

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3933	Date: December 7, 2017
	Change Request 10167

Transmittal 3829, dated August 4, 2017, is being rescinded and replaced by Transmittal 3933, dated December 7, 2017 to include Attachment 1 that was erroneously omitted from the original transmittal. All other information remains the same.

SUBJECT: Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization

I. SUMMARY OF CHANGES: This Change Request revises the record layout for the home health Pricer interface to support new payment and data initiatives. It also adds consistency editing to ensure the accurate reporting of site of service G-codes on home health visit line items.

EFFECTIVE DATE: January 1, 2018 - For requirements 10167.1 through 10167.8, claim "Through" dates on or after this date. For requirements 10167.9 through 10167.14, claim "From" date on or after this date.

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

IMPLEMENTATION DATE: January 2, 2018

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	1/190/Payer Only Codes Utilized by Medicare
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: 3933	Date: December 7, 2017	Change Request: 10167
-------------	-------------------	------------------------	-----------------------

Transmittal 3829, dated August 4, 2017, is being rescinded and replaced by Transmittal 3933, dated December 7, 2017 to include Attachment 1 that was erroneously omitted from the original transmittal. All other information remains the same.

SUBJECT: Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization

EFFECTIVE DATE: January 1, 2018 - For requirements 10167.1 through 10167.8, claim "Through" dates on or after this date. For requirements 10167.9 through 10167.14, claim "From" date on or after this date.

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

IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: In the CY 2016 Home Health Prospective Payment System final rule, CMS finalized its proposal to implement the Home Health Value-Based Purchasing (HHVBP) Model in nine states representing each geographic area in the nation. For all Medicare-certified home health agencies (HHAs) that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA's total performance score on a set of measures already reported via OASIS and HHCAHPS for all patients serviced by the HHA, or determined by claims data, plus three new measures where performance points are achieved for reporting data. The HHVBP Model, as finalized, will be tested by CMS's Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Act. The requirements below make the revisions needed to HH Pricer program to accept the necessary adjustment factor to apply HHVBP adjustment and to capture the adjusted amount on the claim record. Instructions for entering the HHVBP adjustment factor in provider files are in CR 9939.

Additionally, as part of many of its quality and program improvement initiatives, CMS utilizes standardized allowed amounts for HH claims. Standardized allowed amounts are Medicare allowed amounts adjusted to remove sources of variation not directly related to decisions to utilize care, such as variation due to the application of hospital wage indexes and geographic practice cost indexes (GPCIs). Incentive payment and penalty adjustments are also not included in the standardized allowed amount. In other words, standardized amounts reflect a standard Medicare allowed amount as though the incentive programs were not in effect. To facilitate accurate calculation of standardized allowed amounts for HHAs and to facilitate their use by multiple CMS components, this CR requires that standardized allowed amounts be calculated by Medicare systems and passed on to claims history databases using the field created for hospital standardized payment amounts in CR 8746.

Finally, this CR requires system changes to make HH and hospice claims processing more consistent. CR 6440 created edits on hospice claims to ensure that G-codes for service visits are reported with the corresponding revenue code for the service discipline. Similar editing does not exist for HH claims, even though the same G-codes and revenue codes are required. The requirements below create these edits for HH claims.

B. Policy: The HHAs in the nine HHVBP states will have their payments adjusted (upward or downward) in the following manner: a maximum payment adjustment of three percent in CY 2018; a maximum payment adjustment of five percent in CY 2019; a maximum payment adjustment of six percent in CY 2020; a maximum payment adjustment of seven percent in CY 2021; and a maximum payment

adjustment of eight percent in CY 2022.

Medicare systems will produce a standardized allowed amount for each home health claim. The standardized amount will be sent to the Integrated Data Repository (IDR) and the National Claims History (NCH) and will be displayed for informational use only.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility										
		A/B MAC			D M E M A C S	Shared- System Maintainers				Other		
		A	B	H H H		F I S S	M C S	V M S	C W F			
10167.1	The contractor shall modify the input/output record to HH Pricer to reflect the revised record layout in the Medicare Claims Processing Manual, chapter 10, section 70.2.					X						
10167.2	The contractor shall multiply the HH PPS payments otherwise due, after all other payment adjustments are applied, by the HH VBP adjustment factor.											HH PPS Pricer
10167.3	The contractor shall return a HH VBP adjusted payment amounts and an HH VBP adjusted claim total payment amount in existing output record payment fields.											HH PPS Pricer
10167.4	The contractor shall subtract the total HH PPS payment amount before HH VBP adjustment from the total HH VBP adjusted amount and return the result in the HH VBP adjustment amount field of the output record.											HH PPS Pricer
10167.5	The contractor shall place the HH VBP adjustment amount on the claim as a value code QV amount. Note: This may be a positive or a negative amount.					X						
10167.6	The contractor shall calculate an interim standardized allowed amount for all records according to the logic described in Attachment 1 and return the amount in the Pricer output field PPS-STD-VALUE.											HH PPS Pricer
10167.7	The contractor shall calculate a final standardized amount for all HH PPS RAPs, claims and adjustments that meet all the following criteria: 1. Type of bill (TOB) = 032x,					X						

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	2. Through date on or after January 1, 2018, and 3. Nonpayment code = blank.									
10167.7.1	The contractor shall add any positive Medicare payment amounts reported with revenue center codes 029x, 060x, and 0274 to the standardized amount returned by the HH Pricer in the PPS-STD-VALUE field. NOTE: The payment amount shall not include coinsurance.					X				
10167.7.2	The contractor shall reduce the amount calculated in requirement 7.1 by the current amount of sequestration, if sequestration applies.					X				
10167.7.3	The contractor shall add any coinsurance amounts (value codes A2 or B2) and third party primary payer payments (line item primary amounts used by MSPPAY) reported with revenue center codes 029x, 060x, and 0274 to the amount calculated in requirement 7.2 and report this amount as the final standardized amount.					X				
10167.8	The contractor shall record the final standardized amount calculated in requirement 7.3 on the claim in record in the PPS-STNDRD-VALUE field.					X			IDR, NCH	
10167.9	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 042x if the HCPCS code is other than Q5001, Q5002, Q5009, G0151, G0157 or G0159.			X		X				
10167.10	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 043x if the HCPCS code is other than Q5001, Q5002, Q5009, G0152, G0158 or G0160.			X		X				
10167.11	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 044x if the HCPCS code is other than Q5001, Q5002, Q5009, G0153 or G0161.			X		X				
10167.12	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue			X		X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	code 055x if the HCPCS code is other than Q5001, Q5002, Q5009, G0162, G0299, G0300, G0493, G0494, G0495 or G0496.									
10167.13	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 056x if the HCPCS code is other than Q5001, Q5002, Q5009 or G0155.			X		X				
10167.14	The contractor shall return to the provider home health claims (TOB 032x other than 0322) reporting revenue code 057x if the HCPCS code is other than Q5001, Q5002, Q5009 or G0156.			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10167.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10167.3	The individual payment amounts that can be affected by HH VBP adjustment are the HRG-PAY, REVENUE-COST, REVENUE-ADD-ON-VISIT-AMT and OUTLIER-PAYMENT fields.
10167.9 thru .13	The site of service Q-codes can be reported on any service line, so these are included with the discipline specific G-codes in all the new edits.

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

Attachment 1: HH Standardization Logic

The following provides a summary of the standardization algorithm needed to calculate HH standardized allowed amounts for non-LUPA and LUPA claims in shared systems.

For Non-LUPA claims:

Standardized Allowed

$$= (\text{Case Mix Weight} * \text{Base Rate} + \text{NRS Payment}) * \frac{\text{Covered Days}}{60} \\ * \frac{1 + \text{Rural Factor}}{2} * \text{RAP Factor} + \text{Standardized Outlier}$$

Where:

$$\text{Standardized Outlier} = \frac{\text{Outlier}}{(\text{Labor Share} * \text{Wage Index} + (1 - \text{Labor Share}))}$$

Where:

- Case Mix Weight is the payment weight for the episode
- Base Rate is the HH PPS urban per 60-day episode base payment rate (not including reductions for quality reporting)
- NRS Payment is the urban non-routine supply add-on payment for the episode (not including reductions for quality reporting)
- Covered Days is the number of Medicare covered days for the episode (PEPs will have fewer than 60 covered days)
- Rural Factor is the HH PPS rural add-on percentage (e.g. 1.03 for a 3% rural add-on. Half the add-on is applied to all episodes, regardless of whether the provider qualifies as rural.)
- RAP Factor is the payment percentage applied for RAPs (1.0 for non-RAPs, 0.6 for 60% RAPs, 0.5 for 50% RAPs, 0.0 for 0% RAPs)
- Standardized Outlier is the HH PPS outlier payment adjusted to remove geographic differences in wage index

For LUPA claims:

$$\text{Standardized Allowed} = \left(\sum_{i=1}^{\text{\# of visits}} (\text{Visit Rate}_i) + \text{LUPA Addon} \right) * \frac{1 + \text{Rural Factor}}{2}$$

Where:

- # of visits is the number of covered visits for the episode
- Visit Rate is the HH PPS urban per visit rate for the visit type (not including reductions for quality reporting)
- LUPA Addon is the HH PPS urban add-on for the first episode in a sequence of adjacent episodes (not including reductions for quality reporting)
- Rural Factor is the HH PPS rural add-on percentage (e.g. 1.03 for a 3% rural add-on. Half the add-on is applied to all episodes, regardless of whether the provider qualifies as rural.)

70.2 - Input/Output Record Layout

(Rev.3933, Issued: 12-07-17, Effective: 01-01-18, Implementation: 01-02-18)

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	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.
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.

File Position	Format	Title	Description
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.
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.

File Position	Format	Title	Description
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.
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 1.8714. 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.
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

File Position	Format	Title	Description
			11 Final payment, PEP with outlier
			12 Not used.
			13 Not used.
			14 LUPA payment, 1 st 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
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.

File Position	Format	Title	Description
569	X	RECODE-IND	<p>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:</p> <p>0 = default value</p> <p>1 = HIPPS code shows later episode, should be early episode</p> <p>2 = HIPPS code shows early episode, but this is not a first or only episode</p> <p>3 = HIPPS code shows early episode, should be later episode</p>
570	9	EPISODE-TIMING	<p>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:</p> <p>1 = early episode</p> <p>2 = late episode</p>
571	X	CLINICAL-SEV-EQ1	<p>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.</p>
572	X	FUNCTION-SEV-EQ1	<p>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.</p>
573	X	CLINICAL-SEV-EQ2	<p>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.</p>
574	X	FUNCTION-SEV-EQ2	<p>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.</p>
575	X	CLINICAL-SEV-EQ3	<p>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.</p>

File Position	Format	Title	Description
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)	<i>PROV-VBP-ADJ-FAC</i>	<i>Input item: Medicare systems move this information from field 30 of the provider specific file.</i>
605-613	S9(7)V9(2)	<i>VBP-ADJ-AMT</i>	<i>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.</i>
614-622	9(7)V9(2)	<i>PPS-STD-VALUE</i>	<i>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.</i>
623-650	X(28)	<i>FILLER</i>	

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.

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.

70.2 - Input/Output Record Layout

(Rev.3933, Issued: 12-07-17, Effective: 01-01-18, Implementation: 01-02-18)

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	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.
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.

File Position	Format	Title	Description
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.
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.

File Position	Format	Title	Description
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.
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 1.8714. 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.
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

File Position	Format	Title	Description
			11 Final payment, PEP with outlier
			12 Not used.
			13 Not used.
			14 LUPA payment, 1 st 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
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.

File Position	Format	Title	Description
569	X	RECODE-IND	<p>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:</p> <p>0 = default value</p> <p>1 = HIPPS code shows later episode, should be early episode</p> <p>2 = HIPPS code shows early episode, but this is not a first or only episode</p> <p>3 = HIPPS code shows early episode, should be later episode</p>
570	9	EPISODE-TIMING	<p>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:</p> <p>1 = early episode</p> <p>2 = late episode</p>
571	X	CLINICAL-SEV-EQ1	<p>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.</p>
572	X	FUNCTION-SEV-EQ1	<p>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.</p>
573	X	CLINICAL-SEV-EQ2	<p>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.</p>
574	X	FUNCTION-SEV-EQ2	<p>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.</p>
575	X	CLINICAL-SEV-EQ3	<p>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.</p>

File Position	Format	Title	Description
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)	<i>PROV-VBP-ADJ-FAC</i>	<i>Input item: Medicare systems move this information from field 30 of the provider specific file.</i>
605-613	S9(7)V9(2)	<i>VBP-ADJ-AMT</i>	<i>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.</i>
614-622	9(7)V9(2)	<i>PPS-STD-VALUE</i>	<i>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.</i>
623-650	X(28)	<i>FILLER</i>	

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.

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.