

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1036	Date: AUGUST 18, 2006
	Change Request 5242

Subject: Updates to Chapter 10 of the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request updates instructions located in Chapter 10 of the Medicare Claims Processing Manual.

New / Revised Material

Effective Date: October 9, 2006

Implementation Date: October 9, 2006

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.10.3/Submission of Request for Anticipated Payment (RAP)
R	10/10.1.21/Adjustments of Episode Payment - Outlier Payments
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/70.2/Input/Output Record Layout
R	10/90/Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1036	Date: August 18, 2006	Change Request 5242
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SUBJECT: Updates to Chapter 10 of the Medicare Claims Processing Manual

I. GENERAL INFORMATION

A. Background: This Change Request updates instructions located in Chapter 10 of the Medicare Claims Processing Manual. Chapter 10 has been updated to change the Metropolitan Statistical Area (MSA) to the Core Based Statistical Area (CBSA), to conform to changes to the Outcome and Assessment Information Set (OASIS) reporting regulation, and to add Diabetes Outpatient Self-Management Training (DSMT) to section 90.

B. Policy: The OASIS reporting regulation removes the requirement for HHAs to lock OASIS data for transmission to the State agency within 7 days of completion. The update to Chapter 10 conforms with this regulation.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5242.1	RHHIs shall update operational procedures, as necessary, to accommodate the following revisions to Chapter 10 of the Medicare Claims Processing Manual: - changes MSA to CBSA; - updates OASIS reporting regulation; and - adds DSMT to section 90.		X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: October 9, 2006</p> <p>Implementation Date: October 9, 2006</p> <p>Pre-Implementation Contact(s): Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov, or Wil Gehne, (410) 786-6148, Wilfried.Gehne@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Regional Office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
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*Unless otherwise specified, the effective date is the date of service.

10.1.10.3 - Submission of Request for Anticipated Payment (RAP)

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

The HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met.

- After the OASIS assessment is complete, *locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the State;*
- Once a physician's verbal orders for home care have been received and documented;
- A plan of care has been established and *sent* to the physician; and
- The first service visit under that plan has been delivered.

An episode will be opened on CWF with the receipt and processing of the RAP. RAPs, or in special cases, claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

RAPs are submitted on the Form CMS-1450 (UB-92) billing form under TOB (Form Locator 4) 322. RAPs must include the information output by Grouper for HH PPS in addition to other claim elements. While Medicare requires very limited information on RAPs (RAPs do not require charges for Medicare), HHAs have the option of reporting service lines in addition to the Medicare requirements, either to meet the requirements of other payers, or to generate a charge for billing software. In the latter case, HHAs may report a single service line showing an amount equal to the expected payment amount to aid balancing in accounts receivable systems. Medicare will not use charges on a RAP to determine payment or for later data collection.

When at least one billable service has been provided in the episode, RAPs are to be submitted to RHHIs. Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

10.1.21 - Adjustments of Episode Payment - Outlier Payments

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

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.

Outlier determinations will be made by comparing the **total 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.

If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific HRG payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode.

Outlier payment amounts are wage index adjusted to reflect the *CBSA* in which the beneficiary was served. Outlier payments are *to* be made for specific episode claims. The outlier payment is a payment for an entire episode, and therefore carried only at the claim level in paid claim history; and not allocated to specific lines of the claim. Separate outliers will not be calculated for different HIPPS codes with a significant change in condition situation, but rather the outlier calculation will be done for the entire claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim in history with a value code, 17, in Form CMS-1450 (UB-92) Form Locators 39-41, with an associated amount.

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.

40.1 - Request for Anticipated Payment (RAP)

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit an RAP with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the

start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the next remittance advice (RA).

If care continues with the same provider for a second episode of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the next RA will be used to recoup the overpaid amount.

While an RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims. The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number

Required - The 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. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH RAP billing.

FL 3. Patient Control Number

Optional - The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

FL 4. TOB Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

NOTE: While the bill classification of “3,” defined as “Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)” may also be appropriate to an HH PPS claim depending upon a beneficiary’s eligibility, Medicare encourages HHAs to submit all RAPs with bill classification “2.” Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	Definition
2-Interim-First Claim	For HHAs, used for the submission of original or replacement RAPs.
8-Void/Cancel of a Prior Claim	Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code “2” bill (a replacement RAP) must be submitted for the episode to be paid. If an RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted.

RHHIs will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

FL 5. Not required for Medicare HH RAP billing.

FL 6. Statement Covers Period (From-Through)

Required - Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the “from” and “through” date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.). All dates are in the format MM-DD-YY.

FL 7. Not required for Medicare HH RAP billing.

FL 8. Not required for Medicare HH RAP billing.

FL 9. Not required for Medicare HH RAP billing.

FL 10. Not required for Medicare HH RAP billing.

FL 11. Not required for Medicare HH RAP billing.

FL 12. Patient's Name

Required - Patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate

Required - Month, day, and year of birth (MM-DD-YY) of patient.

Left blank if the full correct date is not known.

FL 15. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH RAP billing.

FL 17. Admission Date

Required - Date the patient was admitted to home health care (MM-DD-YY). On the first RAP in an admission, this date should match the statement covers "from" date in FL 6. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

FL 18. Not required for Medicare HH RAP billing.

FL 19. Not required for Medicare HH RAP billing.

FL 20. Source of Admission

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

Code	Definition
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital (CAH)
B	Transfer from Another HHA
C	Readmission to Same HHA

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician’s plan of care.

FL 21. Not required for Medicare HH RAP billing.

FL 22. Patient Status

Required - Indicates the patient’s status as of the “through” date of the billing period (FL 6). Since the “through” date of the RAP will match the “from” date, the patient will never be discharged as of the “through” date. As a result only one patient status is possible on RAPs.

Code structure

Code	Definition
30	Still patient or expected to return for outpatient services

FL 23. Medical Record Number

Optional - This is the number assigned to the patient’s medical/health record. The RHHI must carry information entered in this field through their system and return it to the biller.

FLs 24 - 30. Condition Codes

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

If canceling the RAP (TOB 3X8), the agency reports one of the following:
Claim Change Reasons

Code	Title	Definition
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

Enter “Remarks” in FL 84, indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

FL 31. Not required for Medicare HH RAP billing.

FL 32, 33, 34, and 35. Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YY).

Fields 32A-35A must be completed before fields 32B-35B are used.

FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span “through” date is in the date field.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

For a complete list of Occurrence Codes, see Chapter 25.

FL 36. Occurrence Span Code and Dates

Not Required - Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If canceling an RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case. Show payer A’s ICN/DCN on line “A” in FL 37. Similarly, HHAs show the ICN/DCN for Payer’s B and C on lines B and C respectively, in FL 37.

FL 38. Not required for Medicare HH RAP billing.

FLs 39-41. Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number <i>or Core Based Statistical Area (CBSA) number</i> (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.

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or nondollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the biller must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line “a” and line “b.” FLs 39a through 41a must be used before FLs 39b through 41b (i.e., the first line is used before the second line).

For a complete list of value codes, see Chapter 25.

FL 42 and 43 Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

Revenue Code	Description
0023	Home Health Services

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023.

Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

NOTE: Revenue codes 058X and 059X are not accepted with covered charges on Medicare home health RAPs under HH PPS. Revenue code 0624 (investigational devices) is not accepted at all on Medicare home health RAPs under HH PPS.

HHAs may report a “Total” line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of the charges billed. However, Medicare claims processing systems will overlay this amount with the total payment for the RAP.

FL 44. HCPCS/Rates

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 45. Service Date

Required - On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 46. Units of Service

Optional - Units of service are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line. Medicare claims processing systems will place the payment amount for the RAP in this field on the electronic claim record.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports any necessary charge amounts to meet the requirements of other payers or its billing software. Medicare claims processing systems will not make any payments based upon submitted charge amounts.

FL 48. Noncovered Charges

Not Required - The HHA does not report noncovered charges for Medicare on RAPs.

FL 49. Not required for Medicare HH RAP billing.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric “number” assigned by Medicare (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI). It must be entered on the same line (A, B, or C) as “Medicare” in FL 50.

If a Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number, indicating patient status 06. This claim will be paid a PEP adjustment. Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases report the new provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.

FL 53. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 55. Not required for Medicare HH RAP billing.

FL 56. Not required for Medicare HH RAP billing.

FL 57. Not required for Medicare HH RAP billing.

FLs 58A, B, and C. Insured’s Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, record the patient's name as shown on the patient's HI card or other Medicare notice.

FLs 59A, B, and C. Patient's Relationship to insured, Not required for Medicare HH RAP billing.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required.

See Chapter 25.

FL 61. Not required for Medicare HH RAP billing.

FL 62. Not required for Medicare HH RAP billing.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

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.

FL 64. Not required for Medicare HH RAP billing.

FL 65. Not required for Medicare HH RAP billing.

FL 66. Not required for Medicare HH RAP billing.

FL 67. Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where

applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

FLs 68-75. Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 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-9 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH RAP billing.

FL 77. Not required for Medicare HH RAP billing.

FL 78. Not required for Medicare HH RAP billing.

FL 79. Not required for Medicare HH RAP billing.

FL 80. Not required for Medicare HH RAP billing.

FL 81. Not required for Medicare HH RAP billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has established the plan of care with verbal orders.

FL 83. Not required for Medicare HH RAP billing.

FL 84. Remarks

Required - Remarks are necessary when canceling an RAP, to indicate the reason for the cancellation.

FL 85. Not required for Medicare HH RAP billing.

FL 86. Not required for Medicare HH RAP billing.

40.2 - HH PPS Claims

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

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. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an 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 remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

FL 1. (Untitled) Provider Name, Address, and Telephone Number

Required - The 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. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH PPS claim billing

FL 3. Patient Control 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.

FL 4. TOB

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

NOTE: While the bill classification of 3, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims systems determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - 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 a 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 frequency codes 7, or 8.

HH PPS claims will be submitted with the frequency of “9.” These claims may be adjusted with frequency “7” or cancelled with frequency “8.” FIs do not accept late charge bills, submitted with frequency “5” on HH PPS claims. To add services within the period of a paid HH claim, an adjustment must be submitted by the HHA.

FL 5. Not required for Medicare HH PPS claim billing.

FL 6. Statement Covers Period (From-Through)

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 in FL 22 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 a discharge claim is submitted due to change of FI, see FL 22 below. If the beneficiary has died, the HHA reports the date of death in the through date. In such cases, the “through” date field should represent the date of discharge or last billable service 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.

All dates are submitted in the format MM-DD-YY.

FL 7. Not required for Medicare HH PPS claim billing.

FL 8. Not required for Medicare HH PPS claim billing.

FL 9. Not required for Medicare HH PPS claim billing.

FL 10. Not required for Medicare HH PPS claim billing.

FL 11. Not required for Medicare HH PPS claim billing.

FL 12. Patient’s Name

Required - Enter the patient’s last name, first name, and middle initial.

FL 13. Patient's Address

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

FL 14. Patient's Birthdate

Required - Enter the month, day, and year of birth (MM-DD-YY) of patient. If the **full** correct date is not known, leave blank.

FL 15. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH PPS claim billing.

FL 17. Admission Date

Required - The HHA enters the same date of admission that was submitted on the RAP for the episode (MM-DD-YY).

FL 18. Not required for Medicare HH PPS claim billing.

FL 19. Not required for Medicare HH PPS claim billing.

FL 20. Source of Admission

Required - Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Not required for Medicare HH PPS claim billing.

FL 22. Patient Status

Required - Enter 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.

Code	Definition
01	Discharged to home or self-care (routine charge)
02	Discharged/transferred to other short-term general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care
06	Discharged/transferred to home care of organized home health service

Code	Definition
	organization, OR Discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice
20	Expired
30	Still patient or expected to return for outpatient services
43	Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to a long-term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (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 intermediary to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the intermediary 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 intermediary.

In cases where the ownership of an HHA is changing which causes the Medicare provider number to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number 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 Medicare provider number, 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, refer them to the appropriate state OASIS education coordinator.

FL 23. Medical Record Number

Required - Enter the number assigned to the patient’s medical/health record. The RHHI must carry it through their system and return it on the remittance record.

FLs 24 - 30. Condition Codes

Optional - Enter any NUBC approved code to describe conditions that apply to the claim.

Claim Change Reasons

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Codes
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter “Remarks” in FL 84 indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3x8), HHAs report the condition codes D5 or D6 and enter “Remarks” in FL 84 indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

For a complete list of Condition Codes see Chapter 25.

FL. 31. Not required for Medicare HH PPS claims billing

FL 32, 33, 34, and 35. Occurrence Codes and Dates

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

See Chapter 25.

FL 36. Occurrence Span Code and Dates

Optional - 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.

For a complete list of Occurrence Span codes see Chapter 25.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here. The HHA inserts the ICN/DCN of the claim to be adjusted here. The HHA shows payer A's ICN/DCN on line "A" in FL 37, and shows the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

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 an ICN/DCN on all HH PPS claims, only on adjustments to paid claims.

FL 38. Not required for Medicare HH PPS claim billing.

FLs 39-41. Value Codes and Amounts

Required - See §40.1, FL 39 - 41.

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: FI value codes. Providers report code 61. The FI places codes 17 and 61 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (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 <i>or Core Based Statistical Area (CBSA) number</i> (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 §1812a(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 Common Working File (CWF) indicates all visits on the claim are Part A, the FI 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, change the TOB on the claim record to 33X, 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, change the TOB on the claim record to 32X, 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 not change the TOB and will return the claim to CWF with RIC code U.

FL 42 and 43 Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by “X” in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim. If there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more than once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change. Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero charges in FL 46. See §40.1, FL 44, for more detailed information on the HIPPS code.

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:

<p>027X (NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)</p>	<p>Medical/Surgical Supplies (Also see 062X, an extension of 027X)</p> <p>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.</p>
<p>042X</p>	<p>Physical Therapy</p> <p>Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>043X</p>	<p>Occupational Therapy</p> <p>Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>044X</p>	<p>Speech-Language Pathology</p> <p>Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>055X</p>	<p>Skilled Nursing</p> <p>Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
<p>056X</p>	<p>Medical Social Services</p> <p>Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

057X	<p>Home Health Aide (Home Health)</p> <p>Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
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NOTE: FIs 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 Durable Medical Equipment (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 RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

029X	<p>Durable Medical Equipment (DME) (Other Than Renal)</p> <p>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.</p>
060X	<p>Oxygen (Home Health)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.</p>

Revenue Code for Optional Reporting of Wound Care Supplies

062X	<p>Medical/Surgical Supplies - Extension of 027X</p> <p>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.</p>
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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.

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

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS' 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.

HHAs may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum charges billed. Medicare claims processing systems will assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates

Required - On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a SCIC, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

FL 45. Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. 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.

FL 46. Units of Service Required

The HHA should not report units of service on 0023 revenue code lines. 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 FL 43. For the revenue codes that represent home health visits

(042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as units of service 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. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line (the field may be zero or blank). Medicare claims processing systems will place the episode payment amount for the claim in this field on the electronic claim record. For LUPA claims, the per visit payment will be reported on individual line items.

For line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. 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.

FL 48. Noncovered Charges

Required - The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. The HHA reports all noncovered charges, including no-payment claims.

Claims with Both Covered and Noncovered Charges

The HHA reports (along with covered charges) all noncovered charges, related revenue codes, and HCPCS codes, where applicable.

HHA Bills with All Noncovered Charges

The HHA submits claims when all of the charges on the claim are noncovered (no-payment claim). The HHA completes all items on a no-payment claim in accordance with instructions for completing claims for payment, with exceptions including all charges reported as noncovered. See chapter 1, section 60 for further instructions on no-payment bills.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric “number” assigned by Medicare (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI). It must be entered on the same line as “Medicare” in FL 50.

The HHA reflects a change in Medicare provider number within a 60-day episode by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. In this case, it reports the original provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - See Chapter 25.

FL 53. Not required for Medicare HH PPS claim billing.

FL 54. Not required for Medicare HH PPS claim billing.

FL 55. Not required for Medicare HH PPS claim billing.

FL 56. Not required for Medicare HH PPS claim billing.

FL 57. Not required for Medicare HH PPS claim billing.

FLs 58A, B, and C. Insured’s Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual. Enter the beneficiary’s name as shown on the Health Insurance Claim card. The name should be recorded on line A if Medicare is prime, line B if Medicare is secondary, and line C if Medicare is the tertiary payer. This placement, A, B, or C, should correspond with the line Medicare was recorded on in FL50.

FLs 59A, B, and C. Patient’s Relationship To Insured

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

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual. Enter the Medicare health insurance claim number as shown on the Medicare card. Place this information on Line A, B, or C as consistent with FL 58.

FLs 61A, B, and C. Group Name

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

FLs 62A, B, and C. Insurance Group Number

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

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FL 64. Employment Status Code

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

FL 65. Employer Name

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

Where the HHA is claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, it enters the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location

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

FL 67. Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The

code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FLs 68-75. Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may **not** duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 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-9 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH PPS claim billing.

FL 77. Not required for Medicare HH PPS claim billing.

FL 78. Not required for Medicare HH PPS claim billing.

FL 79. Not required for Medicare HH PPS claim billing.

FL 80. Not required for Medicare HH PPS claim billing.

FL 81. Not required for Medicare HH PPS claim billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has signed the plan of care.

FL 83. Not required for Medicare HH PPS claim billing.

FL 84. Remarks

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

FL 85. Not required for Medicare HH PPS claim billing.

FL 86. Not required for Medicare HH PPS claim billing.

70.2 - Input/Output Record Layout

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

The HH Pricer input/output file will be 450 bytes in length. The required data and format are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	This field will be used for the National Provider Identifier when it is implemented.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from FL 60 of the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit OSCAR system provider number, copied from FL 51 of the claim form.
29-31	X(3)	TOB	Input item: The TOB code, copied from FL 4 of 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 status code in FL 22 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%
37-43	X(7)	FILLER	Blank.
44-46	X(2)	FILLER	Blank.
47-50	X(5)	<i>CBSA</i>	Input item: The <i>core based statistical area (CBSA)</i> code, copied from the value code 61 amount in FLs 39-41 of 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 FL 6 of 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 FL 6 of the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from FL 17 of the 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.
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 in all cases except when the therapy threshold for the claim was not met.
88-90	9(3)	HRG-NO-OF -	Input item: A number of days calculated by the

File Position	Format	Title	Description
		DAYS	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	Five more occurrences of all HRG/HIPPS code related fields defined above, since up to six HIPPS codes can be automatically processed for payment in any one episode.
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.
258-266	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 low utilization payment adjustment (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.
267-275	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 low utilization payment adjustment (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.
276-400	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define

File Position	Format	Title	Description
			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
			03 Initial percentage payment, 0%
			04 Initial percentage payment, 50%
			05 Initial percentage payment, 60%
			06 LUPA payment only
			07 Final payment, SCIC
			08 Final payment, SCIC with outlier
			09 Final payment, PEP
			11 Final payment, PEP with outlier
			12 Final payment, SCIC within PEP
			13 Final payment, SCIC within PEP with outlier
			Error return codes:
			10 Invalid TOB
			15 Invalid PEP days
			16 Invalid HRG days, > 60
			20 PEP indicator invalid
			25 Med review indicator invalid
			30 Invalid MSA/CBSA code
			35 Invalid Initial Payment Indicator
			40 Dates < 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 3x9 or adjustment TOB
403-407	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.
408-412	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 low utilization payment adjustment (LUPA). This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.
413-421	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in

File Position	Format	Title	Description
			addition to any HRG payment amounts.
422-430	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.
431-450	X(20)	FILLER	Blank.

Input records on RAPs will include all input items except for “REVENUE” related items, and input records on RAPs will never report more than one occurrence of “HRG” 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 systems 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 each HIPPS code will be placed in the total charges and the covered charges field of the appropriate 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 systems 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.

90 - Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

(Rev. 1036, Issued: 08-18-06, Effective/Implementation: 10-09-06)

Form CMS-1450 is submitted for certain Part B medical and other health services for which the HHA may receive payment outside of the prospective payment system. (See the Medicare Benefit Policy Manual, Chapter 7). Refer to instructions in Chapter 20 of this manual and [§90.1](#) in this chapter for submitting claims under arrangement with suppliers.

A Patient Not Under A Home Health Plan Of Care

The HHA uses a Form CMS-1450 (TOB 34X) to bill for certain Part B “medical and other health services” when there is no home health plan of care. Specifically the HHA may bill using TOB 34X 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)*

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 Form CMS-1450 (Bill Type 34X). All other services are home health services and should be billed as a HH PPS episode with Bill Type 32X.

- A covered osteoporosis drug, and
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines.

DME, orthotic, and prosthetics can be billed as a home health service or as a medical and other health service on bill types 32X, 33X, and 34X as appropriate.

C Billing Spanning Two Calendar Years

The agency should not submit a Part B medical and other health services bill (bill type 34X 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 FI to apply the appropriate deductible for both years. HH PPS claims (TOB 32X or 33X) may span the calendar year since they represent 60-day episodes, and episodes should be attributed to the Federal fiscal year or 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, on the PPS claim to the RHHI. These services are billed to Medicare carriers using the HHAs carrier number on the Form CMS-1500 claim. To submit such claims to the carrier, the HHA must have a CLIA number and a billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate carrier 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.