CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2680	**Date: April 2, 2013**
	Change Request 8136

Transmittal 2650, dated February 1, 2013, is being rescinded and replaced with Transmittal 2680, dated April 2, 2013, to remove business requirement 8136.12 and corresponding instructions regarding reporting a new modifier. Additionally, policy language is revised regarding the use of the Q codes. All other information remains the same.

SUBJECT: Data Reporting on Home Health Prospective Payment System (HH PPS) Claims

I. SUMMARY OF CHANGES: This Change Request adds new data reporting requirements for HH PPS claims. Home health agencies (HHAs) must report new codes indicating the location where services were provided and indicating whether services were added to the HH plan of care by a physician that did not certify the plan of care.

EFFECTIVE DATE: July 1, 2013 (HH episodes beginning on or after this date.)
IMPLEMENTATION DATE: July 1, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/40.2/HH PPS Claims
R	10/70.2/Input/Output Record Layout

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2680	Date: April 2, 2013	Change Request: 8136

Transmittal 2650, dated February 1, 2013, is being rescinded and replaced with Transmittal 2680, dated April 4,2013, to remove business requirement 8136.12 and corresponding instructions regarding reporting a new modifier. Additionally, policy language is revised regarding the use of the Q codes. All other information remains the same.

SUBJECT: Data Reporting on Home Health Prospective Payment System (HH PPS) Claims

EFFECTIVE DATE: July 1, 2013 (HH episodes beginning on or after this date.)
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: Generally, Original Medicare makes payment under the Home Health Prospective Payment System (HH PPS) on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate pays for the delivery of home health services, which includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Claims must report all home health services provided to the beneficiary within the episode.

HCPCS codes Q5001 through Q5009 currently describe where hospice services were provided (in the patient's home, assisted living facility, etc). These codes have been reported on hospice claims since 2007. Similarly, Medicare plans to capture where home health services were provided by requiring HHAs to report the location on the claim.

B. Policy: HHAs must report where home health services were provided on home health claims, using the Q codes Q5001, Q5002, and Q5009. The definitions of the Q codes Q5001, Q5002, and Q5009 were revised effective April 1, 2013 as follows:

- 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 (NO)

As described in Section 30.1.2 of the Medicare Benefit Policy Manual (Pub 100-02), Chapter 7 (Home Health Services), the patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. Q code Q5002 should be used to indicate that home health services were provided at an assisted living facility (as defined by the State in which the beneficiary is located). Conversely, Q code Q5001 should be used to indicate that home health services provided at a patient's residence except in the cases where the services are provided at an assisted living facility. Finally, Q code Q5009 may be reported in the rare instance an HHA believes the definitions of Q5001 and Q5002 do not accurately describe the location where services are provided.

The location where services were provided should be reported along with the first billable visit in an HH PPS episode. In addition to reporting a service line according to current instructions, 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 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.

NOTE: Revisions to the definitions of the Q codes above will be published in the HCPCS update on March 31, 2013.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8136.1	Medicare contractors shall allow HCPCS codes Q5001, Q5002 and Q5009 on HH PPS claims (types of bill 32x or 33x except for 322 and 332).	X					X	X				
8136.2	Medicare contractors shall ensure that HCPCS codes Q5001, Q5002 or Q5009 are reported on HH PPS claims with the following revenue codes: 042X, 043X, 044X, 055X, 056X or 057X.	X					X					
8136.2.1	Medicare contractors shall return to the provider any HH PPS claims with HCPCS codes Q5001, Q5002 or Q5009 that are reported with a revenue code other than 042X, 043X, 044X, 055X, 056X or 057X.	X					X					
8136.3	Medicare contractors shall ensure that at least one revenue code line reporting HCPCS codes Q5001, Q5002 or Q5009 is present on any HH PPS claim.							X				
8136.3.1	Medicare contractors shall return to the provider any HH PPS claim without at least one revenue code line reporting HCPCS codes Q5001, Q5002 or Q5009.	X					X					
8136.4	Medicare contractors shall ensure that the line item date of service of one line reporting HCPCS codes Q5001, Q5002 or Q5009 matches the earliest dated HH visit line (revenue codes 042X, 043X, 044X, 055X, 056X or 057X) on the claim.							X				
8136.4.1	Medicare contractors shall return to the provider any claim where the earliest dated HH visit line does not contain a line reporting HCPCS codes Q5001, Q5002 or Q5009.	X					X					
8136.5	Medicare contractors shall ensure that for each line reporting HCPCS codes Q5001, Q5002 or Q5009 on an HH PPS claim there is a line with the same revenue code and the same date of service.							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8136.5.1	Medicare contractors shall return to the provider any HH PPS claim where a line reporting HCPCS codes Q5001, Q5002 or Q5009 does not have a matching HH visit on the same date of service.	X					X					
8136.6	Medicare contractors shall ensure that if more than one line item on an HH PPS claim reports Q5001, Q5002 or Q5009 then the same HCPCS code cannot be reported on consecutive dates.							X				
8136.6.1	Medicare contractors shall return to the provider HH PPS claims reporting more than one line item with the same HCPCS Q-code on consecutive dates.	X					X					
8136.7	Medicare contractors shall ensure that lines reporting HCPCS codes Q5001, Q5002 or Q5009 are not included in the visit counts passed to the HH Pricer.							X				
8136.8	Medicare contractors shall ensure that lines reporting HCPCS codes Q5001, Q5002 and Q5009 are not included in the calculation of value code 62 and 63 amounts.							X				
8136.9	Medicare contractors shall exclude lines reporting HCPCS codes Q5001, Q5002 and Q5009 from editing that validates the number of visits on an HH PPS claim against the calculated value code 62 and 63 amounts.										X	
8136.10	Medicare contractors shall exclude lines reporting HCPCS codes Q5001, Q5002 and Q5009 on HH PPS claims from the Medicare Summary Notice.							X				
8136.11	Medicare contractors shall ensure that lines reporting HCPCS codes Q5001, Q5002 or Q5009 are not counted in medical policy parameters that count numbers of visits.							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8136.12	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X					X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
All	All requirements shall use the definition of HH PPS claims shown in requirement 8136.1.

Section B: All other recommendations and supporting information: The term "Medicare contractors" in this instruction refers to both claims processing contractors and shared system maintainers. The responsible party for each requirement should be determined from the responsibilty columns only.

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov (For institutional claims processing), Kristine Chu, kristine.chu@cms.hhs.gov (For HH payment policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

40.2 - HH PPS Claims

(Rev. 2680, Issued: 04-02-13, Effective: 07-01-13, Implementation: 07-01-13)

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

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

Type of Bill

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

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

lst Digit-Type of Facility

3 - Home Health

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

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

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

3rd Digit-Frequency - Definition

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 frequency codes 7, or 8.

HHAs must submit HH PPS claims with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." Medicare contractors do not accept late charge bills, submitted with frequency "5," on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

Statement Covers Period

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

In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal

discharge procedures as the "through" date. If the beneficiary has died, the HHA reports the date of death in the "through date."

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

Patient Name/Identifier

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

Patient Address

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

Patient Birth Date

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

Patient Sex

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

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

Patient Discharge Status

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

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the

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

In cases where an HHA is changing the Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor 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 contractor.

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.

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 3X8), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

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

Occurrence Span Code and Dates

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

Value Codes and Amounts

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

NOTE: Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in the Medicare contractor's online claim history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Contractors 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.

Code	Title	Definition
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (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, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 32X, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will not change the TOB and will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

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

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

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

027X	Medical/Surgical Supplies (Also see 062X, an extension of 027X) Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. **NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills
042X	Physical Therapy Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043X	Occupational Therapy Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

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

NOTE: Contractors do not accept revenue codes 058X or 059X when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

Revenue Codes for Optional Billing of DME

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their Medicare contractor 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 CMS' future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

Validating Required Reporting of Supply Revenue Code

The HH PPS includes a separate case-mix adjustment for non-routine supplies. Non-routine supply severity levels are indicated on HH PPS claims through a code value in the 5th position of the HIPPS code. The 5th 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 5th position containing the letters S through X, the claim must also report a non-routine supply revenue 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 5th 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 Medicare contractor for continued adjudication.

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

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

To report HH visits on episodes beginning before January 1, 2011, the HHA reports a single HCPCS code to represent *a visit by* each HH care discipline. These codes are:

G0151 Services of physical therapist in home health or hospice setting, each 15 minutes.

G0152 Services of an occupational therapist in home health or hospice setting, each 15 minutes.

G0153 Services of a speech language pathologist in home health or hospice setting, each 15 minutes.

G0154 Services of skilled nurse in the home health or hospice settings, each 15 minutes.

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

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

To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports one of the following HCPCS code to represent *a visit by* each HH care discipline:

Physical Therapy (revenue code 042x)

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

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

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

Occupational Therapy (revenue code 043x)

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

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

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

Speech-Language Pathology (revenue code 044x)

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

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

Skilled Nursing (revenue code 055x)

G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

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

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

G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

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 that reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code that reflects the service for which most of the time was spent

during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

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

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

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

Q5009: Hospice or home health care provided in place not otherwise specified (NO)

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

Service Date

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

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. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

Total Charges

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

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

Non-covered Charges

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

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

Payer Name

Required - See chapter 25.

Release of Information Certification Indicator

Required - See chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

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

Patient's Relationship To Insured

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

Insured's Unique Identifier

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

Insured's Group Name

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

Insured's Group Number

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

Treatment Authorization Code

Required - The 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	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
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	G

12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

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: 07JK08AA41GBMDCDLG.

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.

The claims-OASIS matching key on the claim will match that submitted on the RAP.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

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-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-CM code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

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

Other Diagnosis Codes

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

For other diagnoses, the diagnoses and ICD-9-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

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

Remarks

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

70.2 - Input/Output Record Layout

(Rev. 2680, Issued: 04-02-13, Effective: 07-01-13, Implementation: 07-01-13)

The HH Pricer input/output file is 500 bytes in length. The required data and format are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	This field will be used for the National Provider Identifier if it is sent to the HH Pricer in the future.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29-31	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
33-35	9(3)	PEP-DAYS	Input item: The number of days to be used for PEP payment calculation. Medicare claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim.
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-46	X(9)	FILLER	Blank.
47-50	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period “From” date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU	Input item: The statement covers period

File Position	Format	Title	Description
		DATE	"through" date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
77	X	HRG-MED - REVIEW - INDICATOR	Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT - CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim. This code will match the input code unless the claim is recoded due to therapy thresholds or changes in episode sequence.
88-90	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Fields for five more occurrences of all HRG/HIPPS code related fields defined above. Not used.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X, 057X). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY - COV-	Input item: A quantity of covered visits corresponding to each of the six revenue codes.

File Position	Format	Title	Description	
		VISITS	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. *Excludes line items reporting HCPCS codes Q5001, Q5002 or Q5009.*	
258-266	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
267-275	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.	
276-400	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, 1st episode add-on payment applies
			Error return codes:	
			10	Invalid TOB

File Position	Format	Title	Description	
			15	Invalid PEP days
			16	Invalid HRG days, greater than 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid MSA/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates before Oct 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 3x9 or adjustment TOB
403-407	9(5)	REVENUE - SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x, and 044x.	
408-412	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
413-421	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.	
422-430	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the RAP or claim.	
431-435	9(3)V9(2)	LUPA-ADD-ON-PAYMENT	Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the Shared System to the payment for the first visit line on the claim.	
436	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to ‘B’ when condition code 47 is present on the RAP or claim. The indicator is set to ‘1’ in all other cases.	
437	X	RECODE-IND	Input Item: A recoding indicator set by Medicare claims processing systems in response to the Common Working File identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0 = default value	

File Position	Format	Title	Description
			1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 3 = HIPPS code shows early episode, should be later episode
438	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Medicare systems copy this code from the 10th position of the treatment authorization code. Valid values: 1 = early episode 2 = late episode
439	X	CLINICAL-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 11th position of the treatment authorization code.
440	X	FUNCTION-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Medicare systems copy this code from the 12th position of the treatment authorization code.
441	X	CLINICAL-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 13th position of the treatment authorization code.
442	X	FUNCTION-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Medicare systems copy this code from the 14th position of the treatment authorization code.
443	X	CLINICAL-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code

File Position	Format	Title	Description
			from the 15th position of the treatment authorization code.
444	X	FUNCTION-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Medicare systems copy this code from the 16th position of the treatment authorization code.
445	X	CLINICAL-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 17th position of the treatment authorization code.
446	X	FUNCTION-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Medicare systems copy this code from the 18th position of the treatment authorization code.
447-456	9(8)V99	PROV-OUTLIER-PAY-TOTAL	Input item: The total amount of outlier payments that have been made to this HHA during the current calendar year.
457 - 467	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA during the current calendar year.
468-500	X(33)	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 systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for 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 systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice.