

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4378	Date: August 23, 2019
	Change Request 11395

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions

I. SUMMARY OF CHANGES: This Change Request revises additional sections of Pub. 100-04, chapter 10, to support the implementation of the HH PDGM and creates new sections to describe the HH PDGM Grouper program

EFFECTIVE DATE: January 1, 2020 - Claim "From" dates on or after this date

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

IMPLEMENTATION DATE: November 27, 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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	10/10.1.23/Changes in a Beneficiary's Payment Source
R	10/70.4/Decision Logic Used by the Pricer on Claims
R	10/80/HH Grouper Program
N	10/80.1/HH Grouper Input/Output Record Layout
N	10/80.2/HH Grouper Decision Logic and Updates
R	10/100/Temporary Suspension of Home Health Services
D	10/100.1/Billing Procedures for an Agency Being Assigned Multiple CCNs or a Change in CCN
R	10/110.2/Payment Procedures for Terminated HHAs

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

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I. GENERAL INFORMATION

A. Background: In the CY 2019 final Home Health Prospective Payment System Rate Update final rule, CMS finalized an alternative case-mix methodology now called the Patient-Driven Groupings Model (PDGM) which includes the payment reform requirements as set forth in the BBA of 2018 and will be implemented in CY 2020. The manual instructions in this Change Request are revised to conform to the final policies of the PDGM.

B. Policy: This CR further implements the policies of the PDGM, as described in the CY 2019 home health final rule and as required by section 51001 of the BBA of 2018. For the complete policy, see the final rule and CRs 11081 and 11272.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC		D M E	Shared- System Maintainers				Other		
		A	B		H H H	M I A C	F S S	M C S		V M S	C W F
11395.1	The contractor shall be aware of the manual changes to Pub. 100-04, chapter 10, Home Health Agency Billing.			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E	C E D I		
		A	B	H H H			M A C	
11395.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter			X				

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	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.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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: 0

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

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10.1.23 - Changes in a Beneficiary's Payment Source

80 – HH Grouper Program

80.1 – HH Grouper Input/Output Record Layout

80.2 – HH Grouper Decision Logic and Updates

110.1 - RESERVED

10.1.23 - Changes in a Beneficiary's Payment Source

1. Payment Source Changes From Medicare Advantage (MA) Organization to Original Medicare.

If a Medicare beneficiary is covered under an MA Organization during a period of home care, and subsequently decides to change to Original Medicare coverage, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Original Medicare. With that assessment, a RAP may be sent to Medicare to open an HH PPS episode/period of care. HHAs are advised to verify the patient's payer source on a regular basis when providing services to a patient with an MA Organization payer source to avoid the circumstance of not having an OASIS to be used to determine the payment group, or having the patient discharged without an OASIS assessment.

If a follow-up assessment is used to generate a new start of care assessment, CMS highly recommends, but does not require, a discharge OASIS assessment be done.

While this is not a requirement, conducting a "paper" discharge at the point where the patient's change in insurance coverage occurred will provide a clear endpoint to the patient's episode of care for purposes of the individual HHA's outcome-based quality reports. Otherwise, that patient will not be included in the HHA's quality measure statistics. It will also keep that patient from appearing on the HHA's roster report (a report the HHS can access from the OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection.

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M2420 (Discharge Disposition) should be marked with Response 2 (Patient remained in the community (with formal assistive services)). CMS realizes that the wording for M0100 and M2420 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide services though the Medicare payment source has changed from an MA Organization to Original Medicare.

In cases where the patient changes from MA coverage to Original Medicare coverage, the patient's overall Medicare coverage is uninterrupted. This means an HH PPS episode/period may be billed beginning on the date of the patient's Original Medicare coverage. Upon learning of the change in MA election, the HHA should submit a RAP using the date of the first visit provided after the Original Medicare effective date as the episode "from" date, and using the OASIS assessment performed most recently after the change in election to produce a HIPPS code for that RAP.

If a new start of care (SOC) OASIS assessment was not conducted at the time of the change in pay source, a correction to an existing OASIS assessment may be necessary to change the reported payer source and, for episode beginning before January 1, 2020, to complete the therapy item (M2200). The HHA should correct the existing OASIS assessment conducted most closely after the new start date. If more than one episode has elapsed before the HHA learns of the change in payer source, this procedure can be applied to the additional episodes/periods. If the patient is still receiving services, the HHA must complete the routine follow-up OASIS assessments (RFA4) consistent with the new start of care date. In some cases, HHAs may need to inactivate previously transmitted assessments to reconcile the data collections with the new episode dates.

2. Payment Source Changes From Original Medicare to MA Organization

In cases where the patient elects MA coverage during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment - PEP - adjustment). The MA Organization becomes the primary payer upon the MA enrollment date. The HHA may learn of the change after the fact, for instance, upon rejection of their claim by Medicare claims processing systems. The HHA must resubmit this claim indicating a transfer of payer source using patient status code "06," and reporting only the visits provided under the fee-for-service eligibility period. The claim through date and the last

billable service must occur before the MA enrollment date. If the patient has elected to move from Original Medicare to an MA Organization and is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

3. Payment Source Changes Involving Medicaid

There may be cases where a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicaid and the patient experiences a change in status that allows their home health services to meet coverage criteria for Original Medicare. In these cases, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Original Medicare. With that assessment, a RAP may be sent to Medicare to open an HH PPS episode/period of care. The OASIS guidance provided above for changes from Medicare Advantage to Original Medicare apply in this case also.

If a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicare FFS and ceases to meet Medicare coverage criteria, the patient should be discharged for Medicare purposes. Patient status code "06" should not be used. This discharge has no payment impact on the Medicare HH PPS episode/period. If the patient being discharged to Medicaid-only coverage is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

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.

If the "SERV-FROM-DATE" is before January 1, 2020, the Pricer shall perform the following: 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 2nd, 3rd and 4th positions of the HIPPS code as follows.

- recode the 2nd 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 nd 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 3rd 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 rd position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	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 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd 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 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd 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 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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, 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 4th 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 th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 th 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 2nd 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 nd 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 3rd 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 rd 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 2nd 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 nd 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 3rd 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 rd 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 2nd, 3rd and 4th positions of the HIPPS code as follows.

- recode the 2nd 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 nd 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 3rd 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 rd position value
A thru N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	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 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd position value
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A thru B	0 - 1	C1 (Min)	A
C thru H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- recode the 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd 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 3rd 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 rd 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 th 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 4th 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 th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT - CODE 4 th 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 2nd 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 nd 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 3rd 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 rd 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 2nd 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 nd 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 3rd 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 rd 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 2nd, 3rd and 4th positions of the HIPPS code as follows.

- recode the 2nd 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 nd 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 3rd 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 rd position value
A thru M	0 - 12	F1 (Min)	F
N	13	F2 (Low)	G
O+	14+	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 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd position of the HIPPS code according to the table below:

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

- recode the 3rd 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 rd position value
A thru H	0 - 7	F1 (Min)	F
I thru M	8 - 12	F2 (Low)	G
N+	13+	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 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd position value
A thru B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

- recode the 3rd 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 rd 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 4th position of the HIPPS code according to the table below:

REVENUE - SUM 1-3-QTY- THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd, 3rd and 4th positions of the HIPPS code as follows:

- recode the 2nd 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 nd 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 3rd 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 rd 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 th position value
14 - 15	K
16 - 17	L

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 4th 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 th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4 th 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 2nd 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 nd 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 3rd 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 rd 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 2nd 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 nd 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 3rd 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 rd 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.

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.

If the “SERV-FROM-DATE” is on or after January 1, 2020, the Pricer shall perform the following: Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in “INIT-PAY-QRP-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” is less than the LUPA threshold associated with the “HRG-INPUT-CODE” (e.g. threshold is 6, sum is 5 or less), 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. No further calculations are required.

1.5 If “REVENUE-SUM1-6-QTY-ALL” is greater than *or equal to* the LUPA threshold associated with the “HRG-INPUT-CODE”, proceed to the HRG payment calculation in step 2.

2. HRG payment calculations.

2.1. If the “PEP-IND” is an N:

Find the weight for the “HRG-INPUT-CODE” from the weight table for the calendar year in which the “SERV-THRU-DATE” falls. 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 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 to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Proceed to the outlier calculation in step 3.

3.2. If the “PEP-INDICATOR” is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG amount, as in 3.1. Determine the proportion to be used to calculate this PEP by dividing the “PEP-DAYS” amount by 30. 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 in step 3.

3. Outlier calculation:

3.1. 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.

- 3.2. 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.
- 3.3. Subtract the outlier threshold for the episode from the imputed cost for the episode.
- 3.4. If the result determined in step 3.3 is greater than \$0.00, calculate .80 times the result. This is the outlier payment amount.
- 3.5. 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 3.4, 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 3.4, return no payment amount in the “OUTLIER-PAYMENT” field. Assign return code 02 to this record.
- 3.6. If the result determined in step 3.3 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.

4. 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 2 and 3 from the total VBP-adjusted payments calculated in step 4. Return the difference in the “VBP-ADJ-AMT” field.

80 – HH Grouper Program

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

The Home Health Resource Group (HHRG) used to pay home health services billed on TOB 032x are determined by the HH Grouper program. HHRGs are represented on claims in the form of HIPPS codes. Like, the HH Pricer, the HH Grouper is a module within Medicare claims processing systems. The HHA sends a HIPPS code on the claim, using revenue code 0023. Medicare systems combine claim data and OASIS data and send the data to the HH Grouper to determine the HIPPS code used for payment. The HIPPS code from the Grouper replaces the provider-submitted HIPPS code on the claim and is then sent to the HH Pricer for payment calculations.

Medicare claims processing systems must send an input record to Grouper for all claims and most adjustments. RAPs and medical review or other program integrity contractor adjustments are not sent to the Grouper. The Grouper will return an output record to the shared systems whenever an input record is sent.

No part of the Grouper logic is required to be incorporated into an HHA's billing system in order to bill Medicare, unless the HHA chooses to do so to assist their accounts receivable functions. The following is presented for A/B MACs (HHH) and as information for the HHAs, in order to help HHAs understand how their HH claims are processed.

80.1 – HH Grouper Input/Output Record Layout

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

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

<i>File Position</i>	<i>Format</i>	<i>Title</i>	<i>Description</i>
1 - 24	X(24)	Claim ID	Input item: Document control number of the claim record.
25-32	X(8)	From Date	Input item: The Statement Covers "From" date from the claim, in format CCYYMMDD
33	9	Period Timing	Input item: Set to 1 when claim From date matches Admission date or when a CWF sequence edit is received. Otherwise, set to 2.
34 - 35	9(2)	Referral Source	Input item: If occurrence code 61 or 62 are present on the claim, the code value is moved to this field. The occurrence date is not moved.
36 - 42	X(8)	Principal Diagnosis	Input item: The principal diagnosis code from the claim.
43 - 50	X(8)	Secondary Diagnosis	Input item: The first secondary diagnosis code from the claim.
51 - 235	Defined above	Additional Secondary Diagnosis data	Input items: 23 additional occurrences of secondary diagnoses from the claim.
236-275	X(40)	Filler	For future use.
276	9	M1033-HOSP-RISK-HSTRY-FALLS	Input item: Moved from the M1033-HSTRY-FALL field on the QIES/OASIS screen in FISS. Valid values: 0,1
277	9	M1033-HOSP-RISK-WEIGHT-LOSS	Input item: Moved from the M1033-WEIGHT-LOSS field on the QIES/OASIS screen in FISS. Valid values: 0,1
278	9	M1033-HOSP-RISK-MLTPL-HOSPZTN	Input item: Moved from the M1033-MLTPL-HOSPZTN field on the QIES/OASIS screen in FISS. Valid values: 0,1
279	9	M1033-HOSP-RISK-MLTPL-ED-VISIT	Input item: Moved from the M1033-MLTPL-ED-VISIT field on the QIES/OASIS screen in FISS. Valid values: 0,1

<i>File Position</i>	<i>Format</i>	<i>Title</i>	<i>Description</i>
280	9	<i>M1033-HOSP-RISK-MNTL-BHV-DCLN</i>	<i>Input item: Moved from the M1033-MNTL-BHV-DCLN on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
281	9	<i>M1033-HOSP-RISK-COMPLIANCE</i>	<i>Input item: Moved from the M1033-COMPLIANCE on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
282	9	<i>M1033-HOSP-RISK-5PLUS-MDCTN</i>	<i>Input item: Moved from the M1033-5PLUS-MDCTN on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
283	9	<i>M1033-HOSP-RISK-CRNT-EXHSTN</i>	<i>Input item: Moved from the M1033-CRNT-EXHSTN on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
284	9	<i>M1033-HOSP-RISK-OTHR-RISK</i>	<i>Input item: Moved from the M1033-OTHER-RISK on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
285	9	<i>M1033-HOSP-RISK-NONE-ABOVE</i>	<i>Input item: Moved from the M1033-NONE-ABOVE on the QIES/OASIS screen in FISS. Valid values: 0,1</i>
286-287	9(2)	<i>M1800-CRNT-GROOMING</i>	<i>Input item: Moved from the M1800-CRNT-GROOMING on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03</i>
288-289	9(2)	<i>M1810-CRNT-DRESS-UPPER</i>	<i>Input item: Moved from the M1810-DRESS-UPPER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03</i>
290-291	9(2)	<i>M1820-CRNT-DRESS-LOWER</i>	<i>Input item: Moved from the M1820-DRESS-LOWER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03</i>
292-293	9(2)	<i>M1830-CRNT-BATHG</i>	<i>Input item: Moved from the M1830-CRNT-BATHG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06</i>
294-295	9(2)	<i>M1840-CRNT-TOILTG</i>	<i>Input item: Moved from the M1840-CRNT-TOILTG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04</i>
296-297	9(2)	<i>M1850-CRNT-TRNSFRNG</i>	<i>Input item: Moved from the M1850-CRNT-TRNSFRNG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05</i>
298-299	9(2)	<i>M1860-CRNT-AMBLTN</i>	<i>Input item: Moved from the M1860-CRNT-AMBLTN on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06</i>
300-599	X(301)	<i>Filler</i>	<i>For future use.</i>

<i>File Position</i>	<i>Format</i>	<i>Title</i>	<i>Description</i>
601-607	X(7)	<i>Version Used</i>	<i>Output item: The version of the HH Grouper which grouped the current claim. Informational only.</i>
608-612	X(5)	<i>HIPPS Code</i>	<i>Output item: The HIPPS code determined by grouping the input items above. Moved to the HCPCS code field of revenue code 0023 line of the claim.</i>
613-614	9(2)	<i>Validity Flag</i>	<i>Output item: Not used.</i>
615-616	9(2)	<i>Grouper Return Code</i>	<i>Output item: Identified technical issues that may cause no HIPPS code to be assigned.</i>
617-700	X(84)	<i>Filler</i>	<i>For future use.</i>

If the return code is 05, the claim will be returned to the provider for correction because the principal diagnosis is not assigned to a clinical group.

80.2 – HH Grouper Decision Logic and Updates

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

The HH Grouper decision logic, in the form of Java computer software, and related documentation are available to the public on the CMS website at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html

The HH Grouper is updated annually, each October 1, to reflect annual changes to the ICD-10 diagnosis code set. It may also be updated on January 1 if changes to the payment system require it. These changes will be described in payment update regulations in the Federal Register. Whenever the HH Grouper is updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes.

100 - Temporary Suspension of Home Health Services

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health services. When the suspension is temporary (does not extend beyond the end date of the 60-day *certification period*) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same *or subsequent 30-day period of care* and under the same plan of care as before. The episode from date and the admission date remain the same as on the RAP(s). No special indication need be made on the claim(s) for the period of suspended services. Explanation of the suspension need be indicated only in the medical record.

If the suspension extends beyond the end of the current 60-day *certification*, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new plan of care and submit a RAP for a new *period of care*. The admission date would match the episode from date, as the admission is under a new plan of care and care was not continuous.

110.1 - RESERVED

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

110.2 - Payment Procedures for Terminated HHAs

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

Medicare regulations allow that payment may be made for home health services for up to thirty days after a home health agency (HHA) terminates their Medicare provider agreement. This payment may be made if the home health services are furnished under a home health plan of care established before the effective date of the termination.

Medicare continues to make full episode/*period of care* payments for episodes which extend beyond a provider's termination date if the home health services are provided under a plan of care established prior to that date and if the home health episode/period of care ends within the 30 day period.

For episodes beginning before January 1, 2020, in cases where an episode begins prior to a provider's termination date and the episode ends after the 30 day allowance period, the portion of these episodes that falls within the 30-day allowance period receives Medicare payment. The payment mechanism under HH PPS for paying for shortened periods of services is the partial episode payment (PEP) adjustment. Medicare systems will make PEP payments for HH PPS episodes which begin prior to a provider's termination date and which end after the 30 day allowance period.