Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1808 **Date: SEPTEMBER 8, 2000**

CHANGE REQUEST 514

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: 10/1/2000*
IMPLEMENTATION DATE: 10/1/2000

Section 3638, Billing by Home Health Agencies Under Cost/IPS Reimbursement, has been retitled and updated with an introductory paragraph to reflect that §§3638.1 through 3638.11 are specific to cost/IPS reimbursement. Separate instructions for billing under the Home Health Prospective Payment System (HH PPS) begin at §3638.12. Cost/IPS instructions must remain in the MIM for the full timely filling period for cost/IPS claims.

Section 3638.12, Billing by Home Health Agencies Under the Home Health Prospective Payment System (HH PPS), has been added to decribe billing procedures under HH PPS effective 10/01/2000.

Section 3638.13, When Bills Are Submitted, has been added to describe HH PPS changes regarding submissions.

Section 3638.14, Billing for Nonvisit Charges, has been added to describe HH PPS changes regarding nonvisit charges.

Section 3638.15, DME Furnished as a Home Health Benefit, has been added to describe HH PPS changes regarding DME.

Section 3638.16, More Than One Agency Furnished Home Health Services, has been added to describe payment relationships between multiple agencies under HH PPS.

Section 3638.17, Home Health Services Are Suspended or Terminated Then Reinstated, has been added to describe handling physician suspensions of services under HH PPS.

Section 3638.18, Preparation of a Home Health Billing Form in No-Payment Situations, has been added to describe HH PPS changes regarding non-covered charges.

Section 3638.19, Billing for Part B Medical and Other Health Services, has been added to describe HH PPS changes regarding Part B billing.

Section 3638.20, Reimbursement of HHA Claims, has been added to describe HH PPS changes regarding reimbursement.

Section 3638.21, Osteoporosis Injections as HHA Benefit, has been added to describe HH PPS changes regarding osteoporosis injections.

Section 3638.22, Completion of Form HCFA-1450 for Home Health Agency Billing Under HH PPS, has been added to describe HH PPS changes regarding uniform billing.

Section 3638.23, Requests for Anticipated Payment (RAPs), has been added to describe the submission of RAPs under HH PPS.

Section 3638.24, HH PPS Claims, has been added to describe the submission of claims under HH PPS.

Section 3638.25, HH PPS Claims When No RAP Was Submitted, has been added to describe the submission of claims under HH PPS when a RAP was not submitted for an episode.

Section 3639, Background on HH PPS, is added as a new section to provide information necessary to understand the new payment system. New subsections include overviews of new billing and payment processes, and various HH PPS payment adjustments.

Section 3639.1, Creation of HH PPS, has been added to describe the creation of the new payment system.

Section 3639.2, Regulatory Implementation of HH PPS, has been added to describe the basis in regulation of the new payment system.

Section 3639.3, Commonalities of the Cost Reimbursement and HH PPS Environments, has been added to facilitate understanding of the new payment system in regard to the prior one.

Section 3639.4, Effective Date and Scope of HH PPS for Claims, has been added to describe the scope of the new payment system.

Section 3639.5, Configuration of the HH PPS Environment, has been added to describe the systems ronment of the new payment system.

Section 3639.6, New Software for the HH PPS Environment, has been added to describe the new software required in Medicare systems for the new payment system.

Section 3936.7, The Home Health Prospective Payment System (HH PPS) Episode--Unit of Payment, has been added to describe the unit of payment of the new payment system.

Section 3639.8, Number, Duration and Claims Submission of HH PPS Episodes, has been added to describe submissions under the new payment system.

Section 3639.9 , Effect of Election of HMO and Eligibility Changes on HH PPS Episodes, has been added to describe the effect of HMO election under the new payment system.

Section 3639.10, Split Percentage Payment of Episodes and Development of Episode Rates, has been added to describe the split payment provisions of the new payment system.

Section 3639.11, Basis of Medicare Prospective Payment Systems and Case Mix, has been added to describe the conceptual basis of case-mix adjusted PPS systems

Section 3639.12, Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes, has been added to describe the relationship between payment groups and codes under the new payment system.

Section 3639.13, Composition of HIPPS Codes for HH PPS, has been added to describe coding requirements of the new payment system.

Section 3639.14, Significance of HIPPS Coding for HH PPS, has been added to further describe coding requirements of the new payment system.

Section 3639.15, Overview of the Provider Billing Process Under Home Health Prospective Payment, has been added to provide a general overview of the new payment system.

Section 3639.16, Overview--Grouper Links Assessment and Payment, has been added to describe the function of Grouper software under HH PPS.

Section 3639.17, Overview--HIQH Inquiry System Shows Primary HHA, has been added to describe the function of the new HIQH transaction under HH PPS.

Section 3639.18, Overview--Request for Anticipated Payment (RAP) Submission and Processing Establishes HH PPS Episode and Provides First Percentage Payment, has been added to describe RAP submission under HH PPS.

Section 3639.19, Overview--Claim Submission and Processing Completes HH PPS Payment, Closes Episode and Performs A-B Shift, has been added to describe claim submission under HH PPS.

Section 3639.20, Overview--Payment, Claim Adjustments and Cancellations, has been added to describe claim adjustment under HH PPS.

Section 3639.21, Definition of the Request for Anticipated Payment (RAP), has been added to define RAPs under HH PPS.

Section 3639.22, Definition of Transfer Situation Under HH PPS--Payment Effects, has been added to define transfer payments under HH PPS.

Section 3639.23, Definition of Discharge and Readmission Situation Under HH PPS --Payment Effects, has been added to define discharge/readmission payments under HH PPS.

Section 3639.24, Payment When Death Occurs During an HH PPS Episode, has been added to define payments under HH PPS when a beneficiary dies during an episode.

Section 3639.25, Adjustments of Episode Payment--Low Utilization Payment Adjustments (LUPAs), has been added to describe LUPA payments under HH PPS.

Section 3639.26, Adjustments of Episode Payment--Special Submission Case: "No-RAP" LUPAs, has been added to describe "No-RAP" LUPA payments under HH PPS.

Section 3639.27, Adjustments of Episode Payment--Therapy Threshold, has been added to describe therapy threshold adjustments under HH PPS.

Section 3639.28, Adjustments of Episode Payment--Partial Episode Payment (PEP), has been added to describe PEP adjustments under HH PPS.

Section 3639.29, Adjustments of Episode Payment--Significant Change in Condition (SCIC), has been added to describe SCIC adjustments under HH PPS.

Section 3639.30, Adjustments of Episode Payment--Outlier Payments, has been added to describe outlier payments under HH PPS.

Section 3639.31 Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments, has been added to describe the relationship of various payment adjustments under HH PPS.

Section 3639.32, Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustment, has been added to provide illustration of payment situations decribed in section 3639.15 through 3639.31.

Section 3639.33, Exhibit: General Guidance on Line Item Billing Under HH PPS, has been added to provide a reference guide for billing under HH PPS.

Section 3639.34, Exhibit: Acronym Table, has been added to provide a reference for acronyms used repeatedly in all subsection of 3639.

Section 3639.35, Home Health Prospective Payment System (HH PPS) Consolidated Billing and Primary HHAs, has been added to describe the consolidated billing requirements of HH PPS.

Section 3640**,** New Common Working File (CWF) Requirements for the Home Health Prospective Payment System (HH PPS), has been added as a new section to provide information regarding the new Health Insurance Query Access for HHAs (HIQH) system.

Section 3640.1, Creation of the Health Insurance Query System for Home Health Agencies (HIQH) and Hospices in the Common Working File--Replacement of HIQA, has been added to explain the creation of the new Health Insurance Query Access for HHAs (HIQH) system.

Section 3640.2, HIQH Inquiry and Response, has been added to describe inquiries into the HIQH system.

Section 3640.3, Timeliness and Limitations of HIQH Responses, has been added to describe limitiations of the HIQH system.

Section 3640.4, Inquiries to Regional Home Health Intermediaries (RHHIs) Based on HIQH Responses, has been added to describe inquiries via RHHIs into the HIQH system.

Section 3640.5, National Home Health Prospective Payment Episode History File, has been added to describe the episode record accessed by the HIQH system.

Section 3640.6, Opening and Length of HH PPS Episodes, has been added to describe how episodes are maintained on the HIQH system.

Section 3640.7, Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAP and HHA Claim Activity, has been added to describe how episodes are acted upon in CWF.

Section 3640.8, Other Editing and Changes for HH PPS Episodes, has been added to describe editing of episodes performed in CWF.

Section 3640.9, Priority Among Other Claim Types and HH PPS Consolidated Billing for Episodes, has been added to describe consolidated billing enforcement performed in CWF.

Section 3640.10, Medicare Secondary Payment (MSP) and the HH PPS Episode File, has been added to describe MSP editing performed in CWF.

Section 3640.11, Exhibit: Chart Summarizing Effects of RAP/Claim Actions on the HH PPS Episode File, has been added to provide a reference guide for CWF actions described in various subsections of 3640.

Section 3656.7 Home Health Prospective Payment System (HH PPS) Pricer Program, has been added to reflect the implementation of a new Pricer software module for HH PPS claims effective October 1, 2000.

Sections 3752 and 3754, Outpatient Prospective Payment System (OPPS) Remittance Advice Instructions and 3753, Home Health Prospective Payment System (HH PPS) Remittance Advice Instructions, are added to reflect changes to the electronic remittance advices that have been made to accurately represent OPPS and HH PPS payments.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

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3638. BILLING BY HOME HEALTH AGENCIES UNDER COST/IPS REIMBURSEMENT

The following instructions apply to HHA claims for dates of service on or before September 30, 2000. Claims for dates of service on or after October 1, 2000 will be processed under the home health prospective payment system (HH PPS). Instructions for HHA billing under HH PPS begin at §3638.12. Claims with service dates spanning October 1, 2000 cannot be processed. Return these claims to the provider.

HHAs use the Form HCFA-1450 when billing for services furnished under a plan of treatment and for medical and other health services. Beneficiaries are entitled to unlimited home health visits when they meet the requirement of intermittent care and are homebound.

Start of care notices are not required when billing for services, therefore, maintain a Medicare eligibility history file to determine when a beneficiary is entitled to Medicare Part A or Part B. When entitlement is questionable, submit a status query. (See §3507.3.)

3638.1 When Bills are Submitted.--The Form HCFA-1450 is submitted on a periodic basis, e.g., monthly.

- For services furnished under a home health plan of treatment when a bill includes at least one visit.
- For medical and other health services under Part B. (See §3127.)
- The patient (or his representative) refuses to request payment on his behalf.
- When the beneficiary is an HMO enrollee and you have jurisdiction for processing.
- The provider is responsible for not filing a timely claim for payment. (See §3309.1.)

The agency must submit a separate bill for each beneficiary for services provided in different accounting years.

3638.2 Billing for Nonvisit Charges.--For benefits furnished under a Part A home health plan, the HHA will normally prepare and submit a Form HCFA-1450 only when the bill includes charges for at least one visit. If only nonvisit charges (e.g., nonroutine medical supplies, DME) were incurred during the billing period and it is expected that another visit will be made under the existing plan of treatment, the HHA will not immediately submit a bill but include such nonvisit charges on the next billing which does reflect a visit.

When a nonvisit charge is incurred after the last home health visit, but before the plan is terminated, the HHA does not bill for the nonvisit charge until termination of the plan. It then submits a Form HCFA-1450 showing only the nonvisit charge as a separate line item, with an annotation "Final Covered Charge" in FL 84, "Remarks".

Do not forward a bill record showing only the final covered nonvisit charge to HCFA. Instead, pay the covered charge and notify the beneficiary of payment made on his behalf.

Nonvisit charges incurred after termination of the plan are payable under Part B medical and other health services.

3638.3 Payment System for HHA Claims.--Maintain the payment of claims for home health services in three categories to ensure proper accumulation of data for the PS&R and the cost report.

- Services under a plan of treatment, beneficiary is entitled to Part A;
- Services under a plan of treatment, beneficiary is entitled to Part B only (Part B Trust Funds); and
- Medical and other health services.

3638.4 DME Furnished as a Home Health Benefit.--Effective July 18, 1984, medical appliances furnished as a covered home health service are redefined as DME in accordance with the definition in §3113.1 and are subject to 20 percent coinsurance. Items which prior to July 18, 1984, could qualify as medical appliances under the home health benefit, but which do not meet the definition of DME, may be covered if the requirements in §3113.1B3, which pertain to such items, are met. Medicare payment cannot exceed 80 percent of the reasonable cost of the DME. DME furnished free, or at a nominal charge by a public HHA, or by another HHA which requests and receives approval to have payments made to it as a public HHA because a significant portion of its patients are low income, receive interim payment equal to the number of covered visits times the estimated reasonable cost per visit. Coinsurance is applicable for DME furnished at a nominal charge. All DME billed under these instructions must be identifiable for cost report and final cost settlement purposes.

Where a beneficiary meets the criteria for coverage of home health services and the HHA is providing the care under Part A, any DME provided is under Part A (bill type 33). Where the patient meets the criteria for coverage of home health services and the HHA is providing the care under Part B because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be billed under bill type 33 or as a medical and other health service (bill type 34).

3638.12 Billing by Home Health Agencies Under the Home Health Prospective Payment System (HH PPS).--

The following instructions apply to HHA claims for dates of service on or after October 1, 2000. These claims will be processed under the home health prospective payment system (HH PPS). Claims for dates of service on or before September 30, 2000, will be processed under the cost/IPS system. Instructions for HHA billing under cost/IPS reimbursement begin at §3638. Claims with service dates spanning September 30 - October 1, 2000, cannot be processed. Return these claims to the provider.

HHAs use the UB-92/Form HCFA-1450 billing form when billing for services furnished under a plan of treatment and for medical and other health services outside of a plan of care. Beneficiaries are entitled to unlimited home health visits when they meet the requirement of intermittent care and are homebound.

3638.13 When Bills are Submitted.--Agencies submit requests for payment on the UB-92 twice for each episode of care in most instances. In special circumstances, only one submission may be submitted for an episode (see §3639.26). Agencies may submit requests for payment:

- When services are furnished under a home health plan of treatment when a bill includes at least one visit. These requests are submitted on types of bill 32x or 33x.

- When medical and other health services are provided under Part B. (See §3127.) These requests are submitted on type of bill 34x.

- The patient (or his representative) refuses to request payment on his behalf.

- When the beneficiary is an HMO enrollee and you have jurisdiction for processing.

In all cases, the provider is responsible for not filing a timely claim for payment. (See §3309.1.)

3638.14 Billing for Nonvisit Charges.--Under HH PPS all services under a plan of care must be billed as a HH PPS episode. All services within an episode of care must be billed on one claim for the entire episode. Do not accept types of bill 329 and 339 without any visit charges.

Nonvisit charges incurred after termination of the plan of care are payable under Part B medical and other health services on type of bill 34x.

3638.15 DME Furnished as a Home Health Benefit.--Effective July 18, 1984, medical appliances furnished as a covered home health service are redefined as Durable Medical Equipment (DME) in accordance with the definition in §3113.1 and are subject to 20 percent coinsurance. Items which prior to July 18, 1984, could qualify as medical appliances under the home health benefit, but which do not meet the definition of DME, may be covered if the requirements in §3113.1B3, which pertain to such items, are met. Medicare payment cannot exceed 80 percent of the reasonable cost of the DME. DME furnished free, or at a nominal charge by a public HHA, or by another HHA which requests and receives approval to have payments made to it as a public HHA because a significant portion of its patients are low income, receive interim payment equal to the number of covered visits times the estimated reasonable cost per visit. Coinsurance is applicable for DME furnished at a nominal charge. All DME billed under these instructions must be identifiable for cost report and final cost settlement purposes.

Where a beneficiary meets the criteria for coverage of home health services and the beneficiary is under a plan of care, HHAs have the option of billing any DME provided in an episode of care on bill types 329 or 339. Where the HHA is providing DME outside of a plan of care, the DME provided by the HHA may be billed as a medical and other health service (bill type 34x).

3638.16 More Than One Agency Furnished Home Health Services.--When a physician deems it necessary to use two participating HHAs, the physician designates the agency which furnishes the major services and assumes the major responsibility for the patient's care. The primary agency bills for all services furnished by both agencies and keeps all records pertaining to the care. The primary agency's status as primary is established through the submission of a Request for Anticipated Payment (RAP) (see §3639.18). The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies. Two agencies must never bill as primary for the same beneficiary for the same episode of care. When the Common Working File (CWF) indicates an episode of care is open for a beneficiary, deny the RAP of any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

3638.17 Home Health Services Are Suspended or Terminated Then Reinstated.--A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health services. When the suspension is temporary (does not extend beyond the end date of the 60-day episode) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same episode and under the same plan of care as before. The episode from date and the admission date remain the same as on the RAP. No special indication need be made on the episode claim for the period of suspended services. Explanation of the suspension need only be indicated in the medical record.

If, when services are resumed after a temporary suspension (one that does not extend beyond the end date of the 60-day episode), the HHA believes the beneficiary's condition is changed sufficiently to merit a SCIC adjustment, a new OASIS assessment may be performed, and change orders acquired from the physician. The episode may then be billed as a SCIC adjustment, with an additional 0023 revenue code line reflecting the HIPPS code generated by the new OASIS assessment.

If the suspension extends beyond the end of the current 60-day episode, HHAs must submit a discharge claim for the episode. Full payment will be due for the episode. If the beneficiary resumes care, the HHA must establish a new plan of care and submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new plan of care and care was not continuous.

3638.18 Preparation of a Home Health Billing Form in No-Payment Situations.--HHAs must report all non-covered charges on the UB-92, including no-payment claims, as described below. HHAs must report these non-covered charges for all home health services, including both Part A (339 type of bill) and Part B (329 or 34x type of bill) services. Non-covered charges must be reported only on HH PPS claims. RAPs do not require the reporting of non-covered charges. HHA no-payment bills submitted with types of bill 329 or 339 will update any current home health benefit period on the CWF.

A. HHA Claims With Both Covered and Non-Covered Charges.--HHAs must report (along with covered charges) all non-covered charges, related revenue codes, and HCPCS codes, where applicable. (Providers should not report the non-payment codes outlined below.) On the UB-92 flat file, HHAs must use record type 61, Field No. 10 (outpatient total charges) and Field No. 11 (outpatient non-covered charges) to report these charges. Providers utilizing the hard copy UB-92 report these charges in Form Locator (FL 47) "Total Charges," and in FL 48 "Non-Covered Charges."

You must be able to accept these charges in your system and pass them to other payers and the CWF.

B. HHA Claims With All Non-Covered Charges.--HHAs must submit claims when all of the charges on the claim are non-covered (no-payment claim). HHAs must complete all items on a no-payment claim in accordance with instructions for completing payment bills with the exception that all charges are reported as non-covered. You must provide a complete CWF record for these claims. Total the charges on CWF under revenue code 001 (total and non-covered.) Non-payment codes are required in CWF records where no payment is made for the entire claim. Utilize non-payment codes in §3624. These codes alert HCFA to bypass edits in CWF processing that are not appropriate in non-payment cases. Enter the appropriate code in the "Non-payment Code" field of the CWF record if the non-payment situation applies to all services covered by the bill. When payment is made in full by an insurer primary to Medicare, enter the appropriate "Cost Avoidance" codes for MSP cost avoided claims. When you identify such situations in your development or processing of the claim, adjust the claim data the provider submitted, and prepare an appropriate CWF record. See §3893.4 for counting no-payment claims on your workload report.

3638.19 Billing for Part B Medical and Other Health Services.--Form HCFA-1450 is submitted for certain Part B medical and other health services for which the HHA may receive reimbursement outside of the prospective payment system. (See §3127.)

A. Patient Not Under a Home Health Plan of Treatment.--The HHA uses a Form HCFA-1450 (type of bill 34x) to bill for certain Part B "medical and other health services" when there is no home health plan of treatment. Specifically the HHA may bill using type of bill 34x for the following services. (There must be a physician's certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.

- o Rental or purchase of DME.
- o Ambulance service operated by the HHA.

- o Prosthetic devices. (See §3660.6 for billing enteral and parenteral supplies and equipment.)
- o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.
- o Outpatient physical therapy services. (See §§3147ff.)
- o Outpatient speech pathology services. (See §§3147ff.)
- o Outpatient occupational therapy services. (See §§3147ff.)

Bills for services not under a home health plan of treatment should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g. monthly, without regard to an episode of care. These items are not reimbursed under HH PPS.

B. The Patient is Under a Home Health Plan of Treatment.--If a patient is receiving home health services under a plan of treatment, the agency may bill for the following services on Form HCFA-1450 (Bill Type 34X). All other services are home health services and should be billed as a HH PPS episode with Bill Type 32X.

- o Ambulance service operated by the HHA.
- o A covered osteoporosis drug, and
- o Pneumoccocal pneumonia, influenza virus and hepatitis B vaccines.
- o Oral cancer drugs and antiemetics.

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

C. Billing Spanning Two Calendar Years.--The agency should not submit a Part B medical and other health services bill (bill type 34X only) for an inclusive period beginning in one calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits you to apply the appropriate deductible for both years. HH PPS claims (type of bill 32x or 33x) may span the calendar year since they represent 60-day episodes, and episodes should be attributed to the Federal fiscal year or calendar year in which they end.

3638.20 Reimbursement of HHA Claims.--

A. Patient Under A Plan of Treatment (Bill Types 33X and 32X).--Effective for all services provided on or after October 1, 2000, all home health services provided under a plan of treatment will be reimbursed under the HH PPS. (See §3639.)

B. Patient Not Under Plan of Treatment, Part B Medical and Other Health Services (Bill Type 34X).--Outpatient physical therapy, occupational therapy and speech-language pathology services delivered not under a plan of treatment after October 1, 2000, will be reimbursed under the outpatient prospective payment system. For the 34X bill type:

- o Deductible applies; and
- o Coinsurance applies

3638.21 Osteoporosis Injections as HHA Benefit.--Section 4156 of OBRA 1990 provides for Part B coverage of FDA approved injectable drugs for osteoporosis for female beneficiaries. At this time, the only injectable drugs that meet this requirement have the generic name calcitonin-salmon or calcitonin-human. This drug may be covered on a cost basis when provided by an HHA under the circumstances listed below. HHAs list the drug as a non-routine medical supply under Part B on its cost report and bills it under Part B bill type 34X. Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

- o The individual is eligible for Medicare Part B coverage of home health services (the nursing visit to perform the injection may be the individual's qualifying service);
- o The individual sustained a bone fracture that a physician certifies was related to post-menopausal osteoporosis; and
- o The individual's physician certifies that she is unable to learn the skills needed to self-administer the drug, or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

A. Billing Requirements.--The cost of administering the drug is included in the charge for the visit billed under bill type 32X or 33X, as appropriate. The cost of the drug is billed under bill type 34X with revenue code 636 and HCPCS code J0630. This code is defined as up to 400 units. Therefore, the provider must calculate units for FL 46 of the bill as follows:

Units furnished during billing period	Entry on bill
100-400	1
401-800	2
801-1200	3
1201-1600	4
1601-2000	5
2001-2400	6

This is considered part of the home health benefit under Part B.

B. Application of Deductible and Coinsurance.--Payment for the drug is made under Part B. The Part B deductible and coinsurance apply regardless of whether other home health services are covered under Part A or Part B.

C. Denial Messages..--If the claim for an osteoporosis drug is denied because it was not an injectable drug approved by the FDA, use the appropriate message below on the MSN or EOMB.

o MSN Message 6.2: “Drugs not specifically classified as effective by the Food and Drug Administration are not covered.”

o EOMB Message 6.2: "Medicare does not pay for drugs that have not been approved by the Food and Drug Administration."

If the claim for an osteoporosis injection is denied because the patient did not meet the requirements for coverage of the drug, use MSN message 6.5 or EOMB message 6.15, which read "Medicare cannot pay for this injection because one or more requirements for coverage were not met."

D. Edits.--Edit the claim to assure that the beneficiary is female and that diagnosis code 733.01 is present. Also, check your files to assure that a plan of treatment is on file, or that you have paid home health visits for substantially the same period covered by the bill. When scheduling permits, common working file edits bill type 34X with revenue code 636 and HCPCS code J0630 to assure that diagnosis code 733.01 is present and the beneficiary is female.

If the service dates on the 34x claim fall within a HH PPS episode that is open for the beneficiary on CWF, CWF edits to assure that the provider number on the 34x claim matches the provider number on the episode file. This is to reflect that although the osteoporosis drug is paid separately from the HH PPS episode rate it is included in consolidated billing requirements (see §3639.35 regarding consolidated billing.

3638.22 Completion of Form HCFA-1450 For Home Health Agency Billing Under HH PPS.--The information given below details the items that are required from HHAs to bill Medicare for home health services under a plan of care under the home health prospective payment system (HH PPS). Items not listed do not need to be completed, although HHAs may complete them when billing multiple payers. Edit to ensure all required elements are present on HH PPS RAPs and claims. Additional required editing in your systems is detailed beneath each claim element.

3638.23 Requests for Anticipated Payment (RAPs).--HHAs are required to submit the following data elements on a request for anticipated payment under home health PPS. 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. To receive the first part of the HH PPS split payment, HHAs must submit a request for anticipated payment (RAP) with coding as described below.

Each RAP must be based on a current OASIS-based case mix. A RAP and a claim will usually be submitted for each episode period. Each claim 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), automatically cancel the RAP payment in your claims systems. Reflect the full recoupment of the RAP on the HHA's next remittance advice.

If care continues at the same provider for a second episode of care, HHAs may submit the RAP for the second episode even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, use the current mechanism of generating an A/R debit and deducting it on the HHA's next remittance advice (RA) to recoup the overpaid amount.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Untitled
Not required.

FL 3. Patient Control Number
Optional. The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

FL 4. Type of Bill
Required. This three-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 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 a HH PPS claim, HHAs are encouraged to submit all RAPs with bill classification 2. Medicare claims systems determine whether a HH claim should be

paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	Definition
2-Interim-First Claim	Use this code for the first of an expected series of bills or which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment. Use this code for original or replacement RAPs.

FL 4. Type of Bill (cont.)

3rd Digit-Frequency	Definition
8-Void/Cancel of a Prior Claim	Use this code 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 a RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), use this code to cancel so that a corrected RAP can be submitted.

Allow only claims with the following frequency codes to process as adjustments against RAPs: “8,” “9"or “I” (accompanied by a cancel only code of “C”). Do not allow claims with a frequency code of “7" to process as an adjustment against a RAP.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. HHAs must submit the same date in both the “From” and “Through” date fields. On the first RAP in an admission, this date must be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (Day 61, 121, etc.). All dates must be reported in the format MM-DD-YYYY.

Compare the provider effective date in the provider file to the “From” date to ensure that the “From date is on or after the provider effective date. Reject claims which fail this edit.

FL 7. Covered Days
Not Required.

FL 8. Noncovered Days
Not Required.

FL 9. Coinsurance Days
Not Required.

FL 10. Lifetime Reserve Days
Not Required.

FL l2. Patient's Name
Required. Enter the patient's last name, first name, and middle initial.

FL l3 Patient's Address
Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL l4. Patient's Birthdate
Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, leave blank.

FL l5. Patient's Sex
Required. "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL l6. Patient's Marital Status
Not Required.

FL l7. Admission Date
Required. Enter the date the patient was admitted to home health care (MM-DD-YYYY). On the first RAP in an admission, this date should match the statement covers "From" date in FL 6. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care.

FL l8. Admission Hour
Not Required.

FL l9. Type of Admission
Not Required.

FL 20. Source of Admission
Required. Enter a code indicating the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

Code:	Definition:
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement

FL 20. Source of Admission (Cont.)

Code Structure:

9	Information Not Available
A	Transfer From a Critical Access Hospital (CAH)
B	Transfer From Another HHA
C	Readmission to the Same Home Health Agency

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. Enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6). Since the “through” date of the RAP will match the “from” date, the patient will never be discharged as of the “through” date. As a result only one patient status is possible on RAPs.

Code	Definition
30	Still patient

FL 23. Medical Record Number
Optional. The HHA enters the number assigned to the patient's medical/health record. Carry the number the HHA enters through your system and return it to the HHA.

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes

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

If canceling the RAP (TOB 3x8), report 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. Use this code for most corrections to RAPs, including corrections to HIPPS codes.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment.

FL 32, 33, 34, and 35. Occurrence Codes and Dates
Optional. Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Occurrence code 27 is not required on HH PPS RAPs.

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

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the “From” and “Through” dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span “From” dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span “Through” date is in the date field.

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

FL 36. Occurrence Span Code and Dates
Optional. A RAP only applies to one date, therefore occurrence span codes and dates should not apply.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Optional. If canceling a RAP, HHAs enter the control number assigned to the original RAP here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address Not Required.

FLs 39-41. Value Codes and Amounts
Required. Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

Since the value amount is a nine-position field, enter the four-digit MSA in the nine-position field in the following manner. Enter an MSA for Puerto Rico (9940) as 000994000, and the MSA for Abilene TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point (9999999V99) are always zeros.

Optional. Enter any NUBC approved value code to describe other values that apply to the RAP.

FLs 39-41. Value Codes and Amounts (Cont.)

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

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

FL 42 and 43 Revenue Code and Revenue Description
Required. One revenue code line is required on the RAP. This line is used to report the Health Insurance Prospective Payment System (HIPPS) code (defined under FL 44) which is the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs are as follows:

REV. CD.	DESCRIPTION
0023	Home Health Services

Return the Medicare reimbursement for the RAP in the total charges field (FL 47) of the 0023 revenue code line. HHAs must not submit the 0023 revenue code line 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 §3638.24 below). Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

HHAs may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. However, your systems must overlay this amount with the total reimbursement for the RAP.

FL 44. HCPCS/Rates
Required. On the 0023 revenue code line, HHAs must report the HIPPS code for which anticipated payment is being requested.

Definition. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific patient characteristics (or case mix) on which Medicare payment determinations are made. These payment codes represent case-mix groups based on research into utilization patterns among various provider types. HIPPS codes are used in association with special revenue codes used on UB-92 claims forms for institutional providers. One revenue code is defined for each prospective payment system that calls for HIPPS codes. HIPPS codes are placed in Form Locator (FL) 44 ("HCPCS/rate") on the form itself. The associated revenue codes are placed in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim. HIPPS codes are alphanumeric codes of five digits.

Under the home health prospective payment system, which requires the use of HIPPS codes, a case-mix adjusted payment for up to 60 days of care will be made using one of 80 Home Health Resource Groups (HHRG). These HHRGs are determined based on assessments made using the Outcome and Assessment Information Set (OASIS). Grouper software run at the HHA site will use specific data elements from the OASIS data set and assign beneficiaries to an HHRG. On Medicare claims these HHRGs will represented as HIPPS codes. The Grouper will output the HIPPS code which HHAs must enter in FL 44 on the claim.

HHA HIPPS codes are five position alphanumeric codes: the first digit is a static "H" for home health, the second, third and fourth (alphabetical) positions represent the level of intensity respectively to the clinical, functional and service domains of the OASIS. The fifth position (numeric) represents which of the three domains in the HIPPS code were either calculated from complete OASIS data or derived from incomplete OASIS data. (See §3639.13.) A value of "1" in the fifth position should indicate a complete data set that will be accepted by the State Repository for OASIS data. Both HH PPS RAPs and claims must be correct to reflect the HIPPS code accepted by the State repository. Lists of current HIPPS codes used for billing during a specific Federal fiscal year are published in Medicare Program Memoranda.

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 §3638.24.

FL 45. Service Date

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

If the claim "From" date in FL 6 also matches the admission date in FL 17, edit to ensure that the service date on the 0023 line of the RAP matches the claim "From" date.

Optional. If additional revenue codes are submitted on the RAP, report service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §3638.24.

FL 46. Units of Service
Optional. Units of service are not required (i.e., must be zero or blank) on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, HHAs report units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §3638.24.

FL 47. Total Charges
Required. Zero charges must be reported on the 0023 revenue code line. Medicare claims systems will place the reimbursement amount for the RAP in this field on the electronic claim record.

Optional. If additional revenue codes are submitted on the RAP, report any necessary charge amounts to meet the requirements of other payers or your billing software. Medicare claims systems will not make any payment determinations based upon submitted charge amounts.

FL 48. Non-Covered Charges
Not Required. Report non-covered charges only on HH PPS claims, not RAPs.

Examples.--The following provides examples of revenue code lines as HHAs should complete them based on the reporting requirements above.

For the UB-92 Flat File:
Report the required 0023 line as follows:

Record Type	Revenue Code	HCPCS	Date of Service	Units	Total Charges	Non-covered Charges
61	0023	HAEJ1	20001001		0.00	

Report additional revenue code lines as follows:

Record Type	Revenue Code	HCPCS	Date of Service	Units	Total Charges	Non-covered Charges
61	0550	G0154	20001001	1	150.00	

For the hard copy UB-92 (Form HCFA-1450):
Report the required 0023 line as follows:

FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
0023	HAEJ1	10012000		0.00	

Report additional revenue code lines as follows:

FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
550	G0154	10012000	1	150.00	

FL 49. Untitled
Not Required.

FLs 50A, B, and C. Payer Identification
Required. If Medicare is the primary payer, HHAs enter "Medicare" on line A. When Medicare is entered on line 50A, this indicates that the HHA has developed for other insurance coverage and has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, HHAs identify the primary payer on line A and enter Medicare information on line B or C as appropriate. Do not make conditional payments for Medicare Secondary Payer (MSP) situations based on the RAP.

FL 51. Medicare Provider Number
Required. Enter the six position alphanumeric “number” assigned by Medicare. It must be entered on the same line as “Medicare” in FL 50.

If a Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a HH PPS claim, which will receive a PEP adjustment (described in subsequent sections of this manual) under the original provider number, and opening a new episode with a new RAP under the new provider number. IN such cases report the new provider number in this field.

Fls 52A, B, and C. Release of Information Certification Indicator
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments

Not Required.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56. (Untitled)
Not Required
.
FL 57. (Untitled)
Not Required.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his HI card or other Medicare notice.

FLs 59A, B, and C. Patient's Relationship To Insured
Not Required.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

FLs 61A, B, and C. Group Name
Not Required.

FLs 62A, B, and C. Insurance Group Number
Not Required.

FL 63. Treatment Authorization Code
Required. HHAs must enter the claims-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). Verify that eighteen numeric values are reported in this field.

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. HHAs must not change any element that is required by OASIS reporting rules for purposes of submitting the RAP to Medicare.

The investigational device (IDE) revenue code, 624, is not allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Not Required.

FL 65. Employer Name
Not Required.

FL 66. Employer Location
Not Required.

FL 67. Principal Diagnosis Code
Required. HHAs must enter the ICD-9-CM code for the principal diagnosis. The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, do not fill with zeros.

The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis), and on the Form HCFA-485, form item 11 (ICD-9-CM/Principle Diagnosis).

FLs 68-75. Other Diagnoses Codes
Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. These codes must not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form HCFA-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the Form HCFA-485, form item 13, may be reported in FLs 68-75 on the RAP if they are reported in the narrative form item 21 of the Form HCFA-485.

FL 76. Admitting Diagnosis
Not Required.

FL 77. E-Code
Not Required.

FL 78. Untitled
Not Required.

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Not Required.

FL 81. Other Procedure Codes and Dates
Not Required.

FL 82. Attending/Requesting Physician I.D.
Required. HHAs must enter the UPIN and name of the attending physician that has established the plan of care with verbal orders.

Deny the RAP if the UPIN indicated in this field is on the sanctioned provider list.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks
Not Required.

FL 85. Provider Representative Signature
Not Required.

FL 86. Date
Not Required.

3638.24 HH PPS Claims.--HHAs are required to submit the following data elements on a claim under HH PPS. 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. In cases where a RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, HHAs must submit a claim to receive the balance of payment due for the episode.

Process HH PPS claims in Medicare claims systems as debit/credit adjustments against the record created by the RAP. As the claim is processed reverse the payment on the RAP in full and make the full payment due for the episode on the claim. Reflect both the debit and credit actions on the remittance advice (RA) so the net reimbursement on the claim will be easily understood by therovider. See remittance advice information in §3753.

If the RAP corresponding to that claim is suspended, suspend the claim as well. Release that claim for processing once the RAP has finalized.

Coding required for a HH PPS claim is as follows:

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Untitled
Not required.

FL 3. Patient Control Number

Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-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).

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 a HH PPS claim, encourage HHAs to submit all claims with bill classification 2. Medicare claims system determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	Definition
7 - Replacement of Prior Claim	Use to correct a previously submitted bill. Apply this code for the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "9" bill (a replacement claim) must be submitted for the episode to be paid.

FL 4. Type of Bill (Cont.)

3rd Digit-Frequency	Definition
9 - Final Claim for a HH PPS Episode	This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8.

HH PPS claims will be submitted with the frequency of "9." These claims may be adjusted with frequencies "7" or "8." Do not accept Late charge bills, submitted with frequency "5" on HH PPS claims.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period covered by this claim. The "From" date must match the date that the HHA submitted on the RAP for the episode. If this is a No-RAP LUPA claim, the from date for initial episodes will equal the first billable service date in the episode, for subsequent episodes the from date will be the first day of the episode (i.e., the 61st day following the first episode, the 121st day following the second episode). For continuous care episodes (patient status 30), the "Through" date must indicate a full 60 day episode (i.e. must equal the "From" date plus 59 days). In cases where the beneficiary has been discharged in less than 60 days because goals are met or transferred within the 60-day episode period, HHAs will report the date of discharge as the as the "Through" date. If a beneficiary dies during the episode, report the date of death as the through date. Return claims to the provider which do not report the "Through" date in this manner. HHAs may submit claims for payment immediately after the claim "Through" date. HHAs are not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

Require all dates to be submitted in the format MM-DD-YYYY.

Edit to ensure that the "From" date, the admission date and the earliest dated 0023 revenue code line on the claim match the information which was submitted on the RAP for the same episode. Return claims to the provider which fail this edit.

On the first episode in a period of continuous care, edit to ensure that the "From" date, the admission date, the earliest 0023 revenue code line date and the first service date on a revenue code 42x-44x or 55x-57x line all match. Return claims to the provider which fail this edit.

Compare the provider effective date in the provider file to the "From" date to ensure that the "From" date is on or after the provider effective date. Reject claims which fail this edit.

FL 7. Covered Days
Not Required.

FL 8. Noncovered Days
Not Required.

FL 9. Coinsurance Days
Not Required.

FL 10. Lifetime Reserve Days
Not Required.

FL l2. Patient's Name
Required. Enter the patient's last name, first name, and middle initial.

FL l3 Patient's Address
Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL l4. Patient's Birthdate
Required. Enter the month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, leave blank.

FL l5. Patient's Sex
Required. "M" for male or "F: for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL l6. Patient's Marital Status
Not Required.

FL l7. Admission Date
Required. Enter the same date of admission that was submitted on the RAP for the episode (MM-DD-YYYY).

FL l8. Admission Hour
Not Required.

FL l9. Type of Admission
Not Required.

FL 20. Source of Admission
Required. Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. Enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6).

Code	Definition
0l	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to a short-term general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an ICF

FL 22. Patient Status (Cont.)

Code	Definition
05	Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution

06	Discharged/transferred to home under care of another organized home health service organization, OR Discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice or discontinued care
20	Expired (or did not recover - Christian Science Patient)
30	Still patient or expected to return for outpatient services
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility

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 systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

FL 23. Medical Record Number
Required. The HHA enters the number assigned to the patient's medical/health record. Carry the number the HHA enters through your system and return it to the HHA.

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes
Optional. Enter any NUBC approved code to describe conditions that apply to the claim.

If adjusting a HH PPS claim (TOB 3x7), report the following:

Claim Change Reasons

Code	Definition
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS
D7	Change to Make Medicare the Secondary Payer

FLs 24, 25, 26, 27, 28, 29 and 30. Condition Codes (Cont.)

Code	Definition

D8 Change to Make Medicare the Primary Payer

D9 Any Other Change

E0 Change in Patient Status

If adjusting the claim to correct a HIPPS code, use condition code D9.

If canceling the claim (TOB 3x8), report the condition codes D5 or D6 (defined in §3638.23).

FL 32, 33, 34, and 35. Occurrence Codes and Dates
Optional. HHAs may enter any NUBC approved code to describe occurrences that apply to the Claim. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YYYY). Do not require occurrence code 27 on HH PPS claims.

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

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the “From” and “Through” dates of the other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span “From” dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span “Through” date is in the date field.

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

FL 36. Occurrence Span Code and Dates
Optional. HHAs may enter any NUBC approved code to describe occurrences that apply to the claim. Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits. Show dates as MM-DD-YYYY. Occurrence span code 74 is not required to reflect inpatient admissions within an episode.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. If the HHA is submitting a 3x7 adjustment to a claim, they must insert the ICN/DCN of the claim to be adjusted here. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

When processing 3x9 claims, copy the ICN of the corresponding RAP record and populate this field with that ICN. Place the transaction type on the electronic claim record. An adjustment reason code and requestor ID are not required on the electronic claim record for these transactions.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLs 39-41. Value Codes and Amounts
Required. Home health episode payments must be based upon the site at which the beneficiary is served. Return claims without the following value code to the provider:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

Since the value amount is a nine-position field, enter the four-digit MSA in the nine-position field in the following manner. Enter an MSA for Puerto Rico (9940) as 000994000, and the MSA for Abilene TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point (9999999V99) are always zeros. For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim. Payment for the entire episode will be consistent with this location.

Optional. HHAs may enter any NUBC approved value code to describe other values that apply to the claim. Accept this codes and apply any applicable edits specific to those codes.

Intermediary value codes. These value codes may be placed on the claim in processing (providers do not report these codes):

Code	Title	Definition
17	Outlier Amount	Report the amount of any outlier payment returned by the Pricer with this code. (Always place condition code 61 on the claim along with this value code.)
62	HH Visits--Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits--Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement--Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement--Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the SS will place value codes 62 and 64 on the claim record, showing the total visits and total PPS reimbursement amount as the values, change the type of bill on the claim record to 33x, and return to the claim to CWF with RIC code V.

If information returned from the CWF indicates all visits on the claim are Part B, the SS will place value codes 63 and 65 on the claim record, showing the total visits and total PPS reimbursement amount as the values, and return to the claim to CWF with RIC code W. (The SS will change the type of bill as necessary in these cases.)

If information returned from the CW F indicates certain visits on the claim are payable from either Part A or Part B, the SS will place value codes 62, 63, 64 and 65 on the claim record. The SS will 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 SS will return the claim to CWF with type of bill 32x and with RIC code U.

FL 42 and 43 Revenue Code and Revenue Description
Required. HH PPS claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, reject the claim.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), HHAs may report one or more additional 0023 revenue code lines to reflect each change, but assessments that do not change the payment group (i.e., same HHRG, one of eight HIPPS attached to that HHRG) do not have to be reported. SCICs are determined by an additional OASIS assessment of the beneficiary which changes the HIPPS code that applies to the episode and a change order from the physician to the plan of care. In the event that a beneficiary experiences a significant change in condition in a single day, and is assessed twice in that day, report only the later HIPPS code on a single 0023 line for that date. Do not report the earlier HIPPS code for the earlier assessment on the same day. Each additional 0023 revenue code line will show the new HIPPS code in FL 44, the first date on which services were provided under the revised plan of care in FL 45, no units in FL 46 and zero charges in FL 47. See previous section on revenue codes under Requests for Anticipated Payments for more detail on HIPPS coding.

Place the Medicare reimbursement returned by the Pricer for each HIPPS code in the total charges field (FL 47) of the corresponding 0023 revenue code line. (See §3656.7 for information on the HH PPS Pricer.) HHAs must not submit the 0023 revenue code lines with a charge amount.

HHAs must also report on claims all services provided to the beneficiary within the episode period. Each service must be reported in line item detail. Any of the following revenue codes may be used:

27X Medical/Surgical Supplies. (Also see 62X, an extension of 27X.)

Code indicates the charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

Required detail: With the exception of revenue code 274, only service units and a charge must be reported with this revenue code. If also reporting revenue code 623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Revenue code 274 requires a HCPCS code, the date of service units and a charge amount.

42X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

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.

43X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

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.

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

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.

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

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.

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

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.

57X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

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: Do not accept revenue codes 58X, 59X when submitted with covered charges on Medicare home health claims under HH PPS. Do not accept revenue code 624 on HH claims under HH PPS.

Optional:

Revenue codes for optional billing of DME:

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that chose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see §3629.

29X Durable Medical Equipment (DME) (Other Than Renal)

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of New DME	MED EQUIP/NEW
3 - Purchase of Used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)\	MED EQUIP/SUPPLIES/DRUGS\
9 - Other Equipment	MED EQUIP/OTHER

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.

60X Oxygen (Home Health)

Code indicates charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292, or 293.

Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
3 - Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON

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:

62X Medical/Surgical Supplies - Extension of 27X

Code indicates charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed.

Subcategory	Standard Abbreviation
3 - Surgical Dressings	SURG DRESSING

Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 27x to identify non-routine supplies other than those used for wound care, 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 non-routine wound care supplies, using revenue code 623. Notwithstanding the standard abbreviation "surg dressings", HHAs may use this line item to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

§3119.4 defines routine vs. nonroutine supplies. 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 HCFA's future refinement work if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 623. HHAs should ensure that charges reported under revenue code 27x for nonroutine supplies are also complete and accurate.

HHAs may continue to report a “Total” line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of charges billed. Your systems must assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates
Required. On the earliest dated 0023 revenue code line, HHAs must report the HIPPS code (See §3638.23 for definition of HIPPS codes) which was reported on the RAP. On claims reflecting a significant change in condition (SCIC), HHAs must report on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the change in HIPPS code has no payment impact (i.e., same HHRG).

If the Pricer software returns a HIPPS code for payment which is a different payment group (HHRG) than the code submitted by the HHA, carry this second HIPPS code on an additional field on the same 0023 line. This second HIPPS code must be passed to CWF on the claim and shown on the HHA’s electronic remittance advice.

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

FL 45. Service Date
Required. On each 0023 revenue code line, report the date of the first service provided under the HIPPS code reported on that line.

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

FL 46. Units of Service
Required. Do not report units of service on 0023 revenue code lines. For line items detailing all services within the episode period, report units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43 above. Units for revenue codes 42x-44x, 55x-57x, must be reported as the number of 15 minute increments on home health claims, and may include time spent completing the OASIS assessment and medical records in the home. Minutes should be reported/rounded to the nearest 15 minute increment.

FL 47. Total Charges
Required. Zero charges must be reported on the 0023 revenue code line. Medicare claims systems will place the reimbursement amount for the claim in this field on the electronic claim record.

For line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. Medicare claims systems will not make any payment determinations based upon submitted charge amounts.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. (See §3638.18.)

Examples.--The following provides examples of revenue code lines as HHAs should complete them based on the reporting requirements above.

For the UB-92 Flat File:
HHAs must report the multiple 0023 lines in a SCIC situation as follows:

Record Type	Revenue Code	HCPCS	Date of Service	Units	Total Charges	Non-covered Charges
61	0023	HAEJ1	20001001		0.00	
61	0023	HAFM1	20001025		0.00	

HHAs must report service revenue code lines as follows:

Record Type	Revenue Code	HCPCS	Date of Service	Units	Total Charges	Non-covered Charges
61	0270			8	84.73	
61	0291	K0006	20001001	1	120.00	
61	0420	G0151	20001005	3	155.00	
61	0430	G0152	20001007	4	160.00	
61	0440	G0153	20001009	4	175.00	
61	0550	G0154	20001012	1	140.00	
61	0560	G0155	20001014	8	200.00	
61	0570	G0156	20001016	3	65.00	
61	0580		20001018	3		75.00
61	0623			5	47.75	

For the hard copy UB-92 (HCFA-1450):
HHAs must report the multiple 0023 lines in a SCIC situation as follows:

FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
0023	HAEJ1	10012000		0.00	
0023	HAFM1	10012000		0.00	

HHAs must report additional revenue code lines as follows:

FL 42	FL 44	FL 45	FL 46	FL 47	FL 48
270			8	84.73	
291	K0006	10012000	1	120.00	
420	G0151	10052000	3	155.00	
430	G0152	10072000	4	160.00	
440	G0153	10092000	4	175.00	
550	G0154	10122000	1	140.00	
560	G0155	10142000	8	200.00	
570	G0156	10162000	3	65.00	
580		10182000	3		75.00
623			5	47.75	

FL 49. Untitled
Not Required.

FLs 50A, B, and C. Payer Identification
Required. If Medicare is the primary payer, enter "Medicare" on line A. When Medicare is entered on line 50A, this indicates that you have developed for other insurance coverage and have

determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. See §§248, 250, 25l, 252, and 253 to determine when Medicare is not the primary payer. Make conditional and other payments for Medicare Secondary Payer (MSP) situations based only on the HH PPS claim.

FL 51. Medicare Provider Number
Required. Enter the six position alphanumeric “number” assigned by Medicare. It must be entered on the same line as “Medicare” in FL 50. If the Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim, which will receive a PEP adjustment, under the original provider number, and opening a new episode under the new provider number with a RAP.

FLs 52A, B, and C. Release of Information Certification Indicator
Not 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.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Not Required.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56. (Untitled)
Not Required
.

FL 57. (Untitled)
Not Required.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in §§3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and their spouses. (See §3491.);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to l8 months. (See §3490.);

- o LGHPs for disabled beneficiaries;
- o Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490.); or
- o WC, including BL. (See §§3407-3416.)

FLs 59A, B, and C. Patient's Relationship To Insured
Required. If claiming payment under any of the circumstances described under FLs 58A, B, or C enter the code indicating the relationship of the patient to the identified insured.

Code Structure:

Code	Title	Definition
0l	Patient is the Insured	Self-explanatory.
02	Spouse	Self-explanatory.
03	Natural Child/Insured Financial Responsibility	Self-explanatory.
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory.
05	Step Child	Self-explanatory.
06	Foster Child	Self-explanatory.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
l5	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in FLs 39-41, and 50-54, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

If claiming a conditional payment under any of the circumstances described under FLs 58A, B, or C, enter the involved claim number for that coverage on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where you are claiming a payment under the circumstances described in FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

FLs 62A, B, and C. Insurance Group Number
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the identification number, control

number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

FL 63. Treatment Authorization Code
Required. HHAs must enter the claims-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

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

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. HHAs must not change any element that is required by OASIS reporting rules for purposes of submitting the claim to Medicare.

The investigational device (IDE) revenue code, 624, will not be allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Employment Status Code
Required. Where HHAs are claiming a payment under the circumstances described in the second paragraphs of FLs 58A, B, or C, and there is involvement of WC or an EGHP, they enter the code which defines the employment status of the individual identified, if the information is readily available.

Code Structure:

Code	Title	Definition
1	Employed Full Time	Individual claimed full time employment.
2	Employed Part Time	Individual claimed part time employment.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory.
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8		Reserved for national assignment.
9	Unknown	Individual's employment status is unknown.

FL 65. Employer Name
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location
Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc. in which the employer is located.

FL 67. Principal Diagnosis Code
Required. HHA must enter the ICD-9-CM code for the principal diagnosis. 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, do not fill with zeros. The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis), and on the Form HCFA-485, form item 11 (ICD-9-CM/Principle Diagnosis). In most cases, the principal diagnosis code on the claim will match the RAP for the episode. In cases of SCIC adjustments, the principal diagnosis reported must correspond to the OASIS assessment that produced the latest dated HIPPS code reported on an 0023 revenue code line of the claim.

FLs 68-75. Other Diagnoses Codes
Required. HHAs must enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of the establishment of the plan of care. Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form HCFA-485, form item 13 (ICD-9-CM/Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the Form HCFA-485, form item 13, may be reported in FLs 68-75 on the claim if they are reported in the narrative form item 21 of the Form HCFA-485.

FL 76. Admitting Diagnosis
Not Required.

FL 77. E-Code
Not Required.

FL 78. Untitled
Not Required.

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Not Required.

FL 81. Other Procedure Codes and Dates
Not Required.

FL 82. Attending/Requesting Physician I.D.
Required. HHAs must enter the UPIN and name of the attending physician that has signed the plan of care.

Deny the claim if the UPIN indicated in this field is on the sanctioned provider list as of the claim "From" date.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks
Not Required.

FL 85. Provider Representative Signature
Not Required.

FL 86. Date
Not Required.

3638.25 HH PPS Claims When No RAP Was Submitted.--A RAP and a claim must be submitted for all episodes for which payment based on HIPPS codes will be made. However, there may be circumstances in which an HHA is aware prior to billing Medicare at four or fewer visits will be supplied in the episode. In these cases, since the HHA is aware that the episode will be paid a low utilization payment adjustment (LUPA) based on national standardized per visit rates, the HHA is permitted to submit only a claim for the episode. These claims will be referred to as "No-RAP LUPA" claims.

HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim cause the creation of an episode record in CWF and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.

If the agency chooses to submit this "No-RAP LUPA" claim, the claim form should be coded like other claims as described in §3638.24.

3639. BACKGROUND ON HH PPS

3639.1 Creation of **HH PPS**.--The Balanced Budget Act of 1997 (**BBA 97-- see section below for acronym table**), amended by the Omnibus Consolidated Emergency Supplemental Appropriations Act of 1998 (**OCESAA**) and the Balanced Budget Refinement Act of 1999 (**BBRA 99**), created a prospective payment system for Medicare home health services specifying the following *affecting claims operations and individual claim payment*:

- Required payment be made on the basis of a prospective amount;
- Allowed the Secretary of the Department of Health and Human Services (**DHHS**) to determine a new unit of payment;
- Required the new unit of payment to reflect different patient-related conditions (**case mix**) and wage adjustments;
- Allowed for **cost outliers** (supplemental payment for exceptional high-cost cases);
- Required proration of the payment when a beneficiary chooses to transfer among home health agencies (**HHAs**) within an episode;
- Required services to be recorded in 15 minute increments on claims;
- Required **UPINs** (physician identifiers) for prescribing physicians to appear on claims;
- Eliminated **PIP** (periodic interim payment) payments for HHAs;

Required **consolidated billing** by HHAs for all services and supplies for patients under a home health plan of care (**POC**);

-- BBRA 99 removed durable medical equipment (**DME**) from the scope of consolidated billing under BBA 97, *and*

- Required an effective date for implementation of the system of October 1, 2000.

UPINs and 15 minutes increments mentioned in BBA 97 have been required on Medicare home health claims since October 1999. Also, despite the creation of the new payment system, existing laws affecting claims payment, such as those specifying a payment floor and Medicare Secondary Payer payment procedures, are still valid for Medicare claims and were not changed by HH PPS.

3639.2 Regulatory Implementation of HH PPS.--Given the creation of the new payment system in law, HCFA codified implementing provisions in a final notice of rulemaking published in the Federal Register. This notice specified:

- The unit of payment is a **60 day episode**;

- Each episode is anticipated to be paid in two split payments, one billed on a **Request for Anticipated Payment** (**RAP**) at the beginning of the episode and one on a claim at the end of the episode;

- Only claims provide line-items detailing the individual services delivered;

- Home Health Resources Groups (**HHRGs**), also called **HRGs,** represented by HCFA **HIPPS** coding on claims, are the basis of payment for each episode; HHRGs are produced through publicly available **Grouper** software that determines the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the **OASIS** data set) are **input** or "grouped" in this software;

- HHRGs can be changed mid-episode if there is a significant change in a patient's condition (**SCIC adjustment**);

- Episodes can be truncated and given partial episode payments (**PEP adjustment**) if beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60 day period;

- Payments are case-mix and wage adjusted employing **Pricer** software (a module that will be attached to existing Medicare claims processing systems) at the Regional Home Health Intermediary (**RHHI**) processing Medicare home health claims;

- There are also reducing adjustments in payment when the number of visits provided during the episode fall below a certain threshold (low utilization payment adjustments: **LUPAs**);

- There are downward adjustments in HHRGs if the number of therapy services delivered during an episode does not meet anticipated thresholds-- **therapy threshold**;

- There are **cost outliers**, in addition to episode payments;

- The **primary HHA** under **consolidated billing** must identify itself to HCFA and its claims processing agents through submission of RAPs and claims-- only that one HHA, the primary or the one establishing the beneficiary's plan of care, can bill for home health services under the home

health benefit other than DME; if multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency.

3639.3 Commonalities of the Cost Reimbursement and HH PPS Environments.--Much of home health billing remains the same under HH PPS as it was under the prior payment system:

o Payment for services remains specific to the individual beneficiary, who is homebound and under a physician's plan of care;

o Payment is adjusted relative to the site services are delivered, as required by BBA 97;

o Shifting payment for home health claims between the Medicare Part A and B trust funds, as stipulated by another section of BBA 97, is still required; the mechanism will change when the basis of payment changes to episodes, but will not require any action on the part of HHAs;

o Claims will be processed by the current Regional Home Health Intermediaries (RHHIs);

o The platform of existing Medicare claims processing systems is used, including the Common Working File (**CWF**) and the Fiscal Intermediary Standard System (**FISS**) or Arkansas Part A Standard System (**APASS**), known together as the standard systems (**SS**), and the **PS&R** system supporting audit and reimbursement functions;

o HH PPS will employ formats, such as the paper and electronic **Form HCFA-1450 (UB-92)** for RAPs and claims, and related existing transaction formats are still used (i.e., the **835** electronic and paper remittances, Medicare Summary Notice (**MSN;**)

3639.4 Effective Date and Scope of HH PPS for Claims.--As of October 1, 2000, all HHAs must bill all services delivered to homebound Medicare beneficiaries under a home health plan of care under HH PPS. HH PPS will apply to claims billed under the cost reimbursement system on Form HCFA-1450 (UB-92), with Form Locator 4 (FL 4), Type of Bill (TOB), completed with: first digit "3", second digit "2" or "3", and a varying third digit represented as X. HHAs will still occasionally bill Medicare using TOB 34X, but these claims will not be subject to PPS payment.

If an HHA has beneficiaries already under an established plan of care prior to this date, all these open claims for services on or before September 30, 2000 need to be closed, though HHAs may submit these bills for several months in accordance with current time limitations for HHA claims. Under no circumstances should a HHA claim span payment systems or September and October 2000 dates.

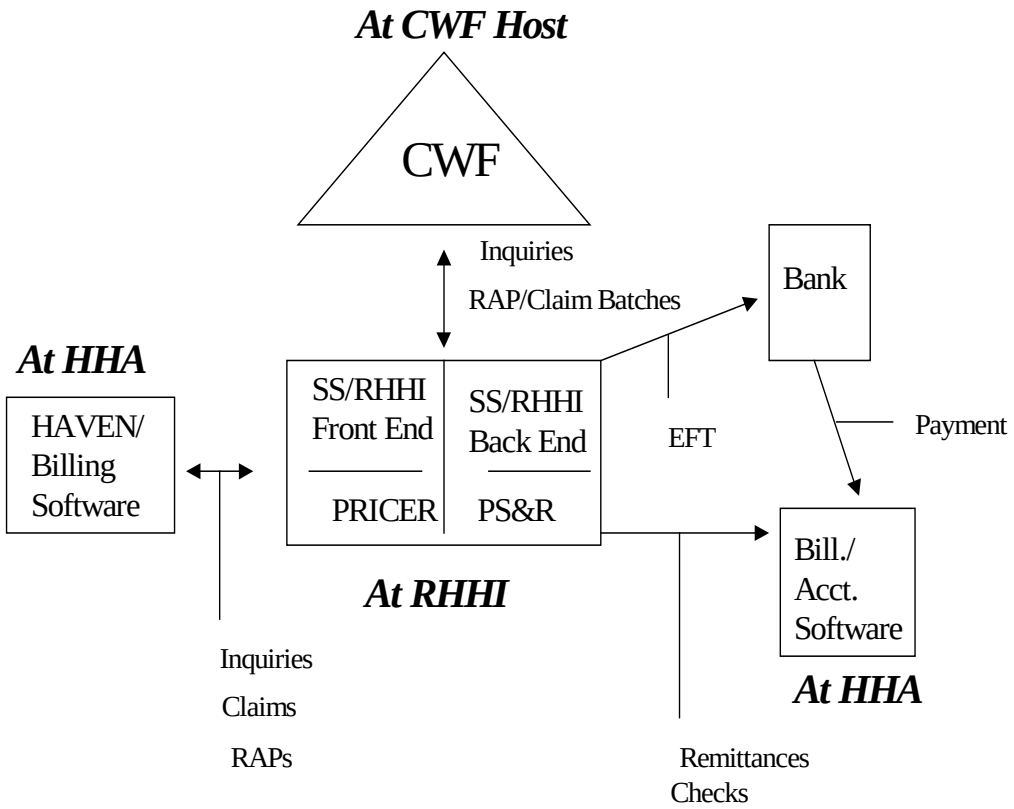
3639.5 Configuration of the HH PPS Environment.--The configuration of Medicare home health claim processing is similar to previous processing systems. The flow from the HHA at the start of billing, to the receipt of remittances and electronic funds transfer (EFT) by the agency, to the recording of payment in either billing or accounting systems (bill./acct software) can be envisioned as follows:

3639.6 New Software for the HH PPS Environment.--New subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing:

- HHRGs for claims are determined at HHAs by entering **OASIS** data (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment) into **Grouper** software at the HHA -- OASIS **HAVEN** software was updated to integrate the Grouper from the advent of HH PPS on, and HCFA has made Grouper specifications available on its web site for those designing their own software.

- There is an **inquiry system** in CWF-- **HIQH**-- available via RHHI remote access, through which HHAs can ascertain if an episode has already been opened for a given beneficiary by another provider (i.e., that they are clearly the primary HHA), and track episodes of beneficiaries for whom they are the primary HHA.

- All HH PPS claims run through **Pricer** software, which is integrated into the standard systems. In addition to pricing HIPPS codes for HHRGs, this software maintains national standard visit



rate tables to be used in outlier and LUPA determinations.

3639.7 The Home Health Prospective Payment System (HH PPS) Episode--Unit of Payment.--The episode is the unit payment for HH PPS. The episode payment is specific to one individual homebound beneficiary, reimburses all home care and routine and non-routine supplies used by that beneficiary during the episode, and is the only Medicare form of payment for such services, with the following exceptions: durable medical equipment (DME), osteoporosis drugs, and other services or items HHAs may deliver to homebound beneficiaries that are not part of the Medicare home health benefit (i.e., vaccines). Routine supplies have not been separately reimbursable for Medicare home health care, and will not be reimbursed in addition to episode payments.

3639.8 Number, Duration and Claims Submission of HH PPS Episodes.--The beneficiary can be covered for an unlimited number of non-overlapping episodes. The duration of a single full-length episode is 60 days. Episodes may be shorter than 60 days. For example, an episode may end before the 60th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA. Payment is pro-rated for these shortened episodes in which more home care is delivered in the same 60-day period. Claims for episodes may be submitted prior to the 60th day if the beneficiary has been discharged and treatment goals have been met, though payment will not be pro-rated unless more home health care is subsequently billed in the same 60-day period.

The initial episode begins with the first service delivered under that plan of care. A second subsequent episode in a period of continuous care would start on the first day after the initial episode was completed, the 61st day from when the first service was delivered, whether or not a service was delivered on the 61st day. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.).

More than one episode for a single beneficiary may be opened by the same or different HHAs for different dates of service. This will occur particularly if a transfer to another HHA, or discharge and readmission to the same HHA, situation exists. Allowing multiple episodes is intended to assure continuity of care and payment.

3639.9 Effect of Election of HMO and Eligibility Changes on HH PPS Episodes.--The home health prospective payment system only applies to Medicare fee-for-service claims. If a Medicare beneficiary is covered under a health maintenance organization (HMO) during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the payment source changes. With that assessment, a Request for Anticipated Payment (RAP) may be sent to Medicare to open an HH PPS episode.

If a beneficiary under fee-for-service receiving home care elects HMO during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment-- PEP-- adjustment). The HMO becomes the primary payer upon the HMO enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

3639.10 Split Percentage Payment of Episodes and Development of Episode Rates.--A split percentage payment will be made for each episode period. There will be 2 payments (initial and final), the first paid in response to a RAP, and the last in response to a claim. Added together, the first and last payment equal 100 percent of the permissible reimbursement for the episode.

There will be a difference in the percentage split of initial and final payments for initial and subsequent episodes for each patient in continuous care. For all initial episodes, the percentage split for the two payments will be 60 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments will equal 50 percent of the estimated case mix adjusted episode payment. There is no set length required for a gap in services between episodes for a following episode to be considered

initial rather than subsequent. If any gap occurs, the next episode should be considered initial for payment purposes.

Payment rates for HH PPS episodes were developed from audited cost reports of previous years' data from claims for each of the six home health visit disciplines. These amounts were updated for inflation, and also include: non-routine medical supplies, even those that could have been unbundled to Medicare Part B, therapy services that could have been unbundled to Part B, and adjustments for OASIS reporting costs, both one time and ongoing. After these adjustments, the resulting rates were further standardized so that case-mix and wage indexing could be appropriately applied, adjusted for budget neutrality, and then reduced to allow for a pool for outlier payments.

3639.11 Basis of Medicare Prospective Payment Systems and Case Mix.--There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types: skilled nursing facilities, outpatient hospital services, home health agencies and rehabilitation hospitals. While there are definite commonalities among these systems, there are also variations in how each system operates, and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

Regarding the creation of the inpatient hospital prospective payment system, in 1982, the Tax Equity and Fiscal Responsibility Act or TEFRA, required Medicare hospital reimbursement limits to include a case mix adjustment, and amendments to the Social Security Act in 1983 created a national hospital inpatient prospective payment system for Medicare. This legislation was passed in an effort to capture an effective framework for monitoring the quality of care and the utilization of services.

The term prospective payment might imply a system where payment would be made before services are delivered, or payment levels were determined prior to the completion of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment will be made at the beginning of the episode with as little as one visit delivered. PPS also means a shift of the basis of payment, such as from payment tied to a claim or distinct revenue or procedural code, to a basis such as episode or diagnosis related group (DRG).

Case mix is related to the creation of PPS through efforts to make payment systems more effective. With the creation of inpatient hospital PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. This concept is replicated in other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care--the concept of case mix complexity. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case mix for home health care.

It is DRGs, or Diagnosis Related Groups, that link case mix to inpatient hospital payment. The current DRG Definitions Manual defines a DRG as "a manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital". For individual Medicare inpatient bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into

appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing intermediary. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs.

In HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment. Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case mix adjusted episode payment is based on elements of the OASIS data set including the therapy hours or visits provided over the course of the episode. The number of therapy hours or visits projected at the start of the episode, entered in OASIS, will be confirmed by the hour or visit information submitted on the claim for the episode. Though therapy hours or visits are only adjusted with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, most commonly incorporated in the HAVEN software supporting OASIS. Pricer software run by the RHHIs processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.

3639.12 Coding of HH PPS Episode Case-Mix Groups on HH PPS Claims: (H)HRGs and HIPPS Codes.--Under the home health prospective payment system, a case-mix adjusted payment for a 60-day episode will be made using one of 80 Home Health Resource Groups (HHRG or HRG), comparable to diagnosis related groups (DRGs) under Medicare's inpatient hospital PPS. On Medicare claims, these HHRGs will be represented as HIPPS codes. HIPPS codes allow the HHRG code to be carried more efficiently and include additional data on how the HHRG was derived.

Health Insurance Prospective Payment System (HIPPS) codes thus represent specific patient characteristics (or case mix) on which Medicare payment determinations are made. For HHAs, a specific set of these payment codes represent case mix groups based on research into utilization and resource use patterns. Other HIPPS coding is used to bill Medicare for skilled nursing facility PPS. Appropriate HIPPS codes must be used when billing Medicare within specific affected payment systems, and are used in association with special revenue codes used on HCFA-Form 1450 (UB-92) claims forms for institutional providers.

3639.13 Composition of HIPPS Codes for HH PPS.--The following scheme has been developed to create distinct 5-position, alpha-numeric home health HIPPS codes. The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

The second, third and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. A full listing of HHRGs can be found in the HH PPS final rule, and future HHRG and HIPPS code lists will be released in annual HH PPS Program Memoranda providing specific payment system annual rate updates. Note the second through fourth positions of the HH PPS HIPPS code will only allow alphabetical characters.

The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters. Codes output with a fifth position value other than "1" are produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

The first position of every home health HIPPS code will be: 'H'. The rest of the five positions discussed above can be summarized as follows:

(Clinical) Position #2	(Functional) Position #3	(Service) Position #4	Position #5	Domain Level
A (HHRG: C0)	**E** (HHRG: F0)	**J** (HHRG: S0)	**1** = 2nd, 3rd & 4th positions computed	= min
B (HHRG: C1)	**F** (HHRG: F1)	**K** (HHRG: S1)	**2** = 2nd position derived	= low
C (HHRG: C2)	**G** (HHRG: F2)	**L** (HHRG: S2)	**3** = 3rd position derived	= mod
D (HHRG: C3)	**H** (HHRG: F3)	**M** (HHRG: S3)	**4** = 4th position derived	= high
	I (HHRG: F4)		**5** = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru **Z**	**9**, **0**	expansion values for future use

For example, the fully computed code for the minimum level in all three domains would be HAEJ1.

3639.14 Significance of HIPPS Coding for HH PPS.--Based on this coding structure:

o The 80 HHRGs are represented in the claims system by 640 HIPPS codes, eight codes for each HHRG, but only one of the eight, with a final digit “1”, indicates a complete data set.

o The eight codes of a particular HHRG have the same case-mix weight associated with them.. Therefore, all eight codes for that HHRG will be priced identically by the Pricer software.

o HIPPS codes created using this structure are only valid on claim lines with revenue code 0023.

3639.15 Overview of the Provider Billing Process Under Home Health Prospective Payment.--The next four sections of this manual lay out the basic HH PPS claim process without payment adjustments. Payment adjustments follow in subsequent sections.

3639.16 Overview--Grouper Links Assessment and Payment.--Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool. OASIS is entered, formatted and locked for electronic transmission to State agencies via HAVEN software made publicly available by HCFA. HAVEN versions were produced incorporating the Grouper module necessary for HH PPS, along with other changes needed for the new payment system, prior to the advent of that system.

Grouper software determines the appropriate HHRG (Home Health Resources Group) for payment of a HH PPS 60-day episode from the results of an OASIS submission for a beneficiary as input or grouped in this software. Grouper outputs HHRGs as HCFA HIPPS (Health Insurance Prospective Payment System) coding. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number, which is not used in billing. Under HH PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims. Note that if an OASIS assessment is rejected upon transmission to a State agency and is consequently corrected resulting in a different HIPPS code, the RAP and/or claim for the episode must also be canceled and re-billed using the corrected HIPPS code.

3639.17 Overview--HIQH Inquiry System Shows Primary HHA.--Prior to October 1, 2000, to establish Medicare eligibility, HHAs sent an inquiry into Medicare's beneficiary database, the Common Working File or CWF, through their RHHI. The Health Insurance Query Access system, or HIQA, within CWF, allows different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility.

With the advent of HH PPS and home health consolidated billing, described in subsequent sections, a given HHA is considered the "primary" HHA in billing situations: this primary agency is the only agency billing Medicare for home care for a given homebound beneficiary at a specific time. Given this, when a homebound beneficiary seeks care at an HHA, the HHA wants to determine if the beneficiary is already being served by another agency-- an agency that then would already be considered primary. HHAs can obtain that information through a new on-line inquiry transaction in CWF -- HIQH: Health Insurance Query for HHAs. HIQH, available at the advent of HH PPS, will show whether or not the beneficiary is currently in a home health episode of care. HIQH includes all pertinent eligibility information from HIQA, so both HHAs and hospices need only reference HIQH of the two transactions.

If the beneficiary is not already under care at another HHA, he or she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode is already open at another HHA if the beneficiary has chosen to transfer.

The agency primary status, or change of primary status from one agency to another in a transfer situation, will be reflected in the HIQH inquiry system following submission of a RAP.

3639.18 Overview--Request for Anticipated Payment (RAP) Submission and Processing Establishes HH PPS Episode and Provides First Percentage Payment.--After assessment, and once a physician's verbal orders for home care have been received and documented, a plan of care has been established and the first service visit under that plan has been delivered, the HHA can submit a Request for Anticipated Payment, or RAP, to Medicare. An episode will be opened on CWF and visible in HIQH with the receipt and processing of the RAP. RAPs, or in special cases, claims, must

be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins in order to assure being established as the primary HHA for the beneficiary.

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

Once coding is complete, and at least one billable service has been provided in the episode, RAPs or claims are to be submitted to Regional Home Health Intermediaries (RHHIs) processing Medicare home health RAPs and claims. Pricer software will determine the first of the two HH PPS split percentage payments for the episode, which is made in response to the RAP.

3639.19 Overview--Claim Submission and Processing Completes HH PPS Payment, Closes Episode and Performs A-B Shift.--The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60 day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services provided in the episode are provided are reflected on the claim and the plan of care and any subsequent verbal order have been signed by the physician. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply. HH claims must be submitted with a new type of bill-- 329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode, including, at a provider's option, any durable medical equipment provided, even though this equipment will be paid in addition to the episode payment. The only exception is billing of osteoporosis drugs, which will continue to be billed separately on 34X claims, even when an episode is open. Pricer will determine claim payment as well as RAP payment for all PPS claims.

The claim will be processed in Medicare systems as a debit/credit adjustment against the record created by the RAP. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

Once the final payment for an episode is calculated, Medicare systems will determine whether the claim should be paid from the Medicare Part A or Part B trust fund. This A-B shift determination will only be made on claims, not on RAPs. HHA reimbursement amounts are not affected by this process. Value codes for A and B visits and dollar amounts may be visible to HHAs on electronic paid claim records, but providers will never submit these amounts directly.

3639.20 Overview--Payment, Claim Adjustments and Cancellations.--This completes the basic process for payment illustrated in the four sections above. However, a number of conditions can cause the episode payment to be adjusted. Both RAPs and claims may be canceled by HHAs if a mistake is made in billing (TOB 328), though episodes will be canceled in CWF as well. Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment. RAPs can only be canceled, not adjusted, though may be re-billed after cancellation.

3639.21 Definition of the Request for Anticipated Payment (RAP).--The RAP is submitted by HHAs to their RHHIs to request the initial split percentage payment for an HH PPS episode, after delivering at least one service to the beneficiary. Though submitted on a Form HCFA-1450 (UB-92) and resulting in Medicare payment for home services, **the RAP is not considered a Medicare home health claim and is not subject to many of the stipulations applied to such claims in regulations**. In particular, RAPs are not subject to any type of payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Appeal rights for the episode are attached to claims submitted at the end of the episode, and these claims are still subject to the payment floor and payment of interest if clean and delayed in processing.

3639.22 Definition of Transfer Situation Under HH PPS--Payment Effects.--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 will be allowed to submit a RAP with a transfer indicator in Form Locator 20 (Source of Admission) of HCFA Form-1450 (UB-92) even when an episode may already be open for the same beneficiary at another HHA. In such cases, the previously open episode will be automatically closed in Medicare systems as of the date services began at the HHA the beneficiary transferred to, and the new episode for the transfer to agency will begin on that same date. **Payment would be pro-rated for the shortened episode of the transferred from agency.** Note HHAs may not submit RAPs opening episodes when anticipating a transfer if actual services have yet to be delivered.

3639.23 Definition of Discharge and Readmission Situation Under HH PPS--Payment Effects.--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: 60 days less the number of days after the date of the delivery of last billable service until what would have been the 60th day. The next episode would begin the date the first service is supplied under readmission, setting a new 60-day "clock". As with transfers, Form Locator 20 (Source of Admission) of Form HCFA-1450 (UB-92) can be used to send "a transfer to same HHA" indicator on a RAP, so that the new episode can be opened by the HHA.

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.

3639.24 Payment When Death Occurs During an HH PPS Episode.--If a beneficiary's death occurs during an episode, full episode payment will still be made. The "Through" date on the claim (Form Locator 6) of Form HCFA-1450 (UB-92) closing the episode in which the beneficiary died should be the date of death. Such claims may be submitted earlier than the 60th day of the episode.

3639.25 Adjustments of Episode Payment--Low Utilization Payment Adjustments (LUPAs).--**If an HHA provides 4 visits or less, they will be reimbursed based on a standardized per visit payment instead of an episode payment for a 60-day period.** Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, non-routine supplies will not be reimbursed in addition to the visit payments, since total annual

supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments when the claim for the episode is received. This offset will be reflected on remittance advices and claims history. If the claim for the LUPA is later adjusted such that the number of visits becomes 5 or more, payments will be adjusted to an episode, rather than visit, basis.

3639.26 Adjustments of Episode Payment--Special Submission Case: "No-RAP" LUPAs.--Normally, there will be two percentage payments (initial and final) paid for an HH PPS episode, the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which an HHAs knows that an episode will be four visits or less even before the episode begins, and therefore the episode will be paid a per-visit-based low-utilization payment adjustment (LUPA) instead of an episode. **In such cases and only in such cases, the HHA may choose not to submit a RAP, foregoing the initial percentage payment that otherwise would later likely be largely recouped automatically against other payments.** Physician orders must be signed when these claims are submitted. If an HHA later has to adjust the claim, so that the claim will have more than 4 visits and no longer be a LUPA, the claim must be canceled, and the entire episode re-billed with a RAP and a claim.

3639.27 Adjustments of Episode Payment--Therapy Threshold.--The total case mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode. Because the advent of 15 minute increment reporting on home health claims only recently preceded HH PPS, therapy hours will be proxied from visits at the start of HH PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent 8 hours of therapy.

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational or speech therapy combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS representing the same payment group: one if a beneficiary does not receive the therapy hours projected, and another if he or she does meet the "therapy threshold". Therefore, when the therapy threshold is not met, there is an automatic "fall back" HIPPS code, and Medicare systems will correct payment without access to the full OASIS data set.

If therapy use is below the utilization threshold appropriate to the HIPPS code submitted on the RAP and unchanged on the claim for the episode, Pricer software in the claims system will regroup the case mix for the episode with a new HIPPS code and pay the episode on the basis of the new code. HHAs will receive the difference between full payment of the resulting new HIPPS amount and the initial payment already received by the provider in response to the RAP with the previous HIPPS code. The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare systems would automatically cancel the claim with the changed HIPPS code and pay the full episode payment based on the original HIPPS. Note that a HIPPS code may also be changed based on of medical review of claims.

3639.28 Adjustments of Episode Payment--Partial Episode Payment (PEP).--Both transfer situations and discharge and readmission to the same agency in a 60-day period result in shortened

episodes. In such cases, payment will be pro-rated for the shortened episode. Such adjustments to payment are called PEPs.

When either the agency the beneficiary is transferring from is preparing the claim for the episode, or an agency that has discharged a patient knows when preparing the claim that the same patient will be readmitted in the same 60 days, the claim should contain patient status code 06 in Form Locator 22 (Patient Status) of the Form HCFA-1450 (UB-92). Based on the presence of this code, Pricer calculates a PEP adjustment to the claim. **This is a proportional payment amount based on the number of days of service provided (count of days from and including the first billable service date to last billable service date).**

3639.29 Adjustments of Episode Payment--Significant Change in Condition (SCIC).--While HH PPS payment is based on a patient assessment done at the beginning or in advance of the episode period itself, sometimes a change in patient condition will occur significant enough to require the patient to be re-assessed during the 60-day episode period. In such cases, the HIPPS code output from Grouper for each assessment should be placed on a separate line of the claim for the completed episode at its close. Since a line-item date is required in every case, Pricer will then be able to calculate the number of days of care provided under each HIPPS code, and **pay proportional amounts under each HIPPS based on the number of days of service provided under each payment group** (count of days under each HIPPS from first billable service to last billable service). The total of these amounts will be the full payment for the episode, and such adjustments are referred to as significant change in condition (SCIC) adjustments. The electronic remittance advice including a claim for a SCIC-adjusted episode will show the total claim reimbursement and separate segments showing the reimbursement for each HIPPS code.

There is no limit on the number of SCIC adjustment that can occur in a single episode. All HIPPS codes related to a single SCIC-adjusted episode should appear on the same claim at the end of that episode. However, if the patient is re-assessed and there is no change in the payment group, the same HHRG/HIPPS does not have to be submitted twice, and a SCIC adjustment will not be applied. This exception is not expected to occur often, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode). Payment will be made based on six HIPPS, determined by RHHI medical review staff if more the six HIPPS are billed.

3639.30 Adjustments of Episode Payment--Outlier Payments.--HH PPS payment groups are based on averages of home care experience. **When cases "lie outside" expected experience by involving an unusually high level of services in a 60-day period, Medicare systems will provide extra or "outlier" payments in addition to the case mix adjusted episode payment**. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations will be made by comparing the total of the products of: each wage and case-mix adjusted national standardized per visit rate for each discipline and the number of visits of each discipline on the claim, with the sum of: the case mix adjusted episode payment and a wage-adjusted standard fixed loss threshold amount. If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific HRG payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode payment.

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

Outlier payments will be made on remittances for specific episode claims-- HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment will be included in the total reimbursement for the episode claim, but it will be identified separately on the claim in history with a value code, 17, in Form HCFA-1450 (UB-92) Form Locators 39-41, with an attached amount, and a condition code, 61, in Form HCFA-1450 (UB-92) Form Locators 24-30, as well as on the electronic remittance advice in a separate segment.

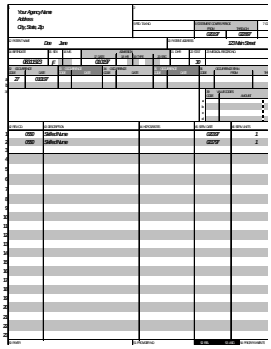
The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

3639.31 Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments.--Episode payment adjustments as described above only apply to claims, not RAPs. Episode claims that are paid on a per-visit or LUPA basis are not subject to therapy threshold, PEP or SCIC adjustment, and also will not receive outlier payments. Of other HH PPS claims, multiple adjustments may apply on the same claim, though some combinations of adjustments are unlikely (i.e., a significant change in condition (SCIC) and therapy threshold adjustment in a shortened episode (PEP adjustment)). All claims except LUPA claims will be considered for outlier payment. Payment adjustments are calculated in HH PPS Pricer Software (see subsequent section).

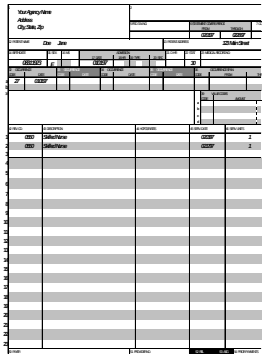
3639.32 Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustment.--The next few pages illustrate RAP and claim submission, and more common payment adjustments, under this payment system.

1. One 60-Day Episode, No Continuous Care (Patient Discharged):

RAP



Claim



Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**

Does not give any **line-item detail** for Medicare use as primary payer (*can carry charges on lines not used by Medicare*)

From and **Through Dates** match, date of first service delivered

Creates **HH Episode** in **HIQH Inquiry System**

Triggers initial percentage payment

Submitted after discharge or 60 days with **Patient Status Code 01**

Contains same **HIPPS Code** as RAP

Gives **all line-item detail** for the entire **HH Episode**

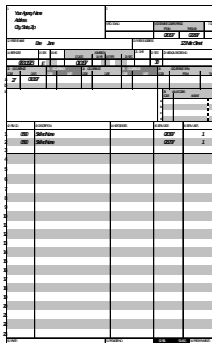
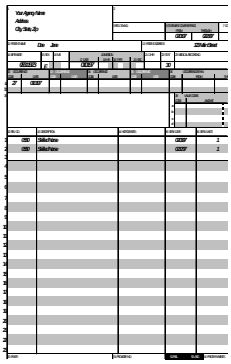
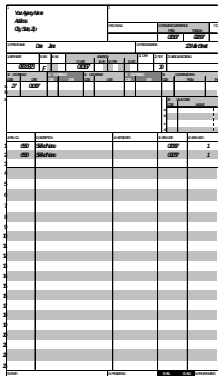
From Date same as RAP, **Through Date** Discharge or Day 60

Closes **HH Episode** in **HIQH Inquiry System**

Triggers final percentage payment for 60-day **HH Episode**

2. Initial Episode in Period of Continuous Care:

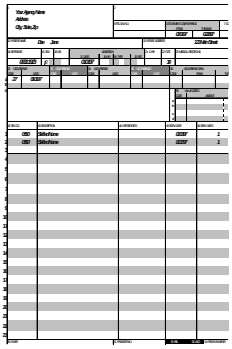
FIRST EPISODE:----------| NEXT EPISODE(s)--:

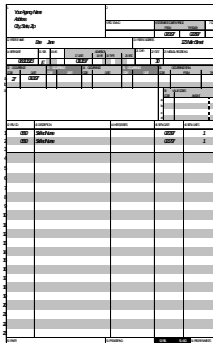
RAP	**Claim**	**RAP(s) &Claim(s)**
		
Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**	*Submitted after 60 days* with **Patient Status Code 30**	Unlike previous RAP in period, **Admission Date** will be the same as that on the first RAP of the period, and will stay the same on RAPs and claims throughout the period of continuous care
Does not give any other **line-item detail** for Medicare use	Contains same **HIPPS Code** as RAP, and gives **all line-item detail** for all the **HH Episode**	
From and **Through Dates** match first service delivered	**From Date** same as RAP, **Through Date**, Day 60 of **HH Episode**	**From** and **Through Dates,** RAP claims, are first day of **HH Episode**, w/ or w/o service (i.e., Day 61, 121, etc.)
Creates **HH Episode** in **HIQH Inquiry System**	Closes **HH Episode** in **HIQH Inquiry System**	Creates or closes **HH Episode(s)**
Triggers initial percentage **payment**	Triggers final percentage **payment** or 60-day **HH Episode**	Triggers **payment(s)**

- **These two scenarios (1. and 2. above) are expected to encompass most episode billings**
- **For RAPs, Source of Admission Code "B" is used is used to receive transfers from other agencies, "C" if readmission to same agency after discharge**
- **There is no number limit on medically-necessary episodes in continuous care periods**

3. <u>A Single LUPA Episode</u>:

RAP **Claim**





Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**

Does not give any other **line-item detail** for Medicare use

From and **Through Dates** match, first service delivered

Creates **HH Episode** in **HIQH Inquiry System**

Triggers initial percentage **payment**

Submitted after discharge or 60 days with **Patient Status Code 01**

Contains same **HIPPS Code** as RAP, Gives **all line-item detail** for the entire **HH Episode**-- **<u>line item detail will not show more than 4 visit for the entire episode</u>**

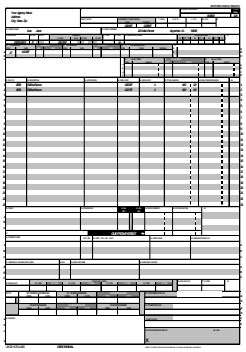
From Date same as RAP, **Through Date** Discharge or Day 60

Closes **HH Episode** in **HIQH Inquiry System**

Triggers final percentage **payment** for 60-day **HH Episode**

- **Though less likely, a LUPA can also occur in a period of continuous care (*scenario not illustrated*)**
- **While also less likely, a LUPA, though never pro-rated, can also be part of a shortened episode (*see PEP Episodes, below*) or an episode in which the patient condition changes (*see SCIC Episode, below*)-- *these less likely scenarios are not illustrated***

4. "No-RAP" LUPA Episode:



Claim

When a home health agency (HHA) knows from the outset that an episode will be 4 visits or less, the agency may choose to bill only a claim for the episode. (Note claims characteristics are the same as the LUPA final claim on the previous page.)

PROs:

Will not get large episode percentage payment up-front for LUPA that will be reimbursed on a visit basis (overpayment concern, but new payment system will recoup such "overpayments" automatically against future payments)

Less paperwork

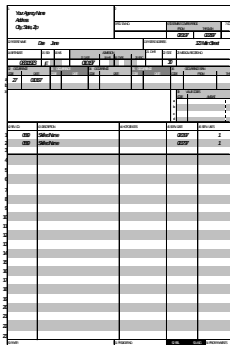
CONs:

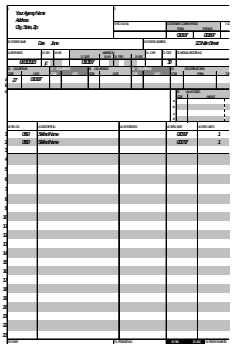
No HH Episode record is created in the Inquiry System, therefore beneficiary is not linked to the HHA providing services UNTIL a claim is received

No payment until claim is processed

5. Episode with a PEP Adjustment--Transfer to AnotherAgency OR Discharge-Known Readmission to Same Agency:

RAP **Claim**





Contains one **HIPPS Code** and **Claim-OASIS Matching Key** output from **Grouper** software linked to **OASIS**

Does not contain other **line-item detail** for Medicare use

From and **Through Dates** match, first service delivered

Creates **HH Episode** in

Submitted after discharge **w/Patient Status Code 06**

Contains same **HIPPS Code** as RAP, and gives **all line-item detail** for all the **HH Episode**

From Date same as RAP, **Through Date** is discharge

Closes **HH Episode** in **HIQH**

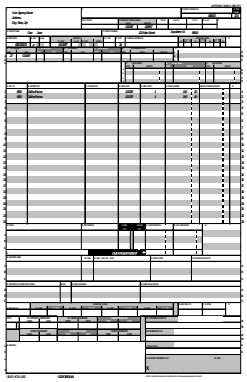
HIQH Inquiry System

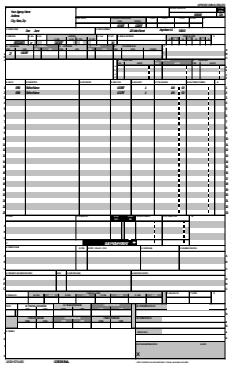
Triggers initial percentage **payment**

number of days

Inquiry System at date of discharge, not 60 days

Triggers final percentage **payment**, and total payment for the episode will be cut back proportionately (x/60), "x" being the





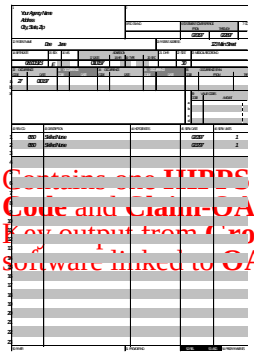
of the shortened episode

- **Known Readmission: agency has found after discharge the patient will be re-admitted in the same 60-day episode ("transfer to self"-- new episode) before final claim submitted**
- **The next episode presumably would be billed as either Scenario 1. or 2. above**
- **A PEP can also occur in a period of otherwise continuous care (*scenario not illustrated*)**
- **A PEP episode can contain a change in patient condition (*see SCIC Episode, below*)-- *this scenario is not illustrated***

6. <u>Episode with a PEP Adjustment</u>--Discharge and "Unknown" Re-Admit, Continuous Care:

FIRST EPISODE----------| START OF NEXT EPISODE-:

RAP **Claim** **RAP**



Contains one **HIPPS Code** and **Claim-OASIS Matching** key output from **Grouper** software linked to **OASIS**

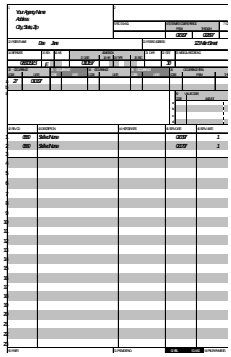
Submitted after discharge or 60 days **w/Patient Status Code 01** in --agency submitted claim before the patient was re-admitted in the

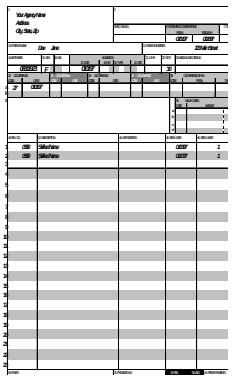
Unlike previous RAP period, **Admission Date** will be the same as that opening

	same 60-day **HH Episode**	the period, and will stay the same on RAPs and claims throughout the period of continuous care
Does not contain other line-item detail for Medicare use Creates **HH Episode** in **HIQH Inquiry System**	Contains same **HIPPS Code** as RAP, and gives all line-item detail for all the **HH Episode** Closes **HH Episode** in **HIQH Inquiry System** 60 days initially, and then revised to less than 60 days after next RAP received	Contains **Source of Admission Code "C"** to indicate patient re-admitted in same 60 days that would have been in previous episode, but now new **HH Episode** will begin and previous episode automatically shortened
From and **Through Dates** match first service delivered	**From Date** same as RAP, **Through Date** Discharge or Day 60 of **HH Episode**	**From** and **Through Dates** equal first episode day, w/ or w/o service (i.e., Day 61, 121)
Triggers initial percentage **payment**	Triggers final percentage **payment**, may be total payment for the episode at first, but will be cut back proportionately (x/60) to the number of days of the shortened episode when next billing received	Opens next **HH Episode** in **HIQH Inquiry System** Triggers initial **payment** for new **HH Episode**

7. Episode with a SCIC Adjustment:

RAP → **Claim**





Contains one **HIPPS Code** and **Claim-OASIS Matching**

Submitted after discharge **with Patient Status Code**

Key output from **Grouper** software linked to **OASIS**	as appropriate (01, 30, etc.)
	Carries **Matching Key** and diagnoses consistent w/**last** **OASIS** assessment
Does not contain **other line-item** detail for Medicare use	Contains same **HIPPS Code** as RAP, additional **HIPPS** output every time patient reassessed because of change in condition, and gives **all line-item** detail for all the **HH Episode**
From and **Through Dates** match, first service delivered	**From Date** same as RAP, **Through Date** Discharge or Day 60
Creates **HH Episode** in **HIQH Inquiry System**	Closes **HH Episode** in **HIQH Inquiry System**
Triggers initial percentage **payment**	Triggers final percentage **payment**

3639.33 Exhibit: General Guidance on Line Item Billing Under HH PPS.--The following tables are added for quick reference on billing most line-item on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first table emphasizes services and the second items and supplies:

TYPE OF LINE ITEM	Episode	Services/Visits	
CLAIM CODING	**New 0023 revenue code** with new HIPPS code (HHRG) on HCPCS field of same line	**Current revenue codes 42x, 43x, 44x, 55x, 56x, 57x w/Gxxxx HCPCS for increment reporting**, *(NOTE revenue codes 58x and 59x not permitted for HH PPS)*	Det **NO**
TYPE OF BILL (TOB)	**Billed on 32x only** (have 485, patient homebound)	**Billed on 32x only if POC**; 34x* if no 485	**App onl** (via
PAYMENT BASIS	**PPS episode rate:** (1) full episode w/ or w/out **SCIC** adjustment; (2) less than full episode w/**PEP** adjustment, (3) **LUPA** paid on visit basis (4) therapy threshold adjustment	**When LUPA on 32x**, visits paid on adjusted national standardized per visit rates; **paid as part of Outpatient PPS for 34x***	**Ad epi onl** on iten

TYPE OF LINE ITEM	Episode	Services/Visits	
PPS CLAIM?	**Yes, RAPs and Claims**	**Yes, Claims only** [34x* no 485/non-PPS]	**Yes**

NOTE: For HH PPS, HHA submitted IC TOB must be 322-- may be adjusted by 328; Claim TOB must be 329-- may be adjusted by 327, or 328.

*** 34x claims for HH visit/services on this chart will not be paid separately if a HH episode for same beneficiary is open on CWF (exceptions noted on chart below).**

TYPE OF LINE ITEM	DME** (non-implantable, other than Oxygen & P/O)	Oxygen & P/O (non-implantable P/O)	Non-routine*** Medical Supplies	Osteoporosis Drugs	Vaccines
CLAIM CODING	**Current revenue codes 29x, 294** for drugs/supplies for effective DME use w/HCPCS	**Current revenue codes 60x** (Oxygen) **and 274** (P/O) w/HCPCS	**Current revenue code 27x** or **62x** w/ or w/o HCPCS, voluntary use of 623 for wound care supplies	**Current revenue code 636 & HCPCS**	**Current revenue codes** (drug) HCPCS, (administrati
TYPE OF	**Billed to RHHI on**	**Billed to RHHI**	**Billed on 32x if**	**Billed on 34x***	**Billed on 3**

TYPE OF LINE ITEM	DME** (non-implantable, other than Oxygen & P/O)	Oxygen & P/O (non-implantable P/O)	Non-routine*** Medical Supplies	Osteoporosis Drugs	Vaccines
BILL (TOB)	**32x if 485**, 34x* if no 485	**on 32x if 485**, 34x* if no 485	**485**, or 34* if no 485	**only**	**only**
PAYMENT BASIS	**Fee Schedule**	**Fee Schedule**	**Bundled into PPS payment if 32x** (even LUPA); paid in cost report settlement **for 34x***	**Cost,** and paid separately with or without open HH PPS episode	**Paid as part Outpatient PPS,** and p separately w or without o HH PPS epis
PPS CLAIM?	**Yes, Claim only** [34x* no 485/non-PPS]	**Yes, Claim only** [34x* no 485/non-PPS]	**Yes, Claim only** [34x* no POC/non-PPS]	**No** (34x* claims only)	**No** (34x* cla only)

NOTE: For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).

*** 34x claims for HH services, except as noted for specific items above, will not be paid separately if a HH episode for same beneficiary is open on CWF.**
****Other than DME treated as routine supplies according the Medicare FI (§3629) and Home Health (§473) Manuals.**
*****Routine supplies are not separately billable or payable under Medicare home health care.**

3639.34 Exhibit: Acronym Table.--The following Acronym Table is offered to help with interpretation of the two previous sections, which, due to format constraints, could not spell out all terms:

ITEM	COMMENTS
Admission Date	For HH PPS, date of first service of episode OR first service in a period of continuous care (multiple episodes) placed in Form Locator 17 of the HCFA Form 1450 (UB-92) found in Medicare and/or NUBC (National Uniform Billing Committee) manuals. **HCFA manuals can be found on its Web Site (www.hcfa.gov/pubforms/p2192toc.htm).**
Claim	Second of two "bookends" at opening and closing of HH PPS episode to receive one of two split percentage payments.
DME	Durable Medical Equipment. Billed by revenue codes &/or HCPCS. Paid by HCFA according to a HCFA DME fee schedule accessible on the HCFA Web Site (www.hcfa.gov/stat/pufiles.htm).
DMERC	DME Regional Carrier. 4 Medicare carriers nationally processing claims for DME on HCFA 1500 claims.
Episode	60-day unit of payment for HH PPS.
Grouper	A software module that "groups" information for payment classification; for HH PPS, data from the OASIS assessment tool is grouped to form HHRGs and output HIPPS codes. **Specifications for the HH PPS Grouper are posted on the HCFA Web Site (www.hcfa.gov/medicare/hhmain.htm)**, and the grouper module is also built into PPS-compatible versions of HAVEN software, software publicly available automating the OASIS assessment tool.
HCFA	The Health Care Financing Administration, the Federal Agency administering the Medicare program and the federal portions of Medicaid and the Child Health program.
HCFA Form-1450	HCFA's version of the UB-92 (see UB-92, below).
HCPC(S) Code(s)	HCFA Common Procedural Coding System. Coding for services or items used on the Form HCFA-1450 (UB-92) in FL 44 or Form HCFA-1500 claim forms. A list of HCPCS is accessible on the HCFA Web Site (www.hcfa.gov/stat/pufiles.htm).
HH	Home Health
HHA(s)	Home Health Agency(ies)
(H)HRG	Home Health Resource Group. One of 80 HH episode payment rates.
HIPPS	Health Insurance Prospective Payment System. Procedural coding used in FL 44 of the Form HCFA-1450 (UB-92) in association with certain HCFA prospective payment systems (skilled nursing facility, home health). 8 HIPPS are assigned to each HHRGs for HH PPS.
Inquiry System (HIQH)	An on-line transaction providing information on HH PPS episodes for specific Medicare beneficiaries for HHAs and hospices. Like the current HIQA eligibility inquiry system, this system will be based on batch claim data available in the Common Working File, a component of Medicare claims processing systems, available to providers via their RHHIs.
Line Item	Service or item-specific detail of claim. Contains repeated entries of Form Locators 42-49 on HCFA Form-1450 (UB-92).
LUPA	Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of HHRGs
National Standard Per Visit Rates	National rates for each 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.

No-RAP LUPAs	**A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.**

OASIS	Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home health care.
Outlier	An addition to a full episode payment when costs of services delivered exceed a fixed loss threshold. HH PPS outliers are computed as part of Medicare claims payment by Pricer for all non-LUPA episodes.
Patient Status Code	Form Locator 22 of the Form HCFA-1450 (UB-92) describing patient status at discharge/end of period; of note for HH PPS in the code list filling this location: "01"= "discharge to home/self care", "06" = "discharged/transferred home/HHA care" and "30" = "still a patient".
PEP	Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharges with readmissions).
POC	Plan of care. Medicare HH services for the homebound beneficiaries must be delivered under a plan established by a physician (see 485 below).
P/O(S)	Prosthetics and orthotics
PPS	Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.
Pricer	Software modules in Medicare claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.
RAP	Request for Anticipated Payment. First of two "bookends" at opening and closing of HH PPS episode to receive one of two split percentage payments. Note although the RAP uses a Form HCFA-1450 (UB-92), it is not a claim according to Medicare statutes, and in not subject to the payment floor, among other differences from claims.
Revenue Code	Payment codes for services or items place in Form Locator 42 of the Form HCFA-1450 (UB-92. Note that a new revenue code 0023 will be used on a distinct line item when billing episode payments (HIPPS in HCPCS field, separate line items for visits and supplies follow on claim); an "x" in the last digit of numeric three digit revenue codes means that value can vary from 0-9.
RHHI	Regional Home Health Intermediary. Five fiscal intermediaries nationally designated to process Medicare home health and hospice claims.
SCIC	Significant Change in Condition (adjustment). When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG is pro-rated to the number of service days delivered under that HHRG, and all pro-rated amounts added for the final episode payment.
Source of Admission Code	Form Locator 20 of the Form HCFA-1450 (UB-92); of note in the code list filling this location are the following new codes for HH PPS: "B" = "transfer from another home health facility", and "C" = "readmission to the same HHA".
TOB	Type of Bill (i.e., 32x, 34x). Coding representing the nature of each Form HCFA-1450 (UB-92) claim (i.e., type of benefit, such as homebound home health; payment source, such as specific Medicare trust fund; and frequency of bill , such as initial or cancellation)-- an "x" in the last digit of numeric three digit type of bill means that value can be from 0-9.
UB-92	The claim or bill form, in either paper or electronic version, used by most institutional health care providers. Published by HCFA as the Form HCFA-1450, but the standard itself is maintained by a non-governmental body: the National Uniform Billing Committee, an entity under the American Hospital Association in Chicago.
10/01/00	Legislated effective date for HH PPS.
1500	The claim form, in either paper or electronic version (NSF), used by most non-institutional health care providers and suppliers to bill Medicare. Published by HCFA as the Form HCFA-1500.
485	HCFA form number for Plan of Care (see POC above).

3639.35 Home Health Prospective Payment System (HH PPS) Consolidated Billing and Primary HHAs.--The Balance Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services is to be made to a single HHA overseeing that plan, and this HHA is known as the primary agency or HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise". Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- o Skilled nursing care;
- o Home health aide services;
- o Physical therapy;
- o Speech-language pathology;
- o Occupational therapy;
- o Medical social services;
- o Routine and non-routine medical supplies;
- o Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; *and*
- o Care for homebound patients involving equipment too cumbersome to take to the home.

The HHA that submits the first Request for Anticipated Payment (RAP) or No-RAP low-utilization payment adjustment (LUPA) claim successfully processed by Medicare systems will be recorded as the primary HHA for a given episode in the Common Working File (CWF)-based HIQH inquiry system for HH PPS. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Fiscal and regional home health intermediaries and carriers will reject any claims from other than the primary HHA that contain billing for the services and items above when billed for dates of service within an established 60-day home health episode. This applies to provider types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers). HHAs and hospices will be able to access information on existing episodes from the HIQH Inquiry system, other institutional providers from the HIQA/HUQA system. Both these inquiry systems, though based on information contained in the CWF, are available to Medicare providers through their intermediaries.

Durable medical equipment (DME) is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DME regional carrier or billed by a HHA, even HHAs other than the primary HHA, to a RHHI. Medicare systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the intermediary and the carrier at the same time for the same beneficiary.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis, in addition to episode payments, and are billed on claims with a bill type not specific to HH PPS (type of bill 34x). When episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them.

NEXT PAGE IS 6-192

3640. NEW COMMON WORKING FILE (CWF) REQUIREMENTS FOR THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

3640.1 Creation of the Health Insurance Query System for Home Health Agencies (HIQH) and Hospices in the Common Working File--Replacement of HIQA.--In the past, the Health Insurance Query Access system, or HIQA, within the CWF, a key part of Medicare claims processing systems, allowed different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility. HIQA has been available to home health agencies (HHAs) and hospices through their Medicare contractor, a RHHI.

With the advent of the home health prospective payment system (HH PPS) and home health consolidated billing, HHAs similarly needed to determine if beneficiaries were already being served by other HHAs, because only one HHA is able to bill during a given episode period, though other agencies may obtain reimbursement under arrangement with the primary agency. In such cases, HHAs already providing services would be considered the primary agency for billing purposes. If the beneficiary is not already under care at another HHA, he or she can be admitted to a new HHA, and that agency would become primary. Beneficiaries can also be admitted to a second agency as primary, even if an episode is already open at another HHA, if a transfer situation exists.

With the implementation of HH PPS in 2000, CWF was expanded so that information pertinent to determining primary HHA status could be obtained through an on-line inquiry transaction in CWF, **HIQH: Health Insurance Query for HHAs.** This transaction is also available to hospices. The agency's primary status, or change of primary status from one agency to another in a transfer situation, is reflected in HIQH following submission of RAPs or claims by HHAs. Since HIQH includes information provided in HIQA, and since beneficiaries often move from home health to hospice care, both HHAs and hospices can employ HIQH as their single CWF inquiry transaction as of October 1, 2000. Unlike HIQA, which is paired with HUQA, HIQH does not have a parallel transaction system.

HIQA/HUQA will continue to exist and be used routinely by other Medicare institutional providers. HIQA will also be expanded so that these providers will be able to know if a HH PPS episode is open, since HH PPS consolidated billing may affect the processing of their claims.

3640.2 HIQH Inquiry and Response.--HIQH is also available through RHHIs like HIQA, and shows whether or not the beneficiary is currently in a home health episode of care (being served by a primary HHA), along with other information. To inquire, an HHA or hospice would enter data matching what was previously entered for HIQA, though under the new transaction identifier HIQH, including:

- The beneficiary's **Health Insurance Claim Number (HICN)**, name and sex;
- The pertinent **Contractor and Provider Numbers**;
- **CWF Host**, *and one new item:*
- **Date the HHA Expects to Serve the Beneficiary**.

CWF will immediately return information on the two episode periods in the CWF Episode File closest to the date the HHA submitted in the new item. If a date is not specified, information on the two most recent episode periods in the file will be returned. The HIQH response will display the following information for the specific beneficiary in response to the inquiry:

- The beneficiary's **Health Insurance Claim Number (HICN)**;
- The pertinent **Contractor and Provider Numbers**;
- **Episode Start and End Dates**--these dates make apparent if a primary HHA is already billing for a beneficiary and for how long;

- **Period Status Indicator**--the patient status codes either on a RAP, if the episode has not yet been closed by a claim, or the claim for the episode: these codes reveal whether a beneficiary has been discharged (01), has transferred or discharged and readmitted (06), has died (20) or is expected to remain in the care of the HHA currently providing services (30);

- **HH Benefit Periods**--the two most recent home health benefit periods, which Medicare uses to pay claims from either the Part A or Part B trust funds;

- **Medicare Secondary Payer (MSP) Information or HMO Entitlement Information**--if it exists for the beneficiary, this information will be returned;

- **Hospice Periods**--the two most recent hospice periods for the patient, if any; *and*

- **HIQA Header Information**--all that pertains to home health and hospice from the basic entitlement information from page 1 of the HIQA inquiry.

HIQH will provide a specific response message in cases when no episodes exist for a given beneficiary. This message will make clear that for the date(s) requested, no home health episode information is available.

3640.3 Timeliness and Limitations of HIQH Responses.--Though inquirers get a response back from HIQH within a very short time frame, these responses are not truly "real time". The CWF auxiliary file that retains episode information is updated by, and is only as current as, each RAP or claim batch run in CWF. All processed RAPs and claims will update the episode file, even if RAPs have zero reimbursement, or if claims or RAPs are ultimately denied. Episodes are only removed from history when HHAs cancel their own RAPs, for episode not yet closed, or claims, for closed episodes, or when RHHIs cancel claims or RAPs for specific reasons (such as fraud).

In general, HIQH responses will be as current as the previous day. Therefore, even when a response indicates a beneficiary is not currently in an episode, the possibility exists that a RAP or claim could be in process, and the inquiring agency would still not be the primary HHA for a beneficiary for whom a 'clear' inquiry was received. In such cases, the inquiring agency would not learn that they were not the primary HHA immediately, waiting until they either looked again in HIQH after new batch updates were reflected, or possibly only once the RAP or claim submitted was rejected. While this situation should occur infrequently, since one beneficiary would have to be going to two different agencies virtually simultaneously, it cannot be avoided given the limitations of current batch-processing systems.

Also possible but even rarer, claims or RAPs from two different HHAs for the same beneficiary for the same date may be in the same batch of claims or RAPs sent to CWF. In such cases, the arbitrary claim process will still result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

3640.4 Inquiries to Regional Home Health Intermediaries (RHHIs) Based on HIQH Responses.--HHAs and hospices may want to follow-up on information they view in HIQH. In such cases, usually to contact the primary agency already on file to bill under arrangement, the provider's RHHI should be contacted through existing provider inquiry channels. HCFA has confirmed that each RHHI may provide information on either the provider or contractor numbers HHAs may request given the HIQH responses they receive may be provided. Information released will be determined by each RHHI, such as name and address, but must be enough for the inquiring HHA to contact either the primary HHA, if under that RHHI's jurisdiction, or another RHHI (contractor number), if the provider number from the HIQH response is attached to another RHHI. If an instance ever exists where an HHA is an individual, such as a provider doing business using a Social Security Number as a tax identification number, information cannot be released, since it would violate the individual's right to privacy.

3640.5 National Home Health Prospective Payment Episode History File.--The new CWF inquiry system for the Home Health Prospective Payment System (HH PPS), HIQH: Health Insurance Query for home health agencies (HHAs), relays information including that contained in the HH PPS episode history file of each beneficiary. CWF was amended for HH PPS to create a national episode history file for each beneficiary, in order to enforce consolidated billing and perform HH PPS processing. Accompanying episode period response trailers were also created, and are to be updated daily in response to HH PPS RAPs and claims, both transactions employ the Form HCFA-1450 (UB-92) form with distinct bill types that are effective October 1, 2000.

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 **Regional Home Health Intermediary, RHHI, (Contractor) and Provider Numbers**;
- **Period Start and End Dates**--the start date is received on a 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;
- **Period Status Indicator**--the patient status code on an HH PPS claim, indicating whether a beneficiary has been discharged (01), has transferred or discharged and readmitted (06), has died (20) or is expected to remain in the care of the HHA currently providing services (30);
- **Transfer/Readmit Indicator**--source of admission codes taken from the RAP or claim as an indicator of the type of admission (transfer, readmission after discharge, etc.);
- **The HIPPS Code(s)**--up to six for any episode, and two for any line item, representing the basis of payment for episodes other than those receiving a low utilization payment adjustment (LUPA);
- **Principle and Secondary Diagnosis Codes**--from the RAP or overlaying claim;
- **A LUPA Indicator**--received from the standard system indicating whether or not there was a LUPA episode; *and*
- **A RAP Cancellation Indicator**--showing whether or not a RAP has been 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", in all other cases, the value is "0".

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

The episode file contains the 36 most recent episodes for any beneficiary. Episodes preceding the most recent 36 will be dropped off the file and will not be retrievable on-line. The date of accretion for an episode is the date the RAP or claim is accepted or applied.

3640.6 Opening and Length of HH PPS Episodes.--Within CWF, the episode history auxiliary file is separate from the home health benefit period auxiliary file, which existed prior to HH PPS. All HH PPS claims will update both these files, in particular the DOEBA, DOLBA and visit counts.

In most cases, an HH PPS episode in an episode file will be opened by the receipt of a RAP, even if the RAP or claim has zero reimbursement.

Note that claims, as opposed to RAPs, will only open episodes in one special circumstance: when a provider knows from the outset that four or fewer visits will be provided for the entire episode, which always results in a LUPA, and therefore decides to forego the RAP as to avoid recoupment of the difference of the large initial percentage episode payment and visit-based payment. This particular billing situation exception is referred to as a No-RAP LUPA.

Multiple episodes can be open for the same beneficiary at the same time. The same HHA may require multiple episodes be opened for the same beneficiary because of an unexpected readmission after discharge, or if for some reason a subsequent episode RAP is received prior to the claim for the previous episode. Multiple episodes may also occur between different providers if a transfer situation exists. CWF will post RAPs received with appropriate transfer and re-admit indicators to facilitate the creation of multiple episodes. Same day transfers are permitted, such that an episode for one agency, based on the claim submitted by that agency, can end on the same date as an episode was opened by another agency for the same beneficiary.

When episodes are created from RAPs, CWF calculates a period end date that does not exceed the start date plus 59 days. CWF will assure no episode exceeds this length under any circumstance, and will auto-adjust the period end date to shorten the episode if needed based on activity at the end of the episode (i.e., shortened by transfer).

3640.7 Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAP and HHA Claim Activity.--CWF will reject RAPs and claims with statement dates overlapping existing episodes using a trailer and a distinct error code, including No-RAP LUPA claims, unless a transfer of discharge and re-admit situation is indicated. CWF will also reject claims in which the dates of the visits reported for the episode do not fall within the episode period established by the same agency. 60-day episodes, starting on the original period start date, will, however, remain on record in these cases.

CWF will auto-cancel claims, and adjust episode lengths, when episodes are shortened due to receipt of other RAPs or claims indicating transfer or readmission. The auto-adjusted episode will default to end on the first date of service of the new RAP or claim causing the adjustment, though the episode length may change once claims finalizing episodes are received. When claims are auto-canceled, CWF will send an unsolicited response to the standard system component of claims processing so that payment for the episode is automatically adjusted, a partial episode payment or PEP adjustment, without necessitating re-billing by the HHA. If when performing such adjustments there is no claim in paid status for the previous episode that will receive the PEP adjustment, CWF will just adjust the period end date, but if the previous claim is in paid status both the claim, via the standard system, and the episode will be adjusted.

In PEP situations, if the first episode claim contains visits with dates in the subsequent episode period, the claim of the first episode will be rejected by CWF with UR reject code that indicates the date of the first overlapping visit. The claims rejected by CWF will then be returned to the HHA by the RHHI for correction. If the situation is also a transfer, when the first HHA with the adjusted episode subsequently receives a rejected claim, the agency can either re-bill by correcting the dates, or seek payment under arrangement from the subsequent HHA. For readmission and discharge, the agency must correct the erroneously billed dates for its own two episodes, but the corrections and adjusments in payment will be made automatically as appropriate whether the agency submits corrections or not.

If the from dates on two simultaneously received RAPs, or No-RAP LUPA claims, overlap, CWF will reject the later received RAP or claim with a trailer and a new error code, even if the later received RAP started with an earlier date of service, unless there is a transfer or readmit indicator. In such cases, RHHIs will return the claims rejected by CWF to providers. CWF will create an internal message in addition to setting appropriate indicators in these circumstances.

If a claim is canceled by an HHA, CWF will cancel the episode. If an HHA cancels a RAP, CWF will also cancel the episode. When claims are denied, auto-canceled or canceled by the system, CWF will not cancel the episode. A RHHI may also take an action that results in cancellation of an episode, usually in cases of fraudulent billing. Other than cancellation, episodes are closed by final processing of the claim for that episode.

3640.8 Other Editing and Changes for HH PPS Episodes.--CWF will assure that the final from date on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary will remain in the care of the same HHA (patient status code 30). If the patient dies, represented with a patient status code of 20, full payment of the episode will be made, but the through date on the claim will indicate the date of death instead of the end of the episode period. When the status of a claim is 06, the episode period end date will be adjusted to reflect the "through date" of that claim, and payment is also be adjusted. When the status of the claim is 01, no change is made in the episode length or claims payment unless a separate RAP or claim is received which overlaps that 60-day period and contains either a transfer or discharge and readmit indicator.

CWF will also act on source of admission codes on RAPs: for example, "B", indicating transfer, and "C", indicating readmission after discharge by the same agency in the same 60-day period. In such cases, CWF will open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone will not trigger creation of a new episode. CWF will also recognize the following action codes sent by the standard systems for HH PPS: "01" for RAPs, bill type 3XG claims and No-RAP LUPA claims, "02" for adjustment on RAPs, and "03" on claims except No-RAP claims, "4" for cancel only claims. Different types of actions will follow 04 cancellations. When the HUHH record is received from the RHHI, based on the cancel-only code also placed on the claim by the standard systems, the following actions will occur based on the code: "A", the episode will not be removed from the episode file, the cancellation indicator will not be set, and the DOEBA and DOLBA dates will be removed; "B", the episode record is not removed and the cancellation indicator is set, and "E" the episode is removed. Cancel only code "F" will be used when either the RAP or claim (HUHH record) is canceled by the provider, and consequently the attached episode will be removed from the episode file.

3640.9 Priority Among Other Claim Types and HH PPS Consolidating Billing for Episodes.--Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive homebound care simultaneously. So that, if an HH PPS claim is received, and CWF finds either an inpatient or skilled nursing facility (SNF) claim with services within the episode dates for the HH PPS claim, CWF will reject the HH claim, since the episode would fall within the range of the statement dates of those other inpatient claims. This would still be the case even if the HH PPS claim was received first and the SNF or inpatient hospital claims came in later, but contained 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 they patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment would likely apply. Occurrence span code 74, previously used in such situations, should not be employed on HH PPS claims. However, if an agency chooses to discharge and a beneficiary still returns to the agency, or another agency, in the same 60-day period, there would be one shortened HH PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period.

CWF developed A-B crossover edits to prevent duplicate billing among RHHIs and DME regional carriers for DME. CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS coding. However, HH PPS consolidated billing does not apply to DME by law. By law, consolidated billing is required for home health services, to be implemented along with HH PPS. In short, consolidated billing requires that only the HHA responsible for a given HH PPS episode, the primary HHA, bill services under the home health benefit, with the exception of DME, for the period of that episode. The type of service most affected are non-routine supplies and outpatient therapies, since these service are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

For home health consolidated billing, non-routine medical supplies are identified as 178 discrete items by HCPCS code in the final rule for HH PPS. If an HH PPS episode is open, only the primary HHA should bill for these items. CWF will reject claims not billed by the primary HHA, submitted to either RHHIs or DME Regional Carriers, for these items when an episode is open, or even if such claims are billed before or after the episode itself, but overlap with the episode period. Such claims will be returned to Part A, Part B, or DMERC standard systems as appropriate. CWF will also return an unsolicited trailer 20 to the Part A standard system as needed in these situations, and develop a new reject response code if warranted. In such cases, both RHHIs and fiscal intermediaries will return the claims rejected by CWF to providers. Routine supplies are not reimbursed by Medicare.

CWF will develop edits to enforce consolidated billing for outpatient therapies, recognized under revenue codes 42x, 43x, 44x, so that only those therapy services billed by the primary HHA will be paid and posted. These revenue codes have been cross-referenced to 54 HCPCS codes listed in the HH PPS final rule approximating the same services. Subsequent services billed after the posting of a HH episode will be rejected back to the appropriate standard system as described above relative to routine supplies.

If revenue code 636 and the HCPCS code for osteoporosis drug is billed on a 34x bill type claim during an open HH episode, CWF must edit to ensure that the provider of the 34x bill is the same as the primary provider of the open episode, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the episode payment. HH PPS will not cause any changes in the billing of outpatient services by HHAs (i.e., vaccines, splints, antigens and casts) or home health visits not under a plan of care on 34x bill type claims.

3640.10 Medicare Secondary Payment (MSP) and the HH PPS Episode File.--CWF will apply MSP edits (auxiliary file) to both RAPs and HH PPS claims, editing all RAPs, whether an HUSP record is present or not, to see if the episode period service date falls within an MSP period. A HUSP record will be created for all RAPs containing MSP information, and this record will create or update the CWF MSP auxiliary file as appropriate. Though both RAPs and claims will create episode records, only claim, not RAP, payment will be affected by primary payer contributions in MSP situations. Therefore, RAPs are marked in Medicare standard systems with a non-payment code if MSP applies, and ultimately sent to a paid status in Medicare systems without processing through post-payment locations, thereby processing with zero payment. First claim development is performed only on claims, not RAPs.

3640.11 Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File.--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 in CWF
Initial RAP (Percentage Payments 0-60)	Opens a 60-day 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 a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Subsequent Episode RAP	Opens another subsequent 60-day 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 a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present
Initial RAP with Transfer Source Code of B	Opens a 60-day episode record using RAP's "from" date; "through" date is automatically calculated to extend through 60th day	• The period end date of the episode of the HHA the beneficiary is transferring from is automatically changed to reflect the from date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from can not bill for services past the date of transfer • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider	60-day episode record is deleted from CWF	• No episode exists to prevent a RAP submission or No-RAP-LUPA claim submission
RAP Cancellation by System	60-day episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted in CWF
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 a transfer source code is present • Other claims, including No-RAP-LUPA claims, will be rejected unless a transfer source code is present
Claim (discharge with goals met prior to day 60)	60-day episode record completed;episode "thorough" date remains at the 60th day; DOLBA updates with date of last service	• Other RAPs submitted during this open episode will be rejected unless a transfer source code is present • Other claims, including No-RAP-LUPA claims, will be rejected unless a transfer source code is present
Claim (transfer)	60-day 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 a 60-day episode record using RAP's "from" date; "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 a transfer source code is present • Other No-RAP-LUPA claims will be rejected unless a transfer source code is present • Because a RAP is not submitted in this situation until the No-RAP-LUPA claim is submitted, another provider can open a 60-day episode by submitting a RAP or by submitting a No-RAP-LUPA claim
Claim (adjustment)	No impact on 60-day episode unless adjustment changes patient status to transfer	• No impact
Claim Cancellation by Provider	60-day episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP-LUPA claim submission
Claim Cancellation	60-day episode record	• Other RAPs submitted during this open episode will be rejected unless a transfer

by System	remains open on CWF	source code is present • No-RAP-LUPA claims will be rejected unless a transfer source code is present

3656.7 Home Health Prospective Payment System (HH PPS) Pricer Program.--

A. General--For dates or service October 1, 2000 and after, all home health services billed on type of bill 32x or 33x will be reimbursed based on calculations made by the HH Pricer. The HH Pricer operates as a call module within HCFA's standard systems. The HH Pricer makes all reimbursement calculations applicable under HH PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, therapy threshold adjustments, significant change in condition (SCIC) adjustments and outlier payments. (See §§3639.7-3639.10, 3639.21-3639.31) Standard systems must send an input record to Pricer for all claims with covered visits and Pricer will send the output record back to the standard systems.

B. Input/Output Record Layout.--The HH Pricer input/output file will be 450 bytes in length. The required data and format are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	This field will be used for the National Provider Identifier when it is implemented.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from FL 60 of the claim form.
23-28	X(6)	PROV-NO	Input item: The six digit OSCAR system provider number, copied from FL 51 of the claim form.
29-31	X(3)	TOB	Input item: The type of bill code, copied from FL 4 of the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a partial episode payment (PEP) adjustment. Standard systems must set a Y if the patient status code in FL 22 of the claim is 06. An N is set in all other cases.
33-35	9(3)	PEP-DAYS	Input item: The number of days to be used for PEP payment calculation. Standard systems determine this number from the span of days from and including

			the first line item service date on the claim to and including the last line item service date on the claim.
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payments should be made on RAP or whether payment should be based on data drawn by the standard systems from field 19 of the provider specific file. Valid values: 0 = Make normal percentage payment 1 = Pay 0%
37-43	X(7)	FILLER	Blank.

File Position	Format	Title	Description
44-46	X(3)	FILLER	Blank.
47-50	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code, copied from the value code 61 amount in FLs 39-41 of the claim form.
51-52	X(2)	FILLER	Blank.
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from FL 6 of the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU DATE	Input item: The statement covers period "Through" date, copied from FL 6 of the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from FL 17 of the claim form. Date format must be CCYYMMDD.
77	X	HRG-MED-REVIEW-INDICATOR	Input item: A single Y/N character to indicate if an HRG has been changed by medical review. Standard systems must set a Y if an ANSI code on the line item indicates medical review involvement. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Standard 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 medical review involvement, standard systems must copy the additional HIPPS code placed on the 0023 revenue code line by the medical reviewer.

83-87	X(5)	HRG-OUTPUT-CODE	Output item: The HIPPS code used by the Pricer to determine the reimbursement amount on the claim. This code will match the input code in all cases except when the therapy threshold for the claim was not met.
88-90	9(3)	HRG-NO-OF-DAYS	Input item: A number of days calculated by the standard systems for each HIPPS code. The number is determined from 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 reimbursement amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The reimbursement amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Five more occurences of all HRG/HIPPS related fields defined above, since up to 6 HIPPS codes can be automatically processed for payment on any one episode.

File Position	Format	Title	Description
251-254	X(4)	REVENUE-CODE	put item: One of the six home health discipline revenue codes (42x, 43x,44x, 55x, 56x, 57x). All six revenue codes must be passed by the standard 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. Standard 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 reimbursement 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 reimbursement for the visits in each discipline if the claim is paid as a low utilization payment adjustment (LUPA). Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
276-400	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.

401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define 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 Error return codes: 10 = Invalid TOB 15= Invalid PEP Days 20 = PEP indicator invalid

			Error return codes (cont.): 25 = Med review indicator invalid 30 = Invalid MSA code 35 = Invalid Initial Pymnt Indicator 40 = Dates are < Oct 1, 2000 or are 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 42x,43x, and 44x.	Output item: The total therapy visits used by the Pricer to determine if therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input with revenue codes
408-412	9(5)	REVENUE-SUM 1-6- QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a low utilization payment adjustment (LUPA). This amount will be the total of all the covered visit quantities input will all six HH discipline revenue codes.
413-421	9(7)V9(2)	OUTLIER-PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts.

422-430	9(7)V9(2)	TOTAL-PAYMENT	Output item: The total reimbursement determined by the Pricer to be due on the RAP or claim.
431-450	X(20)	FILLER	Blank.

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

The standard 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 standard 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.

C. Decision Logic Used By The Pricer On RAPs.--On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

1. a. Find weight for "HRG-INPUT-CODE" from the table of weights for the Federal fiscal year in which the “SERV-THRU-DATE” falls. Multiply the weight times Federal standard episode rate for the Federal fiscal year in which the “SERV-THRU-DATE” falls. The product is the case-mix adjusted rate. This case-mix adjusted rate must also be wage-index adjusted according to labor and non-labor portions of the payment established by HCFA. Multiply the case-mix adjusted rate by .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1" (The current hospital wage index, pre-floor and pre-reclassification, will be used). Multiply the Federal adjusted rate by .22332 to determine the non-labor portion.

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

2. a. If the "INIT-PYMNT-INDICATOR" equals 0, perform the following:

Determine if the “SERV-FROM-DATE” of the record is equal to the "ADMIT-DATE." If yes, multiply the wage index and case-mix adjusted payment by .6 Return the resulting amount as “HRG-PAY” and as “TOTAL-PAYMENT” with return code 05.

If no, multiply the wage index and case-mix adjusted payment by .5 Return the resulting amount as “HRG-PAY” and as "TOTAL-PAYMENT" with return code 04.

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

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

D. Decision Logic Used By The Pricer On Claims.--On input records with TOB 329, 339, 327, 337, 32F, 33F, 32G, 33G, 32H, 33H, 32I, 33I, 32J, 33J, 32K, 33K, 32M, 33M, 32P or 33P (that is, all provider submitted claims and provider or intermediary initiated adjustments), Pricer will perform the following calculations in the numbered order:

1. a. Low Utilization Payment Adjustment (LUPA) calculation.
If the "REVENUE-SUM1-6-QTY-ALL" (the total of the 6 revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the Federal fiscal year in which the"SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust and sum the six products. The result is the total payment for the episode. Return this amount in the "TOTAL-PAYMENT" field with return code 06. No further calculations are required.

1. b. If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to 5, proceed to the therapy threshold determination.

2. a. Therapy threshold determination.
If the "REVENUE-SUM1-3-QTY-THR" (the total of the quantities associated with therapy revenue codes, 42x, 43x, 44x, which will be passed from the standard systems sorted in this order) is less than 10, perform the following:

If the "MED-REVIEW-INDICATOR" is a Y for any HRG, do not perform alter the HIPPS code reported in "HRG-INPUT-CODE" Copy that code to the "HRG-OUTPUT-CODE" field. Proceed to the next HRG occurrence.

If "MED-REVIEW-INDICATOR" is an N for any HRG, read table of codes for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The table of HIPPS codes in the Pricer is arranged in two columns. The first column contains all 640 HIPPS codes. For each code in the first column, the second column shows the code to be used for payment if the therapy threshold is not met. If the code in first column matches the code in the second column (indicating the therapy threshold does not need to be meet for that code), copy the code from the first column to the "HRG-OUTPUT-CODE" field.

If the code in the first column does not match the code in the second column, place the code in the second column in the "HRG-OUTPUT-CODE" field.

2. b. If "HHA-REVENUE-SUM1-3-QTY-THR" is greater than or equal to 10: Copy all "HRG-INPUT-CODE" entries to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the codes in the "HRG-OUTPUT-CODE" fields for all further calculations involving each HRG.

3. a. HRG payment calculations.

If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is an N:

Find the weight for the "HRG-OUTPUT-CODE" from weight table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by .77668 to determine the labor portion. Multiply the labor portion by the wage index corresponding to "MSA1." Multiply the case-mix adjusted rate by .22332 to determine the non-labor portion. Sum the labor and non-labor portions. The sum is the wage index and case-mix adjusted payment for this HRG.

Proceed to the outlier calculation (see 4 below).

3. b. If the "HRG-OUTPUT-CODE" occurrences are less than 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this partial episode payment (PEP) by dividing the "PEP-DAYS" amount by 60. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the PEP payment due on the claim. Proceed to the outlier calculation (see 4 below).

3. c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is an N:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the number of days in the "HRG-NO-OF-DAYS" field for that code divided by sixty. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will returned in separate occurrence of the "HRG-PAY" fields, so that the standard systems can associate them to the claim 0023 lines and pass the amounts to the remittance advice. Therefore each amount must be wage index adjusted separately. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

3. d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to 2, and the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for each HRG, as above. Multiply each of the resulting amounts by the quantity in the "PEP -DAYS" field divided by 60. Multiply the result by the quantity in the "HRG-NO-OF-DAYS" field divided by the quantity in the "PEP-DAYS" field. Repeat this for up to six occurrences of "HRG-CODE." These amounts will returned separately in the corresponding "HRG-PAY" fields. Sum all resulting dollar amounts. This is total HRG payment for the episode. Proceed to the outlier calculation (see 4 below).

4. a. Outlier calculation:

Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the MSA code in the "MSA1" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from all HRG payment calculations. This is the outlier threshold for the episode.

4. b. For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from revenue code table for the Federal fiscal year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results

and wage index adjust this sum as described above, using the MSA code in the “MSA1" field. The result is the wage index adjusted imputed cost for the episode.

4. c. Subtract the outlier threshold for the episode from the imputed cost for the episode.

4. d. If the result is greater than $0.00, calculate .80 times the result. Return this amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the “TOTAL-PAYMENT” field, with return code 01.

4. e. If the result is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeroes in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the “TOTAL-PAYMENT” field, with return code 00.

E. Annual Updates to the HH Pricer.--Rate and weight information used by the HH Pricer are updated annually. Updates occur each October, to reflect the Federal fiscal year. The following update items will be published annually in the ***Federal Register***:

- o The Federal standard episode amount;
- o The fixed loss amount to be used for outlier calculations;
- o A table of case-mix weights to be used for each HRG;
- o A table of national standardized per visit rates;
- o The pre-floor, pre-reclassified hospital wage index; *and*
- o Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and non-labor percentages.

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3752. OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) REMITTANCE ADVICE INSTRUCTIONS

3752.1 Standard Paper Remittance Advice Changes.--Exhibit 1 to this section contains the 2000 version of the Standard Paper Remittance (SPR) Advice. This attachment must be read and printed in landscape. Due to the number of data elements in an SPR, an SPR must be printed and read across, rather than down, a page. If printed in a portrait format, the data in the columns to the far right will scroll to the next line, making an SPR almost illegible. This version will supplant the earlier SPR effective with implementation of OPPS. The following SPR changes are included in this version:

- The reference to HCPCS changed to "procedure code" as other code sets such as the National Drug Code (NDC) may begin to be used in addition to HCPCS in the future.

- The DRG operating amount and the DRG capital amount will no longer be reported separately. A combined DRG operating and capital amount will now be reported in the SPR to correspond to reporting of this information in the 835.

- A summary data element has been added for the TOP, a monthly provider payment which will be issued as warranted to supplement line item payments for services paid under OPPS.

- Date fields in the SPR have been expanded to enable reporting of the century. Some, but not all, SPR dates previously accommodated century reporting.

- Although previously implemented, the hemophilia add on has been added to the format document.

NOTE: Only the third bullet above is directly related to OPPS, but the remaining information must be included to reflect incremental modifications to the SPR.

As with inpatient PPS, only summary data will be reported in the SPR for OPPS. The standard systems maintainers will report detailed service line data only in version 3051.4A.01 and later 835 electronic remittance advice transactions. The Fiscal Intermediary Shared System (FISS) will continue to report claim level summary data without service line information in the version 3030M and 3051.3A 835 transactions. Providers on FISS who wish to receive service line level data must upgrade to the 835 version 3051.4A.01 transaction format.

Exhibit 2 contains field characteristics for the 2000 version of the SPR and mapping information between the SPR and the 835. The FISS maintainer must expand the flat files for the supported 835 versions at the claim or line levels as appropriate to include OPPS-specific data elements (described below), and furnish relevant mapping information between those data elements and the SPR and the supported versions of the 835 (see FISS mapping-required notations in the attachment 4 implementation guide replacement pages).

3752.2 Electronic Remittance Advice Format Requirements.--These requirements are as follows:

- Substitute the replacement pages in Exhibit 3 in your hard copy version 3051.4A.01 implementation guide. These changes are also being added to version 3051.4A.01 at www.hcfa.gov/medicare/edi/edi.htm, and include:

  - 2-062-AMT02 modified to allow reporting of either inpatient or partial hospitalization per diem. NOTE: Make the same "pen and ink" change to the corresponding pages in the version 3030M and 3051.3A implementation guides. This is a claim level segment which will also need to be reported in those versions. (Since those versions were established in obsolete software which is no longer supported, replacement pages cannot be attached to this instruction for those versions.)

Also report the amount of any outlier PRICER determines payable for the claim in a separate AMT loop with ZZ in AMT01 and the outlier amount in AMT02.

- 2-100.A-REF and REF02 modified to allow service line reporting of the APC and the Health Insurance Prospective Payment System (HIPPS, representing a Home Health Resource Group (HHRG) for HH PPS) group numbers. The APC will supplant the Ambulatory Surgical Center (ASC) group upon implementation of OPPS.

- 2-100.B-REF modified to allow service line reporting of the home health payment percentage, when effective. This segment applies to ASC and Home Health PPS, but does not apply to APC payments.

- 2-110.A-AMT modified to allow service line reporting of the allowed amount for APC and home health HIPPS payments.

- The standard provider level adjustment reason codes in Appendix B have been expanded to include the X12 835 code of BN (bonus) for the reporting of transitional OPPS payments. Make the same "pen and ink" change to the corresponding pages in the version 3030M and 3051.3A implementation guides. This is a claim level segment and will need to be reported in those versions. (Since those versions were established in obsolete software which is no longer supported, replacement pages cannot be attached to this instruction for those versions.)

o Treat the amount determined payable for an OPPS service, whether APC, AWP, etc., as the allowed amount for a service in version 3051.4A.01. The type of bill in CLP08 identifies whether a service is an outpatient hospital, CMHC, HHA or other category of intermediary processed claim. In multiple payment option situations, Medicare routinely uses the highest rate permitted by law to determine payment. A remittance advice does not typically identify which of the possible cost bases is being used for payment.

o Report services that do not have a related APC, and which are considered to be included in the payment for one or more other APCs, with Group Code CO and reason code 97 (payment included in the allowance for another service/procedure) in version 3051.4A.01. If a non-APC service on the same claim is denied for another reason, such as not reasonable or necessary (CO 50), report the specific reason code that applies to that denial rather than CO 97.

o Use the 835 version 3051.4A.01 bundling methodology to report APC payment when multiple HCPCS are included in a single APC. When bundling services into an APC grouping, report service line information back to a provider in the same way as billed, so the provider may automatically identify the services involved and post payment information to patient accounts.

o Report each procedure billed in a version 3051.4A.01 remittance advice, even if bundled for payment into a single APC. However, report the payment for all of the services in a single APC on the line for the first listed service in that APC. Since the payment for the entire APC will be higher than for that procedure code alone, you must enter group code OA (other adjustment) and reason code 94 (processed in excess of charges) for the amount of the excess (difference between the billed amount for the service and the allowed rate for the APC) as a negative amount to enable the line and claim to balance. Report the remaining procedures for that APC on the following lines of the remittance advice with group code CO and reason code 97 (payment included in the allowance for another service/procedure) for each. Repeat the process if there are multiple APCs for the same claim.

3752.3 PC-Print Software.--The FISS maintainer must make changes to the PC-Print software to correspond to these changes to Medicare's version 3051.4A.01 835 implementation guide and to the Medicare SPR. The maintainer must make the revised PC-Print software available to all intermediaries at the same time as the OPPS system release. You must then internally test the software and share it with those providers who will use version 3051.4A.01 of the 835.

3752.4 Instructions for Versions Subsequent to Electronic 835 Version 3051.4A.01.--Unless new specific instructions are released in either new manual instructions or a program memorandum, apply the steps in the three subsection above to future versions of the 835 subsequent to Version 3051.4A.01.

3753. HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS) REMITTANCE ADVICE INSTRUCTIONS

3753.1 Scope of Remittance Changes for HH PPS.--Section 3752 of the Fiscal Intermediary Manual contains instructions for HCFA use of the ANSI ASC X12 835 (835) electronic remittance advice for the implementation of the outpatient prospective payment system (OPPS), and lays the foundation for changes in the remittance format necessitated by HH PPS. Additional HH PPS changes in specific versions of the electronic remittance format are presented in the next few subsections of this manual, and are additions to current requirements for the OPPS remittance. However, HCFA will not make additional paper remittance format changes, 835 version 3051.4A.01 implementation guide changes, or PC-Print changes for HH PPS.

All the statements below on home health billing apply only to type of bills 32x, or what was submitted prior to HH PPS on both 32x and 33x claims. Type of bill is reported on form locator 4 on the Form HCFA-1450 (UB-92) claim form.

As with OPPS, detailed service line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data isl not reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported by the Fiscal Intermediary Standard System (FISS). The standard paper remittance advice (SPR), and the FISS version 3051.3A and 3030M 835 transactions continue to report claim level summary data. Home health agencies on FISS that wish to receive service line level data must upgrade to version 3051.4A.01 of the 835. Parallel changes have been made to the Arkansas Part A Standard System to support electronic transmission.

3753.2 Payment Methodology of the HH PPS Remittance: HIPPS Codes.--HH PPS episode payment is represented by a Health Insurance Prospective Payment System (HIPPS) code on a claim or a Request for Anticipated Payment (RAP). As a general rule, the amount of the first payment for a 60-day HH PPS episode, made in response to a RAP submitted on a claim form and processed like a claim, will be reversed and withheld from the full payment made for the episode, in response to a claim, at the end of the 60 days. Episodes of 4 or fewer visits will be paid using standard per visit rates, rather than under HH PPS methodology.

Due to the expansion of the claim in 2000, two HIPPS can appear on a single line item. This new feature is used for HH PPS when, during processing, Medicare finds payment should have been made on a HIPPS other than the one submitted by the provider. In such cases, payment is made on the HIPPS for the line item not previous submitted (the corrected HIPPS). Standard systems carry the corrected HIPPS in the panel code field of the line item. As noted below, the remittance carries both the submitted and paid HIPPS.

3753.3 Durable Medical Equipment (DME) and Other Items Not Included in HH PPS Episode Payment.--By law, DME is not included in payment of home health PPS episodes, though episodes are global payment for most other home health services and items. DME must be reported in a separate line/loop for the claim closing an episode. DME may not be included in the Request for Anticipated Payment (RAP) for an episode. DME will continue to be paid under the DME fee schedule as at present. Continue to pay osteoporosis drug, flu injection, vaccines or outpatient benefits delivered by home health agencies, such as splints or casts, separately from home health PPS as 34x type of bill claims.

3753.4 835 Version 3051.4A.01 Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode.--

1. Enter HC (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SVC01-02. The HIPPS code is being treated as a type of level 3 HCPCS in this version.

2. Enter 0 (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount you are paying in SVC03.

3. Enter 0023 (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service-- this number should be 1, representing the same date used as the from and through date on the RAP.

5. If the HIPPS has been down coded or otherwise changed during adjudication, enter the billed HIPPS in 2-070-SVC06-02 with qualifier HC in 2-070-SVC06-01.

6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than 0023 is billed, report the line item date associated with that revenue code instead of the claim from date. The only line item receiving Medicare payment on RAP should be the single 0023 revenue code line.

7. Enter group code OA (other adjustment), reason code 94 (processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. Report the difference as a negative amount.

8. Enter 1S (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.

9. Enter RB (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.

10. 2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode.

11. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when 4 or fewer visits) rather than on the HIPPS.

12. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial percentage episode payments.

3753.5 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (More than 4 Visits).--

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in §3753.4, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

2. Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

3. The full payment for the episode can now be reported for the end of episode bill.

a. Repeat steps 1-11 from §3753.4 for the service as a reprocessed bill. Report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.

b. In addition to the HIPPS code service loop, also enter the actual individual HCPCS for the services furnished. Include a separate loop for each service. Revenue code 27x, 623, 27x and 62x services may not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

c. Report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero rate if denying the service) in step 9.

d. Report group code CO, reason code 97 (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCSs in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Do not report any allowed amount in 2-110.A-AMT for these lines. Do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

e. Enter the appropriate appeal or other line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME is paid, report in a separate loop(s), and enter the allowed amount for the DME in 2-110.A-AMT.

4. If Pricer determines that a cost outlier is payable for the claim, enter ZZ (outlier amount) in 2-062-AMT01 and the amount of the outlier in AMT02.

NOTE: Since this is a claim level segment, this must also be reported in 835 versions 3030M and 3051.3A.

5. If insufficient funds are due the provider to satisfy the withholding created in step 2 above, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

3753.6 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (4 or fewer Visits).--

1. Follow §3753.5 steps 1-2.

2. Now that the first payment has been reversed, pay and report the claim on a per visit basis rather than on a prospective basis. Enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.

3. Report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. Enter B6 in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. Report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. Enter the appropriate appeal or other line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in §3753.5 step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance

Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

3753.7 Instructions for Versions Subsequent to Electronic 835 Version 3051.4A.01.--Unless new specific instructions are released in either new manual instructions or a Program Memorandum, apply the steps in the three subsection above to future versions of the 835 subsequent to Version 3051.4A.01.

These exhibits are mentioned in reference to the OPPS Remittance Advice (see §3752).

Exhibit 1

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER/ PART A PAID DATE: MM/DD/CCYY REMIT#: 1234567890
PAGE 1
NAME

PATIENT NAME HIC# FROM DT THRU DT CLM STATUS	PATIENT CNTRL# ICN NACHG HICHG TO RC COST COVDY NCOVDY	RC REM RC REM REM PROF RC REM	DRG# OUTCD CAPCD COMP DRG AMT	DRG OUT AMT MSP PAYMT DEDUCTIBLES	COINSURANCE COVD CHGS NCOVD CHGS DENIED CHGS	PAT REFUND ESRD NET ADJ INTEREST	CONTRACT ADJ PER DIEM RTE PROC CD AMT NET REIMB
123456789012345678 1 1 1234567890123456789 12345678 12345678 12	12345678901234567890 12345678901234567890 12 1 123 1234 1234 1234	123 1234 123 1234 123 1234 123 1234	123 1 1 1234567.89 1234567.89	1234567.89 1234567.89 1234567.89	1234567.89 1234567.89 1234567.89 1234567.89	1234567.89 1234567.89 1234567.89	1234567.89 1234567.89 1234567.89 1234567.89
SUBTOTAL FISCAL YEAR 12345 12345 12345	MMCCYY 12345678.90	 12345678.90 12345678.90	 12345678.90 12345678.90	12345678.90 12345678.90 12345678.90 12345678.90	12345678.90 12345678.90 12345678.90 12345678.90	12345678.90 12345678.90 12345678.90	12345678.90 12345678.90 12345678.90
SUBTOTAL PART A 	 123456 123456 123456	 	 123456789.01 123456789.01	123456789.01 123456789.01 123456789.01 123456789.01	123456789.01 123456789.01 123456789.01 123456789.01	123456789.01 123456789.01 123456789.01	123456789.01 123456789.01 123456789.01 123456789.01

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER / PART B PAID DATE: MM/DD/CCYY REMIT#: 1234567890
PAGE 2
NAME

PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
HIC#	ICN	RC	REM	OUTCD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TO RC	REM	PROF	COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS		NET REIMB
123456789012345678 1 1	12345678901234567890	123	1234	123	1234567.89	1234567.89	1234567.89	1234567.89
123456789012345789	12345678901234567890	123	1234	1 1		1234567.89	1234567.89	1234567.89
12345678 12345678	12 1 123	123	1234	1234567.89	1234567.89	1234567.89	1234567.89	1234567.89
12	1234 1234 1234	123	1234	1234567.89	1234567.89	1234567.89		1234567.89
SUBTOTAL FISCAL YEAR	MMCCYY				12345678.90	12345678.90	12345678.90	12345678.90
					12345678.90	12345678.90	12345678.90	12345678.90
				12345678.90	12345678.90	12345678.90	12345678.90	12345678.90
	12345 12345 12345			12345678.90	12345678.90	12345678.90		12345678.90
SUBTOTAL PART B					123456789.01	123456789.01	123456789.01	123456789.01
					123456789.01	123456789.01	123456789.01	123456789.01
				123456789.01	123456789.01	123456789.01	123456789.01	123456789.01
	123456 123456 123456			123456789.01	123456789.01	123456789.01		123456789.01

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER
PROVIDER NUMBER / NAME PAID DATE: MM/DD/CCYY REMIT#: 1234567890

SUMMARY

CLAIM DATA:

DAYS:
- COST: 1234567
- COVDY: 1234567
- NCOVDY: 1234567

CHARGES:
- COVD: 12,345,678.90
- NCOVD: 12,345,678.90
- DENIED: 12,345,678.90

PROF COMP: 12,345,678.90
MSP PAYMT: 12,345,678.90
DEDUCTIBLES: 12,345,678.90
COINSURANCE: 12,345,678.90
PAT REFUND: 12,345,678.90

INTEREST: 12,345,678.90
CONTRACT ADJ: 12,345,678.90
PROC CD AMT: 12,345,678.90
NET REIMB: 12,345,678.90

PASS THRU AMOUNTS:
- CAPITAL: 123,456,789.01
- RETURN ON EQUITY: 123,456,789.01
- DIRECT MEDICAL EDUCATION: 123,456,789.01
- KIDNEY ACQUISITION: 123,456,789.01
- BAD DEBT: 123,456,789.01
- NON-PHYSICIAN ANESTHETISTS: 123,456,789.01
- TOTAL PASS THRU: 123,456,789.01

HEMOPHILIA ADD ON: 123,456,789.01
PIP PAYMENT: 123,456,789.01
SETTLEMENT PAYMENTS: 123,456,789.01
ACCELERATED PAYMENTS: 123,456,789.01
REFUNDS: 123,456,789.01
PENALTY RELEASE: 123,456,789.01
TRANS OUTP PYMT: 123,456,789.01

WITHHOLD FROM PAYMENTS:
- CLAIM ACCOUNTS RECEIVABLE: 123,456,789.01
- ACCELERATED PAYMENTS: 123,456,789.01
- PENALTY: 123,456,789.01
- SETTLEMENT: 123,456,789.01
- TOTAL WITHHOLD 123,456,789.01

PROVIDER PAYMENT RECAP:

PAYMENTS:
- DRG OUT AMT: 123,456,789.01
- INTEREST: 123,456,789.01
- PROC CD AMT: 123,456,789.01
- NET REIMB: 123,456,789.01
- TOTAL PASS THRU: 123,456,789.01
- PIP PAYMENTS: 123,456,789.01
- SETTLEMENT PYMTS: 123,456,789.01
- ACCELERATED PYMTS: 123,456,789.01
- REFUNDS: 123,456,789.01
- PENALTY RELEASE: 123,456,789.01
- TRANS OUTP PYMT: 123,456,789.01
- HEMOPHILIA ADD ON: 123,456,789.01

WITHHOLD: 123,456,789.01

NET PROVIDER PAYMENT: 123,456,789.01
(PAYMENTS MINUS WITHHOLD)

CHECK / EFT NUMBER: 1234567890

2000 VERSION

Changes in SPR 2000 Version from the Prior Version

1. Reference to HCPCS changed to procedure code as other code sets such as the national drug code (NDC) may begin to be used in addition to HCPCS in the future.
2. Separate SPR reporting of the DRG operating amount and the DRG capital amount stopped. A combined operating and capital amount will now be reported on the SPR to correspond to 835 reporting.
3. A summary data element has been added for the transitional outpatient payment, a quarterly provider payment that will be issued as warranted to supplement line item payments for services paid under OPPS.
4. Date fields have been expanded to enable reporting of the century.

Exhibit 2

MEDICARE STANDARD PAPER REMITTANCE (SPR) ADVICE DATA DIRECTORY AND 835 MAP

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Intermediary name/ address/city/state/ zip/phone number	as written	AN 132 characters	Name=1-080.A-N102 Other data elements (DE) are fiscal intermediary (FI) generated.
Provider number	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Determined by bill e.c type in 2-005-TS302
Literal Value: Part B	as written	AN 06	
Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	N 9(l 0)	Fl generated.
Literal Value: Page	as written	AN 06	Fl generated.
Pages 1&2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103
Patient First Name		AN 01	2-030.A-NM104
Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIC#	AN 19	2-030.A-NM109
Statement covers period--start	FROM DT	N MMDDCCYY	2-050.A-DTM02
Statement covers period--end	THRU DT	N MMDDCCYY	2-050.B-DTM02
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	ICN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if 74
HIC change	HICHG	AN 01	2-030.A-NM108 if C

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/ visits	COVDY	N S9(3)	2-064-QTY02 when CA in prior DE
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when NA in prior DE
Reason code (4 occurrences)	RC	AN 05	2-020-CAS02, 05,08 and 11
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA -05, 20, 21, 22 Outpatient: 2-035-MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP1 1
Outlier code	OUTCD	AN 02	2-062-AMT01 if ZZ
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when 89 in prior DE
DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT	AMT N S9(7).99	2-062-AMT02 when ZZ in prior DE
MSP primary amount	MSP PAYMT	N S9(7).99	2-062-AMT02 when NJ in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when and/ or 66 in prior DE
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when 2 in prior DE
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when AU in prior DE
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when AU in prior DE
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18
Patient refund	PAT REFUND	N S9(7).99	2-020 or 2-amount 090-CAS 03, 06, 09, 12, 15 or 18 when 100 in prior DE
Claim ESRD	ESRD NET ADJ	N S9(7).99	2-020 or 2-reduction 090-CAS 03, 06, 09, 12, 15 or 18 when 118 in prior DE
Interest	INTEREST	N S9(6).99	2-060-AMT02 when in prior DE
Contractual	CONTRACT ADJ	N S9(7).99	Total of 2-020 adjustment or 2-090 CAS03, 06, 09, 12, 15 and 17 when CO in CASOI
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when DY in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04

Page 3

Claim Data			
Cost report days	DAYS COST	N S9(3)	Total of claim level SPR COST.
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY.
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY.
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS.
Noncovered charges	CHARGES NCOVD	N S9(7).99	Total of claim level SPR NCOVD CHGS.
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS.
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP.
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount level SPR MSP PAYMT.
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES.
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE.

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND.
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST.
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT.
Claim payment amount	NET REIMB	N S9(7).99	Total of claim level SPR NET REIMB.
Summary Data Pass Thru Amounts			3-010-PLB04, 06, 08 or 10 when:
Capital pass thru	CAPITAL	N S9(7).99	... CP in prior DE
Return on equity	as written	N S9(7).99	...RE in prior DE
Direct medical education	as written	N S9(7).99	... DM in prior DE
Kidney acquisition	as written	N S9(7).99	...KA in prior DE
Bad debt	as written	N S9(7).99	...BD in prior DE
Non-physician anaesthetists	as written	N S9(7).99	...CR in prior DE
Hemophilia add on	as written	N S9(7).99	... ZZ in prior DE
Total pass thru	as written	N S9(7).99	Total of the above pass thru amounts.
Non-Pass Thru Amounts			3-010-PLB04, 06, 08 or 10 when:
PIP payment	as written	N S9(7).99	... PP in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Settlement amounts	SETTLEMENT PAYMENTS	N S9(7).99	... FP in prior DE
Accelerated payments	as written	N S9(7).99	... AP in prior DE
Refunds	as written	N S9(7).99	...RF in prior DE
Penalty release	as written	N S9(7).99	...RS in prior DE
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	... IR in prior DE
Withhold from Payment			3-010-PLB04, 06, 08 or 10 when:
Claims accounts receivable	as written	N S9(7).99	... AA in prior DE
Accelerated payments	as written	N S9(7).99	...AW in prior DE
Penalty	as written	N S9(7).99	...PW in prior DE
Settlement	as written	N S9(7).99	... OR in prior DE
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts.
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	AN 10	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

Exhibit 3

Medicare A 835 Health Care Claim Payment/Advice 2-062-**AMT**

AMT02	**0782**	Monetary Amount	
R 1	15 M	**Total Covered Charges**	**AU=43-10**
		Per Diem Amount (Inpatient and Partial Hospitalization Only)	**DY=22-09**
		Patient Paid Amount	**F5=23-04**
		Interest Amount	**I=40-03**
		MSP Liability Amount Met	**NJ=42-11**
		Negative Reimbursement	**NL=22-08**
		Hemophilia Add-on Amount	**ZK=22-10**
		Outlier Amount	**ZZ=42-04**
AMT03	0478	Credit/Debit Flag Code	
		Not Used	

X12 Segment Name: **REF** Reference Numbers
Name: **ASC, APC or HIPPS Group Number**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To provide the Ambulatory Surgical Center (ASC), Ambulatory Patient Code (APC), or the Health Insurance Prospective Payment System (HIPPS) code assigned to this service.**
Usage: **Conditional**
Example: **REF*1S*1~**
Comments: **The ASC and APC numbers are generated by the Medicare PRICER program. The HIPPS number is submitted on the claim. The applicable number must be reported for a Medicare service paid under the ASC, outpatient PPS or a home health PPS payment methodology.**

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element	Attributes		Data Element Usage	**Flat File Map**
REF01	0128		Reference Number Qualifier	Translator
ID 2	3 M		Code qualifying the Reference number Codes: **1S Ambulatory Patient Group (APG) Number**	Generated (TG)
REF02	0127		Reference Number	**30-15 ASC**
AN 1	30 M		Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. **ASC, APC or home health HIPPS Number**	FISS to furnish APC & HH HIPPS # maps
REF03	0352		Description **Not Used**	

X12 Segment Name: **REF** Reference Numbers

Name: **ASC or HIPPS Rate (percent)**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To convey the ASC or the Health Insurance Prospective Payment System (HIPPS) percentage rate.**
Usage: **Conditional**
Example: **Ref*RB*100~**
Comments: **This segment must be sent for Medicare ASC and home health HIPPS claims.**

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element Attributes		Data Element Usage	Flat File Map
REF01 ID 2	0128 3 M	Reference Number Qualifier Code qualifying the Reference number Codes: **RB Rate Code Number**	Translator Generated (TG)
REF02 AN 1	0127 30 M	Reference Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. **ASC or home health HIPPS Rate (percent)** ASC Codes: HIPPS Codes: **0 Zero percent** **0 Zero percent** **50 50 percent** **50 50 percent** **100 100 percent** **60 60 percent** **150 150 percent** **100 100 percent**	**30-16 ASC** FISS to furnish HIPPS rate map
REF03	0352	Description **Not Used**	

X12 Segment Name: **AMT** Monetary Amount

Name: **ASC, APC or HIPPS Priced Amount**
Loop: SVC
Max. Use: 1
X12 Purpose: To indicate the total monetary amount.
Purpose: **To convey the ASC, APC, or HIPPS priced amount (the allowed amount) generated by PRICER.**
Usage: **Conditional**
Example: **AMT*B6*467~**
Comments: **This segment must be sent on Medicare ASC and APC remittances, and on remittances for home health HIPPS sent at the end of a 60-day benefit period. (Do not report for the payment at the beginning of a home health HIPPS 60-day benefit period.)**

Element Attributes		Data Element Usage	**Flat File Map**
AMT01 ID 1	0522 2 M	Amount Qualifier Code Code to qualify amount: Codes: **B6 Allowed Amount - Actual Amount**	Translator Generated (TG)
AMT02 R 1	0782 15 M	Monetary Amount **ASC, APC or home health HIPPS priced amount**	**30-17 APC** (when entries in 30-15 and 30-16) FISS to furnish the
AMT03	0478	Credit/Debit Flag Code **Not Used**	

STANDARD PROVIDER LEVEL ADJUSTMENT (PLB) REASON CODES

The PLB segment carries provider level financial adjustment data which is not related to the adjustment data for the claims addressed in a specific 835 transaction. As with the CAS financial adjustment segments, positive numbers in monetary amount elements have a negative arithmetic value in the balancing routines, while negative numbers have a positive arithmetic value in the balancing routines.

PLB Code Value	Message
AA	Receivable today
AW	Accelerated payment withholding
AP	Accelerated payment amount
BD	Bad debt pass-thru amount
BF	Balance forward; a negative balance to be carrier forward and applied in a subsequent billing cycle.
BN	Bonus; usedto report a Medicare Transitional Outpatient PPS Payment.
CA	Manual claims adjustment; approved claims payments calculated outside normal processing.
CO	Carryover; a negative balance amount which has been carried forward from a previous billing cycle and applied in the current billing cycle.
CP	Capital pass-thru amount
CR	Nurse anesthetist pass-thru amount (CRNA)
CW	Claim withholding
CX	Total cancel claim amount
DM	Direct medical education pass-thru amount
DS	Disproportionate share amount
FS	Final settlement amount (cost report)
GM	Graduate medical education pass-thru amount
IM	Indirect medical education pass-thru amount
IN	Interest paid

IP	Interest assessed on late-filed cost reports and/or delinquent refunds
IR	Interim rate lump sum adjustment
KA	Organ acquisition pass-thru amount
LR	Late cost report penalty amount
NP	Non-physician pass-thru amount
OA	Part A offset for affiliated provider
OB	Part B offset for affiliated provider

PLB Code Value	Message
OR	Overpayment recovery; overpayment amount not fully satisfied in prior cycles.
OS	Outside recovery; money withheld for external organizations, e.g., IRS
PA	Adjustment for claims paid after PIP effective date. (This amount must be multiplied by negative 1 [-1].)
PL	PIP lump sum adjustment
PO	Other pass-thru amount
PP	PIP payment
PR	Provider refund adjustment (To be used for credit balance reconciliation.)
PS	Pass-thru lump sum adjustment
PW	Penalty withholding
RA	Check received from the provider for credit balancing for Part A amounts due.
RB	Check received from the provider for credit balancing for Part B amounts due.
RE	Return on equity
RF	Refunds
RI	Reissued check amount
RS	Penalty release amount
SW	Penalty withhold amount
TR	Retroactive adjustment (cost report)
TS	Tentative settlement (cost report)