

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 4148</b>	<b>Date: October 19, 2018</b>
	<b>Change Request 10992</b>

**NOTE: This Transmittal is no longer sensitive and is being re-communicated November 15, 2018. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.**

**SUBJECT: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019**

**I. SUMMARY OF CHANGES:** This Change Request updates the 60-day national episode rates, the national per-visit amounts, LUPA add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for CY 2019. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 70.5.

**EFFECTIVE DATE: January 1, 2019**

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

**IMPLEMENTATION DATE: January 7, 2019**

*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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	10/70/70.4 - Decision Logic Used by the Pricer on Claims

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

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

**IV. ATTACHMENTS:**

**Recurring Update Notification**

# Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: IU5839	Date: October 19, 2018	Change Request: 10992
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**EFFECTIVE DATE: January 1, 2019**

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**IMPLEMENTATION DATE: January 7, 2019**

## I. GENERAL INFORMATION

**A. Background:** The Medicare Home Health Prospective Payment System (HH PPS) rates provided to home health agencies (HHAs) for furnishing home health services are updated annually as required by section 1895(b)(3)(B) of the Social Security Act (the Act). The CY 2019 HH PPS rate update includes an update to the case-mix weights as provided by section 1895(b)(4)(A)(i) and (b)(4)(B) of the Act. The CY 2019 HH PPS rates for services provided to beneficiaries who reside in rural areas will be increased as required by section 421(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as amended by section 50208 of the Bipartisan Budget Act of 2018.

## B. Policy: Market Basket Update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended section 1895(b)(3)(B) of the Act such that for home health payments for CY 2019, the market basket percentage increase shall be 2.2 percent. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those home health agencies (HHAs) that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2019, the home health payment update would be 0.2 percent (2.2 percent minus 2 percentage points). The CY 2019 HH PPS final rule also changed the labor-related share used to wage-adjust payments under the HH PPS to 76.1 percent and the corresponding non-labor-related share to 23.9 percent.

## National, Standardized 60-Day Episode Payment

As described in the CY 2019 HH PPS final rule, in order to calculate the CY 2019 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 0.9985 and a case-mix budget neutrality factor of 1.0169 to the previous calendar year's national, standardized 60-day episode rate (\$3,039.64). Then the national, standardized 60-day episode payment rate is updated by the CY 2019 HH payment update percentage of 2.2 percent for HHAs that submit the required quality data and by 2.2 percent minus 2 percentage points, or 0.2 percent, for HHAs that do not submit quality data. These two episode payment rates are shown in Tables 1 and 2 (see attached). These payments are further adjusted by the individual episode's case-mix weight and by the wage index.

## National Per-Visit Rates

In order to calculate the CY 2019 national per-visit payment rates, CMS starts with the CY 2018 national per-visit rates. CMS applies a wage index budget neutrality factor of 0.9996 to ensure budget neutrality for low utilization payment adjustment (LUPA) per-visit payments after applying the CY 2019 wage index. The per-visit rates are then updated by the CY 2019 HH payment update of 2.2 percent for HHAs that submit the required quality data and by 0.2 percent for HHAs that do not submit quality data. The per-visit rates are

shown in Tables 3 and 4.

### Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2019 NRS conversion factors, CMS updates the CY 2018 NRS conversion factor by the CY 2019 HH payment update of 2.2 percent for HHAs that submit the required quality data and by 0.2 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2019 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2019 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

### Rural Add-On Provision

Section 421(b)(1) of the MMA, as amended by section 50208 of the BBA of 2018, provides that rural counties would be placed into one of three categories for purposes of receiving HH rural add-on payments: (1) rural counties and equivalent areas in the highest quartile of all counties or equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of Medicare or enrolled for benefits under part B of Medicare only, but not enrolled in a Medicare Advantage plan under part C of Medicare, as provided in section 421(b)(1)(A) of the MMA (the "High utilization" category); (2) rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area and are not included in the category provided in section 421(b)(1)(A) of the MMA, as provided in section 421(b)(1)(B) of the MMA (the "Low population density" category); and (3) rural counties and equivalent areas not in the categories provided in either sections 421(b)(1)(A) or 421(b)(1)(B) of the MMA, as provided in section 421(b)(1)(C) of the MMA (the "All other" category). CY 2019 HH PPS payments will be increased by 1.5 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "High utilization" category. CY 2019 HH PPS payments will be increased by 4.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "Low population density" category. CY 2019 HH PPS payments will be increased by 3.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the "All other" category. Beginning in CY 2019, HHAs will be required to enter the FIPS state and county code where the beneficiary resides on each claim. HHAs will continue to enter CBSA codes on the claims.

### Outlier Payments

The fixed dollar loss (FDL) ratio and the loss-sharing ratio used to calculate outlier payments must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, we have used a value of 0.80 for the loss-sharing ratio which, we believe, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. The CY 2019 HH PPS final rule lowered the FDL ratio for CY 2019 from 0.55 to 0.51 to better approximate the 2.5 percent statutory maximum. No changes were made to the loss-sharing ratio of 0.80.

In the CY 2017 HH PPS final rule (81 FR 76702), we finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, we now convert the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation

of outlier payments are attached in Table 7.

Medicare Claims Processing Manual

A revision for section 70.4 in Chapter 10 - Home Health Agency Billing in Medicare Claims Processing Manual is attached.

These changes are to be implemented through the Home Health Pricer software found in Medicare contractor standard systems.

**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	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10992.1	The contractor shall install a new HH PPS Pricer software module effective January 1, 2019.					X				HH Pricer
10992.2	The contractor shall apply the CY 2019 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2019, and on or before December 31, 2019.					X				HH Pricer

**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		
10992.3	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 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.	X		X		

#### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

<b>X-Ref Requirement Number</b>	<b>Recommendations or other supporting information:</b>
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**Section B: All other recommendations and supporting information: N/A**

#### V. CONTACTS

**Pre-Implementation Contact(s):** Hillary Loeffler, 410-786-0456 or [hillary.loeffler@cms.hhs.gov](mailto:hillary.loeffler@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: 2**

**TABLE 1: CY 2019 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT**

<b>CY 2018 National, Standardized 60-Day Episode Payment</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>Case-Mix Weights Budget Neutrality Factor</b>	<b>CY 2019 HH Payment Update</b>	<b>CY 2019 National, Standardized 60-Day Episode Payment</b>
\$3,039.64	X 0.9985	X 1.0169	X 1.022	\$3,154.27

**TABLE 2: CY 2019 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA**

<b>CY 2018 National, Standardized 60-Day Episode Payment</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>Case-Mix Weights Budget Neutrality Factor</b>	<b>CY 2019 HH Payment Update Minus 2 Percentage Points</b>	<b>CY 2019 National, Standardized 60-Day Episode Payment</b>
\$3,039.64	X 0.9985	X 1.0169	X 1.002	\$3,092.55

**TABLE 3: CY 2019 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA**

<b>HH Discipline</b>	<b>CY 2018 Per-Visit Payment</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>CY 2019 HH Payment Update</b>	<b>CY 2019 Per-Visit Payment</b>
Home Health Aide	\$64.94	X 0.9996	X 1.022	\$66.34
Medical Social Services	\$229.86	X 0.9996	X 1.022	\$234.82
Occupational Therapy	\$157.83	X 0.9996	X 1.022	\$161.24
Physical Therapy	\$156.76	X 0.9996	X 1.022	\$160.14
Skilled Nursing	\$143.40	X 0.9996	X 1.022	\$146.50
Speech- Language Pathology	\$170.38	X 0.9996	X 1.022	\$174.06

**TABLE 4: CY 2019 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA**

<b>HH Discipline</b>	<b>CY 2018 Per-Visit Rates</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>CY 2019 HH Payment Update Minus 2 Percentage Points</b>	<b>CY 2019 Per-Visit Rates</b>
Home Health Aide	\$64.94	X 0.9996	X 1.002	\$65.04
Medical Social Services	\$229.86	X 0.9996	X 1.002	\$230.23
Occupational Therapy	\$157.83	X 0.9996	X 1.002	\$158.08
Physical Therapy	\$156.76	X 0.9996	X 1.002	\$157.01
Skilled Nursing	\$143.40	X 0.9996	X 1.002	\$143.63
Speech- Language Pathology	\$170.38	X 0.9996	X 1.002	\$170.65

**TABLE 5A: CY 2019 NRS CONVERSION FACTOR  
FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA**

<b>CY 2018 NRS Conversion Factor</b>	<b>CY 2019 HH Payment Update</b>	<b>CY 2019 NRS Conversion Factor</b>
\$53.03	X 1.022	\$54.20

**TABLE 5B: CY 2019 NRS PAYMENT AMOUNTS  
FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA**

<b>Severity Level</b>	<b>Points (Scoring)</b>	<b>Relative Weight</b>	<b>CY 2019 NRS Conversion</b>	<b>CY 2019 NRS Payment</b>
1	0	0.2698	\$54.20	\$14.62
2	1 to 14	0.9742	\$54.20	\$52.80
3	15 to 27	2.6712	\$54.20	\$144.78
4	28 to 48	3.9686	\$54.20	\$215.10
5	49 to 98	6.1198	\$54.20	\$331.69
6	99+	10.5254	\$54.20	\$570.48

**TABLE 6A: CY 2019 NRS CONVERSION FACTOR  
FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA**

<b>CY 2018 NRS Conversion Factor</b>	<b>CY 2019 HH Payment Update Percentage Minus 2 Percentage Points</b>	<b>CY 2019 NRS Conversion Factor</b>
\$53.03	X 1.002	\$53.14

**TABLE 6B: CY 2019 NRS PAYMENT AMOUNTS  
FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA**

<b>Severity Level</b>	<b>Points (Scoring)</b>	<b>Relative Weight</b>	<b>CY 2019 NRS Conversion Factor minus 2 percentage points</b>	<b>CY 2019 NRS Payment Amount</b>
1	0	0.2698	\$53.14	\$14.34
2	1 to 14	0.9742	\$53.14	\$51.77
3	15 to 27	2.6712	\$53.14	\$141.95
4	28 to 48	3.9686	\$53.14	\$210.89
5	49 to 98	6.1198	\$53.14	\$325.21
6	99+	10.5254	\$53.14	\$559.32

**TABLE 7: COST-PER-UNIT PAYMENT RATES FOR THE  
CALCULATION OF OUTLIER PAYMENTS**

		For HHAs that DO Submit the Required Quality Data		For HHAs that DO NOT Submit the Required Quality Data	
HH Discipline	Average Minutes per Visit	CY 2019 Per-Visit Payment	Cost-per-unit (1 unit = 15 minutes)	CY 2019 Per-Visit Payment	Cost-per-unit (1 unit = 15 minutes)
Home Health Aide	63.0	\$66.34	\$15.80	\$65.04	\$15.49
Medical Social Services	56.5	\$234.82	\$62.34	\$230.23	\$61.12
Occupational Therapy	47.1	\$161.24	\$51.35	\$158.08	\$50.34
Physical Therapy	46.6	\$160.14	\$51.55	\$157.01	\$50.54
Skilled Nursing	44.8	\$146.50	\$49.05	\$143.63	\$48.09
Speech- Language Pathology	48.1	\$174.06	\$54.28	\$170.65	\$53.22



# Medicare Claims Processing Manual

## Chapter 10 - Home Health Agency Billing

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*(Rev. , )*

## 70.4 - Decision Logic Used by the Pricer on Claims

*(Rev.4148, Issued: 10-19-18, Effective: 01-01-19, Implementation: 01-07-19)*

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

On input records with TOB 329, 327, 32F, 32G, 32H, 32I, 32J, 32K, 32M, 32Q, 33Q or 32P (that is, all provider submitted claims and provider or A/B MAC (HHH) initiated adjustments), Pricer will perform the following calculations in the numbered order.

Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in “INIT-PYMNT-INDICATOR.” If the value is 0 or 1, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2 percent due to the failure of the provider to report required quality data.

### 1. Low Utilization Payment Adjustment (LUPA) calculation.

1.1 If the “REVENUE-SUM1-6-QTY-ALL” (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six “REVENUE-QTY-COV-VISITS” fields from the revenue code table for the calendar year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated “REVENUE-COST” field.

1.2 If the following conditions are met, calculate an additional LUPA add-on payment:

- the dates in the “SERV-FROM-DATE” and “ADMIT-DATE” fields match
- the first position of the HIPPS code is a 1 or a 2
- the value in “LUPA-SRC-ADM” is not a B AND
- the value in “RECODE-IND” is not a 2.

Compare the earliest line item dates for revenue codes 042x, 044x and 055x and select the revenue code with the earliest date.

If the earliest date for revenue codes 042x or 044x match the revenue code 055x date, select revenue code 055x.

If the earliest date for revenue codes 042x and 044x match and revenue code 055x is not present, select revenue code 042x.

1.3 Apply the appropriate LUPA add-on factor to the selected earliest dated line.

- If revenue code 055x, multiply the national per-visit amount by 1.8451.
- If revenue code 042x, multiply the national per-visit amount by 1.6700.

- If revenue code 044x, multiply the national per-visit amount by 1.6266.

Return the resulting payment amount in the “REVENUE-ADD-ON-VISIT-AMT” field.

- 1.4 Return the sum of all “REVENUE-COST” amounts and the “REVENUE-ADD-ON-VISIT-AMT” amount, if applicable, in the “TOTAL-PAYMENT” field. If the LUPA payment includes LUPA add-on amount, return 14 in the “PAY-RTC” field. Otherwise, return 06 in the “PAY-RTC” field. These distinct return codes assist the shared systems in apportioning visit payments to claim lines. No further calculations are required.
- 1.5 If “REVENUE-SUM1-6-QTY-ALL” is greater than or equal to 5, proceed to the recoding process in step 2.

## 2. Recoding of claims based on episode sequence and therapy thresholds.

- 2.1. Read the “RECODE-IND.” If the value is 0, proceed to the applicable section below labeled Therapy Visit Recoding, based on the claim “Through” date.

If the value in “RECODE-IND” is 1, find the number of therapy services reported in “REVENUE - SUM 1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in “RECODE-IND” is 3, find the number of therapy services reported in “REVENUE - SUM 1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

- 2.2. Read the alphabetic values in the “CLINICAL-SEV-EQ” field and “FUNCTION-SEV-EQ” field for which the number at the end of the field names corresponds to the recoded first position of the HIPPS code determined in step 2.1. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric value. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

Proceed to the applicable section below labeled Episode Sequence Recoding, based on the claim “Through” date.

Episode Sequence Recoding for claims with “Through” dates on or after January 1, 2017 and before January 1, 2018:

If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows.

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0-5	K
6	L
7-9	M
10	N
11-13	P

If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru G	0 - 6	F1 (Min)	F
H thru N	7 - 13	F2 (Low)	G
O +	14+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
14 - 15	K
16 - 17	L
18 - 19	M

If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0 - 5	K
6	L
7 - 9	M
10	N

11 - 13	P
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If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru B	0 - 1	F1 (Min)	F
C thru J	2 - 9	F2 (Low)	G
K+	10+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
14 - 15	K
16 - 17	L

18 - 19	M
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Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.

Therapy Visit Recoding for claims with “Through” dates on or after January 1, 2017 and before January 1, 2018:

If the first position of the HIPPS code submitted in “HRG-INPUT-CODE” is a 5 and the number of therapy services in “REVENUE - SUM 1-3-QTY-THR” is less than 20, read the value in the “EPISODE-TIMING” field.

If the value in the “EPISODE-TIMING” field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in the “EPISODE-TIMING” field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

Return to the start of this step and recode the remaining positions of the HIPPS code as described above.

In all cases, read only the “REVENUE - SUM 1-3-QTY-THR” field and recode the 4<sup>th</sup> positions of the HIPPS code according to the table below, if possible:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 <sup>th</sup> position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 <sup>th</sup> position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.



If the HIPPS code begins with 1 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 1, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 3, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 1 or 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5
- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F

D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

If the HIPPS code begins with 3 or 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5  
recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R +	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

Episode Sequence Recoding for claims with “Through” dates on or after January 1, 2018 *and before January 1, 2019*, use the following translation:

If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows.

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0-5	K
6	L
7-9	M
10	N

11-13	P
-------	---

If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru H	0 - 7	F1 (Min)	F
I thru P	8 - 15	F2 (Low)	G
Q+	16+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
14 - 15	K
16 - 17	L

18 - 19	M
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If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0 - 5	K
6	L

7 - 9	M
10	N
11 - 13	P

If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru H	3 - 7	F2 (Low)	G
I+	8+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
---------------------------------	--

14 - 15	K
16 - 17	L
18 - 19	M

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.

Therapy Visit Recoding for claims with “Through” dates on or after January 1, 2018 *and before January 1, 2019*:

If the first position of the HIPPS code submitted in “HRG-INPUT-CODE” is a 5 and the number of therapy services in “REVENUE - SUM 1-3-QTY-THR” is less than 20, read the value in the “EPISODE-TIMING” field.

If the value in the “EPISODE-TIMING” field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in the “EPISODE-TIMING” field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

Return to the start of *this* step and recode the remaining positions of the HIPPS code as described above.

In all cases, read only the “REVENUE - SUM 1-3-QTY-THR” field and recode the 4<sup>th</sup> positions of the HIPPS code according to the table below, if possible:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 <sup>th</sup> position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 <sup>th</sup> position value
0-5	K	14-15	K
6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.

If the HIPPS code begins with 1 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 1, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 3, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 1 or 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5
- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
FUNCTION-SEV-			



EQ2 value			
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

If the HIPPS code begins with 3 or 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5  
recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R +	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

Episode Sequence Recoding for claims with “Through” dates on or after *January 1, 2019*, use the following translation:

If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows.

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 – CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 – FUNCTION-SEV-EQ1 value	FUNCTION-SEV-EQ1 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru <i>M</i>	0 - <i>12</i>	F1 (Min)	F
<i>N</i>	<i>13</i>	F2 (Low)	G
<i>O+</i>	<i>14+</i>	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0-5	K

6	L
7-9	M
10	N
11-13	P

If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru H	0 - 7	F1 (Min)	F
I thru <i>M</i>	8 - <i>12</i>	F2 (Low)	G
<i>N+</i>	<i>13+</i>	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
14 - 15	K
16 - 17	L
18 - 19	M

If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 – CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 – FUNCTION-SEV-EQ3 value	FUNCTION-SEV-EQ3 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru G	0 - 6	F1 (Min)	F
H thru K	7 - 10	F2 (Low)	G
L +	11+	F3 (Mod)	H

- change the 4<sup>th</sup> position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 <sup>th</sup> position value
0 - 5	K
6	L
7 - 9	M
10	N
11 - 13	P

If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE - SUM 1-3-QTY-THR” field to recode the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> positions of the HIPPS code as follows:

- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru B	0 - 1	C1 (Min)	A
C thru J	2 - 9	C2 (Low)	B
K +	10+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru H	3 - 7	F2 (Low)	G
I+	8+	F3 (Mod)	H

- change the 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY- THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
14 - 15	K
16 - 17	L
18 - 19	M

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.

Therapy Visit Recoding for claims with “Through” dates on or after *before January 1, 2019*:

If the first position of the HIPPS code submitted in “HRG-INPUT-CODE” is a 5 and the number of therapy services in “REVENUE - SUM 1-3-QTY-THR” is less than 20, read the value in the “EPISODE-TIMING” field.

If the value in the “EPISODE-TIMING” field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

If the value in the “EPISODE-TIMING” field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

Return to the start **this** step and recode the remaining positions of the HIPPS code as described above.

In all cases, read only the “REVENUE - SUM 1-3-QTY-THR” field and recode the 4<sup>th</sup> positions of the HIPPS code according to the table below, if possible:

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 or 4	
REVENUE - SUM 1-3- QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value	REVENUE - SUM 1-3- QTY-THR value	Resulting HRG - OUTPUT – CODE 4 <sup>th</sup> position value
0-5	K	14-15	K

6	L	16-17	L
7-9	M	18-19	M
10	N		
11-13	P		

Move the resulting recoded HIPPS code to the “HRG-OUTPUT-CODE” fields. Proceed to HRG payment calculations. Use the weights associated with the code in the “HRG-OUTPUT-CODE” field for all further calculations.

If the HIPPS code begins with 1 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 3 and the value in “REVENUE - SUM 1-3-QTY-THR” is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 1, and set the “RECODE-IND” to 1. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is less than 14, change the first position of the HIPPS code to 3, and set the “RECODE-IND” to 3. Return to step 2.1 and recode the remaining positions of the HIPPS code as described above.

If the HIPPS code begins with 1 or 2 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5
- recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 – CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 – FUNCTION-SEV-EQ2 value	FUNCTION-SEV-EQ2 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

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

If the HIPPS code begins with 3 or 4 and the value in “REVENUE - SUM 1-3-QTY-THR” is 20 or more:

- change the first position of the HIPPS code to 5  
recode the 2<sup>nd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 – CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG - OUTPUT – CODE 2 <sup>nd</sup> position value
A thru D	0 - 3	C1 (Min)	A
E thru Q	4 - 16	C2 (Low)	B
R +	17+	C3 (Mod)	C

- recode the 3<sup>rd</sup> position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 – FUNCTION-SEV-EQ4 value	FUNCTION-SEV-EQ4 converted point value	Functional Severity Level	Resulting HRG - OUTPUT – CODE 3 <sup>rd</sup> position value
A thru C	0 - 2	F1 (Min)	F
D thru G	3 - 6	F2 (Low)	G



H+	7+	F3 (Mod)	H
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- change the 4th position of the HIPPS code to K.

### 3. HRG payment calculations.

#### 3.1. If the “PEP-INDICATOR” is an N:

Find the weight for the first four positions of the “HRG-OUTPUT-CODE” from the weight table for the calendar year in which the “SERV-THRU-DATE” falls. Determine the applicable episode rate using step 1 of the RAP calculation. Multiply the weight times the applicable episode rate for the calendar year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate.

Multiply the case-mix adjusted rate by the current labor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the labor portion. Multiply the labor portion by the wage index corresponding to the “CBSA” field. Multiply the case-mix adjusted rate by the current nonlabor-related percentage (which is updated via Recurring Update Notifications, per section 70.5 below) to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Find the non-routine supply weight corresponding to the fifth positions of the “HRG-OUTPUT-CODE” from the supply weight table for the calendar year in which the “SERV-THRU-DATE” falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the “SERV-THRU-DATE” falls. The result is the case-mix adjusted payment for non-routine supplies.

Sum the payment results for both portions of the “HRG-OUTPUT-CODE” and proceed to the outlier calculation (see step 4 below).

#### 3.2. If the “PEP-INDICATOR” is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG and supply amounts, as above. Determine the proportion to be used to calculate this PEP by dividing the “PEP-DAYS” amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (step 4 below).

### 4. Outlier calculation:

- #### 4.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the “SERV-THRU-DATE” falls, using the CBSA code in the “CBSA” field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from the HRG payment calculation. This is the outlier threshold for the episode.

4.2. Claims with “Through” dates before January 1, 2017: For each quantity in the six “REVENUE-QTY-COV-VISITS” fields, read the national standard per visit rates from the revenue code table for the year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the “CBSA” field. The result is the wage index adjusted imputed cost for the episode.

Claims with “Through” dates on or after January 1, 2017: For each quantity in the six “REVENUE-QTY- OUTLIER-UNITS” fields, read the national standard per unit rates from the revenue code table for the year in which the “SERV-THRU-DATE” falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the “CBSA” field. The result is the wage index adjusted imputed cost for the episode.

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

4.4. If the result determined in step 4.3 is greater than \$0.00, calculate .80 times the result. This is the outlier payment amount.

4.5. Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:

- Multiply the amount in the “PROV-PAYMENT-TOTAL” field by 10 percent to determine the HHA’s outlier limitation amount.
- Deduct the amount in the “PROV-OUTLIER-PAY-TOTAL” from the outlier limitation amount. This result is the available outlier pool for the HHA.
- If the available outlier pool is greater than or equal to the outlier payment amount calculated in step 4.4, return the outlier payment amount in the “OUTLIER-PAYMENT” field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the “TOTAL-PAYMENT” field, with return code 01.
- If the available outlier pool is less than the outlier payment amount calculated in step 4.4, return no payment amount in the “OUTLIER-PAYMENT” field. Assign return code 02 to this record.

4.6. If the result determined in step 4.3 is less than or equal to \$0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the “OUTLIER-PAYMENT” field. Return the total of all HRG payment amounts in the “TOTAL-PAYMENT” field, with return code 00.

5. Value-Based Purchasing Adjustment:

Multiply all payment amounts by adjustment factor in "PROV-VBP-ADJ-FAC." Return the results as the final Medicare payment amounts in all appropriate output fields.

Subtract the total payments calculated in steps 3 and 4 from the total VBP-adjusted payments calculated in step 5. Return the difference in the "VBP-ADJ-AMT" field.