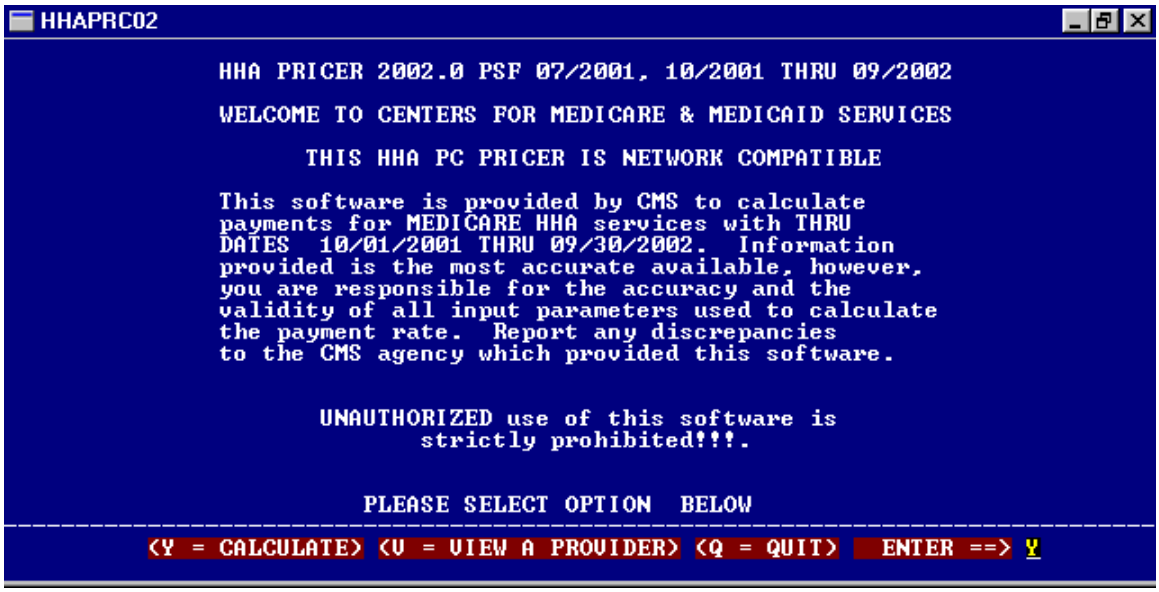
3. How do I calculate payments?

3.1 Navigating the screens of the PC Pricer

Opening the program:

To launch the PC Pricer, open the HHAPRC*xx* folder (as shown above) and double click on the file named HHAPRC*xx*.EXE. A CMS masthead screen like the one pictured on the cover page of this manual will appear. The cursor will be blinking under the letter C in the lower right-hand corner of the screen, indicating the drive on which the program is loaded. Press the "Enter" key on your keyboard to advance to the next screen.

The welcome screen below will be displayed.



There are three options available at the ENTER> field in the bottom left corner, to calculate (Y), to view a provider (V) [see Chapter 4] or to quit. The default setting is a Y to calculate, so press the Enter key on your keyboard to advance to the RAP/claim entry screen [see 3.2 below].

Basic Navigation:

The primary tool to navigate around the RAP/claim entry screen and other screens in the program is the Tab key on your keyboard. The Tab key jumps the cursor forward from one entry field to the next. You may also advance through fields by pressing the spacebar, but this advances through each position of a field one at a time before advancing to the next field and is much more cumbersome than tabbing. Use the Shift and Tab keys together to reverse back through fields (for instance if you spot a data entry error or a skipped field).

The End key on the keyboard moves you to the option field at the bottom left of the screen. From this position, the Enter key will cause the software to calculate a payment. However, it is not necessary to tab to the option field. Pressing the Enter key at any time will initiate the payment calculation. If any information required to calculate a payment is missing when the Enter key is pressed, an error message will be displayed that indicates the missing information.

The fields on all of the screens of the PC Pricer are not sensitive to input from your PC's mouse. That is, you cannot position the cursor at a particular field by clicking the mouse over that field. Only the title bar at the top of the PC Pricer display is sensitive to the mouse. Like most Windows screens, clicking and holding the mouse button on this bar allows you to drag the screen around your desktop. The minimize, maximize and exit buttons in the top right-hand corner also respond to the mouse.

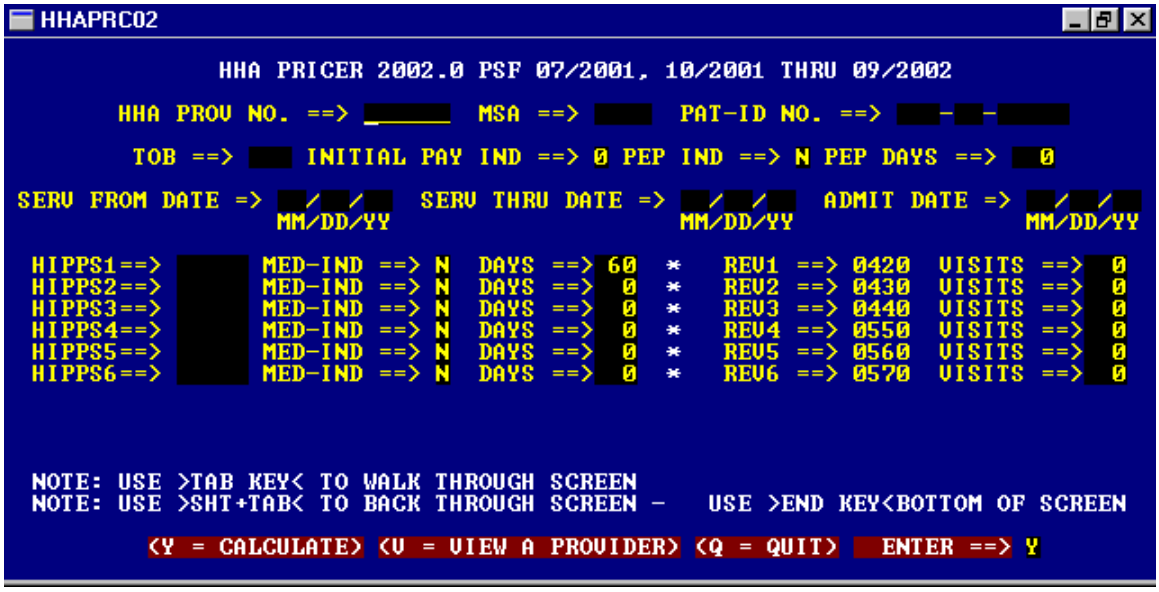
Closing the program:

There are two ways to terminate the program. Using the mouse, you can click the exit button in the title bar. This causes a message box to display "Application Terminated." Clicking the "Okay" button in this message box completes your exit from the program. Entering "Q" in the ENTER> field at the bottom left displays the same message box.

Message Box:

3.2 Definition of the fields on the RAP/claim entry screen

The information provided below defines the information required by each field on the RAP/claims entry screen. It also indicates whether the field is required or optional for payment calculation, and provides an explanation of each field's purpose. Fields marked "required, with default" are filled automatically by the program with the value most likely to apply. Normally, these fields may be tabbed over, but they may be overwritten with other values as necessary.



HH PROV NO. – Required. Home health agency provider number. Enter your agency's six digit Medicare provider number in this field. The PC Pricer contains a file of all the provider numbers that were reported to CMS by a Regional Home Health Intermediary as an active HHA provider as of the quarter in which your version of the software was created. If your provider number is not this file, your RAP/claim will be calculated with zero payment and you will receive a message reading "No provider number found". If this occurs, or if you are an entity other than an HHA, you may enter a new provider in the provider file (see Chapter 4).

MSA – Required. Metropolitan statistical area. Enter the metropolitan statistical area code that corresponds to the location where the Medicare beneficiary received services. This code is the same code that is entered on the RAP/claim in association with value code 61 in FLs 39-41 of the UB-92. This code is used to determine the wage index value to apply in payment calculations.

PAT-ID NO. – Optional. Patient identification number. This field is designed to accommodate a Medicare health insurance claim (HIC) number (the beneficiary's Social Security Number plus a character suffix). Any identifying number may be entered in this field. Positions left blank will be filled with zeroes. This item may be useful to the home health agency in associating a printed payment report with a patient's file.

TOB – Required. Type of bill. The type of bill code reported on the RAP/claim submitted to Medicare. This code is reported in FL 4 of the UB-92. This item is used by the program to determine the type of payment calculation to apply.

Valid entries: RAPs: 322, 332

Claims: 329, 339, adjustment bill types (3x7, etc.)

INITIAL PAY IND – Required, with default. Initial Payment Indicator. This is an item that is added to a RAP in Medicare processing, to indicate whether a particular provider has been determined ineligible for RAP payments. The default value of this field is zero, which means that normal percentage payments are made on RAPs. If the item is set to 1, all RAP calculations will result in zero. Providers do not need to change the value in this field.

Valid entries: 0, 1

PEP IND – Required, with default. Partial episode payment (PEP) indicator. This field is used by the program to determine if a PEP payment calculation should be applied. The default value of N indicates that a PEP is not applied. Change this value to Y if the patient status code in FL 22 of the UB-92 claim would be 06, since these claims are always paid as PEPs. This field will never be changed on RAPs.

Valid entries: Y, N

PEP DAYS – Required, with default. Partial episode payment (PEP) days. This field is used by the program in payment calculations in the rare event that a significant change in condition (SCIC) adjustment must be made to a claim that is also subject to a PEP adjustment. In that case, enter the number of days between the first and last billable visit in the episode in this field. In all other cases, tab over this field leaving the default value of zero. This field will never be changed on RAPs.

SERV FROM DATE – Required. Service From Date. Enter the date from a RAP or claim that corresponds to the Statement Covers Period "From" field on the UB-92 (FL 6). This field is used by the program to ensure the record falls within the fiscal year period that a particular PC Pricer version is designed to calculate. It is also used on RAPs to compare to the ADMIT DATE field (see below) in order to apply the correct percentage payment.

Valid entries: Must use MM/DD/YY date format.

SERV THRU DATE – Required. Service Through Date. Enter the date from a RAP or claim that corresponds to the Statement Covers Period "Through" field on the UB-92 (FL 6). This field is used by the program to ensure the record falls within the fiscal year period that a particular PC Pricer version is designed to calculate.

Valid entries: Must use MM/DD/YY date format.

ADMIT DATE-- Required. Admission Date. Enter the date from a RAP or claim that corresponds to the Admission date field on the UB-92 (FL 17). This field is used by the program on RAPs to compare to the SERV FROM DATE field (see above)

in order to apply the correct percentage payment. If these two dates match, a 60% payment is calculated. If they do not match, a 50% payment is calculated.

Valid entries: Must use MM/DD/YY date format.

HIPPS1--Required. First HIPPS code. Enter the Health Insurance Prospective Payment System (HIPPS) code that corresponds to the earliest dated revenue code 0023 line on a RAP or claim. RAP entries will only have one HIPPS code. Claim entries may have more than one HIPPS code (see HIPPS2-6 below). This field is used by the program to determine the appropriate case-mix weight for payment calculations.

Valid entries: Any valid HIPPS code (see Appendix C for complete list of valid codes)

MED-IND—Required, with default. Medical Review Indicator. This field was created for use by RHHI medical review or appeals unit staff to indicate a HIPPS code that was changed as a result of RHHI adjudication of the claim. If a value of Y is entered in this field, the program will not change the HIPPS code but will accept the RHHI determination for calculation purposes. Non-RHHI users of the program should always leave the default N value in this field.

Valid entries: Y, N

DAYS—Required, with default. Number of Days of Service Provided Under HIPPS Code. This field shows the number of days of service to be paid under each HIPPS code reported on the claim. For claims subject to PEP adjustments, enter the span of days between the first and last visits provided in the episode. For claims subject to SCIC adjustments, enter the span of days between the first and last visits provided under a particular HIPPS code. For other RAPs or claims, accept the default value of 60 days.

Valid entries: 0 – 60

HIPPS2-6—Optional. Additional HIPPS codes. For claims subject to SCIC adjustments, enter the HIPPS code that corresponds to any additional revenue code 0023 lines on the claim. RAP entries will only have one HIPPS code. This field is used by the program to determine the additional case-mix weights to apply in SCIC payment calculations.
Enter the MED-IND and DAYS fields corresponding to these codes as described above.

Valid entries: Any valid HIPPS code (see Appendix C for complete list of valid codes)

REV VISITS fields—The following six fields are not required on RAPs. On claims, a number of visits in one or more of the six fields is required. These fields are used by the program to determine whether a low utilization payment adjustment (LUPA) applies and to calculate any applicable outlier payment amount.

REV1==>0420 VISITS==> -- Physical Therapy Visits. Enter the number of physical therapy visits provided in the episode, which correspond to the number of revenue code 42x lines on a claim.

REV2==>0430 VISITS==> -- Occupational Therapy Visits. Enter the number of occupational therapy visits provided in the episode, which correspond to the number of revenue code 43x lines on a claim.

REV3==>0440 VISITS==> -- Speech-Language Pathology Visits. Enter the number of speech therapy visits provided in the episode, which correspond to the number of revenue code 44x lines on a claim.

REV4==>0550 VISITS==> -- Skilled Nursing Visits. Enter the number of skilled nursing visits provided in the episode, which correspond to the number of revenue code 55x lines on a claim.

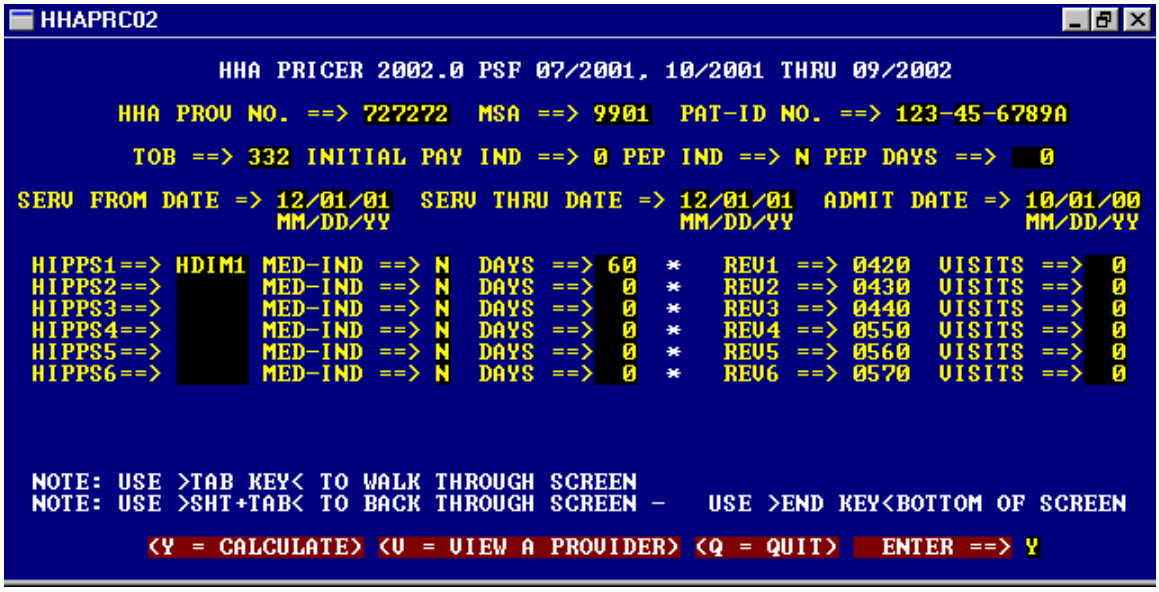
REV5==>0560 VISITS==> -- Medical Social Work Visits. Enter the number of medical social worker visits provided in the episode, which correspond to the number of revenue code 56x lines on a claim.

REV6==>0570 VISITS==> --Home Health Aide Visits. Enter the number of home health aide visits provided in the episode, which correspond to the number of revenue code 57x lines on a claim.

3.3 Entering RAPs

Entry Screen:

The following instructions outline the steps for entering a Request for Anticipated Payment (RAP) for calculation. A completed RAP entry screen is pictured below.



1. Enter your provider number and the MSA representing the beneficiary's site of service (i.e. the value code 61 amount from the claim.)

2. If a patient specific record is desired, enter the beneficiary's Health Insurance Claim number in the PAT-ID NO field. If not, tab over this field.

3. Enter 322 or 332 in the TOB field.

4. Tab over the INITIAL PAY IND, PEP IND and PEP DAYS fields, leaving their default values unchanged.

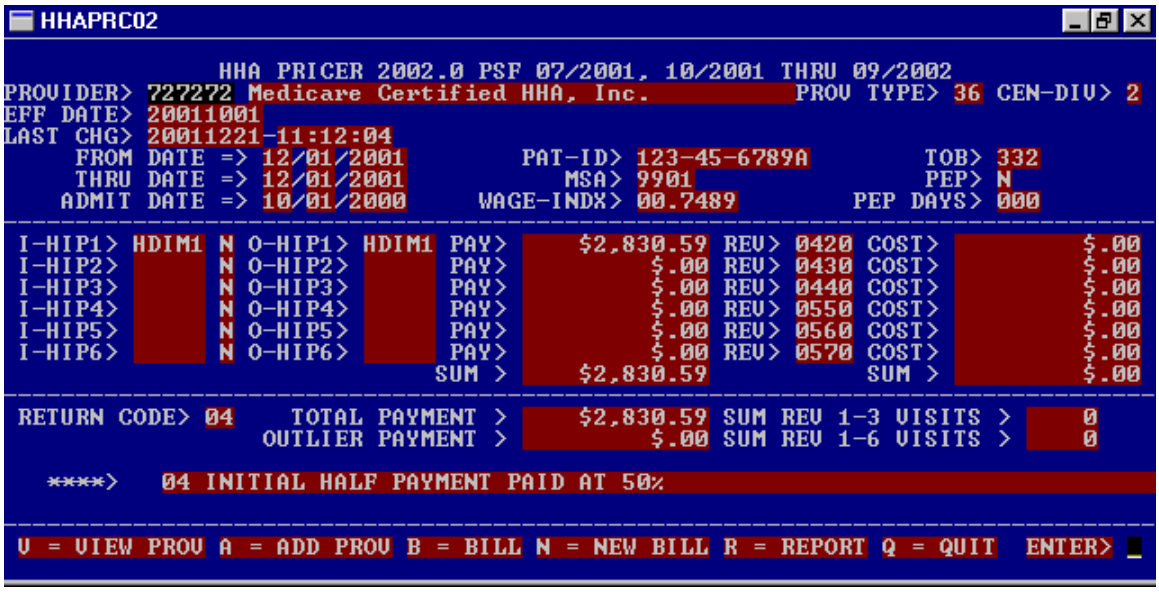
5. Enter the dates in the SERV FROM, SERV THRU and ADMIT DATE fields, corresponding to the RAP. Note: on RAPs the FROM and THRU dates should always match.

6. Enter the HIPPS code from the revenue code 0023 line on the RAP in the HIPPS1 field.

7. No further fields need to be changed. Hit the "Enter" key on your keyboard to calculate the payment.

Payment Report:

A payment report screen will be displayed, similar to this example:



In addition to displaying information you have entered identifying the provider, beneficiary and claim information, three important results fields appear on the report:

WAGE-INDX> This field displays the weight value applied to the labor portion of the payment in the wage adjustment calculation.

TOTAL PAYMENT > This field displays the payment for the RAP you have entered. On RAPs this field will also match the results in the HIP1> PAY and SUM > fields immediately above it.

RETURN CODE> This field displays a two digit numeric code that explains the method of payment applied on the record. The code and its definition are displayed after the arrow at the bottom of the screen. Typical return codes for RAPs are 04 (50% payment) and 05 (60% payment).

Next Steps: The flashing cursor will be waiting at the ENTER> field in the lower right hand corner of the screen.

Enter B to make changes to the RAP record you have just entered.

Enter N to create a completely new RAP or claim.

Enter R to print a hard copy report of the results of this RAP calculation. The following page displays a sample printout of a RAP report.

```
                HHA PRICER 2002.0 PSF 07/2001, 10/2001 THRU 09/2002

PROVIDER> 727272 Medicare Certified HHA, Inc.          PROV TYPE> 36 CEN-DIV> 2

EFF DATE> 20011001
LAST CHG > 20011221-11:12:04

     FROM DATE => 12/01/2001      PAT-ID => 123-45-6789A          TOB => 332
     THRU DATE => 12/01/2001        MSA => 9901                   PEP => N
    ADMIT DATE => 10/01/2000    WAG-INDX => 00.7489          PEP DAYS => 000
                                                        INITIAL PAY IND => 0

-------------------------------------------------------------------------------

    INPUT       MEDICAL      OUTPUT       HIPPS         NO OF          HIPPS
    HIPPS        IND         HIPPS        WTG           DAYS           PAYMENT

 1) HDIM1         N          HDIM1      02.8113          060          $2,830.59
 2)               N                     00.0000          000               $.00
 3)               N                     00.0000          000               $.00
 4)               N                     00.0000          000               $.00
 5)               N                     00.0000          000               $.00
 6)               N                     00.0000          000               $.00

                                                         SUM>          $2,830.59

-------------------------------------------------------------------------------

    REVENUE     NO OF       DOLLAR       REVENUE
     CODE       VISITS       RATE          COST

 1) 0420          000          $.00             $.00
 2) 0430          000          $.00             $.00
 3) 0440          000          $.00             $.00
 4) 0550          000          $.00             $.00
 5) 0560          000          $.00             $.00
 6) 0570          000          $.00             $.00

                      SUM>                     $.00

-------------------------------------------------------------------------------

RETURN CODE > 04   TOTAL PAYMENT >     $2,830.59   SUM REV 1-3 VISITS >     0

                  OUTLIER PAYMENT >          $.00   SUM REV 1-6 VISITS >     0

-------------------------------------------------------------------------------

   ****** >  04 INITIAL HALF PAYMENT PAID AT 50%

-------------------------------------------------------------------------------
```

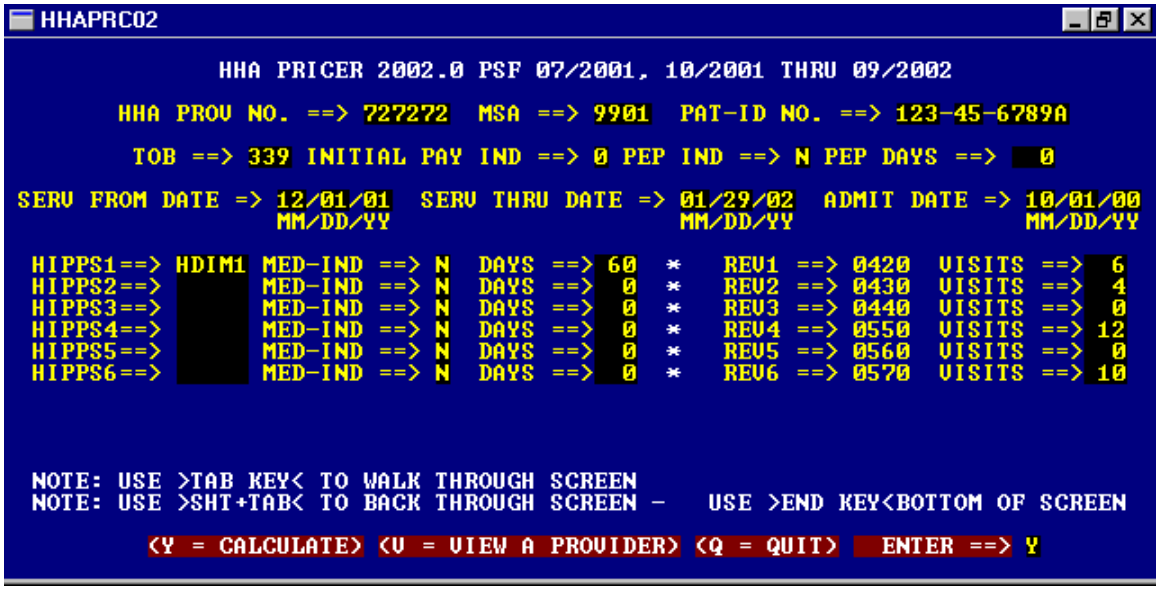
3.4 Entering claims

The next five subsections provide specific instructions for entering claims for each of the HH PPS payment types.

3.4.1 Typical HH PPS claim

Entry Screen:

The following instructions outline the steps for entering a typical claim for calculation. These instructions apply to claims for which no HH PPS payment adjustments apply. A completed claim entry screen is pictured below.



1. Enter your provider number and the MSA representing the beneficiary's site of service (i.e. the value code 61 amount from the claim.)

2. If a patient specific record is desired, enter the beneficiary's Health Insurance Claim number in the PAT-ID NO field. If not, tab over this field.

3. Enter 329 or 339 in the TOB field.

4. Tab over the INITIAL PAY IND, PEP IND and PEP DAYS fields, leaving their default values unchanged.

5. Enter the dates in the SERV FROM, SERV THRU and ADMIT DATE fields, corresponding to the claim.

6. Enter the HIPPS code from the revenue code 0023 line on the claim in the HIPPS1 field.

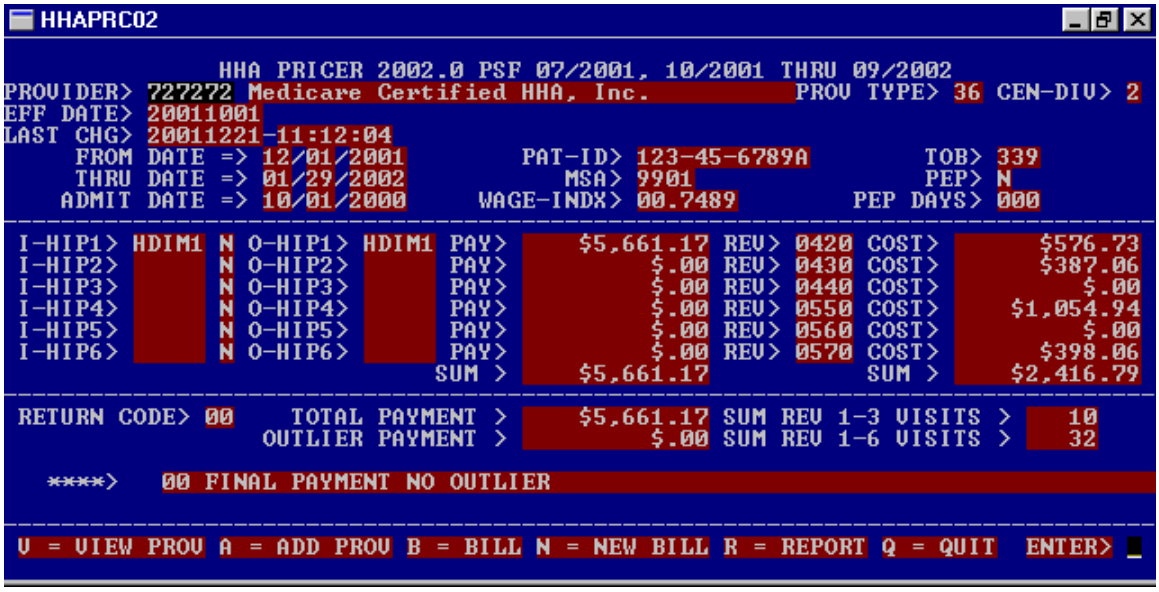
7. Tab over the remaining HIPPS, MED-IND and DAYS fields leaving their default values unchanged.

8. Enter the total numbers of home health discipline visits in the appropriate REV VISITS fields (i.e. the total number of lines with each revenue code).

9. Tab through any remaining REV VISITS fields until the cursor rests at the ENTER> field in the lower right hand corner with the Y default value displayed. Press the Enter key on your keyboard.

Payment Report:

A payment report screen will be displayed, similar to this example:



In addition to displaying information you have entered identifying the provider, beneficiary and claim information, several important results fields appear on the report:

WAGE-INDX> This field displays the weight value applied to the labor portion of the payment in the wage adjustment calculation.

TOTAL PAYMENT > This field displays the payment for the claim you have entered. On typical claims this field will also match the results in the HIP1> PAY and SUM > fields immediately above it.

RETURN CODE> This field displays a two digit numeric code that explains the method of payment applied on the record. The code and its definition are displayed after the arrow at the bottom of the screen.

The return code on a typical claim is 00, final payment with no outlier.

REV COST fields — These fields display the imputed costs for each home health discipline that were used to determine whether an outlier payment applied to the claim.

SUM REV 1-3 VISITS — This field displays the total number of therapy visits that were reported on the claim. This is the total that was used by the program to determine whether the therapy threshold was met.

SUM REV 1-6 VISITS — This field displays the total number of visits that were reported on the claim. This is the total that was used by the program to determine whether the LUPA threshold was met.

Next Steps: The flashing cursor will be waiting at the ENTER field in the bottom right hand corner of the screen.

Enter B to make changes to the claim record you have just entered.

Enter N to create a completely new RAP or claim.

Enter R to print a hard copy report of the results of this claim calculation. The following page displays a sample printout of a typical claim report.

HHA PRICER 2002.0 PSF 07/2001, 10/2001 THRU 09/2002

PROVIDER> 727272 Medicare Certified HHA, Inc. PROV TYPE> 36 CEN-DIV> 2

EFF DATE> 20011001
LAST CHG > 20011221-11:12:04

FROM DATE => 12/01/2001 PAT-ID => 123-45-6789A TOB => 339
THRU DATE => 01/29/2002 MSA => 9901 PEP => N
ADMIT DATE => 10/01/2000 WAG-INDX => 00.7489 PEP DAYS => 000
INITIAL PAY IND => 0

	INPUT HIPPS	MEDICAL IND	OUTPUT HIPPS	HIPPS WTG	NO OF DAYS	HIPPS PAYMENT
1)	HDIM1	N	HDIM1	02.8113	060	$5,661.17
2)		N		00.0000	000	$.00
3)		N		00.0000	000	$.00
4)		N		00.0000	000	$.00
5)		N		00.0000	000	$.00
6)		N		00.0000	000	$.00
					SUM>	$5,661.17

	REVENUE CODE	NO OF VISITS	DOLLAR RATE	REVENUE COST
1)	0420	006	$119.41	$576.73
2)	0430	004	$120.21	$387.06
3)	0440	000	$129.75	$.00
4)	0550	012	$109.21	$1,054.94
5)	0560	000	$175.05	$.00
6)	0570	010	$49.45	$398.06
		SUM>		$2,416.79

RETURN CODE > 00 TOTAL PAYMENT > $5,661.17 SUM REV 1-3 VISITS > 10

OUTLIER PAYMENT > $.00 SUM REV 1-6 VISITS > 32

****** > 00 FINAL PAYMENT NO OUTLIER

3.4.2 Therapy and outlier adjustments

Entry Screen:

Calculations internal to the PC Pricer determine whether claim payments need to adjusted because the therapy threshold of 10 visits was not met, the outlier threshold was exceeded or both. So the entry of these claims is no different from the entry of the typical claim described in 3.4.1 above. However, the results of the payment report will change if these adjustment apply.

Payment Report:

1) If the therapy threshold is not met on a claim, the PC Pricer automatically "downcodes" the claim. That is, the PC Pricer changes the HIPPS code you entered to reflect the HIPPS code that applies for fewer than 10 therapy visits. This change appears on the payment report in the following fields:

I-HIP1> This field shows the input HIPPS code. That is, the field reports back the code you entered on the previous screen.

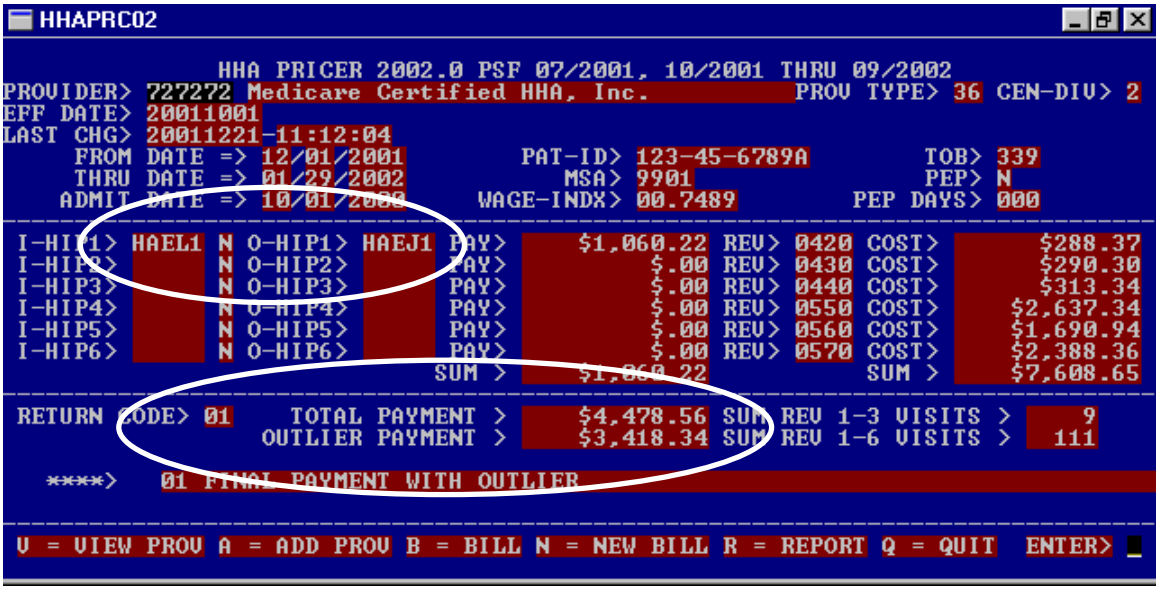
O-HIP1> This field shows the output HIPPS code. That is, the field reports the code that the Pricer used to calculate the payment. The dollar amounts reported in the HIP1 PAY and SUM fields relate to this code.

2) If the outlier threshold is exceeded on a claim, the PC Pricer calculates the additional outlier payment due over and above the HIPPS code amount. This adjustment appears on the payment report screen in the following fields.

OUTLIER PAYMENT > This fields shows the additional outlier payment calculated. The amount in this field added to the amount in the SUM field above will always equal the amount in the TOTAL PAYMENT field.

RETURN CODE> This field will contain 01, indicating a final payment with an outlier.

It is possible for both of these adjustments to apply to the same claim. The following is a sample payment report screen demonstrating both adjustments.



3.4.3 Partial episode payments (PEPs)

Entry Screen:

The entry of a claim for which a partial episode payment (PEP) adjustment applies varies from the entry of a typical claim in two ways.

First, after entering the type of bill press the tab key only once, stopping at the PEP IND field. Always enter a Y in this field on PEP claims. If you are working from a copy of a submitted claim, enter a Y in this field any time the patient status code in FL 22 of the claim is 06. In the unusual event that the PEP claim also involves a SCIC adjustment, you must also enter the span of days between the first and last visits in the entire episode in the next field, PEP DAYS. In most cases, though, you will be able to tab over the PEP DAYS field, leaving the default value of zero.

Next, after you enter the dates of the claim and its HIPPS code, you must alter the default value of 60 that appears in the DAYS field corresponding to the HIPPS code. Enter the span of days from and including the first visit to and including the last visit in the entire episode in the DAYS field. Enter the remainder of the claim normally.

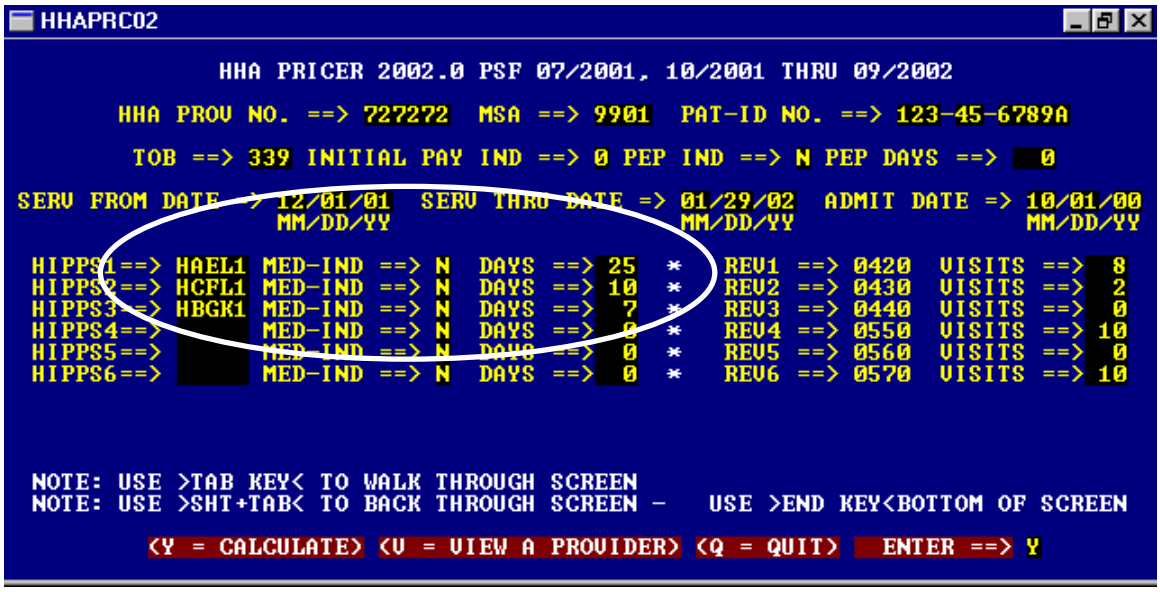
Payment Report:

The payment report will carry over the PEP IND and (if applicable) PEP DAYS information you entered, but otherwise the payment report will appear similar to a typical claim.

3.4.4 Significant changes in condition (SCICs)

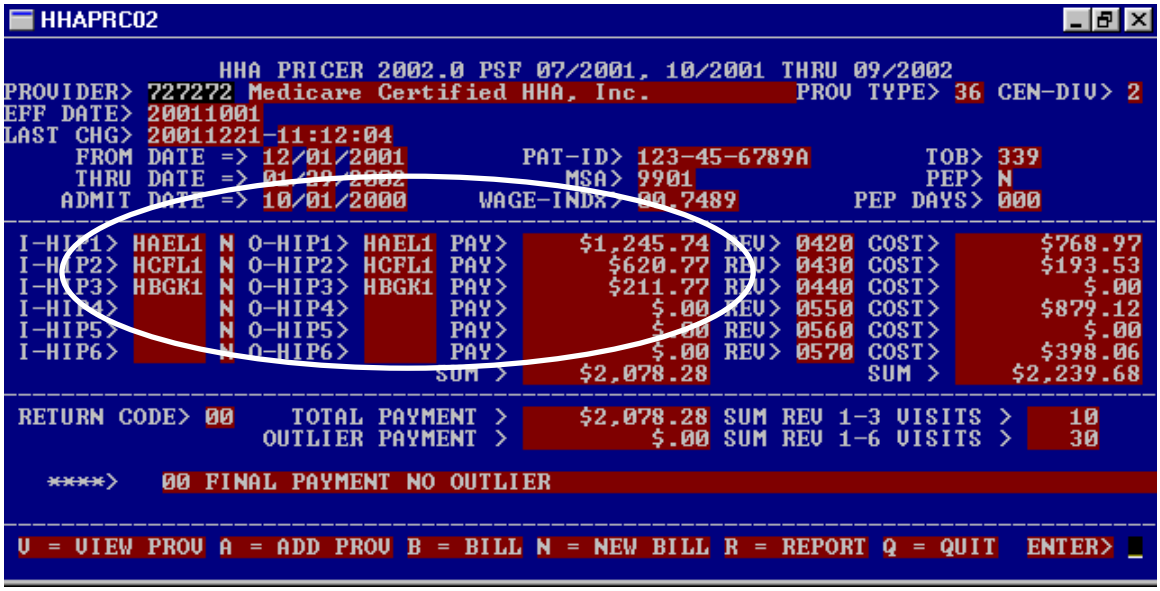
Entry Screen:
The entry of a claim for a significant change in condition (SCIC) varies from the entry of a typical claim in only one respect. You must enter multiple HIPPS codes, using as many of fields HIPPS2 through HIPPS6 of the claims entry screen as necessary. Be sure to change the default value of 60 in the DAYS field of the HIPPS1 line to reflect the span of days between the first and last visit provided under the first HIPPS code. Then enter the additional HIPPS code(s) and their corresponding spans of days.

The following is a sample claim entry screen for a SCIC claim:



Payment Report:

On the payment report screen, payments for each HIPPS code will be reported on separate lines with numbers corresponding to the numbers on the entry screen. The O-HIP1 PAY through O-HIP6 PAY fields will display the separate payment amounts for each part of the SCIC. A subtotal amount of all these payments is reported in the SUM field. In other respects this payment report is similar to a typical claim:



3.4.5 Low utilization payment adjustments (LUPAs)

Entry Screen:

The entry of LUPA claims does not vary from the entry of typical claims. Enter all the required claim fields, including the HIPPS code of the claim and the numbers of visits.

Payment Report:

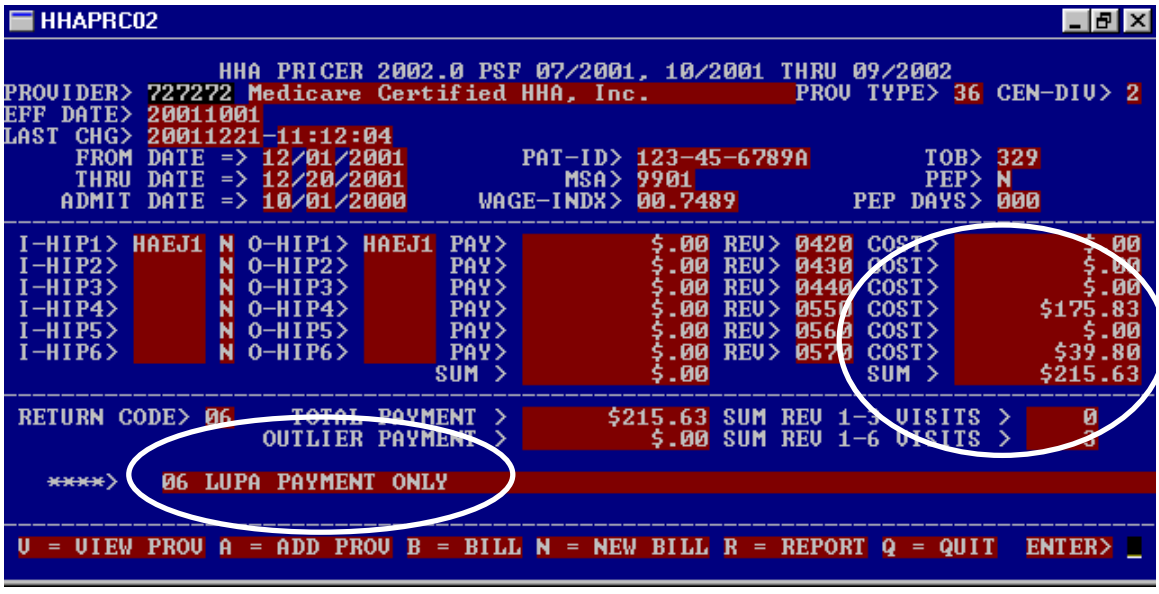
Based on the presence of four or fewer visits on a claim record, the PC Pricer will automatically calculate a LUPA payment. In this case, the payment report screen will reflect the LUPA payment using the following fields:

REV COST> These fields are used on LUPA claims to show the actual payment amounts which are calculated on a per visit basis. The HIPPS PAY fields will show zero.

REV SUM> The separate per visit payments are subtotaled in this field. The SUM field under the HIPPS PAY fields will show zero. This subtotal will match the TOTAL PAYMENT field also.

RETURN CODE> The code in this field will be 06, indicating LUPA payment only.

A sample LUPA payment report:



3.5 Correcting the RAP/claim you are calculating

You may notice after you have calculated a RAP or claim record that you made an entry error on the RAP or claim and wish to correct the record you have just entered. In this case, you can go back to that record and correct the errors instead of re-keying the entire screen. To do this, enter a B in the ENTER> field in the lower right-hand corner of the results screen. This will return you to the RAP/Claim entry screen, which will still display the record previously entered. The cursor will be flashing in the first position of the first field on the entry screen (the provider number field). Tab forward to the field you wish to correct, and key over the erroneous entry. Repeat this step for as many fields as necessary to correct the complete record.

Then you can jump the cursor to the ENTER == > field in the lower right hand corner of the entry screen by using the End key on your keyboard. If the cursor is on the last position of any field in the entry screen, pressing the End key once will jump the cursor to the ENTER == > field. If the cursor is in any other position of a field, pressing the End key twice will jump the cursor to the ENTER == > field. The default value of Y (for calculate) will be present in this field. Pressing the Enter key on your keyboard will display the results screen for the corrected record.

TIP: If you are calculating a batch of similar records (for instance, same provider number, patient id or billing periods), it may be more convenient to use this correction feature to enter the records than to create entirely new records each time. Only changing the fields that differ between one RAP/claim and the next could save a significant amount of data entry.