Home Health PC Pricer –
Claim Calculation Instructions for 30-day versions

The following instructions apply to the 30-day period of care versions of the HH PC Pricer. All claims with "From" dates on and after January 1, 2020 should use the 30-day period of care versions of the HH PC Pricer. Claims for earlier dates of service should use the 60-day episode versions.

When launched, the PC Pricer initially displays a 'Welcome' Screen.

Click the 'Enter Claim' button, and the program will display the claim entry screen.

Field-by-Field Entry Screen Instructions:

Provider Number: Enter the six-digit CMS Certification Number (CCN) of the home health agency (HHA).

Patient ID: If a patient specific record is desired, enter the beneficiary's Health Insurance Claim number or the HHA's internal patient identifier. If not, tab over this field.

CBSA: Enter the Core-Based Statistical Area code representing the beneficiary's site of service. This is the value code 61 amount from the claim.

COUNTY Code: Enter the Federal Information Processing Standards (FIPS) State and County code representing the beneficiary's site of service. This is the value code 85 amount from the claim.

The FIPS State and County codes are available at:
https://www.census.gov/geographies/reference-files/2017/demo/popest/2017-fips.html .

FROM Date: Enter the Statement Covers "From" date from the claim.

THRU Date: Enter the Statement Covers "Through" date from the claim.

ADMIT Date: Enter the Admission Date from the claim.

TOB: Type of bill. Enter 322 if calculating a RAP payment, 329 if calculating a claim payment, or 327 if calculating an adjustment claim.

INITIAL-PAY-QRP-IND: This field shows the HHA's status under the quality reporting program. Enter 0 unless the HHA is subject to the 2% reduction for not reporting quality data. If the reduction applies, enter 2.

VBP FAC: If your HHA is in a HH Value-Based Purchasing (VBP) State, enter your agency's VBP adjustment factor. Other HHAs may skip past this field, leaving the default value of 1.00000 in place.

PEP IND: Enter Y if the patient status code on the claim is 06, indicating a partial episode payment (PEP) will apply. In all other cases, enter N.

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SOURCE ADM CODE: If condition code 47 is reported on the claim, enter 'B' in this field. In all other cases, enter 1.

HIPPS: Enter the HIPPS code from the revenue code 0023 line on the claim.

HRG DAYS: Enter 30, unless the PEP IND is a Y. In that case, enter the number of days between the first and last visits on the claim.

Date of Service: Enter the earliest visit date for a physical therapy visit (revenue code 0420), speech language pathology visit (revenue code 0440) or skilled nursing visit (revenue code 0550).

Visits: Enter the total number of covered visits for each revenue code (i.e. the total number of lines on the claim with each revenue code).

Units: Enter the total number of covered units for each revenue code (i.e. the sum of the units on covered lines with each revenue code). Units considered for outlier payment are subject to a limit of 32 units (8 hours), summed across the six disciplines of care, per date of service. The user should apply this limit before entering the total units in this field. For example, if 38 units of revenue code 055x were provided on 1 day, apply only 32 to that total.

If more than one revenue code is provided in 1 day and there were more than 8 hours of care provided that day, apply the units up to 32 to the highest cost revenue codes first. Revenue codes in highest to lowest cost order: 056x, 044x, 042x, 043x, 055x, 057x. For example, if 20 units of revenue code 056x and 16 units of revenue code 044x were provided, apply all 20 units to 056x and 12 units to 044x.

When all fields are completed, hit the "Submit Claim" button to proceed to the payment results screen.