CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3655	**Date: November 10, 2016**
	Change Request 9736

Transmittal 3585, dated August 12, 2016, is being rescinded and replaced by Transmittal 3655, dated November 10, 2016, to revise the position numbers in Pricer record layout in section 70.2, to add language defining negative pressure wound therapy to section 90.3, to remove the Sensitive/Controversial designation as this is no longer sensitive/controversial, and to update Attachment 1 to reflect final rates. All other information remains the same.

SUBJECT: Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System

I. SUMMARY OF CHANGES: The CR implements a separate payment for home health agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. In addition, this instruction will implement changes to the methodology used to calculate outlier payments to HHAs. Lastly, this CR creates new G codes associated with registered nurse and licensed practical nurse visits in the home health setting.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments
R	10/20.2.2/Therapy Editing
R	10/40.2/HH PPS Claims
R	10/50/Beneficiary-Driven Demand Billing Under HH PPS
R	10/70.2/Input/Output Record Layout
R	10/70.4/Decision Logic Used by the Pricer on Claims
R	10/70.5/Annual Updates to the HH Pricer
R	10/90/Medical and Other Health Services Submitted Using Type of Bill 034x

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	10/90.3/Billing Instructions for Disposable Negative Pressure Wound Therapy Services

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3655	Date: November 10, 2016	Change Request: 9736

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SUBJECT: Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

I. GENERAL INFORMATION

A. Background: Provision of Negative Pressure Wound Therapy (NPWT) Using a Disposable Device

The Consolidated Appropriations Act of 2016 (Pub. L. 114-113) requires a separate payment to be made to Home Health Agencies (HHAs) for disposable NPWT devices when furnished, on or after January 1, 2017, to an individual who receives home health (HH) services for which payment is made under the Medicare home health benefit.

Change in the Methodology Used to Calculate Outlier Payments

Currently, the Centers for Medicare & Medicaid Services (CMS) calculates the estimated cost for an episode using the number of visits by discipline and multiplying them by the national per-visit rates finalized in our rules. The Report to Congress on home health access to care and payment for vulnerable patient populations (required per section 3131(d) of the Affordable Care Act), indicated that HHAs can make a profit on outlier episodes by providing shorter visits than what is assumed in the national per-visit rates. Thus, the current methodology for calculating the cost of an episode of care potentially overestimates the costs associated with an episode where shorter visits are provided than is assumed in the national per-visit rates. In addition, the study findings noted that certain types of patients may be associated with lower margins, such as those who require parenteral nutrition or require substantial assistance with bathing. These types of patients, on average, typically require longer visits and are thus more costly to treat.

Analysis of calendar year (CY) 2015 data indicates that there is significant variation in the visit length by discipline for outlier episodes. Those agencies with 5 percent or more of their total payments as outlier payments are providing shorter but more frequent skilled nursing visits than agencies with less than 5 percent of their total payments as outlier payments

Creation of New G Codes for RN and LPN in Home Health Episodes

Effective for January 1, 2016, CMS divided the G0154 code into two different codes (codes G0299 and G0300) that differentiate registered nurse (RN) from licensed practical nurse (LPN) and may be used in both HH and Hospice settings. This change was made in order to furnish a hospice add-on payment that is only payable for RN visits (not LPN visits) through the Service Intensity Add-on Payment.

As of CY 2015, we now annually recalibrate the HH case-mix weights. The weights are determined by calculating the cost for each episode of care, grouping the episodes by similar levels of resource use, and comparing the group’s average resource use to overall mean. The cost of an episode of care is calculated

using the Bureau of Labor Statistics (BLS) average hourly wage rate for the discipline that performed the visit multiplied by the minutes per visit reported on the HH claim. Currently, we have separate G-codes for therapist versus therapist assistant visits so we are able to use the appropriate BLS average hourly wage rate depending on whether the visit was performed by a therapist or an assistant. However, for skilled nursing services, because G0163 and G0164 are for an RN or LPN, we have to assume a certain percentage are performed by a RN versus an LPN.

Since we have begun differentiating direct skilled nursing using the two new G-codes (codes G0299 and G0300), CMS believes it is appropriate to differentiate G0163 and G0164 as well so that we no longer have to use an assumption in calculating the cost per episode when those two services are performed, allowing for increased payment precision.

B. Policy: Provision of Negative Pressure Wound Therapy (NPWT) Using a Disposable Device

As described in the Consolidated Appropriations Act of 2016 (Pub. L. 114-113), the separate payment amount for an applicable disposable device will be set equal to the amount of the payment that would otherwise be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I Healthcare Common Procedure Coding System (HCPCS) code, otherwise referred to as Current Procedural Terminology (CPT-4) codes.

Currently CPT codes 97607 and 97608 (APC 5052), with status indicator "T" (Procedure or Service, Multiple Procedure Reduction Applies), include payment for both performing the service and the disposable NPWT device:

- HCPCS 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

- HCPCS 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

To avoid duplication of payment, for instances where the sole purpose for an HHA visit is to perform NPWT using a disposable device (integrated system of a vacuum pump, receptacle for collecting exudate, and dressings for the purposes of wound therapy), Medicare will not pay for a skilled nursing or therapy visit under the HH PPS. Rather, performing NPWT using a disposable device for a patient under a home health plan of care is separately reimbursed the OPPS amount relating to payment for covered Outpatient Department (OPD) services. In this situation, the HHA bills under type of bill 034x and reports the appropriate revenue code (0559, 042X, 043X), along with the appropriate HCPCS code (97607 or 97608).

NOTE: This visit is not reported on the HH PPS claim (type of bill 32x).

If NPWT using a disposable device is performed during the course of an otherwise covered home health visit (e.g., to perform a catheter change), the visit would be covered as normal but the HHA must not include the time spent performing NPWT in their visit charge or in the length of time reported for the visit. Performing NPWT using a disposable device for a patient under a home health plan of care will be separately reimbursed the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills under type of bill 34X and reports revenue code (0559, 042X, 043X) along with the appropriate HCPCS code (97607 or 97608).

NOTE: This visit is also reported on the HH PPS claim (type of bill 32x).

Change in the Methodology Used to Calculate Outlier Payments

Given the analysis described above, as well as the findings from the 3131(d) study, we are concerned the current methodology for calculating outlier payments creates a financial disincentive for providers to treat medically complex beneficiaries that require longer visits. In addition, the current methodology does not accurately calculate the precise cost of an episode of care for instances where the length of the visit is greater than or less than the average length of a visit assumed in the national per-visit rates. Therefore, we are changing the methodology used to calculate outlier payments to a cost-per-unit approach rather than a cost-per-visit approach.

HHAs currently report visit lengths in 15 minute increments (15 minutes = 1 unit). To implement this new methodology, the national per-visit rates will be converted into per unit rates as described in Attachment 1. The new per-unit rates will then be 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. This change in the methodology will be budget neutral as we would still target to pay up to, but no more than, 2.5 percent of total HH PPS payments as outlier payments.

In conjunction with the change to a cost-per-unit approach to estimate episode costs and determine whether an outlier episode should receive outlier payments, we are implementing a cap on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier calculation purposes, limiting the amount of time per day (summed across the six disciplines of care) at 8 hours or 32 units total.

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

Creation of New G Codes for RN and LPN in Home Health Episodes

Given the reporting needs articulated above, we are requesting that G0163 and G0164 be retired, effective January 1, 2017, and instead replaced with four new G-codes:

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

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

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

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility

		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9736.1	The contractor shall allow revenue code 0559 on claims with Type of Bill (TOB) 034x.			X						
9736.2	The contractor shall ensure that if revenue code 0559 is billed on TOB 034x only disposable negative pressure wound therapy services (HCPCS codes 97607 or 97608) are reported.					X				
9736.2.1	The contractor shall return to the provider any claim reporting HCPCS codes other than 97607 and 97608 with revenue code 0559 on TOB 34x.			X						
9736.3	The contractor shall ensure that if HCPCS codes 97607 or 97608 are billed on TOB 034x the revenue code is 042x, 043x or 0559.					X				
9736.3.1	The contractor shall return to the provider any claim reporting HCPCS codes 97607 and 97608 with revenue codes other than 042x, 043x or 0559 on TOB 34x.			X						
9736.4	The contractor shall pay disposable negative pressure wound therapy services provided to a beneficiary in a home health (HH) episode of care based on the Outpatient Prospective Payment System (OPPS) amount.					X				IOCE, OPPS Pricer
9736.4.1	The contractor shall ensure claims with HCPCS 97607 and 97608 on TOB 034x are assigned an Ambulatory Patient Classification (APC).									IOCE
9736.4.2	The contractor shall ensure claims with HCPCS 97607 and 97608 on TOB 034x are sent to the OPPS Pricer and calculate the OPPS payment amount.					X				OPPS Pricer
9736.4.3	The contractor shall pay claims with HCPCS 97607 and 97608 on TOB 034x the calculated OPPS amount unless the date of service is subsequently identified as not falling within a HH episode. (**NOTE:** Claims will be identified as outside a HH episode by the CWF edit described in BR 9736.5.)					X				
9736.5	The contractor shall reject claim lines with HCPCS 97607 and 97608 on TOB 034x if the line item date of service does not overlap the from and through dates of an existing HH episode.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The edit shall be overrideable.									
9736.5.1	When a claim with HCPCS 97607 and 97608 on TOB 034x is identified as not falling within a HH episode, the contractor shall pay lines reporting revenue code 042x and 043x under the Medicare Physician Fee Schedule.					X				
9736.5.2	When a claim with HCPCS 97607 and 97608 on TOB 034x is identified as not falling within a HH episode, the contractor shall deny lines reporting revenue code 0559.			X		X				
9736.5.2.1	The contractor shall apply the following remittance advice messages when denying HCPCS 97607 and 97608 on TOB 034x reporting revenue code 0559: Group Code: CO CARC: 170 RARC: N95			X						
9736.5.3	The contractor shall apply the CWF edit override code when taking the actions described in 9736.5.1 and 9736.5.2.					X				
9736.6	The contractor shall bypass HH consolidated billing edits for claim lines with HCPCS 97607 and 97608 on TOB 034x								X	
9736.7	The contractor shall revise the input record for the HH Pricer as shown in the revised section 70.2 of Pub. 100-04, Medicare Claims Processing Manual, chapter 10.					X				HH PPS Pricer
9736.8	The contractor shall return to provider a HH PPS claim (TOB 032x) if greater than 96 units are reported on any line with revenue code 042x, 043x, 044x, 055x, 056x or 057x.			X		X				
9736.9	The contractor shall accumulate the number of units reported on all lines with revenue codes 042x, 043x, 044x, 055x, 056x or 057x with covered charges and send the total to the HH Pricer in the REVENUE-QTY- OUTLIER-UNITS field.					X				HH PPS Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9736.9.1	The contractor shall add the number of units to the corresponding REVENUE-QTY- OUTLIER-UNITS total on any line item with revenue codes 042x, 043x, 044x, 055x, 056x or 057x, if there is only one line with these revenue codes for the date of service and the number of units is 32 or less.					X				
9736.9.2	The contractor shall add 32 units to the corresponding REVENUE-QTY- OUTLIER-UNITS total on any line item with revenue codes 042x, 043x, 044x, 055x, 056x or 057x, if there is only one line with these revenue codes for the date of service and the number of units is greater than 32.					X				
9736.9.3	The contractor shall add the number of units to the corresponding REVENUE-QTY- OUTLIER-UNITS if there are more than one line with revenue codes 042x, 043x, 044x, 055x, 056x or 057x for the same date of service and the total number of units on the lines is 32 or less.					X				
9736.9.4	The contractor shall apportion the number of units to the corresponding REVENUE-QTY- OUTLIER-UNITS as shown in Attachment Two if there are more than one line with revenue codes 042x, 043x, 044x, 055x, 056x or 057x for the same date of service and the total number of units on the lines is greater than 32.					X				
9736.10	The contractor shall calculate the imputed cost portion of the HH PPS outlier calculation by multiplying the per-unit amount shown in Attachment One by the number in REVENUE-QTY- OUTLIER-UNITS for each revenue code and summing the results. **NOTE:** All other steps of the outlier calculation are not changing.									HH PPS Pricer
9736.11	The contractor shall allow HCPCS codes G0493 through G0496 on claims with TOB 032x, effective January 1, 2017.			X						
9736.12	The contractor shall no longer allow HCPCS codes G0163 and G0164 on claims with TOB 032x, effective January 1, 2017.			X						
9736.13	The contractor shall ensure effective dates of HCPCS			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	codes are set as follows for TOB 032x: • HCPCS codes G0493 through G0496 - Line effective date of 1/1/2107, effective date indicator (EFF) set to 'D' • HCPCS codes G0163 and G0164 - Header termination date blank, enter line termination date of 12/31/2016 and EFF indicator set to 'F'									
9736.14	The contractor shall send the earliest line item date for a skilled nursing visit to the HH Pricer based on the date of service, as follows: • For dates of service before January 1, 2016, when revenue code 055x is present on the earliest date and the HCPCS code is G0154, G0162, G0163, or G0164. • For dates of service on or after January 1, 2016, and before January 1, 2017, when revenue code 055x is present on the earliest date and the HCPCS code is G0299, G0300, G0162, G0163, or G0164. • For dates of service on or after January 1, 2017, when revenue code 055x is present on the earliest date and the HCPCS code is G0299, G0300, G0162, G0493, G0494, G0495 and G0496.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9736.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters"			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

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 (claims processing) , Sharon Ventura, 410-786-1985 or sharon.ventura@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

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 3655, Issued: 11-10-16)

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

HH PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 60-day periods, Medicare claims processing systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

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

- The *episode's estimated cost, calculated as sum of the products of the* number of visits of each discipline on the claim **and** each wage-adjusted national standardized per visit rate for each discipline; with

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

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

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

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

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

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

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

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment shall be included in the total payment for the episode claim on a

remittance, but it will be identified separately on the claim using value code 17 with an associated dollar amount representing the outlier payment.

Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

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

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

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

Group Code: CO
CARC: B5
RARC: N523
MSN: N/A

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

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

20.2.2 - Therapy Editing

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services

billed under revenue codes 042x, 043x, 044x. These revenue codes are subject to consolidated billing when submitted on types of bill 013x, 023x, 034x, 074x, 075x or 085x. *Consolidated billing edits do not apply on TOB 034x when the HHA is billing for disposable negative pressure wound therapy services during a HH episode.*

On claims submitted by practitioners using the professional claim format, CWF enforces consolidated billing for outpatient therapies using a list of HCPCS codes which represent therapy services.

Therapy services on professional claims are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.

The following specialty codes indicate a physician for purposes of this edit:

Code	**Physician Specialty**
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
28	Colorectal Surgery (formerly proctology)

Code	Physician Specialty
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

40.2 - HH PPS Claims

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

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

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

Billing Provider Name, Address, and Telephone Number

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

Patient Control Number and Medical/Health Record Number

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

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

Type of Bill

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

032x - Home Health Services under a Plan of Treatment

4th Digit - Definition

7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims

must be accepted at any point within the timely filing period after the payment of the original claim.

8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

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

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

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

Statement Covers Period

Required - The beginning and ending dates of the period covered by this claim. The "from" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "through" date must be 59 days after the "from" date. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal discharge procedures as the "through" date. If the beneficiary has died, the HHA reports the date of death in the "through date."

Any NUBC approved patient status code may be used in these cases. The HHA may submit claims for payment immediately after the claim "through" date. It is not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

Patient Name/Identifier

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

Patient Address

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

Patient Birth Date

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

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

Patient Discharge Status

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

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

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

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

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

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

Condition Codes

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

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

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

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

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

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

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

Occurrence Codes and Dates

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

Occurrence Span Code and Dates

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

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. For episodes in which the beneficiary's site of service changes from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: A/B MAC (HHH)-entered value codes. The A/B MAC (HHH) enters codes 17 and 62 - 65 on the claim in processing. They may be visible in the A/B MAC (HHH)'s online claim history and on remittances.

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

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

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

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

Revenue Code and Revenue Description

Required

HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. The fifth position of the code represents the NRS severity level. This fifth position may differ to allow the HHA to change a code that represents that supplies were provided to a code that represents that supplies were not provided, or vice versa. However, the fifth position may only change between the two values that represent the same NRS severity level. Section 10.1.9 of this chapter contains the pairs of corresponding values. If these criteria are not met, Medicare claims processing systems will return the claim.

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

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 042x, 043x, 044x, 055x, 056x and 057x) must be reported as a separate line. Any of the following revenue codes may be used:

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

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

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

Revenue Codes for Optional Billing of DME

Billing of DME provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their (A/B MAC (HHH)) processing home health claims or to have the services provided under arrangement

with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20 of this manual.

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

Revenue Code for Optional Reporting of Wound Care Supplies

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

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

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

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

Validating Required Reporting of Supply Revenue Code

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

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

Medicare systems will return the claim to the HHA if the HIPPS code indicates non-routine supplies were provided and supply charges are not reported on the claim. When the HHA receives a claim returned for this reason, the HHA must review their records regarding the supplies provided to the beneficiary. The HHA may take one of the following actions, based on the review of their records:

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

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

Medicare may change the HIPPS used for payment of the claim in the course of claims processing, but the HIPPS code submitted by the provider in this field is never changed or replaced. If the HIPPS code is changed, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

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

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

Physical Therapy (revenue code 042x)

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

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

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

Occupational Therapy (revenue code 043x)

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

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

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

Speech-Language Pathology (revenue code 044x)

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

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

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

Skilled Nursing (revenue code 055x)

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

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

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

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

Care plan oversight:
For dates of service before January 1, 2017:
G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

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

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

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

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

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

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

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

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

<u>Medical Social Services (revenue code 056x)</u>

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

Home Health Aide (revenue code 057x)

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

Regarding all skilled nursing and skilled therapy visits

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

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

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

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

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

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

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

Service Date

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

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

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

Service Units

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

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

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

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

Total Charges

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

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

Non-covered Charges

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

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

Payer Name

Required - See chapter 25.

Release of Information Certification Indicator

Required - See chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

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

Patient's Relationship To Insured

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

Insured's Unique Identifier

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

Insured's Group Name

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

Insured's Group Number

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

Treatment Authorization Code

Required - The code on the claim will match that submitted on the RAP.

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

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

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

Document Control Number (DCN)

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

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

Employer Name

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

Principal Diagnosis Code

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

The ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

The principal diagnosis code on the claim will match that submitted on the RAP.

Other Diagnosis Codes

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

For other diagnoses, the diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness

of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

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

Other Provider (Individual) Names and Identifiers

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

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

Remarks

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

50 - Beneficiary-Driven Demand Billing Under HH PPS

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in an Advance Beneficiary Notice of Noncoverage (ABN), which also must be signed by the beneficiary or appropriate representative. Instructions for the ABN are found in chapter 30 of this manual.

Beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the "demand bill" are covered and pays for them, the HHA

would refund the previously collected funds for these services. If the Medicare determination upholds the HHA's judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the A/B MAC (HHH) determines the ABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is an episode of care, usually 60 days in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care and (2) at least one service must have been provided to the beneficiary, so that a RAP can be sent to Medicare and create a record of an episode in Medicare claims processing systems. Therefore, demand billing under HH PPS must conform to ALL of the following criteria:

- Situations in which disputed services are called for under a plan of care, but the HHA believes the services do not meet Medicare criteria for coverage;
- Claims sent to Medicare with TOB 032x; and
- Episodes on record in Medicare claims processing systems (at least one service in episode).

A. Interval of Billing

Under HH PPS, the interval of billing is standard. At most, a RAP and a claim are billed for each episode. Providers may submit a RAP after the delivery of the first service in the 60-day episode, and they must submit a claim either after discharge or after the end of the 60-day episode. This does not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

B. Timeliness of Billing

Medicare requests that HHAs submit demand bills promptly. Timely filing requirements were not changed by HH PPS (see chapter 1 for information on timely filing). Medicare has defined "promptly" for HH PPS to mean submission at the end of the episode in question. The beneficiary must also be given either a copy of the claim or a written statement of the date the claim was submitted. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments are automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §40.3.

C. Claim Requirements

Original HH PPS claims are submitted with TOB 0329, and provide all other information required on that claim for the HH PPS episode, including all visit-specific detail for the entire episode (the HHA must NOT use TOB 0320). When such claims

also serve as demand bills, the following information must **also** be provided: condition code "20" and the services in dispute shown as noncovered line items. Demand bills may be submitted with all noncovered charges. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 0327, may also be submitted but must have been preceded by the submission of a TOB 0329 claim for the same episode. RAPs are not submitted as demand bills, but must be submitted for any episode for which a demand bill will be submitted. Such RAPs should not use condition code 20, only the claim of the episode uses this code.

Cases may arise in which the services in dispute are visits for which an HHA has physician's orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of these visits that is not covered by Medicare may be covered by another payer (e.g., an 8-hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as *two* line *items. One line will represent* the portion potentially covered by Medicare with a covered charge amount and *units reporting the Medicare-covered visit time*. *The second line will represent* the portion to be submitted for consideration by other insurance with a noncovered charge amount *and units reporting non-Medicare visit time*.

Cases may also arise in which a State Medicaid program requests the demand bill on the beneficiary's behalf regarding services which have been billed to Medicaid. In these cases, the dates of service for which the State requests the demand bill may not correspond exactly to the episode periods billed to Medicare. These cases require special instructions:

Request begins during non-Medicare episode:

A Medicare-Medicaid dually-eligible patient may be admitted to home care with the expectation that no services will be billed to Medicare. Later, the State may request demand bills beginning during the course of that episode. This may occur when requests correspond to a calendar year. For example, the patient may be admitted in December and the request for demand bills is effective January 1. In this case, the HHA should submit a demand bill to Medicare with episode dates corresponding to the OASIS assessment that began in December. All services in the episode should be submitted as non-covered line items. As with any demand bill, condition code 20 should be reported on this claim.

Request applies to services immediately following Medicare discharge:

A dually-eligible patient may be discharged from Medicare home health services before the end of a 60-day episode due to the patient meeting their treatment goals. The patient may remain under the care of the HHA receiving services billed to Medicaid. States may vary in their requirements for a new Start of Care OASIS assessment in these cases.

If the State requesting a demand bill for the services within the original Medicare 60-day episode does not require a new OASIS assessment, the HHA should submit an

adjustment to their previously paid Medicare claim, using TOB 0327. The HHA should add condition code 20 to the adjustment claim, change the statement "Through" date to reflect the full 60-day period and add the services provided during the demand bill request period as non-covered line items. The HHA should then submit claims with condition code 20 and all non-covered line items for any episodes of continuous care within the demand bill request period.

If the State requesting a demand bill for the services within the original Medicare 60-day episode requires a new OASIS assessment, the HHA should submit RAPs and submit claims with condition code 20 as they would for any other demand bill situation. When Medicare receives the RAP for the demand billed episode it will cause a PEP adjustment to apply to the prior episode. Medicare cannot presume that the demand billed episode will or will not be covered based on the RAP. If the final claim for the demand billed episode is later reviewed and found to be entirely non-covered, Medicare systems will automatically adjust the prior episode to restore the appropriate full episode payment.

D. Favorable Determinations and Medicare Payment

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will change only with the addition of covered visits if one or more of the following conditions apply:

- An increase in the number of therapy visits results in a change in the payment group for the episode - in such cases, the payment group of the episode would be changed by the A/B MAC (HHH) in medical review;

- An increase in the number of overall visits that either:

    1. Changes payment from a low-utilization payment adjustment to a full episode; or

    2. Results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode).

- A favorable ruling on a demand bill adds days to an episode that received a PEP adjustment.

If a favorable determination is made, A/B MACs (HHH) will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

E. Appeals

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health

claims. HH PPS RAPs do not have appeal rights; rather, appeals rights are tied to the claims that represent all services delivered for the entire episode unit of payment.

F. Specific Demand Billing Scenarios

1. Independent Assessment. Billing questions relative to the ABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all such cases, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, Medicare providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

> 42 CFR 484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. ABNs can be used for this purpose.

2. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, an HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and an ABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an ABN. Billing services in excess of the benefit is discussed in C in this section.

3. One-Visit Episodes. Since intermittent skilled nursing care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim

with use of patient status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, an HHA should still give the beneficiary an ABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary**.** However, there are options for billing these non-covered services as discussed in chapter 1, section 60 of this manual. Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in number 1, immediately above.

70.2 - Input/Output Record Layout

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

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

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

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

File Position	Format	Title	Description
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code unless the claim is recoded due to therapy thresholds or changes in episode sequence. If recoded, the Medicare claims processing system stores this output item in the APC-HIPPS field on the claim record.
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Fields for five more occurrences of all HRG/HIPPS code related fields defined above. Not used.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-*262*	*9(5)*	*REVENUE-QTY - OUTLIER-UNITS*	*Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.*
263-270	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.

File Position	Format	Title	Description	
271-279	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
280-288	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
289-297	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055x, then this is the national per-visit amount multiplied by 1.8714. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6841. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6293.	
298-532	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
533-534	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies

File Position	Format	Title	Description	
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates before Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 03x9 or adjustment TOB
535-539	9(5)	REVENUE - SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.	
540-544	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
545-553	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.	
554-562	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.	
563-567	9(3)V9(2)	LUPA-ADD-ON-PAYMENT	Output item: For claim "Through" dates before January 1, 2014, the add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim. For claim "Through" dates on or after January 1, 2014, zero filled.	
568	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the RAP or claim. The indicator is set to '1' in all other cases.	

File Position	Format	Title	Description
569	X	RECODE-IND	Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0 = default value 1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 3 = HIPPS code shows early episode, should be later episode
570	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values: 1 = early episode 2 = late episode
571	X	CLINICAL-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment authorization code.
572	X	FUNCTION-SEV-EQ1	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.
573	X	CLINICAL-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.
574	X	FUNCTION-SEV-EQ2	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.

File Position	Format	Title	Description
575	X	CLINICAL-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 15th position of the treatment authorization code.
576	X	FUNCTION-SEV-EQ3	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code.
577	X	CLINICAL-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.
578	X	FUNCTION-SEV-EQ4	Input item: A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
579-588	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
589-599	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
600-650	*X(51)*	FILLER	

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

The Medicare claims processing system will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for the HIPPS code will be placed in the total charges and the covered charges field of the revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount. If the return code is 06 (indicating a low utilization payment adjustment), the Medicare claims processing system will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice. If the return code is 14, the Medicare claims processing system will apply the H-HHA-REVENUE-ADD-ON-VISIT-AMT to the earliest line item with the corresponding revenue code.

Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code.

If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451.

If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700.

If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

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 step 3.1, 4.1 or 5.1 below (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.

3. If the claim "Through" date is before January 1, 2015, use the following translation. Otherwise, proceed to step 4.

   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 2nd position value
A thru D	0-4	C1 (Min)	A
E thru H	5-8	C2 (Low)	B
I +	9+	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 3rd position value
A thru E	0-5	F1 (Min)	F
F	6	F2 (Low)	G
G +	7+	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 4th 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 2nd position value
A thru F	0-6	C1 (Min)	A
G thru N	7-14	C2 (Low)	B
O+	15+	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 3rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	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 4th 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 2nd position value
A thru B	0-2	C1 (Min)	A
C thru E	3-5	C2 (Low)	B
F+	6+	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 3rd position value
A thru H	0-8	F1 (Min)	F
I	9	F2 (Low)	G
J +	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 4th 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 2nd position value
A thru H	0-8	C1 (Min)	A

I thru P	9-16	C2 (Low)	B
Q+	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 3rd position value
A thru G	0-7	F1 (Min)	F
H	8	F2 (Low)	G
I +	9+	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 4th 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.

3.1 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 step 3 and recode the remaining positions of the HIPPS code as described above.

3.2 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 4th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th 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 2nd position value
A thru G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	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 3rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	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 2nd position value
A thru G	0-7	C1 (Min)	A
H thru N	8-14	C2 (Low)	B
O +	15+	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 3rd position value
A thru F	0-6	F1 (Min)	F
G	7	F2 (Low)	G
H +	8+	F3 (Mod)	H

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

4. For claims with "Through" dates on or after January 1, 2015 and before January 1, 2016, use the following translation. Otherwise, proceed to step 5.

   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 2nd 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 3rd position value
A thru O	0 - 14	F1 (Min)	F
P	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 4th 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 2nd 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 3rd position value
A thru D	0 - 3	F1 (Min)	F
E thru N	4 - 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 4th 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 2nd position value
A	0	C1 (Min)	A
B	1	C2 (Low)	B
C+	2+	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 3rd position value
A thru J	0 - 9	F1 (Min)	F
K	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 4th 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 2nd position value
A thru F	0 - 5	C1 (Min)	A

G thru M	6 - 12	C2 (Low)	B
N +	13+	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 3rd position value
A	0	F1 (Min)	F
B thru H	1 - 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 4th 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.

4.1 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 step 4 and recode the remaining positions of the HIPPS code as described above.

4.2 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 4th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th 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 2nd 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 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru F	3 - 5	F2 (Low)	G
G+	6+	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 2nd 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 3rd position value
A thru C	0 - 2	F1 (Min)	F
D thru F	3 - 5	F2 (Low)	G
G+	6+	F3 (Mod)	H

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

5. For claims with "Through" dates on or after January 1, 2016, 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 2nd 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 3rd position value
A thru O	0 - 14	F1 (Min)	F
P	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 4th 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 2nd 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 3rd 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 4th 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 2nd position value
A	0	C1 (Min)	A
B	1	C2 (Low)	B
C+	2+	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 3rd 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 4th 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 2nd position value
A thru D	0 - 3	C1 (Min)	A

E thru M	4 - 12	C2 (Low)	B
N +	13+	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 3rd position value
A	0	F1 (Min)	F
B thru H	1 - 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 4th 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.

5.1 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 step 5 and recode the remaining positions of the HIPPS code as described above.

5.2 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 4th position value	REVENUE - SUM 1-3-QTY-THR value	Resulting HRG - OUTPUT – CODE 4th 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 2nd 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 3rd 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 2nd 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 3rd 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.

6. HRG payment calculations.

6.1. 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. Multiply the weight times the Federal standard 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 7 below).

6.2. 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 7 below).

7. Outlier calculation:

7.1. 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.

7.2. *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 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 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.

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

7.4. If the result determined in step 7.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

7.5. 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 7.4, 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 7.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

7.6. If the result determined in step 7.3 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.

70.5 - Annual Updates to the HH Pricer

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the Federal Register**:**

- The Federal standard episode amount;
- The Federal conversion factor for non-routine supplies;
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights to be used for each HRG;
- A table of supply weights to be used to adjust the non-routine supply conversion factor;
- A table of national standardized per visit rates *and per unit rates*;
- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and nonlabor percentages.
- Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the HH Pricer.

90 - Medical and Other Health Services *Submitted Using* Type of Bill 034x

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

HHAs may submit claims for certain medical and other health services which are paid from the Part B trust fund. The HHA may receive payment for these services outside of the prospective payment system (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 7).

A. Patient Not Under A Home Health Plan Of Care

The HHA submits claims with TOB 034x to bill for certain “medical and other health services” when there is no home health plan of care. Specifically the HHA may bill using TOB 034x for the following services. (There must be a physician’s certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. (See chapter 20 for billing enteral and parenteral supplies and equipment.)

- Rental or purchase of DME. (See chapter 20 for billing enteral and parenteral supplies and equipment.)

- Prosthetic devices. (See chapter 20 for billing enteral and parenteral supplies and equipment.)

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

- Outpatient physical therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)

- Outpatient speech-language pathology services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)

- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)

- Diabetes Outpatient Self-Management Training (DSMT). (See the Medicare Benefit Policy Manual, chapter 15, section 300.5.1)

- Bone Mass Measurements. (See the Medicare Claims Processing Manual, chapter 13, section 140.)

- Smoking and Tobacco-Use Cessation Counseling Services. (See the Medicare Claims Processing Manual, chapter 32, section 12.)

Bills for services not under a home health plan of care should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g., monthly, without regard to an episode of care. These items are not reimbursed under HH PPS.

B. The Patient is Under a Home Health Plan of Care

If a patient is receiving home health services under a plan of care, the agency may bill for the following services on TOB 034x:

- A covered osteoporosis drug,

- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines, *and*

- *Disposable negative pressure wound therapy services.*

All other services are home health services and should be billed as an HH PPS episode with Type of Bill 032x.

DME, orthotic, and prosthetics can be billed as a home health service using type of bill 032x or as a medical and other health service using type of bill 034x as appropriate. Alternately, these services may be provided to HH beneficiaries by a supplier. Refer to instructions in chapter 20 of this manual for submitting claims under arrangement with suppliers.

C Billing Spanning Two Calendar Years

The agency should not submit a medical and other health services bill paid from the Part B trust fund (TOB 034x only) for an inclusive period beginning in 1 calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits the A/B MAC (HHH) to apply the appropriate deductible for both years. HH PPS claims (TOB 032x) may span the calendar year since they represent 60-day episodes, and episodes should be paid based on the payment rates in effect in the calendar year in which they end.

D Billing For Laboratory Services

HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not report laboratory services, even when on the HH plan of care, to an A/B MAC (A) or (HHH) using an institutional claim format. These services are always billed to A/B MACs (B) using a professional claim format. To submit such claims, the HHA must have a CLIA number and a professional billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate MAC to obtain a billing number. The survey process is used to validate that laboratory services in an HHA facility are being provided in accordance with the CLIA certificate.

90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services

(Rev. 3655, Issued: 11-10-16, Effective: 01-01-17, Implementation: 01-03-17)

Effective January 1, 2017, Medicare makes a separate payment amount for a disposable negative pressure wound therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPPS).

Disposable NPWT services are billed using the following HCPCS codes:

- *97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.*

- *97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.*

The HHA reports the HCPCS code with one of three revenue codes, depending on the practitioner that provided the service:

- *Skilled nurse – 0559*
- *Physical therapist – 042x*
- *Occupational therapy – 043x.*

When using revenue codes 042x or 043x, the HHA should not use the therapy plan of care modifiers (GO or GP) for NPWT services.
These HCPCS codes include payment for both performing the service and the disposable NPWT device, which is defined as an integrated system comprised of a nonmanual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy. Services related to the provision of NPWT using a disposable device that do not encompass the provision of the entire integrated system should be billed per existing HH PPS guidelines.
To avoid duplication of payment, for instances where the sole purpose for an HHA visit is to perform NPWT using a disposable device, Medicare will not pay for a skilled nursing or therapy visit under the HH PPS. Rather, performing NPWT using a disposable device for a patient under a home health plan of care is be separately reimbursed the OPPS amount. In this situation, the HHA bills only under TOB 034x. This visit is not reported on the HH PPS claim (TOB 032x).

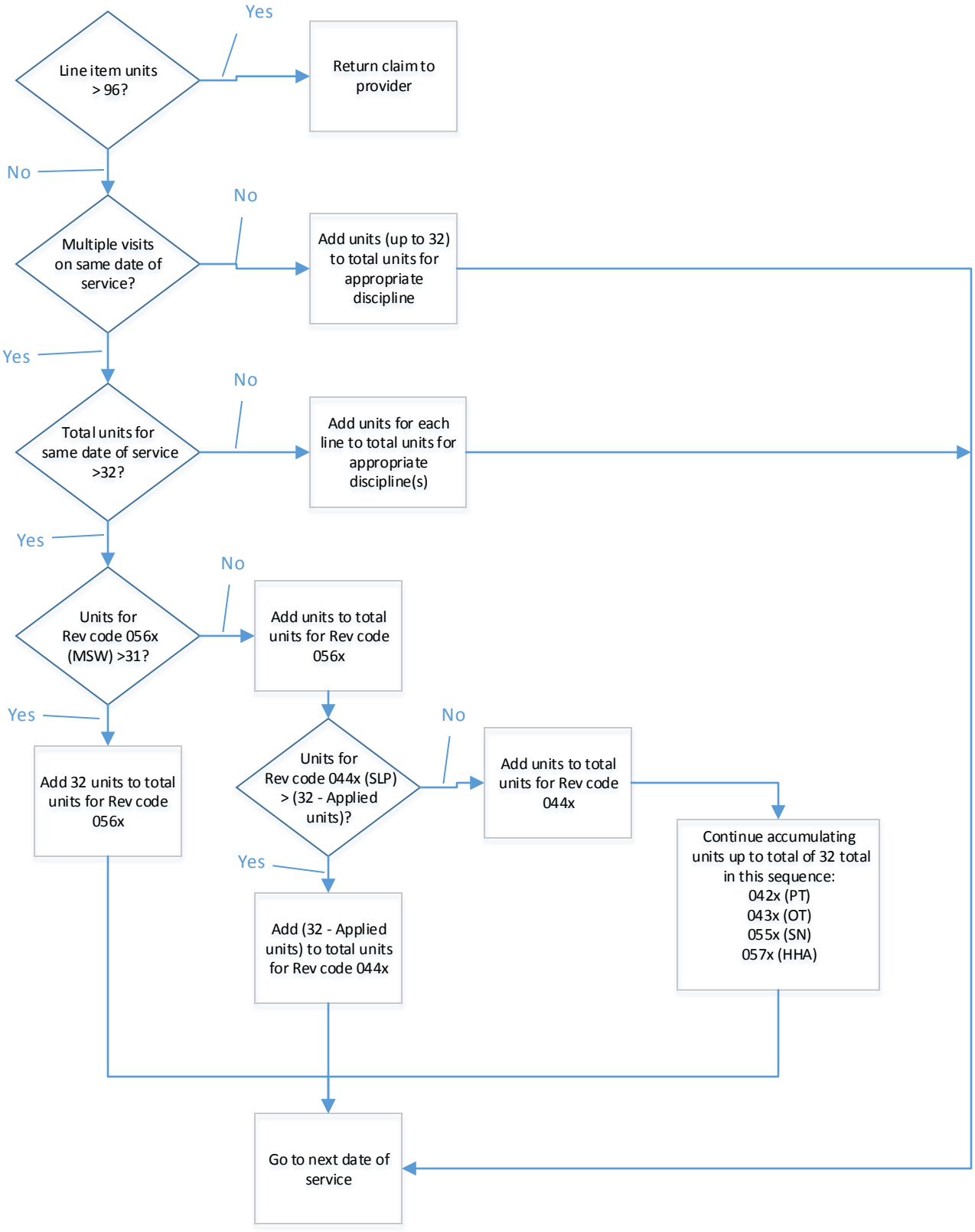
If NPWT using a disposable device is performed during the course of an otherwise covered home health visit (e.g., to perform a catheter change), the visit would be covered as normal. Performing NPWT using a disposable device will be separately reimbursed the OPPS amount. In this situation, the HHA bills under TOB 034X and this visit is also reported on the HH PPS claim (TOB 032x). The HHA must not include the time spent performing NPWT in their visit charge or in the length of time reported for the visit on the HH PPS claim.

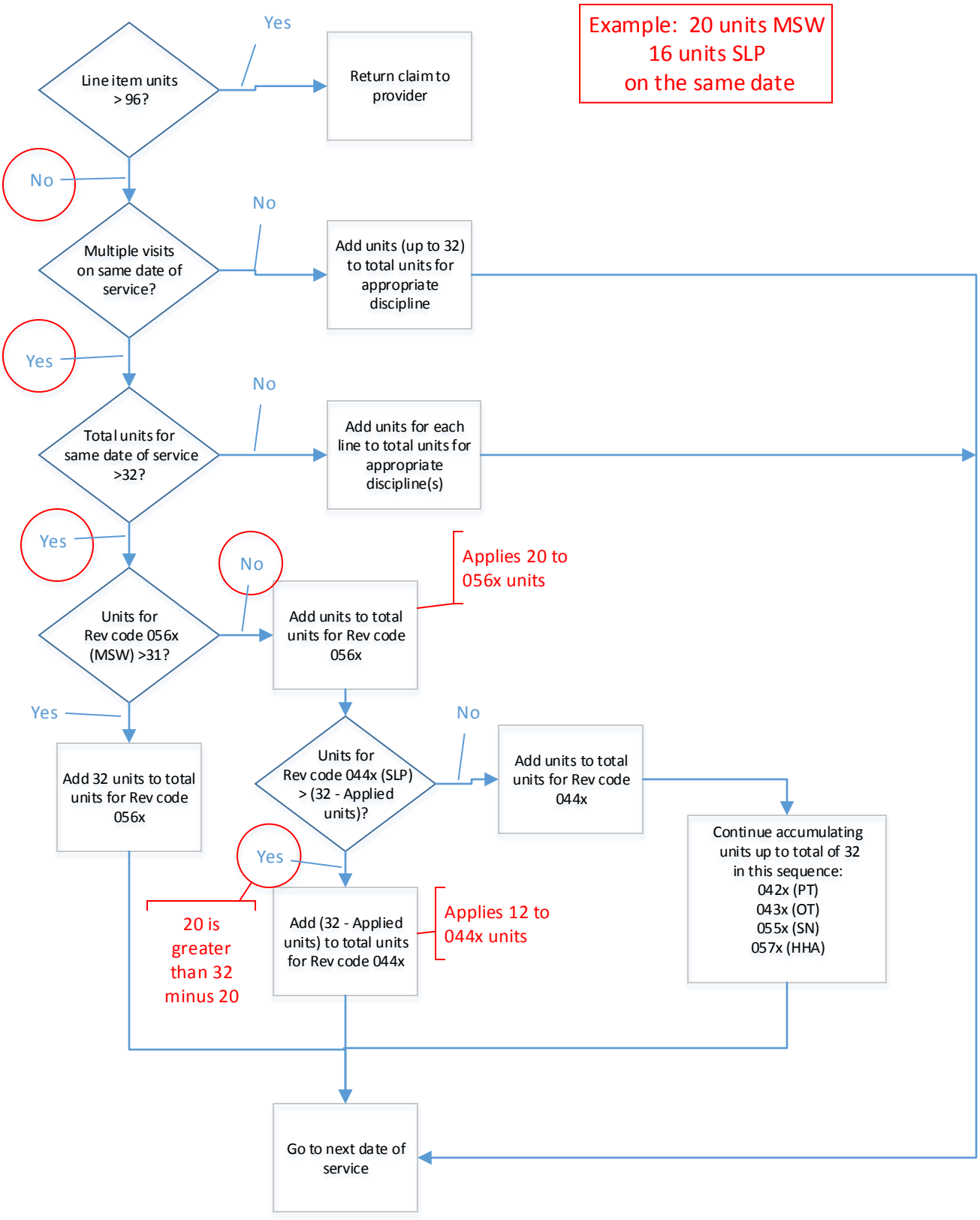
Attachment 1: Cost-per-Unit Payment Rates for the Calculation of Outlier Payments

for CY 2017

		Non-rural		No data submitted		Rural		Rural no data submitted	
Discipline	Average minutes per visit	Per visit rate	Cost per unit (1 unit = 15 mins)	Per visit rate	Cost per unit (1 unit = 15 mins)	Per visit rate	Cost per unit (1 unit = 15 mins)	Per visit rate	Cost per unit (1 unit = 15 mins)
HH Aide	63.0	$64.23	$15.29	$62.97	$14.99	$66.16	$15.75	$64.86	$15.44
Med Soc	56.5	$227.36	$60.36	$222.92	$59.18	$234.18	$62.17	$229.61	$60.96
OT	47.1	$156.11	$49.72	$153.06	$48.75	$160.79	$51.21	$157.65	$50.21
PT	46.6	$155.05	$49.91	$152.03	$48.94	$159.70	$51.41	$156.59	$50.40
SN	44.8	$141.84	$47.49	$139.07	$46.56	$146.10	$48.92	$143.24	$47.96
Speech	48.1	$168.52	$52.55	$165.23	$51.53	$173.58	$54.13	$170.19	$53.07

Attachment 2: Apportioning Units for HH Outlier Calculation




Example: 20 units MSW
16 units SLP
on the same date
Line item units > 96?
Yes
Return claim to provider
No
Multiple visits on same date of service?
No
Add units (up to 32) to total units for appropriate discipline
Yes
Total units for same date of service >32?
No
Add units for each line to total units for appropriate discipline(s)
Yes
Units for Rev code 056x (MSW) >31?
No
Add units to total units for Rev code 056x
Applies 20 to 056x units
Yes
Add 32 units to total units for Rev code 056x
Units for Rev code 044x (SLP) > (32 - Applied units)?
No
Add units to total units for Rev code 044x
Continue accumulating units up to total of 32 in this sequence:
042x (PT)
043x (OT)
055x (SN)
057x (HHA)
Yes
20 is greater than 32 minus 20
Add (32 - Applied units) to total units for Rev code 044x
Applies 12 to 044x units
Go to next date of service