CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4482	**Date: December 20, 2019**
	Change Request 11081

Transmittal 4244, dated February 15, 2019, is being rescinded and replaced by Transmittal 4482, dated, December 20, 2019, to add FISS as a responsible party to business requirement 11081.5.1 and add a requirement and update attachment 3 to facilitate handling claims with no matching assessment. Also, manual sections are updated to reflect changes made by subsequent transmittals for CRs 11272, 11527 and 11536. All other information remains the same.

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation

I. SUMMARY OF CHANGES: This Change Request implements the policies of the HH PDGM as described in the November 2018 home health final rule.

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019 - for design and requirements; October 7, 2019 - for coding and testing including Beta HH Pricer; January 6, 2020 - for continued testing and implementation. To the extent feasible, tasks during the three releases may be worked using an Agile process.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.1/Creation of HH PPS and Subsequent Refinements
R	10/10.1.4/The HH PPS Unit of Payment
R	10/10.1.5/Number, Duration, and Claims Submission of HH PPS Episodes
R	10/10.1.5.1/More Than One Agency Furnished Home Health Services
R	10/10.1.5.2/Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes
R	10/10.1.6/Split Percentage Payment
R	10/10.1.7/Basis of Medicare Prospective Payment Systems and Case-Mix
R	10/10.1.8/Coding of HH PPS Case-Mix Groups on HH PPS Claims: HHRGs 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	10/10.1.10.4/Claim Submission and Processing
R	10/10.1.11/Payment, Claim Adjustments and Cancellations
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 Payment - Partial Episode Payment (PEP)
R	10/10.1.16/Payment When Death Occurs During an HH PPS Episode/Period
R	10/10.1.17/Adjustments of Payment - Low Utilization Payment Adjustments (LUPAs)
R	10/10.1.18/Adjustments of Payment - Special Submission Case: “No-RAP” LUPAs
R	10/10.1.19/Adjustments of Payment - Confirming OASIS Assessment Items
R	10/10.1.19.1/Adjustments of Episode Payment - Therapy Thresholds
R	10/10.1.19.2/Adjustments of Episode Payment - Early or Later Episodes
R	10/10.1.19.3/Adjustments of Payment – Validation of HIPPS Codes
R	10/10.1.21/Adjustments of Payment - Outlier Payments
R	10/10.1.22/Multiple Adjustments to Payments
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/70.2/Input/Output Record Layout

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4482	Date: December 20, 2019	Change Request: 11081

Transmittal 4244, dated February 15, 2019, is being rescinded and replaced by Transmittal 4482, dated, December 20, 2019, to add FISS as a responsible party to business requirement 11081.5.1 and add a requirement and update attachment 3 to facilitate handling claims with no matching assessment. Also, manual sections are updated to reflect changes made by subsequent transmittals for CRs 11272, 11527 and 11536. All other information remains the same.

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019 - for design and requirements; October 7, 2019 - for coding and testing including Beta HH Pricer; January 6, 2020 - for continued testing and implementation. To the extent feasible, tasks during the three releases may be worked using an Agile process.

I. GENERAL INFORMATION

A. Background: Since October 2000, home health agencies (HHAs) are paid under a prospective payment system (HH PPS) for a 60-day episode of care that includes all covered home health services. The 60-day payment amount is adjusted for case-mix and area wage differences. Additionally, home health episodes of care can receive higher payments if certain therapy thresholds are met. As part of the HH PPS payment structure, HHAs receive approximately half of the expected final payment amount up front, after performing the first visit in a 60-day episode of care, with the remaining amount received at the end of the 60-day episode of care upon final claim submission.

In July, 2017, CMS proposed the Home Health Groupings Model (HHGM), an alternative case-mix adjustment methodology to better align payment with patient care needs. The HHGM used 30-day periods, rather than 60-day episodes, and relied more heavily on clinical characteristics and other patient information (e.g., principal diagnosis, functional level, comorbid conditions, referral source, and timing) to place patients into meaningful payment categories. While the HHGM leveraged many of the same aspects of the current system, the HHGM eliminated the use of the therapy thresholds in the case-mix system.

In 2017, CMS conducted analysis projects to develop draft business requirements for the implementation of the HHGM; however, the HHGM was not finalized in order to allow CMS additional time to consider public comments for potential refinements to the model. In early February of 2018, section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018) became law and included several requirements for home health payment reform, effective January 1, 2020. These reform measures include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of service to a 30-day unit of service. In the CY 2019 final Home Health Prospective Payment System Rate Update final rule, CMS finalized an alternative case-mix methodology now called the Patient-Driven Groupings Model (PDGM) which includes the payment reform requirements as set forth in the BBA of 2018 and will be implemented in CY 2020. The requirements below and the attached documents revise the products of the earlier analysis to conform to the final policies of the PDGM.

B. Policy: This CR implements the policies of the PDGM, as described in the CY 2019 home health final rule and as required by section 51001 of the BBA of 2018. These policies include a change to the unit of payment from 60-day episodes of care to 30-day periods of care and the elimination of therapy thresholds for use in determining home health payment. The PDGM will assign 30-day periods of care into one of 432 case-mix groups based on the following variables:

- Timing: The first 30-day period of care is an early period of care. The second or later 30-day period of care is a late period of care;
- Admission Source: If the patient was referred to home health from the community or an acute or post-acute care referral source;
- Clinical Group: The primary reason the patient requires home care, represented by distinct clinical groups as determined by the principal diagnosis reported on the home health claim;
- Functional Impairment Level: The patient's functional impairment level is based on OASIS items for activities of daily living; and
- Comorbidity Adjustment: If the patient has certain comorbid conditions reported on the home health claim, the 30-day period of care can receive a no, low, or high comorbidity adjustment.

In conjunction with the PDGM, this final rule implements a change to the Low-Utilization Payment Adjustment (LUPA) threshold from the current four or fewer visits per 60-day episode of care to thresholds that vary based on the 10th percentile of visits in a 30-day period of care for each case-mix group in the PDGM.

Finally, beginning in CY 2020, newly enrolled HHAs, meaning those HHAs certified for participation in Medicare on or after January 1, 2019, will no longer receive split-percentage payments. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, would still be required to submit a "no pay" RAP at the beginning of care to establish the home health period of care, as well as, every 30 days thereafter upon implementation of the PDGM in CY 2020. Existing HHAs, meaning those HHAs certified for participation in Medicare prior to January 1, 2019, will continue to receive RAP payments upon implementation of the PDGM in CY 2020. For split percentage payments to be made, existing HHAs would have to submit a RAP at the beginning of each 30-day period of care. For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.1	**QIES Interface Requirements**					X				QIES
11081.1.1	For HH claims and adjustments received with "From" dates on or after January 1, 2020, the contractor shall format the finder file transmitted to QIES according to the record layout shown in Attachment 3.					X				QIES
11081.1.2	For finder file records with "From" dates on or after January 1, 2020, the contractor shall add the OASIS data shown in Attachment 3 to the response portion of the record and return this information to FISS.									QIES
11081.1.3	For finder file records with "From" dates on or after January 1, 2020, when no matching assessment is									QIES

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	found, the contractor shall fill the new fields on the response portion of the record with 9 or 99, and return this information to FISS. Note: RETURN-HIPPS1 continues to be filled with ZZZZZ when no assessment is found.									
11081.1.4	The contractor shall copy the new fields on the response portion of the record from QIES onto the corresponding claim record.					X				
11081.1.4.1	The contractor shall display the QIES response information in a format showing the OASIS item label, the QIES response data (protected) and a copy of the QIES response data that can be changed by the MAC. See Attachment 6 for screen mock-up.			X		X				
11081.1.4.2	The contractor shall validate entries to change OASIS items as follows: • OASIS M1033 items - entries must be 0 or 1 • OASIS items M1800 through M1860 - entries must be two position numeric in the range 00 - 06.					X				
11081.1.4.3	The contractor shall ensure the QIES response information can be updated by the MAC on all HH claims and adjustments so it can be used on pre-payment reviews, post-payment reviews and appeals reviews.			X		X				
11081.1.4.4	The contractor shall ensure that when OASIS data is changed by the MAC, the claim does not process through the QIES interface again but does process through the HH Grouper again.					X				
11081.1.4.5	If a claim does not receive a QIES response in the required number of days, the contractor shall update the OASIS items as follows before releasing the claim to continue processing: • OASIS M1033 items - enter 9 • OASIS items M1800 through M1860 - enter 99.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.1.5	The contractor shall ensure the screen created by requirement 1.4.1 is not viewable by the provider.					X				
11081.1.6	The contractor shall make the new fields created by requirement 1.4 accessible for use by mass adjustment programs and Expert Claims Processing System (ECPS) events.					X				
11081.1.7	The contractor shall include the new fields created by requirement 1.4 in the claim record sent to the Integrated Data Repository (IDR).					X				IDR
11081.1.8	The contractor shall ensure the new fields created by requirement 1.4 are not included in the coordination of benefits (COB) outbound transaction.					X				
11081.2	**Grouper Interface Requirements**					X				
11081.2.1	The contractor shall implement an interface with the Java Home Health Grouper. NOTE: This interface will build on work from previous analysis and proof of concept projects regarding Java Groupers.					X				
11081.2.2	The contractor shall call the Java Home Health Grouper for all claims with TOB 032x (other than 0320 and 0322) with claim "From" dates on or after January 1, 2020.					X				
11081.2.3	The contractor shall format the interface with the Java Home Health Grouper according to the specification shown in Attachment 4.					X				
11081.2.4	The contractor shall send the Grouper a Period Timing indicator of '1' when the claim From date and Admission date match.					X				
11081.2.5	The contractor shall send the Grouper a Period Timing indicator of '2' when the claim From date and Admission date do not match.					X				
11081.2.6	If occurrence code 61 is present on the claim and the associated date is within 14 days of the claim From date, the contractor shall send the Grouper the					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	occurrence code in the Referral Source field.									
11081.2.7	If occurrence code 61 or 62 are present on the claim and the associated date is within 14 days of the claim From date and the claim From and Admission dates match, the contractor shall send the Grouper the occurrence code in the Referral Source field.					X				
11081.2.8	The contractor shall bypass calling the Grouper if the APC-HIPPS code field is populated and the first payment indicator (IND) field is M, P, R, or U. Note: R indicator will be populated when entering changes resulting from a RAC review. U indicator will be populated when entering changes resulting from a Unified Program Integrity Contractor (UPIC) review.					X				
11081.2.8.1	The contractor shall set the first payment indicator (IND) to R when the claim Type of Bill (TOB) is 032H and the adjustment reason is RI.					X				
11081.2.8.2	The contractor shall set the first payment indicator (IND) to U when the claim Type of Bill (TOB) is 032H and the adjustment reason is ZP or PI.					X				
11081.2.9	The contractor shall move the HIPPS code returned by the Grouper to the HCPCS field of the 0023 line, replacing the provider-submitted HIPPS code.					X				
11081.2.10	The contractor shall return to the provider HH claims (TOB 0329, 0327 and 032Q) with a principal diagnosis code that is not sufficient to determine the HHRG assignment under the PDGM. Note: The list of diagnosis codes will be contained in the Grouper.			X		X				
11081.3	**HH Pricer Interface Requirements**					X				HH Pricer
11081.3.1	For HH claims and adjustments received with "From" dates on or after January 1, 2020, the contractor shall format the interface with the HH Pricer according to the record layout shown in Attachment 5 and send the record to a new iteration of the HH Pricer program.					X				HH Pricer
11081.3.2	For HH claims and adjustments received with "From" dates before January 1, 2020, the contractor shall					X				HH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	format the interface with the HH Pricer using the current record layout and send the record to the existing iteration of the HH Pricer program.									
11081.3.3	The contractor shall move claims data to the input fields of the revised HH Pricer record layout according to the instructions in the "Description" field in Attachment 5.					X				HH Pricer
11081.3.4	The contractor shall move data from the output fields of the revised HH Pricer record layout to the claim according to the instructions in the "Description" field in Attachment 5.					X				HH Pricer
11081.4	**HH Claim Processing Requirements**			X		X				
11081.4.1	The contractor shall auto-cancel Requests for Anticipated Payment (RAPs - TOB 0322) when the final claim is not received within 90 days of the start date of the RAP or 60 days from the RAP paid date, whichever is greater.					X				
11081.4.2	The contractor shall return to the provider (RTP) claims with TOBs 0329, 0327 or 032Q if the span of days between the claim "From" and "Through" dates exceeds 30 days. NOTE: If the From Date is prior to 1/1/2020, the contractor will continue to apply the existing logic to not allow From and Through dates to exceed 60 days.			X		X			X	
11081.4.3	The contractor shall require occurrence code 50 to be present on TOB 032x, other than 0322 and shall ensure that only one occurrence code 50 is reported.			X		X				
11081.4.3.1	The contractor shall return to provider HH claims, TOB 032x, other than 0322, when occurrence code 50 is not present or when more than one occurrence code 50 is present.			X						
11081.4.4	The contractor shall accept new occurrence codes 61 and 62.					X				CCEM
11081.4.5	The contractor shall return to the provider HH claims (TOB 0329, 0327 or 032Q) that report more than one occurrence of occurrence codes 61 and 62 or that			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	report both occurrence code 61 and 62.									
11081.4.6	The contractor shall no longer edit to ensure the reporting of supply revenue codes based on the fifth position of the HIPPS on HH claims.					X				
11081.4.7	The contractor shall not require treatment authorization codes on HH claims, TOB 032x unless required by Pre-Claim Review requirements.					X				
11081.4.7.1	The contractor shall not validate the format of the first 18 positions of the treatment authorization code on HH claims, TOB 032x.					X				
11081.4.7.2	The contractor shall zero fill the first 18 positions of the treatment authorization code field on HH claims (TOB 0329, 0327 or 032Q) and move the provider-submitted REF02 data beginning in the nineteenth position of the field.					X				
11081.4.7.3	On Direct Data Entry (DDE) HH claims (TOB 0329, 0327 or 032Q), when the provider enters the tracking number in the treatment authorization code field, the contractor shall zero fill the first 18 positions of the treatment authorization code field and move the provider-entered data beginning in the nineteenth position of the field when the screen is submitted.					X				
11081.4.8	The contractor shall ensure all Health Insurance Prospective Payment System (HIPPS) code combinations that are valid per Attachment 1 are loaded in the Healthcare Common Procedure Coding System (HCPCS) file and set up to be effective based on From dates on of after January 1, 2020. Note: CMS will provide a complete list of valid values.					X				
11081.4.9	The contractor shall ensure all HIPPS codes not described in Attachment 1 are set up as follows: • to be effective based on From dates before January 1, 2020 and • to allow the Through date to span January 1, 2020.			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.4.10	The contractor shall no longer validate the L low utilization payment adjustment (LUPA) indicator based on the number of visits if the From date is on or after January 1, 2020. Note: the single threshold of 4 visits used in the existing edit no longer applies.								X	
11081.5	**HH Pricer Processing Requirements**									HH Pricer
11081.5.1	The contractor shall apply low utilization payment adjustments (LUPAs) based on a minimum number of visits associated with the HIPPS code on the claim. Note: The Pricer will contain a table that contains the LUPA threshold for each HIPPS code.					X				HH Pricer
11081.5.2	The contractor shall no longer re-code the HIPPS code during payment calculations.									HH Pricer
11081.5.3	The contractor shall calculate 30-day period payments and all applicable payment adjustments.									HH Pricer
11081.5.4	The contractor shall ensure that all HHAs with new Medicare enrollments beginning on or after January 1, 2019 have field 19 of their provider specific file set to 1 or 3 to prevent RAP payments.			X						
11081.6	**30-Day Period of Care Requirements**								X	
11081.6.1	The contractor shall maintain all the current data elements on HH periods of care, only the span of days between period start and end dates will change. Note: The term "period of care" will replace "episode" under the PDGM. Periods of care will continue to be tracked using the HHEH auxiliary file.								X	
11081.6.2	The contractor shall calculate period end dates as the From date plus 29 days based on RAPs (0322) and LUPA final claims (0329 with Pricer return codes 06 and 14). Note: If the period Start date is on or after January 1, 2020, the contractor will also use 30 day periods when recalculating periods that were subject to erroneous partial episode payment (PEP) adjustment (see CR								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	7865).									
11081.6.3	The contractor shall ensure that claims and adjustments with a HIPPS code containing 1 or 2 in the 1st position represent the first 30-day period of care in a sequence of related periods. Note: Sequence of periods continues to be defined by a 60 day gap.								X	
11081.6.3.1	The contractor shall reject for recoding claims and adjustments submitted with a HIPPS code containing 1 or 2 in the 1st position that are not the first 30-day period in a sequence. Note: Claims subject to LUPA payment (Pricer return codes 06 or 14) are excluded.								X	
11081.6.3.2	Upon receipt of a claim that is found not to be the first period in a sequence, the contractor shall • send the claim back to the HH Grouper with a Period Timing indicator of '2' • send the resulting recoded HIPPS code to the HH Pricer • record the recoded HIPPS code in the APC-HIPPS field and set the payment indicator (IND) to P, and • return the recoded claim to CWF					X				HH Pricer
11081.6.4	The contractor shall ensure that claims and adjustments submitted with HIPPS code containing 3 or 4 in the 1st position represent the second or later period of care in a sequence of related periods. Note: Sequence of periods is defined by a 60 day gap.								X	
11081.6.4.1	The contractor shall reject for recoding claims and adjustments submitted with a HIPPS code containing 3 or 4 in the 1st position that are not the second or later period of care in a sequence. Note: Claims subject to LUPA payment (Pricer return codes 06 or 14) are excluded.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.6.4.2	Upon receipt of a claim that is found to be the first period in a sequence, the contractor shall • send the claim back to the HH Grouper with a Period Timing indicator of '1' • send the resulting recoded HIPPS code to the HH Pricer • record the recoded HIPPS code in the APC-HIPPS field and set the payment indicator (IND) to P, and • return the recoded claim to CWF					X				HH Pricer
11081.6.5	The contractor shall review HH periods of care when a new HH claim is received and identify any HIPPS codes on previously paid claims that represent an incorrect position in the sequence.								X	
11081.6.5.1	The contractor shall modify informational unsolicited responses (IURs) to trigger an automatic adjustment of any previously paid claims identified in requirement 6.5.								X	
11081.6.5.2	Upon receipt of an IUR to correct period sequence, the contractor shall adjust the paid claim, changing the Period Timing indicator in the Grouper input as indicated by the IUR.					X				
11081.6.6	The contractor shall reject for repricing claims and adjustments paid a LUPA add-on amount (Pricer return code 14) that is not the first or only 30-day period of care in a sequence.								X	
11081.6.6.1	Upon receipt of a LUPA add-on claim rejected as not the first or only 30-day period in a sequence, the contractor shall return the claim to the HH Pricer, setting the adjustment indicator (ADJ-IND) in the input record to '2.'					X				HH Pricer
11081.6.7	The contractor shall ensure that if a claim or adjustment is submitted with a HIPPS code containing 1 in the 1st position (community referral source, early), there is no inpatient claim (TOB 011x, 018x or 021x) with a Through date within 14 days before the incoming claim From date.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.6.7.1	The contractor shall reject for recoding claims and adjustments submitted with a HIPPS code containing 1 in the 1st position when an inpatient claim within 14 days is found and shall return the TOB and the provider number (CCN) of the inpatient claim. This edit shall be overrideable. Note: The following claims are excluded: • Claims subject to LUPA payment (Pricer return codes 06 or 14) • HH claims with a no-pay code present. • Inpatient claims with a no-pay code present.								X	

11081.6.7.2	Upon receipt of a claim that is found not to be a community referral/early, the contractor shall
	
	• send the claim back to the HH Grouper with a Referral Source indicator corresponding to the TOB and provider number
	  • if TOB 011x and the provider number is within the range 0001-0879 or 1300-1399, send 61
	  • if TOB 018x or 021x, send 62
	  • if TOB 011x and the provider number is within the range 3025 -3099 or the third position of the provider number is T, send 62
	  • if TOB 011x and the provider number is within the range 2000-2299, send 62
	  • if TOB 011x and the provider number is within the range 4000-4499 or the third position of the provider number is S, send 62
	• send the resulting recoded HIPPS code to the HH Pricer
	• record the recoded HIPPS code in the APC-HIPPS field and set the payment indicator (IND) to P, and
	• return the recoded claim to CWF
						X				HH Pricer

11081.6.8	The contractor shall ensure that if a claim or adjustment is submitted with a HIPPS code containing 3 in the 1st position (community referral, late), there is no inpatient hospital claim (TOB 011x the provider								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	number is within the range 0001-0879 or 1300-1399) with a Through date within 14 days before the incoming claim From date.									
11081.6.8.1	The contractor shall reject for recoding claims and adjustments submitted with a HIPPS code containing 3 in the 1st position when an inpatient hospital claim within 14 days is found.This edit shall be overrideable. Note: The following claims are excluded: • Claims subject to LUPA payment (Pricer return codes 06 or 14) • HH claims with a no-pay code present. • Inpatient claims with a no-pay code present.								X	
11081.6.8.2	Upon receipt of a claim that is found not to be a community referral source/late, the contractor shall: • send the claim back to the HH Grouper with a Referral Source indicator of 61 • send the resulting recoded HIPPS code to the HH Pricer • record the recoded HIPPS code in the APC-HIPPS field and set the payment indicator (IND) to P, and • return the recoded claim to CWF					X				HH Pricer
11081.6.9	The contractor shall review HH periods of care when a new inpatient claim (TOB 011x, 18x or 21x) is received and identify any periods with HIPPS codes beginning with 1 that begin within 14 days of the inpatient claim From date.								X	
11081.6.9.1	The contractor shall create an IUR to trigger an automatic adjustment of the previously paid claim identified in requirement 6.9 and shall return the TOB and the provider number (CCN) of the inpatient claim.								X	
11081.6.9.2	Upon receipt of an IUR to correct the referral source to institutional early, the contractor shall adjust the paid claim, taking the same actions described in BR 6.7.2.					X				HH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11081.6.10	The contractor shall review HH periods of care when a new inpatient hospital claim (TOB 011x the provider number is within the range 0001-0879 or 1300-1399) is received and identify any periods with HIPPS codes beginning with 3 that begin within 14 days of the inpatient claim From date.								X	
11081.6.10.1	The contractor shall create an IUR to trigger an automatic adjustment of the previously paid claim identified in requirement 6.10.								X	
11081.6.10.2	Upon receipt of an IUR to correct the referral source to institutional late, the contractor shall adjust the paid claim, taking the same actions described in BR 6.8.2.					X				HH Pricer
11081.6.11	The contractor shall revise any edits or unsolicited responses that use 60 day episodes in their criteria to apply 30 day periods of care if the claim From date is on or after January 1, 2020.								X	
11081.7	The contractor shall participate in up to 3 one hour conference calls to discuss any additional issues that arise in finalizing the requirements of this CR. NOTE: The calls may occur on an ad hoc basis at any time during the split implementation period. No contractor minutes will be required. CMS will document outcomes in corrected requirements or other supporting documentation.			X		X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11081.8	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
3.1	CMS will provide a separate HH Driver program that will accept the new copybook and route claims to the calculation modules for CY 2020 and after. Top level nodes in the copybook will serve to distinguish the new copybook from the existing one.
1.4.1	This display will be used by MAC medical reviewers to rescore episodes based on submitted documentation, replacing their current use of the QIES RHHI extract tool and the freestanding web grouper. However, since FISS screens are not accessible to the UPICs, similar tools will remain available to enable UPIC reviews.
.6	The BRs in this section assume that the change to how CWF sets the period end dates on HHEH is sufficient to ensure existing processes will function for 30-day periods of care in the same way they functioned for 60-day episodes. Consolidated billing edits and episode overlap edits will read the new period dates and will not require additional changes.
3.2	The existing HH Driver program will continue to accept the current copybook and route claims to the existing calculation modules for CY 2019 and earlier. If these earlier modules need to be changed, this version of the Driver will also need to be reissued.
2.6 and following	Occurrence codes 61 and 62 are new codes recently approved by the National Uniform Billing Committee (NUBC). The presence of these codes will be used to identify claims in the 'Institutional' payment groups. If no occurrence code 61 or 62 is present, the claim will be paid a "community" payment group.
4.10	The current CWF edit is A041.
5.1	The table of LUPA thresholds is in the HH Final Rule, Federal Register /Vol. 83, No. 219 /Tuesday, November 13, 2018, starting on p.56493.

X-Ref Requirement Number	Recommendations or other supporting information:
6.5.1	The existing IURs are 524P and 524Q.

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 4482, Issued: 12-20-19)

10.1.1 - Creation of HH PPS and Subsequent Refinements
(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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.

The initial implementation of the HH PPS *was effective* for dates of service on and after October 1, 2000. *Refinements to the case-mix system of* the HH PPS system were for episodes of care beginning on and after January 1, 2008. *Effective for periods of care beginning on and after January 1, 2020, the original HH PPS system is replaced with the Patient-Driven Grouping Model. Since claims for calendar year 2019 services subject to the 2008 case-mix system will remain timely until December 1, 2020, the sections that follow describe billing for services both before and after January 1, 2020.*

10.1.4 - The HH PPS Unit of Payment

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The episode *or period of care* is the unit of payment for HH PPS. The episode*/period of care* payment is specific to one individual homebound beneficiary. It pays all Medicare covered home care that is reasonable and necessary for the patient's care, including routine and nonroutine supplies used by that beneficiary during the episode/*period of care*. It is the only Medicare form of payment for such services, with the exceptions described in §10.B.

See §40 for details on billing these services.

10.1.5 - Number, Duration, and Claims Submission of HH PPS Episodes

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The beneficiary can be covered for an unlimited number of nonoverlapping episodes or periods of care. *For episodes beginning before January 1, 2020,* the duration of a single full-length episode is 60 days. Episodes may be shorter than 60 days. *For periods of care beginning on or after January 1, 2020, the duration of a period is 30 days. Periods of care may be shorter than 30 days.*

For example, an episode*/period* may end *earlier* in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened episodes, in which more home care is delivered in the same *episode/period*. Claims for episodes*/periods* may be submitted prior to the if the beneficiary has been discharged and treatment goals have been met, though payment will not be pro-rated unless more home health care is subsequently billed in the same *episode/period*.

Other claims for overlapping episodes*/periods* may also be submitted prior to the *end of that period* if the beneficiary has been discharged, dies or is transferred to another HHA. In transfer cases payment for the episode will be prorated.

The initial episode*/period* begins with the first service delivered under that plan of care. A second subsequent episode*/period* of continuous care would start on the first day after the initial episode*/period* was completed.

More than one episode*/period* for a single beneficiary may be opened by the same or different HHAs for different dates of service. This will occur particularly if a transfer to another HHA, or discharge and readmission to the same HHA, situation exists. Refer to §10.1.5.1 below for more information on multiple agencies furnishing home health services. Allowing multiple episodes*/periods* is intended to assure continuity of care and payment.

10.1.5.1 - More Than One Agency Furnished Home Health Services

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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. 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, receipt and processing of a Request for Anticipated Payment (RAP) for the home health care for the beneficiary. 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*/period* of care. When the Common Working File (CWF) indicates an episode*/period* of care is open for a beneficiary, the A/B MAC (HHH) returns to the provider the RAP of any other agency billing unless the RAP indicates a transfer or discharge and readmission situation exists.

In order to ensure that other providers who may intend to provide HH services to a beneficiary have the benefit of the most current information via the CWF, Medicare encourages primary HHAs to submit their RAPs as promptly as possible.

In rare cases, a Medicare beneficiary may receive an organ transplant and the organ donor's post-operative services are covered by the Medicare program. Since the donor is frequently not a Medicare beneficiary, services for the donor are billed using the Medicare beneficiary's Medicare number. If both the organ recipient and organ donor are receiving post-operative home health services, CWF cannot process HH PPS episodes*/periods* for both patients for the same dates of service. In this case, the HH *claim* for the organ recipient is accepted by CWF. The HH *claim* for the donor is processed by the A/B MAC (HHH) outside CWF.

10.1.5.2 - Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

If a Medicare beneficiary is covered under an MA organization during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the Medicare payment source changes. With that assessment, a RAP may be sent to Medicare to open an HH PPS episode*/period*.

If a beneficiary under fee-for-service receiving home care elects an MA organization during an HH PPS episode*/period*, the *period* will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The MA organization becomes the primary payer upon the MA organization enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

For additional information about MA eligibility changes, see section 80.

10.1.6 - Split Percentage Payment

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Medicare makes a split percentage payment for most HH PPS *episodes/periods*. The first payment is in response to a RAP, and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. There are two exceptions to split payment, the No-RAP LUPA, discussed in §§10.1.18 and 40.3 in this chapter, and the RAPs paying zero percent as discussed in §10.1.12 in this chapter.

There is a difference in the percentage split of RAP and final claim payments for initial and subsequent episodes*/periods* for patients in continuous care. For all initial episodes*/periods*, the percentage split for the two payments is 60 percent in response to the RAP, and 40 percent in response to the claim. Initial, *for* the purpose of determining the RAP percentage, *is* identified in claims processing by an admission date that matches the RAP's "From" date. For all continuous care, each of the two percentage payments is 50 percent of the estimated casemix adjusted payment.

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

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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.

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 *or 30-day period* unit of payment is made at the beginning of the episode with as little as one visit delivered.

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 A/B MAC (A). Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In HH PPS, payments are case-mix adjusted using elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and reassess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted payment is based on elements of the OASIS data set *and other information provided on the claim. P*ayments made for the episode*/period* are case-mix adjusted based on Grouper software run by the HHAs *(before January 1, 2020) or run in Medicare systems (after January 1, 2020).* Pricer software run by the A/B MAC (HHH) processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

10.1.8 - Coding of HH PPS Case-Mix Groups on HH PPS Claims: HHRGs and HIPPS Codes

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Under the home health prospective payment system, *before January 1, 2020,* a case-mix adjusted payment for a 60-day episode is made using one of 153 HHRGs. *After January 1, 2020, under the Patient-Driven Payment Model, a case-mix adjusted payment for a 30-day period of care is made using one of 432 HHRGs.* On Medicare claims, these HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes.

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 A/B MACs (HHH). 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.

10.1.9 - Composition of HIPPS Codes for HH PPS

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

For HH PPS episodes beginning on and after January 1, 2008 *and before January 1, 2020*, the distinct 5-position, alphanumeric home health HIPPS codes are 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 covered 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	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	1 (0-13 Visits)	A (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	S (Severity Level: 1)	1 (Severity Level: 1)	= min

(1st & 2nd)	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 4CHLV
- Third episode, 22 therapy visits, clinical domain score is low, function domain score is moderate, service domain score for all episodes over 20 therapies is the same (minimum) and supply severity level 6 = HIPPS code 5BHKX

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 1836 HIPPS codes in all (i.e., 153 case-mix groups times 12 NRS codes (two each per NRS severity level).
- Each HIPPS code will represent a distinct payment amount, without any duplication of payment weights across codes.

For HH PPS periods of care beginning on and after January 1, 2020, the distinct 5-position, alphanumeric home health HIPPS codes are created as follows:

- *The first position remains a numeric value, but no longer represents a grouping step. The first position represents a combination of the referral source (communty or institutional) and the period timing (early or late).*
- *The second and third positions continue to represent the clinical and functional domains of the HHRG coding system.*

- *The fourth position represents the co-morbidity category that applies to the patient.*
- *The fifth position is a placeholder for future use, required only because the field used to report HIPPS codees requires five positions.*

Position #1	***Position #2***	***Position #3***	***Position #4***	***Position #5***
Source & Timing	***Clinical Group***	***Functional Level***	***Co-Morbidity***	***Placeholder***
1 *- Community Early*	***A*** *- MMTA Other*	***A*** *- Low*	***1*** *- None*	***1***
2 *- Institutional Early*	***B*** *- Neuro Rehab*	***B*** *- Medium*	***2*** *- Low*	
3 *- Community Late*	***C*** *- Wounds*	***C*** *- High*	***3*** *- High*	
4 *- Institutional Late*	***D*** *- Complex Nursing Interv.*			
	E *- MS Rehab*			
	F *– Behavioral Health*			
	G *– MMTA Surgical Aftercare*			
	H *– MMTA Cardiac & Circulatory*			
	I *– MMTA Endrocine*			
	J *– MMTA GI/GU*			
	K *– MMTA Infectious Disease*			
	L *– MMTA Respiratory*			

Using this structure, a second period for a patient with a hospital inpatient stay during the period, in the Wounds group, high functional severity and no co-morbidity would be coded 4CC11.

HIPPS codes created using either of these structures are valid only on claim lines with revenue code 0023.

10.1.10.1 - Grouper Links Assessment and Payment

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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. To support OASIS transmission, Medicare makes HAVEN software publicly available. However, some HHAs have chosen software vendors to create their own software applications for these purposes.

Before January 1, 2020, Grouper software *run at the HHA* 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. Grouper outputs:

- case-mix groups as HIPPS (Health Insurance Prospective Payment System) codes.
- 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.

For periods of care beginning on or after January 1, 2020, the Grouper software is incorporated in Medicare claims processing systems. The Grouper will use claims data and OASIS data from the CMS quality data repository to assign the HIPPS code used for payment on the claim.

10.1.10.2 - Health Insurance Beneficiary Eligibility Inquiry for Home Health Agencies

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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*/period* 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. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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 national assessment system;
- 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*/period* will be opened on CWF with the receipt and processing of the RAP. 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 TOB 0322. The HH Pricer software will determine the first of the two HH PPS split percentage payments, which is made in response to the RAP. *See sections 10.1.12 and 40.1 for more details on RAPs.*

10.1.10.4 - Claim Submission and Processing

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The remaining split percentage payment due to an HHA for an episode*/period of care* will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services are provided for the episode and the physician has

signed the plan of care and any subsequent verbal order. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

HH claims must be submitted with TOB 0329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode*/period*. At a provider's option, any durable medical equipment, oxygen or prosthetics, and orthotics provided may also be billed on the HH PPS claim, and this equipment will be paid in addition to the episode payment.

However, osteoporosis drugs must be billed separately on TOB 034x claims, even when an episode*/period* is open. *See section 90.*

An HH PPS claim with TOB 0329 is processed in Medicare claims processing systems as a debit/credit adjustment against the record created by the RAP. The related remittance advice will show the RAP payment was recouped in full and a 100 percent payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

Claims for episodes*/periods* may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100 percent payment is made in the next calendar or fiscal year, at that year's rates, since claim payment rates are determined using the Statement Covers Period "Through" date on the claim, for all services.

Once the final payment for an episode is calculated, Medicare claims processing systems will determine whether the claim should be paid from the Medicare Part A or Part B trust fund. This A-B shift determination will be made only on claims, not on RAPs. HHA payment amounts are not affected by this process. Value codes for A and B visits (value codes 62 and 63) and dollar amounts (64 and 65) may be visible to HHAs on electronic claim remittance records, but providers do not submit these value codes.

10.1.11 - Payment, Claim Adjustments and Cancellations

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

A number of conditions can cause the episode*/period* payment or the RAP to be adjusted or cancelled.

The HHA must cancel a RAP sent in error. RAPs cannot be adjusted. They may be rebilled with appropriate information after cancellation. Type of bill 0328 is used for a cancel transaction, for both claims and RAPs.

Claims may be cancelled by HHAs or adjusted. Adjustments (TOB 0327) are used to correct information which may change payment. A cancellation is needed to change the beneficiary HICN or the HHA's provider number, if originally submitted incorrectly.

10.1.12 - Request for Anticipated Payment (RAP)

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The HHA submits a RAP to their A/B MAC (HHH) to request the initial split percentage payment for an HH PPS episode*/period*. The RAP may be submitted after receiving verbal orders and delivering at least one service to the beneficiary. Though they are submitted on standard institutional claim formats, the RAP is not considered a Medicare home health claim and is not subject to many of the stipulations applied to claims in regulations. (NOTE: RAPs may be considered claims for purposes of other Federal laws and regulations.) In particular, RAPs are not subject to the 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.

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

- a provider has lost the privilege of receiving RAP payment,
- the beneficiary is enrolled in a Medicare Advantage plan, or
- *for periods of care beginning on January 1, 2020, is a new provider with a participation date on or after January 1, 2019.*

10.1.13 - Transfer Situation - Payment Effects

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Transfer describes when a single beneficiary chooses to change HHAs during the same *episode/period*. By law under the HH PPS system, beneficiaries must be able to transfer among HHAs, and payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs submit a RAP with a transfer indicator in the condition code field on the institutional claim when an episode*/period* 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*/period* 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*/period* for the "transfer to" agency will begin on that same date. Payment will be pro-rated for the shortened episode*/period* of the "transferred from" agency, adjusted 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 when anticipating a transfer if actual services have yet to be delivered.

In rare cases, a beneficiary may elect to transfer between HHAs and their admission date at the "transfer to" HHA may fall on the day immediately following the end of an episode*/period* at the "transferred from" agency. The "transferred from" agency may not have submitted a RAP for the new episode of continuous care, so the "transfer to" HHA may not see a record of an open episode when they access the Medicare inquiry system. They will likely see the record of the immediately adjacent episode*/period* and should provide the same notifications to the beneficiary as in any other transfer situation. Documentation of these notifications may be needed if the transfer is disputed and verification is required as described in the Medicare Benefit Policy Manual, chapter 7, section 10.8.E.

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

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Under HH PPS, HHAs may discharge beneficiaries before the episode/period 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 episode/period, but the beneficiary is readmitted to the same agency in the same 60 or 30 days. Since no portion of the episode/period can be paid twice, the first payment must be pro-rated to reflect the shortened period (see §10.1.15). A new episode/period can be opened by the HHA. Medicare systems will allow this in cases where the CMS certification number (CCN) on the new RAP matches the CCN on the prior episode/period. The next episode/period will begin the date the first service is supplied under readmission (setting a new 60-day or 30-day "clock").

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. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day or 30-day period, the same episode continues. 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 period, the discharge is not recognized for Medicare payment purposes. All the HH services provided in the complete episode/period, both before and after the inpatient stay, should be billed on one claim. When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same episode/period.

Discharge should be made at the end of the *60-day certification period* in all cases if the beneficiary has not returned to the HHA. *If the beneficiary returns to HH after an inpatient stay that spans the end of the certification period, a new start of care assessment and a RAP and claim with a new admission date are required.*

For services after January 1, 2020, discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a certification period. The HHA should submit the RAP and claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge. Medicare systems will allow the HH claim to overlap the inpatient claim for dates in which there are no HH visits.

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

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened episodes*/periods*. In such cases, payment will be pro-rated. 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 *or 30-day period of care*, which will be indicated by using a Patient Discharge Status code of 06 on the final claim; or

b. When a patient transfers to another HHA during a 60-day episode *or 30-day period of care*, 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.

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

Group Code: CO
CARC: B20
RARC: N120
MSN: N/A

10.1.16 - Payment When Death Occurs During an HH PPS Episode*/Period*

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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 Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

For episodes of care beginning before January 1, 2020, 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. *For periods of care beginning on or after January 1, 2020, if an HHA providers fewer than the threshold of visits specified for the period's HHRG, they will be paid a standardized per visit payment instead of a payment for a 30- day period of care.* Such payment adjustments 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. 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 *HHRG* basis, rather than a visit basis.

If the LUPA episode*/period* is the first in a sequence of adjacent episodes*/periods* or is the only episode*/period* of care the beneficiary received, Medicare will make an additional add-on payment. For LUPA episodes ending on or after January 1, 2014, Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if *claims* are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated episode*/period* in the same sequence.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

10.1.18 - Adjustments of Payment - Special Submission Case: "No-RAP" LUPAs

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Normally, there will be two percentage payments (initial and final) paid for an HH PPS episode*/period*, the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which a HHA knows that an episode*/period* will be *below the LUPA threshold* even before *service* begins or before the RAP is submitted. In such cases and only in such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage payment that otherwise would later likely be largely recouped. Physician orders must be signed when these claims are submitted. If a HHA later needs to add visits to the claim, so that the claim will have more than four visits and no longer be a LUPA, the claim should be adjusted and the full payment based on the HIPPS code will be made.

10.1.19 - Adjustments of Payment - Confirming OASIS Assessment Items
(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

For episodes beginning before January 1, 2020, the total case-mix adjusted episode payment is based on the OASIS assessment. Medicare claims systems may confirm certain OASIS assessment items in the course of processing a claim and adjust the HH PPS payment accordingly.

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

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

10.1.19.1 - Adjustments of Episode Payment - Therapy Thresholds
(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

This section applies on to episodes beginning before January 1, 2020.

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.

The 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, meeting a threshold can change the payment equation that applies to a particular episode. Also, additional therapy visits may change the score in the service domain of the HIPPS code.

Due to the 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.

Since the number of therapy visits provided can change the payment equation used under the refined four-equation case mix model, in some cases this recoding may change several positions of the HIPPS code. In these cases, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

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 - Early or Later Episodes
(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

This section applies on to episodes beginning before January 1, 2020.

The HH PPS uses a 4-equation case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early episode of care (1st or 2nd episode in a sequence of adjacent covered episodes) or a later episode of care (the 3rd episode and beyond in a sequence of adjacent covered episodes).

Early episodes include not only the initial episode in a sequence of adjacent covered episodes, but also the next adjacent covered episode, if any, that followed the initial episode. Later episodes are defined as all

adjacent episodes beyond the second episode. Episodes are considered to be adjacent if they are separated by no more than a 60-day period between claims.

The 60-day period to determine a gap that will begin a new sequence of episodes is generally counted from the calculated 60-day end date of the episode. That is, in most cases Medicare systems will count from ''day 60'' of an episode without regard to an earlier discharge date in the episode. The exception is episodes subject to PEP adjustment. In PEP cases, Medicare systems will count 60 days from the date of the last billable home health visit provided in the PEP episode.

Any Original Medicare covered episode for a beneficiary is considered in determining adjacent covered episodes. A sequence of adjacent covered episodes is not interrupted if a beneficiary transfers between HHAs. Episodes covered by Medicare Advantage plans are not considered in determining adjacent episodes.

Example: A patient is admitted to Agency A on July 5th into a payment episode that ends on the date of Sept 2nd. The patient is then recertified on Sept 3rd, with an end of episode date of November 1st. Agency B admits on Jan 1.

When determining if two eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1. Continue counting to, and including, the first day of the next episode.

In this example, November 1st was the last day of the episode and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent.

The episode starting January 1st would be reported by Agency B as “early”. December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “later.”

HHAs report whether an episode is “early” or “later” using OASIS item M0110. This OASIS information is then used to determine the HIPPS code used for billing. The first position of the HIPPS code shows whether an episode is “early” or “later.” Since HHAs may not always have complete information about previous episodes, the HIPPS code is validated by Medicare systems. The Common Working File reads the episode history described in section 30.5 to determine whether an episode has been coded correctly based on the most current information available to Medicare. If the HIPPS code disagrees with Medicare’s episode history, the claim will be recoded.

The receipt of any episode may change the sequence of previously paid claims. For instance, a claim may be paid as “early” because the HHA was not aware of prior episodes and the previous HHA had not billed for the prior episodes. When the earlier dated episodes are received, Medicare systems will initiate an automatic adjustment to recode the previously paid claim and correct its payment.

When claims are recoded, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

10.1.19.3 - Adjustments of Episode Payment – Validation of HIPPS

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

Recoding Based on OASIS-calculated HIPPS Codes

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

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

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

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

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

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

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

When an OASIS Assessment Has Not Been Submitted

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

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

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

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

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

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

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

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

10.1.21 - Adjustments of Payment - Outlier Payments

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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 *episodes or 30-day periods of care*, 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.

For episodes ending before January 1, 2017, outlier determinations shall be made by comparing:

- The episode's estimated cost, calculated as sum 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.

For episodes ending on or after January 1, 2017, outlier determinations shall be made by comparing:

- The episode's estimated cost, calculated as the sum of the products of number of units of each discipline on the claim and each wage-adjusted national standardized per unit rate for each discipline (1 unit = 15 minutes); with

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

If the estimated cost is greater than the wage adjusted and case-mix specific payment amount plus the wage adjusted fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the estimated cost exceeds the sum will be paid to the HHA as an outlier payment. For episodes*/periods* ending on or after January 1, 2017, units considered for outlier payment are subject to a limit of 32 units (8 hours), summed across the six disciplines of care, per date of service.

For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in 1 day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of cost in order to cap the estimation of cost at 8 hours of care, summed across the six disciplines, per day.

The outlier payment is a payment for an entire episode*/period*, and therefore carried only at the claim level on the paid claim. It is not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment shall be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim 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*/periods* of care for eligible beneficiaries is unlimited.

Outlier payments made to each HHA are subject to an annual limitation. Medicare systems ensure that outlier payments comprise no more than 10 percent of the HHA's total HH PPS payments for the year. Medicare systems track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier payments that each HHA has received. When each HH PPS claim is processed, Medicare systems compare these two amounts and determine whether the 10 percent has currently been met.

If the limitation has not yet been met, any outlier amount is paid normally. (Partial outlier payments are not made.) If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the episode are paid but any outlier amount is not paid.

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

Group Code: CO
CARC: 119
RARC: N/A
MSN: N/A

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

These adjustments appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (TOB 032I) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

10.1.22 - Multiple Adjustments to Payments

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The payment adjustments as described above apply only to claims, not to requests for anticipated payment (RAPs). Claims that are paid on a per-visit or LUPA basis are not subject to PEP adjustment *and* 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. Payment adjustments are calculated in Pricer software (see section 70).

40.1 - Request for Anticipated Payment (RAP)

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

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

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

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

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

Provider Name, Address, and Telephone Number

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

Patient Control Number

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

Type of Bill

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

032x - Home Health Services under a Plan of Treatment

4th Digit	Definition

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

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

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

Statement Covers Period (From-Through)

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

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

Patient Name/Identifier

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

Patient Address

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

Patient Birth Date

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

Left blank if the full correct date is not known.

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

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

Patient Discharge Status

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

Condition Codes

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

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

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

Enter "Remarks" indicating the reason for cancellation.

Occurrence Codes and Dates

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

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

Value Codes and Amounts

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

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

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

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

Revenue Code and Revenue Description

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

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

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

Service Date

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

The one exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's plan of care requires that the beneficiary is seen every 6 weeks and there is a recertification, the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare's Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment.

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

Service Units

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

Total Charges

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

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

Payer Name

Required - See Chapter 25.

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

Release of Information Certification Indicator

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

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

Insured's Name

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

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - On RAPs with "From" dates before January 1, 2020, the HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to

individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

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

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

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

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

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

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

Document Control Number (DCN)

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

Principal Diagnosis Code

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

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

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

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

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

Other Diagnosis Codes

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

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

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

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

Attending Provider Name and Identifiers

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

Remarks

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

40.2 - HH PPS Claims

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Home health services under a plan of care are paid based on a 60-day episode of care (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode or period will usually be made in two parts. After a RAP has been paid and an episode or period has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due.

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

Billing Provider Name, Address, and Telephone Number

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

Patient Control Number and Medical/Health Record Number

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

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

Type of Bill

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

032x - Home Health Services under a Plan of Treatment

4th Digit - Definition

> 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.
>
> 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

9 - Final Claim for an HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace codes 7, or 8.

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

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

Statement Covers Period

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

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

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

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

Patient Name/Identifier

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

Patient Address

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

Patient Birth Date

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

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

Patient Discharge Status

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

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a PEP adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode or 30-day period, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the episode or period. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

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

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

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

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

Condition Codes

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

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

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

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

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

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

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

Occurrence Codes and Dates

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

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

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

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

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

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

Occurrence Span Code and Dates

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

Value Codes and Amounts

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

Provider-submitted codes:

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

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

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. A/B MACs (HHH) always place condition code 61 on the claim along with this value code.)
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

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

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

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

Revenue Code and Revenue Description

Required

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

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

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

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

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

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

042x	Physical Therapy Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043x	Occupational Therapy Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
044x	Speech-Language Pathology Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
055x	Skilled Nursing Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
056x	Medical Social Services Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
057x	Home Health Aide (Home Health) Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

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

Revenue Codes for Optional Billing of DME

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

0274	Prosthetic/Orthotic Devices Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.
029x	Durable Medical Equipment (DME) (Other Than Renal) Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.
060x	Oxygen (Home Health) Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

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

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

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

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

Validating Required Reporting of Supply Revenue Code

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

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

Medicare systems will return the claim to the HHA if the HIPPS code indicates non-routine supplies were provided and supply charges are not reported on the claim. When the HHA receives a claim returned for

this reason, the HHA must review their records regarding the supplies provided to the beneficiary. The HHA may take one of the following actions, based on the review of their records:

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

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Speech-Language Pathology (revenue code 044x)

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

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

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

Skilled Nursing (revenue code 055x)

General skilled nursing:

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

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

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

Care plan oversight:

For dates of service before January 1, 2017:

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

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

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

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

or hospice setting).

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

Training:

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

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

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

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

Medical Social Services (revenue code 056x)

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

Home Health Aide (revenue code 057x)

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

Regarding all skilled nursing and skilled therapy visits

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

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

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

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

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

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

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

Service Date

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

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

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

Service Units

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

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

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

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

Total Charges

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

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

Non-covered Charges

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

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

Payer Name

Required - See chapter 25.

Release of Information Certification Indicator

Required - See chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

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

Patient's Relationship To Insured

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

Insured's Unique Identifier

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

Insured's Group Name

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

Insured's Group Number

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

Treatment Authorization Code

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

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

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

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

On claims with "From" dates on of after January 1, 2020, treatment authorization codes are no longer required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim

Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

Document Control Number (DCN)

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

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

Employer Name

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

Principal Diagnosis Code

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

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

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

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

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

Other Diagnosis Codes

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

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

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

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

Attending Provider Name and Identifiers

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

Other Provider (Individual) Names and Identifiers

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

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

Remarks

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

70.2 - Input/Output Record Layout

(Rev. 4482, Issued: 12-20-19, Effective: 01-01-20, Implementation: 07-01-19)

The required data and format for the HH Pricer input/output record for episodes beginning before January 1, 2020 are shown below:

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

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

File Position	Format	Title	Description
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Fields for five more occurrences of all HRG/HIPPS code related fields defined above. Not used.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-262	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.
263-270	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
271-279	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
280-288	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.

File Position	Format	Title	Description	
289-297	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.	
298-532	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
533-534	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates before Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 03x9 or adjustment TOB

File Position	Format	Title	Description
535-539	9(5)	REVENUE - SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.
540-544	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.
545-553	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.
554-562	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.
563-567	9(3)V9(2)	LUPA-ADD-ON-PAYMENT	Output item: For claim "Through" dates before January 1, 2014, the add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim. For claim "Through" dates on or after January 1, 2014, zero filled.
568	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the RAP or claim. The indicator is set to '1' in all other cases.
569	X	RECODE-IND	Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0 = default value 1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 3 = HIPPS code shows early episode, should be later episode
570	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values: 1 = early episode 2 = late episode

File Position	Format	Title	Description
571	X	CLINICAL-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment authorization code.
572	X	FUNCTION-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.
573	X	CLINICAL-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.
574	X	FUNCTION-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.
575	X	CLINICAL-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code.
576	X	FUNCTION-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code.
577	X	CLINICAL-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.
578	X	FUNCTION-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
579-588	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
589-599	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
600-604	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from field 30 of the provider specific file.

File Position	Format	Title	Description
605-613	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.
614-622	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.
623-650	X(28)	FILLER	

The required data and format for the HH Pricer input/output record for periods of care beginning on or after January 1, 2020 are shown below:

File Position	**Format**	**Title**	**Description**
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments).
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
46-56	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.

File Position	Format	Title	Description
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only episode in a sequence. The indicator is set to '0' in all other cases.
96	X	PEP-IND	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
104-109	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
110-118	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
119-122	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
125-127	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.

File Position	Format	Title	Description	
128-132	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.	
133-140	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.	
141-149	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
150-158	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
159-167	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.	
168-402	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
403-404	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Initial percentage payment, 0%
			04	Initial percentage payment, *20%*
			05	*No longer used.*
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP

File Position	Format	Title	Description	
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
405-409	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
410-418	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. Added to the claim as a value code 17 amount.	
419-427	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
428-436	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.	
437-445	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.	
446-650	X(205)	FILLER		

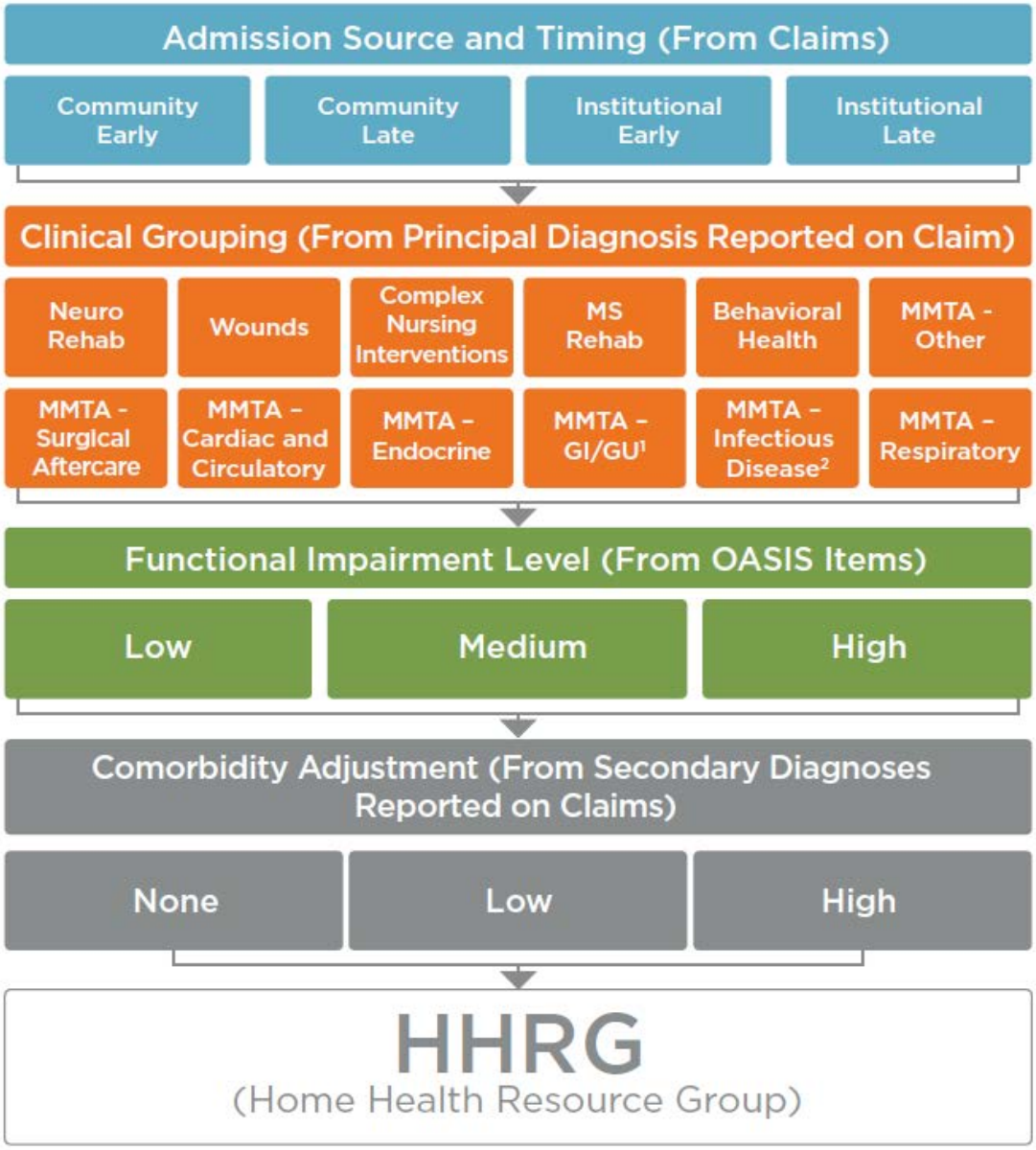
Input records on RAPs will include all input items except for "REVENUE" related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

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

the remittance advice. If the return code is 14, the Medicare claims processing system will apply the H-HHA-REVENUE-ADD-ON-VISIT-AMT to the earliest line item with the corresponding revenue code.

ATTACHMENTS: 6

Attachment 1 - **HHRGs and HIPPS Codes in HH PPS Case-Mix Reform**
This diagram summarizes the case-mix system for the PDGM.



Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

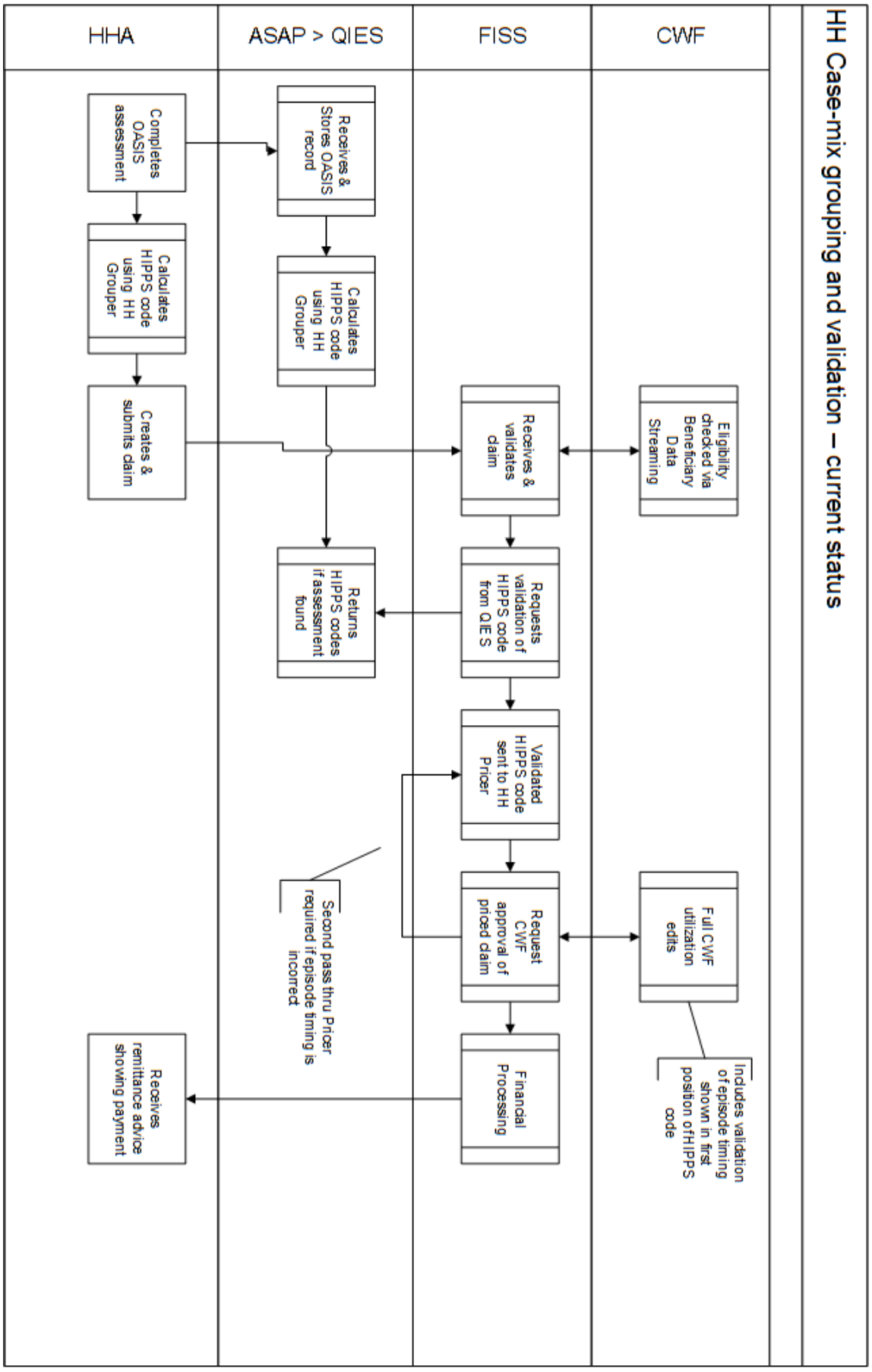
1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

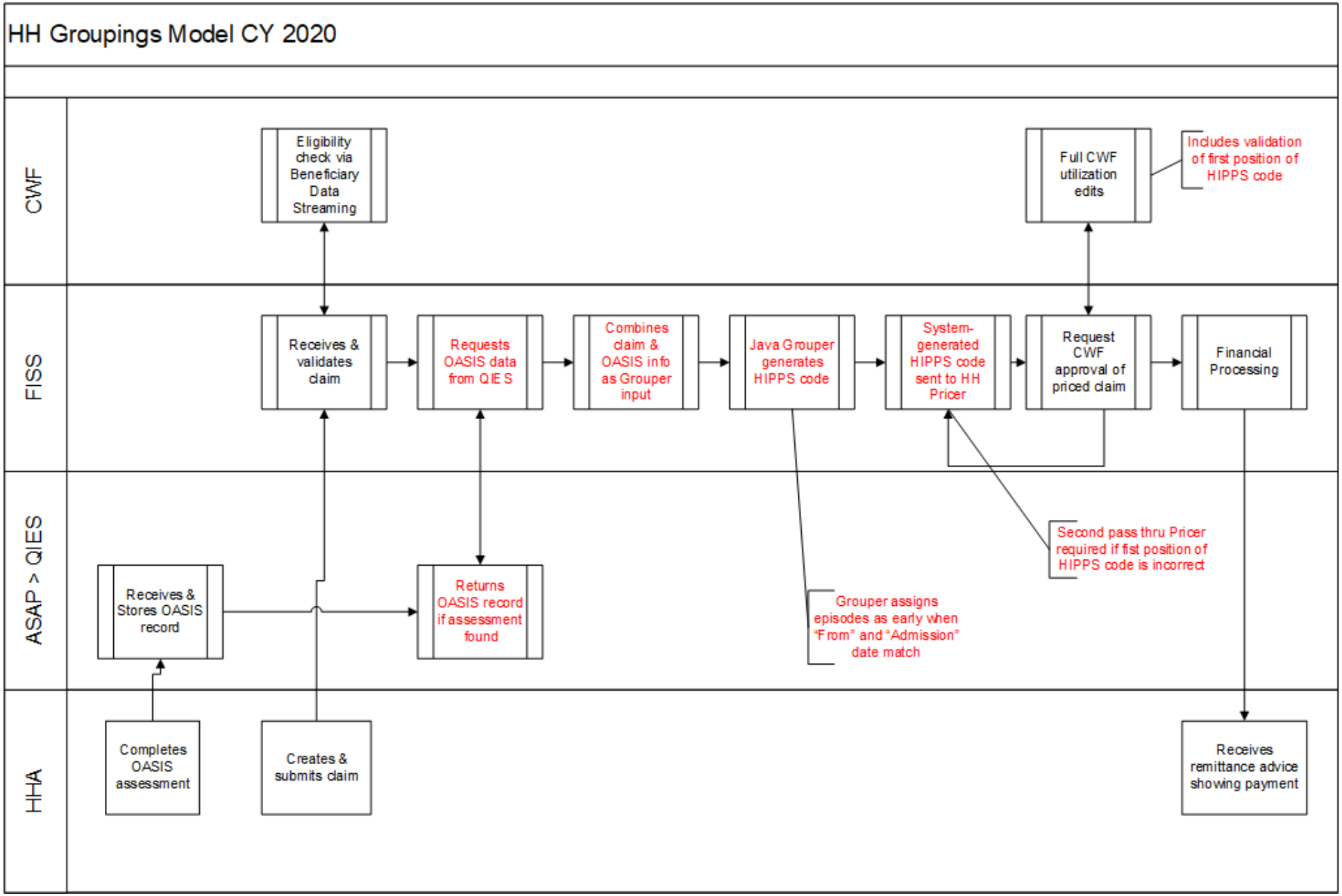
The HHRG system above will be recorded on claims as HIPPS codes, using the following code structure:

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	**Clinical Group**	**Functional Level**	**Co-Morbidity**	**Placeholder**
1 - Community Early	**A -** MMTA Other	**A -** Low	**1 -** None	**1**
2 - Institutional Early	**B -** Neuro Rehab	**B -** Medium	**2 -** Low	
3 - Community Late	**C -** Wounds	**C -** High	**3 -** High	
4 - Institutional Late	**D -** Complex Nursing Interv.			
	E - MS Rehab			
	F – Behavioral Health			
	G – MMTA Surgical Aftercare			
	H – MMTA Cardiac & Circulatory			
	I – MMTA Endrocine			
	J – MMTA GI/GU			
	K – MMTA Infectious Disease			
	L – MMTA Respiratory			

Using this structure, a second period for a patient with a hospital inpatient stay during the period, in the Wounds group, high functional severity and no co-morbidity would be coded **4CC11**.

Attachment 2 – HH PPS Process Flows – Current and To-Be




HH Groupings Model CY 2020
CWF
FISS
ASAP > QIES
HHA
Eligibility check via Beneficiary Data Streaming
Full CWF utilization edits
Includes validation of first position of HIPPS code
Receives & validates claim
Requests OASIS data from QIES
Combines claim & OASIS info as Grouper input
Java Grouper generates HIPPS code
System-generated HIPPS code sent to HH Pricer
Request CWF approval of priced claim
Financial Processing
Second pass thru Pricer required if fist position of HIPPS code is incorrect
Receives & Stores OASIS record
Returns OASIS record if assessment found
Grouper assigns episodes as early when "From" and "Admission" date match
Completes OASIS assessment
Creates & submits claim
Receives remittance advice showing payment

Current FISS Claim Path Locations HHA Future State

Adjudication Stage	Claim Path	Reason Codes Assigned	Functional Driver	Hospital Inpat. Part A 11X	Hospital Swing Beds 18X	SNF Inpatient Part A 21X	Home Health 32X	Religious Non-Med 41X 51X	ESRD Freestanding 72X	Hospice 81X 82X	Outpat, etc. XXX
ONLINE CREATION	02	309xx	FSSO2410	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
UNIBILL EDITOR	04	10125 - 19999	FSSO2420	O04	O04	O04	O04	O04	O04	O04	O04
CONSISTENCY (I)	05	31000 - 31299	FSSO2430	O05	O05	O05	O05	O05	O05	O05	O05
CONSISTENCY (II)	06	31300 - 31649,	FSSO2440	O06	O06	O06	O06	O06	O06	O06	O06
ADM,MCE,IOCE, IP GRPR	15	31650 - 32999, Wxxxx	FSSO2450	O15	O15	O15	O15	O15	O15	O15	O15
DUPLICATE CHECKING	25	38000 - 38599	FSSO2460	O25	O25	O25	O25	O25	O25	O25	O25
ENTITLEMENT,QIES, **HHPPS GRPR**	30	37069-37071, 39xxx	FSSO2470	O30	O30	O30	O30	O30	O30	O30	O30
LAB HCPCS	35	36300 - 36999	FSSO2480	O35			O35	O35		O35	O35
ESRD	40	36000 - 36299	FSSO2490						O40		
MEDICAL POLICY	50	5xxxx, 7xxxx	FSSO2500	O50	O50	O50	O50		O50	O50	O50
SEQUENTIAL BILLING	53	37400 - 37402	FSSO25A0							O53	
UTILIZATION	55	39500 - 39699	FSSO2510	O55	O55	O55	O55	O55	O55	O55	O55
HHPPS PRICER	63	37042, 37215 -	FSSO2590				O63				
IPPS/IRF/FQHC/LTCH/SNF PRICERS	65	39700 - 39799	FSSO2520	O65	O65	O65					
PAYMENT	70	37500 - 37999	FSSO2530	O70	O70	O70	O70	O70	O70	O70	O70
MSP PRIMARY	80	38600 - 38999	FSSO2540	O80	O80	O80	O80	O80	O80	O80	O80
MSP SECONDARY	85	34000 - 34499	FSSO2550	O85	O85	O85	O85	O85	O85	O85	O85
CLAIM CLEAN-UP	89	NCOVD, 319xx,	FSSO2920	O89	O89	O89	O89	O89	O89	O89	O89
CWF	90	None going to CWF	FSSO2DNE	B90	B90	B90	B90	B90	B90	B90	B90
SESSION TERM	99	37151 - 37199	FSSO2600	B99	B99	B99	B99	B99	B99	B99	B99

RED = key HHA locations **BLUE = New Process for PDGM**

Note: Claims released from medical review will bypass QIES and cycle back through the HH PPS GRPR unless a HIPPS code is manually entered on claim p. 31 and payment IND is set to M.

Attachment 3: Record Layout for Data File Exchanged Between FISS & QIES

(Changes from current process in Red Italics):

File Position	Format	Title	Description
FISS-Updated Elements in the Finder File			
1-12	X(12)	HIC	The beneficiary HIC number from the claim. Updated identically on all 3 claim types.
13 -35	9(23)	DCN	The claim's document control number. Updated identically on all 3 claim types.
36 -43	9(8)	DOB	The beneficiary date of birth from the claim. Updated identically on all 3 claim types.
44-49	X(6)	CCN	The provider CCN from the claim. Updated identically on all 3 claim types.
50-57	9(8)	FROM	The Statement Covers "From" date from the claim. Updated identically on all 3 claim types.
58-65	9(8)	THRU	The Statement Covers "Through" date from the claim. Updated identically on all 3 claim types.
66-70	X(5)	PROV-HIPPS	The provider-submitted HIPPS code SNF/SB claims: updated from the HCPCS field of the revenue code 0022 line. HH claims: updated from the HCPCS field of the revenue code 0023 line. IRF claims: updated from the HCPCS field of the revenue code 0024 line.
71-79	X(9)	ASSES-DATE	Assessment date information from the claim. SNF/SB claims: updated from the occurrence code 50 date that corresponds to the HIPPS code in the PROV-HIPPS field and the filler character A. HH claims: *updated from occurrence code 50 date on the claim and the filler character A.* IRF claims: updated from the admission date on the claim and the filler character A.
80-82	9(3)	LINE-NUMBER	The line number of the service line to which the response information should be associated.
83-93	X(11)	MBI	The Medicare Beneficiary Identifier (MBI) number submitted on the claim or the MBI crosswalked from the HIC. Updated identically on all 3 claim types.
94	X(1)	ID IND	Indicates the type of beneficiary ID that was submitted on the claim, udpated as follows: 'H' if claim was submitted with HICN 'M' if claim was submitted with MBI.
QIES Tool-Updated Elements Added to the Response File			
95-99	X(5)	RETURN-HIPPS1	One of two system-generated HIPPS codes copied from the assessment record, if found. SNF/SB claims: updated from the therapy HIPPS code on the assessment. HH & IRF claims: Updated from the re-calculated HIPPS code on the assessment*, for claim From dates before January 1,*

File Position	Format	Title	Description
			2020. For claim From dates on or after January 1, 2020, updated with NNNNN unless an assessment is not found. All claims: Updated with ZZZZZ if no corresponding assessment is found.
100-104	X(5)	RETURN-HIPPS2	Second of two system-generated HIPPS codes copied from the assessment record, if found: SNF/SB claims: updated from the non-therapy HIPPS code on the assessment. HH & IRF claims: zero filled. All claims: Updated with ZZZZZ if no corresponding assessment is found.
105-112	9(8)	SUB-DATE	The assessment submission date from the assessment record. Zero filled if no corresponding assessment is found.
113-120	9(8)	ASSES-DATE-CONV	HH claims: The assessment date converted from the hexavigesimal coded date sent in the finder file*, for claim From dates before January 1, 2020. For claim From dates on or after January 1, 2020, the ASSESS-DATE used from the Finder portion* IRF & SNF/SB claims: Zero filled.
121-135	X(15)	ASSES-ID	The assessment unique identifier from the assessment record. Zero filled if no corresponding assessment is found.
136-200	X(65)	Filler	*IRF &SNF/SB claims: Filler*
For HH Claims with From dates on or after January 1, 2020, QIES returns the following OASIS items:			
136	*9(1)*	*M1033-HOSP-RISK-HSTRY-FALLS*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
137	*9(1)*	*M1033-HOSP-RISK-WEIGHT-LOSS*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
138	*9(1)*	*M1033-HOSP-RISK-MLTPL-HOSPZTN*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
139	*9(1)*	*M1033-HOSP-RISK-MLTPL-ED-VISIT*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
140	*9(1)*	*M1033-HOSP-RISK-MNTL-BHV-DCLN*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
141	*9(1)*	*M1033-HOSP-RISK-COMPLIANCE*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
142	*9(1)*	*M1033-HOSP-RISK-5PLUS-MDCTN*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
143	*9(1)*	*M1033-HOSP-RISK-CRNT-EXHSTN*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
144	*9(1)*	*M1033-HOSP-RISK-OTHR-RISK*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*

File Position	Format	Title	Description
145	*9(1)*	*M1033-HOSP-RISK-NONE-ABOVE*	*Valid values: 0 = unchecked (No), 1 = checked (Yes), 9 = no match*
146-147	*9(2)*	*M1800-CRNT-GROOMING*	*Valid values: 00, 01, 02, 03 or 99 (if no match)*
148-149	*9(2)*	*M1810-CRNT-DRESS-UPPER*	*Valid values: 00, 01, 02, 03 or 99 (if no match)*
150-151	*9(2)*	*M1820-CRNT-DRESS-LOWER*	*Valid values: 00, 01, 02, 03 or 99 (if no match)*
152-153	*9(2)*	*M1830-CRNT-BATHG*	*Valid values: 00, 01, 02, 03, 04, 05, 06 or 99 (if no match)*
154-155	*9(2)*	*M1840-CRNT-TOILTG*	*Valid values: 00, 01, 02, 03, 04 or 99 (if no match)*
156-157	*9(2)*	*M1850-CRNT-TRNSFRNG*	*Valid values: 00, 01, 02, 03, 04, 05 or 99 (if no match)*
158-159	*9(2)*	*M1860-CRNT-AMBLTN*	*Valid values: 00, 01, 02, 03, 04, 05, 06 or 99 (if no match)*
160-200	*X(41)*	*Filler*	*Filler*

Attachment 4: Record Layout for FISS – HH Grouper Interface

Input items:

Field Name	Length	Position	# of Occ	Source	Description	Values	Comments
Claim ID	24	1	1	Claim	Patient Claim ID	Alphanumeric	
From Date	8	25	1	Claim	Claim From date	Date: MMDDYYYY	FISS moves the Statement Covers "From" date on the claim to this field.
Period Timing	1	33	1	FISS	Determination of initial or subsequent period	1 = Early 2 = Late	FISS sets 1 when claim From date matches Admission date or when receive CWF sequence edit. Otherwise, sets 2.
Referral Source	2	34	1	Claim	Determination of beneficiary referral to HHA	Occurrence Codes for Institutional referral: 61: Acute hospital 62: SNF, IRF, LTCH or IPF Default (no institutional Occurrence Code present): Community referral	One code field needed. Provider will only report a single discharge date per claim. Grouper needs only Occurrence code, not date.
Principal Diagnosis	8	36	1	Claim	ICD-10-CM primary diagnosis code (FL 67)	8-character diagnosis code (includes POA in 8th char)	Noted that while POA indicator is not needed in HH, we are including the 8th character for any possible future needs.
Secondary Diagnoses	8	44	24	Claim	ICD-10-CM diagnosis codes (FL 67 A-Q)	8-character diagnosis codes, up to 24 (includes POA in 8th char)	All 24 sdx codes will be moved by FISS, though future policy decision needed whether all are used for comorbidity identification.
FILLER-Item 1	8	236	5	NA	Potential future dx		
Functional Level Items (see OASIS items listed below):				OASIS	Determination of functional score: Grouper to calculate Functional Level as Low, Medium or High (3rd HIPPS character)	Using fields M1033, M1800, M1810, M1820, M1830, M1840, M1850, M1860	
M1033-HOSP-RISK-HSTRY-FALLS	1	276	1	FISS	Risk for hospitalization – falls	0 = No 1 = Yes	
M1033-HOSP-RISK-WEIGHT-LOSS	1	277	1	FISS	Risk for hospitalization – weight loss	0 = No 1 = Yes	
M1033-HOSP-RISK-MLTPL-HOSPZTN	1	278	1	FISS	Risk for hospitalization – multiple hospitalizations	0 = No 1 = Yes	
M1033-HOSP-RISK-MLTPL-ED-VISIT	1	279	1	FISS	Risk for hospitalization – multiple emergency department visits	0 = No 1 = Yes	
M1033-HOSP-RISK-MNTL-BHV-DCLN	1	280	1	FISS	Risk for hospitalization – mental behavior decline	0 = No 1 = Yes	
M1033-HOSP-RISK-COMPLIANCE	1	281	1	FISS	Risk for hospitalization – compliance	0 = No 1 = Yes	
M1033-HOSP-RISK-5PLUS-MDCTN	1	282	1	FISS	Risk for hospitalization – currently taking 5 or more medications	0 = No 1 = Yes	
M1033-HOSP-RISK-CRNT-EXHSTN	1	283	1	FISS	Risk for hospitalization – exhaustion	0 = No 1 = Yes	
M1033-HOSP-RISK-OTHR-RISK	1	284	1	FISS	Risk for hospitalization – other risks	0 = No 1 = Yes	
M1033-HOSP-RISK-NONE-ABOVE	1	285	1	FISS	Risk for hospitalization – none of the above	0 = No 1 = Yes	
M1800-CRNT-GROOMING	2	286	1	FISS	Grooming	00, 01, 02, 03	
M1810-CRNT-DRESS-UPPER	2	288	1	FISS	Dress upper body	00, 01, 02, 03	

M1820-CRNT-DRESS-LOWER	2	290	1	FISS	Dress lower body	00, 01, 02, 03	
M1830-CRNT-BATHG	2	292	1	FISS	Bathing	00, 01, 02, 03, 04, 05, 06	
M1840-CRNT-TOILTG	2	294	1	FISS	Toileting	00, 01, 02, 03, 04	
M1850-CRNT-TRNSFRNG	2	296	1	FISS	Transferring	00, 01, 02, 03, 04, 05	
M1860-CRNT-AMBLTN	2	298	1	FISS	Ambulation	00, 01, 02, 03, 04, 05, 06	
FILLER-Item 2	301	300	1	NA	Future expansion		

Output items:

Field Name	Length	Position	# of Occ	Source	Description	Values	Comments
Version Used	7	601	1	Grouper Input	Version defining grouper used to produce HIPPS code based on Assessment date passed as input. Positions defined as: XX. = Grouper Version number X. = Sequential release number XX = Year	tbd	The Grouper Version would increment with each annual release in October; sequential release number would be 0 or 1 depending on January or October release; current year is represented in final two positions
HIPPS Code	5	608	1	Grouper Input	5-digit alphanumeric code defining grouping results. Positions defined as: 1st Position = Episode Timing and Referral Source (1, 2, 3 or 4) 2nd Position = Clinical Group (A thru L) 3rd Position = Functional Level (A, B or C) 4th Position = Comorbidity Level (1, 2 or 3) 5th Position = Placeholder (1)	HIPPS code represents the outcome of grouping results	Example of HIPPS code: 4CC11: 4 = Late Institutional C = Wound care group C = High functional level 1 = No comorbiditiy 1 = Placeholder
Validity Flag	2	613	1	Grouper Input	Identifies clinical issues that may impact HIPPS code assigned or ungroupable results.	TBD, alphanumeric	
Grouper Return Code	2	615	1	Grouper	Identifies technical issues that may terminate grouper processing and result in no HIPPS code assigned.	TBD	
FILLER - Item 3	84	617	1	Filler	Future expansion		

Attachment 5 – HH Pricer Specifications

Input/Output Record Layout Instructions

The required data and format for the HH Pricer input/output record are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments).
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
46-56	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period “From” date, copied from the claim form. Date format must be CCYYMMDD.

File Position	Format	Title	Description
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only episode in a sequence. The indicator is set to '0' in all other cases.
96	X	PEP-IND	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
105-110	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
111-119	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
120-123	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
124-126	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.

File Position	Format	Title	Description	
127-131	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.	
132-139	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.	
140-148	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
149-157	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
158-166	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055x, then this is the national per-visit amount multiplied by 1.8714. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6841. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6293.	
167-401	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
402-403	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Not used.
			04	Not used.
			05	Not used.

File Position	Format	Title	Description	
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
404-408	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
409-417	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. Added to the claim as a value code 17 amount.	
418-426	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
427-435	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.	
436-444	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.	
445-650	X(206)	FILLER		

Attachment 6 – Mock-up of FISS screen to review OASIS items

This mock-up is provided by the FISS maintainer based on earlier CMS proposal drafts.

```
MAP103N   PG 43           FISS MAINTAINER - CICSTT3         APLCITT3
XX/XX/XX
XXXXXX    SC                 XXXX CLAIM  INQUIRY            CXXXXXXX
XX:XX:XX
DCN XXXXXXXXXXXXXXXXX        HIC XXXXXXXXXX   STMT COV FROM XXXXXX  TO
XXXXXX
ST/LOC X XXXXX  PROV XXXXXX  MBI              TOB 32X  RECT XXXXXX TRN
XXXXXX

                          QIES/OASIS INFORMATION
                                              USERID XXXXXX__ DT ENTERD XX/XX/XX
 M1033-HSTRY-FALL    OA  0 MR 01     M1033-WEIGHT-LOSS    OA  0 MR 01
 M1033-MLTPL-HOSPZTN OA  0 MR 01     M1033-MLTPL-ED-VISIT OA  0 MR 01
 M1033-MNTL-BHV-DCLN OA  X MR XX     M1033-COMPLIANCE     OA  X MR XX
 M1033-5PLUS-MDCTN   OA  X MR XX     M1033-CRNT-EXHSTN    OA  X MR XX
 M1033-OTHER-RISK    OA  X MR XX     M1033-NONE-ABOVE     OA  X MR XX
 M1800-CRNT-GROOMING OA  X MR XX     M1810-DRESS-UPPER    OA  X MR XX
 M1820-DRESS-LOWER   OA  X MR XX     M1830-CRNT-BATHG     OA  X MR XX
 M1840-CRNT-TOILTG   OA  X MR XX     M1850-CRNT-TRNSFRNG  OA  X MR XX
 M1860-CRNT-AMBLTN   OA  X MR XX



+@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@
+@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@@
```