG - OUTPUT – CODE 2nd position value*	*FUNCTION-SEV-EQ3 numeric value*	*Resulting HRG - OUTPUT – CODE 3rd position value*	*REVENUE - SUM 1-3-QTY-THR value*	*Resulting HRG - OUTPUT – CODE 4th position value*
0-2	*A*	*0-9*	*F*	*0-5*	*K*
3-4	*B*	*9-10*	*G*	*6*	*L*
5+	*C*	*11+*	*H*	*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 according to the table below:

CLINICAL-SEV-EQ4 numeric value	*Resulting HRG - OUTPUT – CODE 2nd position value*	*FUNCTION-SEV-EQ4 numeric value*	*Resulting HRG - OUTPUT – CODE 3rd position value*	*REVENUE - SUM 1-3-QTY-THR value*	*Resulting HRG - OUTPUT – CODE 4th position value*
0-4	*A*	*0-9*	*F*	*14-15*	*K*
5-12	*B*	*9-10*	*G*	*16-17*	*L*
13+	*C*	*11+*	*H*	*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.

c. 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 then 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 step b and recode the remaining positions of the HIPPS code as described above.

d. In all other 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 necessary:

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.

3. HRG payment calculations.

a. 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 4 below).

b. 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 partial episode payment (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 (4 below).

4. Outlier calculation:

a. 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 all HRG payment calculations. This is the outlier threshold for the episode.

b. 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.

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

d. If the result is greater than $0.00, calculate .80 times the result. Return this 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.

e. If the result 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.

70.5 - Annual Updates to the HH Pricer

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by legislation. Prior to January 2005, updates occurred each October to reflect the Federal fiscal year. The following update items, when changed, are published in the Federal Register**:**

- The Federal standard episode amount;
- *The Federal conversion factor for non-routine supplies;*
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights to be used for each HRG;
- *A table of supply weights to be used to adjust the non-routine supply conversion factor;*
- A table of national standardized per visit rates;
- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and nonlabor percentages.
- Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and contractors about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the HH Pricer.