CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10696	**Date: March 31, 2021**
	Change Request 11855

Transmittal 10403, dated October 27, 2020, is being rescinded and replaced by Transmittal 10696, dated, March 31, 2021 to revise principal diagnosis code reporting instructions in chapter 10, section 40.1 and to revise service date reporting instructions in chapter 10, section 40.2 to ensure claims successfully match to their corresponding Request for Anticipated Payment (RAP). All other information remains the same.

SUBJECT: Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

I. SUMMARY OF CHANGES: This Change Request implements the calendar year 2021 home health RAP payment policies.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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	3/Addendum A
R	10/10.1.6/Split Percentage Payment
R	10/10.1.10.1/Grouper Links Assessment and Payment
R	10/10.1.12/Request for Anticipated Payment (RAP)
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	10/70.3/Decision Logic Used by the Pricer on RAPs
R	10/70.4/Decision Logic Used by the Pricer on Claims

III. FUNDING:
For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10696	Date: March 31, 2021	Change Request: 11855

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I. GENERAL INFORMATION

A. Background: Section 1895(b)(2) of the Social Security Act ("the Act"), as amended by section 51001(a) of the Bipartisan Budget Act of 2018 (BBA of 2018), requires Medicare to change the unit of payment under the Home Health Prospective Payment System (HH PPS) from 60 days to 30 days. Under the HH PPS, Medicare makes a split-percentage payment for most 60-day episodes/30-day periods of care. The first payment is made in response to a Request for Anticipated Payment (RAP) submitted at the beginning of the episode/period of care and a second payment is made in response to a final claim submitted at the end of the 60-day episode/30-day period of care. Added together, the first and second payment equal 100 percent of the permissible payment for the episode/30-day period. The RAP has also serves a greater operationally role for the Medicare program by establishing the beneficiary's primary home health agency (HHA) in the Common Working File (CWF) so that the claims processing system can reject claims from providers or suppliers, other than the primary HHA, for the services and items subject to consolidated billing.

In the CY 2019 HH PPS final rule with comment period, CMS finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split-percentage payments beginning in CY 2020 (83 FR 56463). Those HHAs are still required to submit a RAP at the beginning of a period of care in order to establish the home health period of care, as well as every 30 days thereafter; however, but no payment will be associated with the RAP submission.

In the CY 2020 HH PPS final rule with comment period, CMS finalized that existing HHAs, meaning those HHAs that are certified for participation in Medicare with effective dates prior to January 1, 2019, would continue to receive split-percentage payments upon implementation of the PDGM and the change to a 30-day unit of payment in CY 2020, but the upfront payment would be decreased to from 60/50 percent to 20 percent (84 FR 60548). Starting in CY 2021, the split-percentage payment would be lowered to zero for all HHAs (newly-enrolled and existing); however, all HHAs would still be required to submit a RAP at the beginning of each 30-day period of care (84 FR 60548). Since no payment will be associated with the submission of the RAP in CY 2021, HHAs are to submit the RAP when: 1) the appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented as required at §§ 484.60(b) and 409.43(d); and 2) the initial visit within the 60-day certification period has been made and the individual is admitted to home health care. (84 FR 60548). The information needed for submission of the RAP in CY 2021 will mirror the one-time notice of admission (NOA) process, also finalized in the CY 2020 HH PPS final rule with comment period, starting in CY 2022 (84 FR 60549). Lastly, CMS finalized a non-timely submission payment reduction when the HHA does not submit the RAP within 5 calendar days from the start of care date for the first 30-day period of care in a 60-day certification period and within 5 calendar days of day 31 for the second 30-day period of care in the 60-day certification period (84 FR 60549).

B. Policy: For CY 2021, Medicare will lower the up-front split percentage payment made in response to the RAP to zero for all HHAs for all 30-day periods of care beginning on or after January 1, 2021. However, HHAs will still be required to submit RAPs as the RAP serves a greater operational role for the Medicare program by establishing the beneficiary's primary home health agency (HHA) in the Common Working File (CWF) so that the claims processing system can reject claims from providers or suppliers, other than the primary HHA, for the services and items subject to consolidated billing. In instances where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549). Submission of the RAP can be done when the following criteria have been met: (1) the appropriate physician’s written or verbal order that sets out the services required for the initial visit has been received and documented, as required in regulation at 42 CFR 484.60(b) and 42 CFR 409.43(d); (2) the initial visit within the 60-day certification period must have been made and the individual admitted to home health care.

Additionally, for CY 2021, there will be a non-timely submission payment reduction when the HHA does not submit the RAP within 5 calendar days from the start of care date (“admission date” and “from date” on the claim will match the start of care date) for the first 30-day period of care in a 60-day certification period and within 5 calendar days of the “from date” for the second 30-day period of care in the 60-day certification period. This reduction in payment will be equal to a 1⁄30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date/admission date, or “from date” for subsequent 30-day periods, until the date the HHA submits the RAP. In other words, the 1/30th reduction would be to the 30-day period payment amount, including any outlier payment, that the HHA otherwise would have received absent any reduction. For LUPA 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The payment reduction cannot exceed the total payment of the claim. The payment reduction for the late submission of a RAP can be waived for exceptional circumstances as outlined in regulation at 42 CFR 484.205(i)(3).

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H	M A C	F I S S	M C S	V M S	C W F	
11855.1	For all RAPs (Type of Bill 0322) with "From" dates on or after January 1, 2021, the contractor shall calculate a percentage payment of 0%.					X				HH Pricer
11855.2	The contractor shall no longer manually update HHA provider files to prevent RAP payments to new HHAs or in response to abusive RAP submission practices. Note: The Federal PPS Blend Indicator field will no longer be set to 1 or 3. The values of 0 and 2 will continue to be used to apply the 2% reduction to the HH annual payment update due to not reporting required quality data.			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11855.3	The contractor shall allow the claim From date, claim Through date and any line item date to be a future date if the Type of Bill is 0322 and the From date is on or after January 1, 2021. Note: This requirement applies to both FISS and PC-ACE.					X				
11855.4	The contractor shall not auto-cancel RAPs (TOB 0322) with a From date on or after January 1, 2021 when the final claim is not received within 90 days of the start date of the RAP or 60 days from the RAP paid date, whichever is greater.					X				
11855.5	The contractor shall store the RAP receipt date in a file location where the date can be used in processing the payment of the associated final claim.					X				
11855.5.1	The contractor shall remove the record for a RAP from the file after the associated final claim is processed.					X				
11855.5.2	The contractor shall enter a RAP receipt date of 99999999 on the claim if an associated RAP is not found and the claim has 6 or fewer service visits (line items with revenue codes 042x, 043x, 44x, 055x, 056x or 057x). Note: This requirement is to allow for the continued processing of no-RAP LUPAs.					X				
11855.5.3	The contractor shall periodically purge RAP records from the file, removing records whose paid dates are over 24 months old.					X				
11855.6	For HH RAPs, claims and adjustments received with "From" dates on or after January 1, 2021, the contractor shall format the interface with the HH Pricer according to the revised record layout shown in Pub. 100-04, chapter 10, section 70.2.					X				HH Pricer
11855.7	The contractor shall accept the KX modifier when reported with the HIPPS code on the revenue code 0023 line of TOB 032x (other than 0322 and 0320) as an indicator that a home health agency requests an exception to the late RAP penalty.			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11855.7.1	The contractor shall return to the provider claims with TOB 032x if the KX modifier is reported with a HCPCS code associated with any revenue code other than 0023.			X		X				
11855.8	The contractor shall create a new one-position field on the claim record to store an indicator that can be used to override the application of late RAP penalties in the HH Pricer.					X				
11855.8.1	The contractor shall initialize the RAP penalty override field with a value of N and accept a value of Y as the only other valid value.					X				
11855.8.2	The contractor shall send the value in RAP penalty override field to the HH Pricer in the OVERRIDE-IND field.					X				
11855.8.3	The contractor shall make the RAP penalty override field accessible to ECPS and mass adjustment processes.					X				
11855.9	The contractor shall request documentation from the HHA to support its request for an exception to waive of the consequences of late filing of a RAP when the claim reports the KX modifier when reported on the revenue code 0023 line of TOB 032x (other than 0322 and 0320).			X						
11855.9.1	If the documentation provided by the HHA supports an allowable exceptional circumstance, then the contractor shall set the override indicator created in BR .8 to Y.			X						
11855.10	If the value in OVERRIDE-IND is Y, the contractor shall not calculate a late RAP reduction amount.									HH Pricer
11855.11	If the value in OVERRIDE-IND is N, the contractor shall calculate a late RAP reduction amount by: • calculating the number of days between the RAP receipt date to the claim From date • If the resulting number is greater than 5, reduce the claim payment by the resulting number/30.									HH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11855.12	The contractor shall move the value in LATE-SUB-PENALTY-AMT to the claim as a payer-only value code QF amount when the amount is greater than zero.					X				
11855.12.1	The contractor shall ensure value code QF is not sent on the COB outbound transaction.					X				
11855.12.2	The contractor shall accept value code QF on home health claims.									HIGLAS
11855.13	When applying LUPA payment amounts to line items, the contractor shall reduce the payment to zero if the line item date of the visit falls within the span of days between the From date and the RAP receipt date (excluding a date of 99999999) and the OVERRIDE-IND is N. Note: The reason code for this process shall be overrideable.					X				
11855.13.1	The contractor shall sum the total of per-visit amounts and LUPA add-on amounts that were reduced to zero and move this value to the claim as a payer-only value code QF amount.					X				
11855.13.2	When LUPA line item amounts are reduced to zero, the contractor shall apply the following remittance advice messages to the rejected lines: Group Code: CO CARC: 95 ("Plan procedures not followed") RARC: N385 ("Notification of admission was not timely according to published plan procedures")			X		X				
11855.14	The contractor shall, at their discretion or when notified by CMS of a lapse in response files from iQIES, move claims from iQIES-related suspense locations to a location that will allow the claims to trigger another iQIES finder file.			X						
11855.15	The contractor shall report the following remittance advice messages for the late submission payment reduction in the Claim Level CAS segment (loop 2100) on Home Health Claims on the 835 ERA.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO CARC: 95 ("Plan procedures not followed")									
11855.16	The contractor shall report the following messages for the late submission payment reduction in the Claim Level CAS segment (Loop 2320) on Home Health Claims to the 837I COB. Group Code: CO CARC: 95 ("Plan procedures not followed")					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11855.17	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
.9	The HH&H MACs have discretion for determining their own process for this review. One possibility is to create a non-medical ADR to request information supporting the exception reason provided by the HHA in the Remarks field of the claim. Standard ADR timeframes and procedures apply.
.14	For example, MACs may use their discretion under this requirement if they observe large suspense volumes in locations SMFRX3 or SMFRX4. To prevent these claims from RTPing in error, the MAC may use the MOVE utility to set claims back to location SB0100 so they will suspend with reason code 37071 again and trigger a new iQIES finder file.
.5	The HRAP file that is used to ensure a final claim cancels the associated RAP is a logical location for this data. The receipt date can replace the current provider number, which is redundant information since all RAPs in a file are for a single provider.
.4	Auto-cancellation of RAPs is no longer necessary since there is no payment to recover. This requirement will reduce burden for HHAs, who will not need to resubmit RAPs when billing later final claims. It will also reduce administrative burden on MACs during emergencies, since the RAP auto-cancellation date will no longer need to be extended.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov , Carla Douglas, carla.douglas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 10696, Issued: 03-31-21)

Addendum A - Provider Specific File

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table>
</td></tr>
</table>

Data Element	File Position	Format	Title	Description
3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric

Data Element	File Position	Format	Title	Description
				06 Hospital Distinct Parts (Provider type “06” is effective until July 1, 2006. At that point, provider type “06” will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services

Data Element	File Position	Format	Title	Description
				49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.

Data Element	File Position	Format	Title	Description
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** For "From" dates before 1/1/2021: Enter the value to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. 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% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments). For "From" dates on or after 1/1/2021: Enter the value to indicate whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2% **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002.

Data Element	File Position	Format	Title	Description
				LTCH PPS: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. Federal % Facility% 1 20 80 2 40 60 3 60 40 4 80 20 5 100 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. Federal % Facility% 1 25 75 2 50 50 3 75 25 4 100 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the

Data Element	File Position	Format	Title	Description
				count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.

Data Element	File Position	Format	Title	Description
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field

Data Element	File Position	Format	Title	Description
				35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a “1” or “2.”
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard

Data Element	File Position	Format	Title	Description
				deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter “0” if not participating in Hospital Readmissions Reduction program. Enter “1” if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter “2” if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if “1” is entered in Data Element 53. Leave blank if “0” or “2” is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a ‘Y’ if the hospital is subject to a reduction under the HAC Reduction Program. Enter a ‘N’ if the hospital is NOT subject to a reduction under the HAC Reduction Program.

Data Element	File Position	Format	Title	Description
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index* 2=Future use 3=Future use Enter blank if it does not apply **Note:** For LTCH's providers this is the IPPS prior year wage index.
65	277-310	X(34)	Filler	

10.1.6 - Split Percentage Payment

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

Medicare makes a split percentage payment for most HH PPS episodes/periods. The first payment is in response to a RAP, and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible payment for the episode. There are two exceptions to split payment, the No-RAP LUPA, discussed in §§10.1.18 and 40.3 in this chapter, and the RAPs paying zero percent as discussed in §10.1.12 in this chapter.

For all periods of care with "From" dates on or after January 1, 2020 and before January 1, 2021, the percentage payment on RAPs is 20%. For all periods of care with "From" dates on or after January 1, 2021, Medicare no longer makes payment on RAPs, though RAP submission is still required for periods of care other than No-RAP LUPAs.

10.1.10.1 - Grouper Links Assessment and Payment

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool. OASIS is entered, formatted and locked for electronic transmission to State agencies. To support OASIS transmission, Medicare makes HAVEN software publicly available. However, some HHAs have chosen software vendors to create their own software applications for these purposes.

Before January 1, 2020, Grouper software run at the HHA determines the appropriate case-mix group for payment of a HH PPS 60-day episode from the results of an OASIS submission for a beneficiary. Grouper outputs:

- case-mix groups as HIPPS (Health Insurance Prospective Payment System) codes.

- a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and

- a Grouper Version Number that is not used in billing.

Under HH PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims. Note that if an OASIS assessment is rejected upon transmission to a State Agency and consequently corrected resulting in a different HIPPS code, the RAP and/or claim for the episode must also be re-billed using the corrected HIPPS code.

For periods of care beginning on or after January 1, 2020, the Grouper software is incorporated in Medicare claims processing systems. The Grouper uses claims data and OASIS data from the CMS quality data repository to assign the HIPPS code used for payment on the claim.

In the event of a temporary failure of the file transfer process that connects the claims and quality data systems, the MACs may resubmit claims to the quality system to ensure matching OASIS data is found. This action may occur in response to notification from CMS or at the discretion of the MAC.

10.1.12 - Request for Anticipated Payment (RAP)

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

The HHA submits a RAP to their A/B MAC (HHH) to request the initial split percentage payment for an HH PPS episode/period. The RAP may be submitted after receiving verbal orders and delivering at least one service to the beneficiary. Though they are submitted on standard institutional claim formats, the RAP is not considered a Medicare home health claim and is not subject to many of the stipulations applied to

claims in regulations. (NOTE: RAPs may be considered claims for purposes of other Federal laws and regulations.) In particular, RAPs are not subject to the payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode.

In addition to a split percentage payment (see §10.1.6), RAPs may be paid zero percent if:

- Medicare is the secondary payer, or
- a provider has lost the privilege of receiving RAP payment,
- the beneficiary is enrolled in a Medicare Advantage plan, or
- for periods of care beginning on January 1, 2020 and before January 1, 2021, is a new provider with a participation date on or after January 1, 2019.

For periods of care beginning on and after January 1, 2021, all RAPs are paid zero percent.

40.1 - Request for Anticipated Payment (RAP)

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

The following data elements are required to submit a RAP under HH PPS. Home health services under a plan of care are paid based on a 60-day episode of care (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). 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 a RAP using the coding described below.

In general, a RAP and a claim will be submitted for each episode or period of care. Each claim must represent the actual utilization over the episode period. If the claim is not received 60 days after the calculated end date of the episode (day 120) or period (day 90) 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 HHA's next remittance advice (RA). RAPs with "From" dates on or after January 1, 2021 will no longer be automatically canceled because there will be no payment to recoup.

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

While a RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims.

A timely-filed RAP is submitted to the A/B MAC (HHH) and accepted by the A/B MAC (HHH) within 5 calendar days after the From date of a HH period of care. While a timely-filed RAP is submitted to and accepted by the Medicare contractor A/B MAC (HHH) within 5 calendar days after the From date, posting to the CWF may not occur within that same time frame. The date of posting to the CWF is not a reflection of whether the RAP is considered timely-filed.

In instances where a RAP is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payment, by the number of days from the home health From date to the date the RAP is submitted to, and accepted by, the A/B MAC (HHH), divided by 30. No LUPA per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

If an HHA fails to file a timely-filed RAP, it may request an exception which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception to the consequences of filing the RAP more than 5 calendar days after the HH period of care From date are as

follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;

2. an event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the HHA;

3. a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or,

4. other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA.

The HHA shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the exception request. If the remarks are not sufficient, Medicare contractors shall request documentation.

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 CMS Certification Number to verify provider identity.

Patient Control Number

Required - The patient's control number assigned by the HHA for association and reference purposes.

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 type of bill accepted for HH PPS requests for anticipated payment is:

032x - Home Health Services under a Plan of Treatment

4th Digit	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 replacement RAP must be submitted for the episode to be paid. If a 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.

Medicare contractors will allow only provider-submitted cancellations of RAPs or provider-submitted final claims to process as adjustments against original RAPs. Provider may not submit adjustments (frequency code '7') to RAPs.

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

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 or period.

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior RAP submission instructions for RAPs with “From” dates before January 1, 2020. The HHA should follow PDGM instructions for RAPs with “From” dates on or after January 1, 2020.

Patient Name/Identifier

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

Patient Address

Required - 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 - Month, day, and year of birth of patient.

Left blank if the full correct date is not known.

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 - Date the patient was admitted to home health care. On the first RAP in an admission, this date should match the statement covers “from” date. 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.

Point of Origin for Admission or Visit

Required - Indicates the patient’s point of origin for the admission.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code.

Patient Discharge Status

Required - Indicates the patient’s status as of the “through” date of the billing period. 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 30 which represents that the beneficiary is still a patient of the HHA.

Condition Codes

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

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

If canceling the RAP (TOB 0328), the agency reports a condition code indicating the appropriate claim change reason.

Enter "Remarks" indicating the reason for cancellation.

Occurrence Codes and Dates

Conditional – The HHA enters any NUBC approved code to describe occurrences that apply to the RAP. Occurrence code values are two alphanumeric digits, and the corresponding dates are shown as eight numeric digits.

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

Value Codes and Amounts

Required **-** Home health episode payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. To ensure these payment adjusts are applied accurately, the HHA reports the following codes on RAPs with "From" dates before January 1, 2021:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	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.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

Value codes 61 and 85 are optional for RAPs with "From" dates on and after January 1, 2021.

Conditional - Any NUBC approved Value code to describe other values that apply to the RAP. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

Revenue Code and Revenue Description

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

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

For RAPs with "From" dates on or after January 1, 2020, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code in order to meet this requirement.

For RAPs with "From" dates before January 1, 2021, the percentage payment for the RAP is based on the HIPPS code as submitted. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. RAPs with "From" dates on of after January 1, 2021 are paid zero percent and the total payment for the period of care is made on the corresponding claim.

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.

Service Date

Required - For initial episodes/periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered, unless one of the exceptions below applies.

One exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's plan of care requires that the beneficiary is seen every 6 weeks and there is a recertification, the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare's Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment.

Another exception is when submitting RAPs for all subsequent periods of care in calendar year 2021. The HHA may submit these RAPs with the first day of the period of care as the service date on the 0023 line. This will allow for the submission of RAPs for two 30-day periods of care immediately after the start of a 60-day certification period. It will also prevent delaying the submission of the RAP for subsequent periods when the first visit in that period would be beyond the 5-day timeframe for a timely-filed RAP.

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.

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

Total Charges

Required – The HHA reports zero charges on the 0023 revenue code line.

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.

Payer Name

Required - See Chapter 25.

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

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.

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

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, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - On RAPs with "From" dates before January 1, 2020, the HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99

3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2015	15
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2016	16
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	H
12	Functional severity points – under Equation 1	2	C
13	Clinical severity points – under Equation 2	13	N
14	Functional severity points – under Equation 2	4	E
15	Clinical severity points – under Equation 3	3	D
16	Functional severity points – under Equation 3	4	E
17	Clinical severity points – under Equation 4	12	M
18	Functional severity points – under Equation 4	7	H

This is an example of a treatment authorization code created using this format:

The treatment authorization code that would appear on the claim would be, in this example: 15JK16AA41HCNEDEMH.

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.

On RAPs with “From” dates on of after January 1, 2020, treatment authorization codes are no longer required on RAPs.

Document Control Number (DCN)

Required - If canceling a RAP, HHAs must enter the control number (ICN or DCN) that the contractor assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case.

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.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

For "From" dates on or after January 1, 2021, the RAP may report any valid diagnosis code, in order to facilitate timely submission. Since these RAPs are not paid, the accurate principal diagnosis code that supports payment is needed only on the claim for the period of care.

Other Diagnosis Codes

Required – For RAPs with "From" dates before January 1, 2021, 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.

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. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Other Diagnosis Codes are optional for RAPs with "From" dates on and after January 1, 2021.

Attending Provider Name and Identifiers

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

Remarks

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

40.2 - HH PPS Claims

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

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 (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode or period will usually be made in two parts. After a RAP has been paid and an episode or period has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due.

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 claims 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

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior claims submission instructions for claims with "From" dates before January 1, 2020, including episodes that span into 2020. The HHA should follow PDGM instructions for claims with "From" dates on or after January 1, 2020.

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 for a 60-day episode or 29 days after the "From" date for a 30-day period of care

In cases where the beneficiary has been discharged or transferred within the episode or 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."

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 episode or period 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 30-day period, 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 episode or period. 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

Required – On claims with "From" dates on or after January 1, 2020, the HHA enters occurrence code 50 and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090). If occurrence code 50 is not reported on a claim or adjustment, the claim will be returned to the provider for correction.

On claims for initial periods of care (i.e. when the From and Admission dates match), the HHA reports an inpatient admission that ended within 14 days of the "From" date by using one of the following codes.

Code	Short Descriptor	Long Descriptor
61	Hospital Discharge Date	The Through date of a hospital stay that ended within 14 days prior to the From date this HHA claim.
62	Other Institutional Discharge Date	The Through date of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days prior to this HHA admission.

On claims for continuing periods of care, the HHA reports an inpatient hospital admission that ended within 14 days of the "From" date by using occurrence code 61.

To determine the 14 day period, include the "From" date, then count back using the day before the "From" date as day 1. For example, if the "From" date is January 20th, then January 19th is day 1. Counting back from January 19th, the 14 day period is January 6 through January 19. If an inpatient discharge date falls on any date in that period or on the admission day itself (January 20), it is eligible to be reported on the claim.

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent applicable discharge date. Claims reporting more than one of any combination of occurrence codes 61 and 62 will be returned to the provider for correction.

Conditional - The HHA enters any other 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 certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. For episodes in which the beneficiary's site of service changes from one CBSA or county to another within the episode period, HHAs should submit the CBSA code or State and County code corresponding to the site of service at the end of the episode on the claim.

Provider-submitted codes:

Code	Title	Definition
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.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the HHA.

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.

Code	Title	Definition
QF	Late-filed RAP penalty amount	The dollar amount the claim payment was reduced due to the RAP being filed more than 5 days after the HH From date.
QV	Value-based purchasing adjustment amount	The dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. May be a positive or a negative amount.

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. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.

For claims with "From" dates before January 1, 2020, 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/period. All services must be billed on one claim for the entire episode/period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.

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

For claims with "From" dates before January 1, 2020, 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. For claims with "From" dates before January 1, 2020, 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.

For episodes with "From" dates before January 1, 2020, 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 episodes with "From" dates on or after January 1, 2020, Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changed based on medical review or other processes, 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:

<u>Physical Therapy (revenue code 042x)</u>

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.
G2168 Services performed by a physical therapist assistant in the home health setting in the 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.
G2169 Services performed by an occupational therapist assistant in the home health setting in the 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:

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:

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).

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:

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.

Medical Social Services (revenue code 056x)

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.

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.

Modifiers

If the RAP that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 40.1), append modifier KX to the HIPPS code reported on the revenue code 0023 line.

Service Date

Required - For initial episodes/periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent episodes, the HHA reports on the 0023 revenue code line the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered, *unless the HHA submitted the corresponding RAP using the first day of the period of care as the service date on the 0023 line. In that case, the HHA reports a service date on the 0023 revenue code line that matches the date submitted on the RAP. This is necessary in order to ensure Medicare systems can correctly match the claim to the RAP during processing.*

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 line item, 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 - On claims with "From" dates before January 1, 2020, 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.

On claims with "From" dates on of after January 1, 2020, treatment authorization codes are no longer required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

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.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For claim "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

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.

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. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Corrections to diagnosis codes reported on a RAP that reflect the patient's condition as of the start of a period of care may be reflected on the claim for the current period of care. Changes to diagnosis codes that reflect a change in the patient's condition during a period of care should be reflected on the RAP and claim for the next period.

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 – If the RAP that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 40.1), enter information supporting the exception category that applied to the RAP.

If the RAP that corresponds to a claim was originally received timely but the RAP was canceled and resubmitted to correct an error, enter remarks to indicate this condition, (e.g., "Timely RAP, cancel and rebill"). Append modifier KX to the HIPPS code reported on the revenue code 0023 line. HHAs should resubmit corrected RAPs promptly (generally within 2 business days of canceling the original RAP).

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

70.2 - Input/Output Record Layout

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

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

File Position	Format	Title	Description
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.

File Position	Format	Title	Description
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	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP and/or whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value 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% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments).
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
46-56	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.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only episode in a sequence. The indicator is set to '0' in all other cases.

File Position	Format	Title	Description
96	X	PEP-IND	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.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	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.
104-109	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
110-118	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
119-122	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.
125-127	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.
128-132	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.
133-140	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
141-149	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.

File Position	Format	Title	Description
150-158	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.
159-167	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 1.8451. 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.
168-402	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.
403-404	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, 20% 05 No longer used. 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
			Error return codes:
			10 Invalid TOB 15 Invalid PEP days 16 Invalid HRG days, greater than 30 20 PEP indicator invalid 25 Med review indicator invalid 30 Invalid CBSA code 31 Invalid/missing County Code 35 Invalid Initial Payment Indicator 40 Dates before January 2020 or invalid 70 Invalid HRG code

File Position	Format	Title	Description
			75 No HRG present in 1st occurrence
			80 Invalid revenue code
			85 No revenue code present on adjustment TOB
405-409	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.
410-418	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. Added to the claim as a value code 17 amount.
419-427	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.
428-436	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.
437-445	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.
446-650	X(205)	FILLER	

The required data and format for the HH Pricer input/output record for periods of care beginning on or after January 1, 2021 are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.
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	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value from field 18 of the provider specific file. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2%
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.

File Position	Format	Title	Description
46-56	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.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only episode in a sequence. The indicator is set to '0' in all other cases.
96	X	PEP-IND	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.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	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.
105-110	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
111-119	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
120-123	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.

File Position	Format	Title	Description
124-126	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.
127-131	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.
132-139	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
140-148	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.
149-157	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.
158-166	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 1.8451. 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.
168-401	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.
402-403	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.

File Position	Format	Title	Description	
			03	Initial percentage payment, 0%
			04	Not used.
			05	Not used.
			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
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
404-408	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.	
409-417	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. Added to the claim as a value code 17 amount.	
418-426	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
427-435	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.	
436-444	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.	
445-452	X(8)	RECEIPT-DATE	Input item: The receipt date of the corresponding RAP for this claim. Date format must be CCYYMMDD. In the case of no-RAP LUPA claims, this field will be blank.	

File Position	Format	Title	Description
453	X	OVERRIDE-IND	Input item: An indicator of whether an exception request to the late filing penalty has been granted by the MAC. Valid values: Y = Exception has been granted, no late filing penalty will be calculated N = No exception applies, calculate late filing penalty, if applicable.
454-462	9(7)V9(2)	LATE-SUB-PENALTY-AMT	Output item: The late submission penalty amount, determined by subtracting the total payment after the late submission penalty from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QF amount.
463-650	X(188)	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.

70.3 - Decision Logic Used by the Pricer on RAPs

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

On input records with TOB 322 and "SERV-FROM-DATE" on or after January 1, 2020 and before January 1, 2021, Pricer will perform the following calculations in the numbered order:

1. Determine the applicable Federal standard episode rate to apply by reading the values in "INIT-PAY-QRP-INDICATOR." If the value is 0 or 1, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

   For certain dates of service when required by law, read "CBSA" and "COUNTY-CODE" to determine if a rural add-on payment applies. If yes, use the appropriate rural episode rate with or without quality data in subsequent calculations.

2. Find weight for "HRG-INPUT-CODE" from the table of weights for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times Federal standard episode rate for the year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate.

   This case-mix adjusted rate must also be wage-index adjusted according to labor and nonlabor portions of the payment. Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to "CBSA." Multiply the Federal adjusted rate by the current non-labor-related percentage) to determine the nonlabor portion.

Sum the labor and nonlabor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

3. a. If the "INIT-PAY-QRP-INDICATOR" equals 0 or 2, perform the following:

   Multiply the wage index and case-mix adjusted payment by .2. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 04.

   b. If the "INIT-PYMNT-INDICATOR" = 1 or 3, perform the following:

   Multiply the wage index and case-mix adjusted payment by 0. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code 03.

On input records with TOB 322 and "SERV-FROM-DATE" on or after January 1, 2021, Pricer will perform the following calculations in the numbered order:

1. Perform no calculations. Return "HRG-PAY" and "TOTAL-PAYMENT" amounts as $0.00.

2. Set the 'PAY-RTC" value to 03.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 10696, Issued: 03-31-21, Effective: 01-01-21, Implementation: 01-04-21)

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

If the "SERV-FROM-DATE" is on or after January 1, 2020, the Pricer shall perform the following:

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

1. Low Utilization Payment Adjustment (LUPA) calculation.

   1.1 If the "REVENUE-SUM1-6-QTY-ALL" is less than the LUPA threshold associated with the "HRG-INPUT-CODE" (e.g. threshold is 6, sum is 5 or less), read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

   1.2 If the following conditions are met, calculate an additional LUPA add-on payment:
   - the dates in the "SERV-FROM-DATE" and "ADMIT-DATE" fields match
   - the first position of the HIPPS code is a 1 or a 2
   - the value in "LUPA-SRC-ADM" is not a B AND
   - the value in "RECODE-IND" is not a 2.

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

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

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

- If revenue code 055x, multiply the national per-visit amount by 1.8451.
- If revenue code 042x, multiply the national per-visit amount by 1.6700.
- If revenue code 044x, multiply the national per-visit amount by 1.6266.

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

1.4 Return the sum of all "REVENUE-COST" amounts and the "REVENUE-ADD-ON-VISIT-AMT" amount, if applicable, in the "TOTAL-PAYMENT" field. If the LUPA payment includes LUPA add-on amount, return 14 in the "PAY-RTC" field. Otherwise, return 06 in the "PAY-RTC" field. No further calculations are required.

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

2. HRG payment calculations.

2.1. If the "PEP-IND" is an N:

Find the weight for the "HRG-INPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the applicable episode rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate.
Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to the "CBSA" field. Multiply the case-mix adjusted rate by the current nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG. Proceed to the outlier calculation in step 3.

2.2. If the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG amount, as in 3.1. Determine the proportion to be used to calculate this PEP by dividing the "PEP-DAYS" amount by 30. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation in step 3.

3. Outlier calculation:

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

3.2. For each quantity in the six "REVENUE-QTY- OUTLIER-UNITS" fields, read the national standard per unit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and

wage index adjust this sum as described above, using the CBSA code in the "CBSA" field. The result is the wage index adjusted imputed cost for the episode.

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

3.4. If the result determined in step 3.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

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

- Multiply the amount in the "PROV-PAYMENT-TOTAL" field by 10 percent to determine the HHA's outlier limitation amount.

- Deduct the amount in the "PROV-OUTLIER-PAY-TOTAL" from the outlier limitation amount. This result is the available outlier pool for the HHA.

- If the available outlier pool is greater than or equal to the outlier payment amount calculated in step 3.4, return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from HRG payment calculation. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.

- If the available outlier pool is less than the outlier payment amount calculated in step 3.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

3.6. If the result determined in step 3.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the HRG payment amount in the "TOTAL-PAYMENT" field, with return code 00.

4. Late-filed RAP payment penalty:

4.1 If the value in "OVERRIDE-IND" is equal to Y, continue to step 5.

4.2 If the span of days between the "FROM-DATE" and "RECEIPT-DATE" is greater than five and the value in"OVERRIDE-IND" is equal to N, reduce the "HRG-PAY" and "OUTLIER-PAYMENT" amounts by the span of days/30.

4.3 Subtract the sum of the"HRG-PAY" and "OUTLIER-PAYMENT" amounts reduced by the late-filed RAP penalty from step 4.2 from the sum of the "HRG-PAY" and "OUTLIER-PAYMENT" amounts before the penalty. Return the result in "LATE-SUB-PENALTY-AMT." Continue to step 5.

5. Value-Based Purchasing Adjustment:

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

Subtract the total payments calculated in steps 2 and 3 from the total VBP-adjusted payments calculated in step 5. Return the difference in the "VBP-ADJ-AMT" field.