CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1904	**Date: FEBRUARY 5, 2010**
	Change Request 6757

SUBJECT: Coding Patient Transfers Under the Home Health Prospective Payment System (HH PPS)

I. SUMMARY OF CHANGES: This Change Request revises Medicare processing of HH PPS claims to account for recent changes to the UB-04 code set by the National Uniform Billing Committee.

New / Revised Material
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.13/Transfer Situation - Payment Effects
R	10/10.1.14/Discharge and Readmission Situation Under HH PPS - Payment Effects
R	10/30.5/National Home Health Prospective Payment Episode History File
R	10/30.9/Coordination of HH PPS Claims Episodes With Inpatient Claim Types
R	10/30.11/Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	10/70.2/Input/Output Record Layout

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within 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 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1904	Date: February 5, 2010	Change Request: 6757

SUBJECT: Coding Patient Transfers Under the Home Health Prospective Payment System (HH PPS)

Effective Date: July 1, 2010
[Note: Unless otherwise specified, the effective date is the date of service.]

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: When the National Uniform Billing Committee (NUBC) replaced the UB-92 institutional claim form with the UB-04, they made several changes to the names and definitions of claim fields. One of these changes was to redefine the 'Source of Admission' field as 'Point of Origin for Admission or Visit' and to specify that codes in this field must represent a place rather than a referral source. The NUBC has continued to review the code values that are valid for this field to ensure they are consistent with the current definition. They have found that codes B (defined as 'transfer from another home health agency') and C (defined 'readmission to the same home health agency') are not consistent with the definition. NUBC will retire these codes effective for dates of service on or after July 1, 2010.

These two codes are significant to Medicare claims processing of home health (HH) claims under the HH PPS. Both codes are used as indicators to show Medicare's Common Working File (CWF) that a partial episode payment (PEP) adjustment will apply to an HH episode. When these codes are present, CWF is programmed to allow a request for anticipated payment (RAP) which overlaps a previously established episode. The previously established episode is shortened and a new episode is created, allowing the overlapping RAP to be paid.

The NUBC has created a new condition code, code 47, to replace the point of origin code B. The title of this new code is "Transfer from another Home Health Agency." The definition is "The patient was admitted to this home health agency as a transfer from another home health agency." The NUBC will not replace point of origin C. The requirements below describe how Medicare systems must be revised to accommodate these code changes.

B. Policy: This transmittal contains no policy changes. It ensures Medicare systems can continue to implement existing policies appropriately despite changes in coding.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6757.1	Medicare contractors shall no longer accept point of origin codes B or C on institutional claims.					X	X			X	HH MAC
6757.2	Medicare contractors shall accept condition code 47 on institutional claims.					X	X				HH MAC
6757.3	Medicare contractors shall allow an HH RAP									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	(institutional claims with type of bill 322 or 332) or a no-RAP LUPA claim to overlap an existing HH episode record if condition code 47 is present on the RAP.										
6757.3.1	Medicare contractors shall set the transfer/readmission indicator on the HH episode created by the record allowed in 6757.3 with a value of 'B'.									X	
6757.4	Medicare contractors shall allow an HH RAP (institutional claims with type of bill 322 or 332) or a no-RAP LUPA claim to overlap an existing HH episode record if the CCN on the RAP and the episode record match.									X	
6757.4.1	Medicare contractors shall set the transfer/readmission indicator on the HH episode created by the record allowed in 6757.4 with a value of 'C'.									X	
6757.5	Medicare contractors shall calculate an add-on payment to low utilization payment adjustments on institutional home health claims when the following conditions are met: • The dates in the claim "From" date and admission dates match • The first position of the HIPPS code is 1 or 2 • Condition code 47 is not present, and • The recoding indicator of 2 is not set.						X				HH Pricer
6757.5.1	Medicare contractors shall cease to pass the point of origin code on a home health claim to the LUPA-SRC-ADM field in the HH Pricer input record.						X				
6757.5.2	Medicare contractors shall set the LUPA-SRC-ADM code value in the HH Pricer input record to 'B' when condition code 47 is present.						X				
6757.5.3	Medicare contractors shall set the LUPA-SRC-ADM code value in the HH Pricer input record to '1' when condition code 47 is not present.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6757.6	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 site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your 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					HH MAC

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
6757.5	While the HH Pricer will continue to perform this calculation, the FISS requirements in 6757.5.1 through 6757.5.3 make the change transparent to the HH Pricer software and no Pricer logic changes are required. Populating the LUPA-SRC-ADM field based on the condition code rather than using the condition code directly in the HH Pricer input prevents an expansion and redesign of the HH Pricer input/output record.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148 or Yvonne Young, yvonne.young@cms.hhs.gov, 410-786-1886

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

10.1.13 - Transfer Situation - Payment Effects

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

Transfer describes when a single beneficiary chooses to change HHAs during the same 60-day period. By law under the HH PPS system, beneficiaries must be able to transfer among HHAs, and episode payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs submit a RAP with a transfer indicator in the *condition code* field on the institutional claim even when an episode may already be open for the same beneficiary at another HHA. In order for a receiving (new) HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). The receiving HHA must also document in its records that it accessed the Medicare inquiry system to determine whether or not the patient was under an established home health plan of care and contacted the initial HHA on the effective date of transfer.

In such cases, the previously open episode will be automatically closed in Medicare claims processing systems as of the date services began at the HHA the beneficiary transferred to, as reported in the RAP; and the new episode for the "transfer to" agency will begin on that same date. **Payment will be pro-rated for the shortened episode of the "transferred from" agency**, adjusted to a period less than 60 days either according to the claim closing the episode from that agency or according to the RAP from the "transfer to" agency**.** Note that HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

Under HH PPS, HHAs may discharge beneficiaries before the 60-day episode has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a 60-day episode, but the beneficiary is readmitted to the same agency in the same 60 days. Since no portion of the 60-day episode can be paid twice, the payment for the first episode must be pro-rated to reflect the shortened period (see §10.1.15). *A* new episode can be opened by the HHA. *Medicare systems will allow this in cases where the CMS certification number (CCN) on the new RAP matches the CCN on the prior episode.* The next episode will begin the date the first service is supplied under readmission (setting a new 60-day "clock").

Note that beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. When discharging, full episode payment would still be made unless the beneficiary received more home care

later in the same 60-day period. Discharge should be made at the end of the 60-day episode period in all cases if the beneficiary has not returned to the HHA, and is not expected to return for treatment under any existing plan of care.

30.5 - National Home Health Prospective Payment Episode History File

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

CWF maintains a national episode history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. Only Medicare contractors, not providers, may view this file.

The episode file, populated as soon as the first HH PPS episode is opened for a beneficiary with either a RAP or a claim, contains:

- The beneficiary's Health Insurance Claim Number (HICN);
- The pertinent Contractor and Provider Numbers;
- Period Start and End Dates - the start date is received on an RAP or claim, and the end date is initially calculated to be the 60th day after the start date, changed as necessary when the claim for the episode is finalized;
- DOEBA and DOLBA, Dates of Earliest and Latest Billing Activity (respectively) - dates needed to attribute episode payment to the correct Medicare trust fund, drawn from the existing home health benefit period file;
- Patient Status Indicator - the patient discharge status code on an HH PPS claim, indicating the status of the HH patient at the end of the episode. This indicator will also be populated by RAPs, but the value will always be "30";
- Transfer/Readmit Indicator – *code values in this field indicate the reason this episode record was allowed to overlap the 60-day period of the previous episode:*

  'B' indicates the episode record was a transfer from another HHA (i.e., condition code 47 was on the RAP or claim;

  'C' indicates the episode record was a discharge and admission from the same HHA (i.e., CCNs on the two episodes are the same).

- The HIPPS Code(s) - up to six for any episode (though only one will be used for episodes beginning on or after January 1, 2008), representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
- Principle Diagnosis Code and First Other Diagnosis Code - from the RAP or claim;

- A LUPA Indicator - received from the shared system indicating whether or not there was a LUPA episode; and

- A RAP Cancellation Indicator - showing whether or not a RAP has been auto-canceled for this episode because a claim was not received in required time frames: in such cases, distinguished by the internally used cancel only code "B," this indicator is a value of "1." For episodes beginning on or after January 1, 2008, this indicator is also used when a final claim has been denied as fully non-covered by medical review. In these cases, the indicator is a value of "2." In all other cases, the value is "0."

Separate from the episode file, CWF passes the Claims-OASIS matching key on the RAP or claim to CMS' National Claims History (NCH). This enables NCH claims data to be linked to individual OASIS assessments supporting the payment of individual claims. The LUPA indicator is also passed to NCH, in addition to routinely passed claim data.

A transfer/readmit indicator is present on the internal episode file used in CWF editing but it is not displayed on the episode history screen. If contractors need to validate this data used in CWF editing, they must research the claim record on CWF history. The episode file contains the 36 most recent episodes for any beneficiary. Episodes that precede the most recent 36 will be dropped off the file and will not be retrievable online. The date of accretion, meaning dates on which episode records are created or updated, for an episode is the date the RAP or claim is accepted or applied.

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility (SNF) services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive home care simultaneously. Thus, if an HH PPS claim is received, and CWF finds dates of service on the HH claims that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), Medicare systems will reject the HH claim. This would still be the case even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later, but contained dates of service duplicating dates of service within the HH PPS episode period.

A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, *the discharge is not recognized for Medicare payment purposes. All the HH services*

provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim.

30.11 - Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

The following chart summarizes basic effects of HH PPS claims processing on the episode record:

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP (Percentage Payments 0-60)	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission is* present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present
Subsequent Episode RAP	Opens another subsequent episode using RAP's "from" date; "through" date is automatically calculated to extend through next 60 days	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission is* present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present
Initial RAP with *condition code 47*	Opens an episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• The period end date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the day before the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider or Contractor	The episode record is deleted from CWF	• No episode exits to prevent RAP submission or No-RAP LUPA claim submission
RAP Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission* is

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
		present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present • To correct information on this RAP, the original RAP must be replaced, cancelled by the HHA and then re-submitted once more with the correct information
Claim (full episode)	60-day episode record completed; episode "through" date remains at the 60th day; Date of Latest Billing Action (DOLBA) updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission* is present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present
Claim (discharge with goals met prior to Day 60)	Episode record completed; episode "through" date remains at the 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission* is present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present
Claim (transfer)	Episode completed; episode period end date reflects transfer; DOLBA updates with date of last service	• A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date
No-RAP LUPA Claim	Opens an episode record using claim's "from" date; the "through" date is automatically calculated to extend through 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission* is present • Other No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim
Claim	No impact on the episode	• No impact

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
(adjustment)	unless adjustment changes patient status to transfer	
Claim Cancellation by Provider or Contractor	The episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP LUPA claim submission
Claim Cancellation by System	The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless *an indicator of a transfer or discharge/readmission* is present • No-RAP LUPA claims will be rejected unless *an indicator of a transfer or discharge/readmission* is present

40.1 - Request for Anticipated Payment (RAP)

(Rev.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

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

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the next remittance advice (RA).

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

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

Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity.

Patient Control Number

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

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 requests for anticipated payment 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 care).

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

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

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

Statement Covers Period (From-Through)

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

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 3X8), the agency reports one of the following:
Claim Change Reasons

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

Enter "Remarks" indicating the reason for cancellation.

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

Occurrence Codes and Dates

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

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

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

Value Codes and Amounts

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

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number 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.

Conditional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

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

Revenue Code and Revenue Description

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

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

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

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.

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

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

Service Units

Optional – Service units are not required on the 0023 revenue code line. 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 - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

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.

The following represents an example of a treatment authorization code created using this format:

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

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

Document Control Number (DCN)

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

Principal Diagnosis Code

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

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

Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis.

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 M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-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.

OASIS form items M0245 or M0246, which report 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 M0240 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 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.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be

reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the UB-04 (Form CMS-1450) hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See chapter 1.)

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 a discharge claim is submitted due to change of Medicare contractor, see instructions for patient status code below. 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 which causes the Medicare certification number (known as the OSCAR number) to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. In changes of ownership which do not affect the Medicare certification number, billing for episodes is also unaffected.

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

If HHAs require guidance on OASIS assessment procedures in these cases, 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. For a complete list of Condition Codes see chapter 25.

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 following codes representing Claim Change Reasons:

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

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

Required - If canceling the claim (TOB 3X8), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

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

Occurrence Codes and Dates

Conditional - The HHA enters any NUBC approved code to describe occurrences that apply to the claim. For a complete list of Occurrence Codes see chapter 25.

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.

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

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 CMS online history and on remittances.

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

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

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

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

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

Revenue Code and Revenue Description

Required

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

Claims for episodes beginning before January 1, 2008, must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will return the claim.

Claims for episodes beginning on or after January 1, 2008, 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.

For episodes beginning before January 1, 2008, if there is a change in the HIPPS code, refer to the significant change in condition (SCIC) chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more than once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day. If the claim represents an episode in which the beneficiary experienced a SCIC, the HHA reports one or more additional 0023 revenue code lines to reflect each change.

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

For episodes beginning on or after January 1, 2008, 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 (**NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)	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.

042X	Physical Therapy Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043X	Occupational Therapy Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
044X	Speech-Language Pathology Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
055X	Skilled Nursing Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
056X	Medical Social Services Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
057X	Home Health Aide (Home Health) Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

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

Revenue Codes for Optional Billing of DME

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their 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. For additional instructions for billing DME services see chapter 20.

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.
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

062X	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 will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS' future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs

should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

Validating Required Reporting of Supply Revenue Code

With the advent of the refined HH PPS, the payment system includes a separate case-mix adjustment for non-routine supplies. Effective for HH PPS episodes beginning on or after January 1, 2008, non-routine supply severity levels will be 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 refined 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 (see §40.1 for definition of HIPPS codes) 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.

On claims reflecting a SCIC that occurred in an episode that began prior to January 1, 2008, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

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

Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above. 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 - The HHA should not report service units on 0023 revenue code lines. For line items detailing all services within the episode period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under 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 may be zero or blank).

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. 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 total noncovered charges pertaining to the related revenue code are entered here.

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 links the claim record to the specific OASIS assessment used to produce the HIPPS code.

For episodes beginning before January 1, 2008, this is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

For episodes beginning on or after January 1, 2008, the following is the new format of the treatment authorization code:

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.

The following represents an example of a treatment authorization code created using this format:

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

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.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

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 M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases applicable for episodes beginning before January 1, 2008, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

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 M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-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.

OASIS form items M0245 or M0246, which report 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 M0240 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.1904, Issued: 02-05-10, Effective: 07-01-10, Implementation: 07-06-10)

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 OSCAR system provider number, copied from the claim form.
29-31	X(3)	TOB	Input item: The TOB code, copied from the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Medicare claims processing systems must set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
33-35	9(3)	PEP-DAYS	Input item: The number of days to be used for PEP payment calculation. Medicare claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim.

File Position	Format	Title	Description
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the Medicare claims processing systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-43	X(7)	FILLER	Blank.
44-46	X(2)	FILLER	Blank.
47-50	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period “From” date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
77	X	HRG-MED - REVIEW - INDICATOR	Input item: A single Y/N character to indicate if a HIPPS code has been changed by medical review. Medicare claims processing systems must set a Y if an ANSI code on the line item indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medical review change, Medicare claims processing systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG - OUTPUT -	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim.

File Position	Format	Title	Description
		CODE	This code will match the input code in all cases except when the therapy threshold for the claim was not met.
88-90	9(3)	HRG-NO-OF - 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	Five more occurrences of all HRG/HIPPS code related fields defined above, since up to six HIPPS codes can be automatically processed for payment in any one episode.
251-254	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X, 057X). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-266	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
267-275	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a 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	Additional	Five more occurrences of all REVENUE related

File Position	Format	Title	Description	
	above	REVENUE data	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
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Final payment, SCIC
			08	Final payment, SCIC with outlier
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Final payment, SCIC within PEP
			13	Final payment, SCIC within PEP with outlier
			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 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	

File Position	Format	Title	Description
			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 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

File Position	Format	Title	Description
			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 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-	Input item: The total amount of outlier payments

File Position	Format	Title	Description
		OUTLIER-PAY-TOTAL	that have been made to this HHA during the current calendar year.
456 - 466	9(8)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.
467-500	X(34)	FILLER	

Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HRG" related items. Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

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