

Chapter 12

Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

Revision:

Due to the size of [Figure 12.P-1](#), please go to the next page.

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-1 REQUEST FOR ANTICIPATED PAYMENT (RAP) - NON-TRANSFER SITUATION

1 Your Agency Name		2		3a PAT CNTL #		3b MED REC #		3c VLR DR #	
Address								322	
City		ST Zip		5 FED. TAX NO		6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
						10012000		10012000	
8 PATIENT NAME a Doe Jane M				9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000					
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE	
03151920		F		10012000		1		30	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE		35 OCCURRENCE SPAN FROM THROUGH	
36 CODE		37 OCCURRENCE SPAN FROM THROUGH		38 CODE		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
						61 1900 00			
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV DATE		46 SERV UNITS	
0023 0001		HH Services		HAEJ1		10012000		47 TOTAL CHANGES 0 00	
								48 NON-COVERED CHANGES 0 00	
PAGE		OF		CREATION DATE		TOTALS			
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
A Medicare		167999		Y				55 EST. AMOUNT DUE	
58 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
A Doe, Jane M				123456789A					
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME	
A 200010012000093001									
66		67		68		69		70	
1629									
71 PPS CODE		72 ECI		73		74 ATTENDING NPI		75	
						A12345			
76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		80	
LAST Green		LAST		LAST		LAST		FIRST Mark	
QUAL		QUAL		QUAL		QUAL		QUAL	
FIRST		FIRST		FIRST		FIRST		FIRST	
81 CD		82		83		84		85	
a		b		c		d		e	
86 REMARKS		87		88		89		90	
APPROVED OMB NO.		NURC		THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.					

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FIGURE 12.P-2 RAP - NON-TRANSFER SITUATION WITH LINE ITEM SERVICE ADDED

[illegible]

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FIGURE 12.P-3 RAP - TRANSFER SITUATION

Note: Source of Admission [Form Locator (FL) 15] is a B, which indicates that this beneficiary transferred to your HHA from another HHA.

1 Your Agency Name Address City ST Zip		2		3a PAT. CNTL. #		3b MED. REC. #		3c TYPE OF BILL 322	
4 PATIENT NAME a Doe Jane M		5 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000		6 STATEMENT FROM 10162000		7 COVERS PERIOD THROUGH 10162000		8	
9 BIRTHDATE 03151920		10 SEX F		11 DATE OF ADMISSION 10162000		12 TYPE B		13 SRC 30	
14 DRG 03151920		15 STAT B		16 DRG 30		17		18	
19 OCCURRENCE CODE 0023		20 DATE 0001		21		22		23	
24		25		26		27		28	
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624		625		626		627		628	
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834		835		836		837		838	
839		840		841		842		843	
844		845		846		847		848	
849		850		851		852		853	
854		855		856		857		858	
859		860		861		862		863	
864		865		866		867		868	
869		870		871		872		873	
874		875		876		877		878	
879		880		881		882		883	
884		885		886		887		888	
889		890		891		892		893	

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FIGURE 12.P-4 RAP - DISCHARGE/RE-ADMIT

Source of Admission (FL 15) is a C, which indicates that this beneficiary was discharged from your HHA, but was readmitted within the same 60-day episode.

1 Your Agency Name Address City ST Zip										2 3a PAY CNTL # b. MED REC # 5 FED. TAX NO										6 STATEMENT COVERS PERIOD FROM 10162000 THROUGH 10162000										7 8 TYPE OF SERVICE 3X2																																																																															
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000										c										d										e																																																																					
10 BIRTHDATE 03151920										11 SEX F										12 DATE OF ADMISSION 10162000										13 HR										14 TYPE C										15 SRC 30										16 DRG										17 STAT										18 19 20 21										22 23 24 25 26 27 28										29 ACDT 39 STATE									
31 OCCURRENCE DATE										32 OCCURRENCE CODE										33 OCCURRENCE DATE										34 OCCURRENCE CODE										35 OCCURRENCE DATE										36 OCCURRENCE CODE										37 OCCURRENCE DATE										38 OCCURRENCE CODE										39 OCCURRENCE DATE										40 OCCURRENCE CODE																			
38										41 CODE										42 VALUE CODES AMOUNT										43 CODE										44 VALUE CODES AMOUNT										45 CODE										46 VALUE CODES AMOUNT										47 CODE										48 VALUE CODES AMOUNT																													
43 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHANGES										48 NON-COVERED CHANGES										49																																							
1 0023										HH Services										HAEJ1										10162000																				0.00										0.00																																																	
2 0001																																																																																																													
23										PAGE ____ OF ____										CREATION DATE										TOTALS																																																																															
50 PAYER										51 HEALTH PLAN ID										52 REL INFO										53 ASSO BEN										54 PRIOR PAYMENTS										55 EST. AMOUNT DUE										56 NPI																																																	
A Medicare										167999										Y																																																																																									
58 INSURED'S NAME										59 PREL										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																					
A Doe, Jane M																				123456789A																																																																																									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																																									
A 200010162000101401																																																																																																													
66 EX 1629																																																																																																													
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI										73																																																																					
74 PRINCIPAL PROCEDURE CODE										75 OTHER PROCEDURE CODE										76 ATTENDING NPI										A12345										QUAL																																																																					
77 OPERATING NPI										78 OTHER NPI										79 OTHER NPI										QUAL																																																																															
79 OTHER NPI										79 OTHER NPI										QUAL																																																																																									
80 REMARKS										81CQ a										b										c										d																																																																					
UB-04 CMS-1450										APPROVED OMB NO.										NUBC National Uniform Billing Committee LIC9213257										THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF																																																																															

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FIGURE 12.P-5 RAP - CANCELLATION

Note: The Type of Bill (TOB) changes to end in an 8, a Claim Change Reason Code (e.g., D5) is included, and the RHHI's Internal Control Number (ICN) that identified the original RAP is included.

1 Your Agency Name Address City ST Zip		2		3a PAT. CNTRL. # b. MED. REC. #		4 TYPE OF BILL 328	
5 FED. TAX NO.		6 STATEMENT FROM 10012000		7 COVERS PERIOD THROUGH 10012000			
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000					
b		c		d		e	
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000		13 ADMISSION 13 HR 14 TYPE 15 SRC C	
16 DRG 30		17 STAT D5		18		19	
20		21		22		23	
24		25		26		27	
28		29		30		31	
32		33		34		35	
36		37		38		39	
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812		813		814		815	
816		817		818		819	
820		821		822		823	
824		825		826		827	
828		829		830		831	
832		833		834		835	
836		837		838		839	
840		841		842		843	
844		845		846		847	
848		849		850		851	
852		853		854		855	
856		857		858		859	
860		861		862		863	
864		865		866		867	
868		869		87			

Chapter 12, Addendum P

FIGURE 12.P-6 CLAIM - NON-TRANSFER SITUATION

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Billing Committee LIC9213257

Chapter 12, Addendum P

FIGURE 12.P-7 CLAIM - TRANSFER SITUATION - BENEFICIARY TRANSFERS TO YOUR HHA

Your Agency Name										3a PAT CNTL # b. MED REC #		c. TYPE OF RES 329							
Address																			
City ST Zip										5 FED. TAX NO		6 STATEMENT FROM THROUGH COVERS PERIOD THROUGH 10012000 11292000							
8 PATIENT NAME a Doe Jane M					9 PATIENT ADDRESS a 123 Main Street b Anywhere c SI d 50000 e														
10 BIRTHDATE b 03151920		11 SEX F		12 DATE 10012000		ADMISSION 13 HR 14 TYPE 15 SPC B		16 DRG 30		17 STAT 30		CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 29 ACCT 39 STATE							
31 OCCURRENCE DATE CODE		32 OCCURRENCE DATE CODE		33 OCCURRENCE DATE CODE		34 OCCURRENCE DATE CODE		35 OCCURRENCE SPAN FROM THRU		36 OCCURRENCE SPAN FROM THRU		37							
38										41 VALUE CODES AMOUNT a 61 1900 00 b c d		42 VALUE CODES AMOUNT e f g h							
42 REV CD		43 DESCRIPTION				44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHANGES		49			
1	0023	HH Services				HAEJ1		10012000				0 00							
2	0550	Skilled Nurse Visit				G0154		10012000		2		150 00							
3	0570	HH Aide				G0156		10012000		3		75 00							
4	0550	Skilled Nurse Visit				G0154		10102000		2		150 00							
5	0570	HH Aide				G0156		10102000		2		75 00							
6	0420	Physical Therapy				G0151		10152000		3		200 00							
7	0550	Skilled Nurse Visit				G0154		10202000		2		150 00							
8	0570	HH Aide				G0156		10202000		2		75 00							
9	0420	Physical Therapy				G0151		10252000		3		200 00							
10	0550	Skilled Nurse Visit				G0154		10302000		2		150 00							
11	0570	HH Aide				G0156		10302000		2		75 00							
12	0420	Physical Therapy				G0151		11042000		3		200 00							
13	0550	Skilled Nurse Visit				G0154		11102000		1		150 00							
14	0570	HH Aide				G0156		11102000		2		75 00							
15	0420	Physical Therapy				G0151		11142000		3		200 00							
16	0550	Skilled Nurse Visit				G0154		11202000		2		150 00							
17	0570	HH Aide				G0156		11202000		3		75 00							
18	0420	Physical Therapy				G0151		11242000		3		200 00							
19	0550	Skilled Nurse Visit				G0154		11292000		2		150 00							
20	0570	HH Aide				G0156		11292000		2		75 00							
21	0270	Supplies								11		132 58							
22	0001									43		2707 58							
PAGE ____ OF ____										CREATION DATE		TOTALS							
50 PAYER Medicare				51 HEALTH PLAN ID 167999				52 REL INFO Y		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI			
58 INSURED'S NAME Doe, Jane M				59 PREL				60 INSURED'S UNIQUE ID 123456789A				61 GROUP NAME		62 INSURANCE GROUP NO.					
63 TREATMENT AUTHORIZATION CODES 200010012000093001						64 DOCUMENT CONTROL NUMBER						65 EMPLOYER NAME							
66 1629										68									
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73											
74 PRINCIPAL PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI A12345		QUAL			
														LAST Green		FIRST Mark			
77 OPERATING NPI				OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE				78 OTHER NPI		QUAL			
														LAST		FIRST			
79 OTHER NPI				OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE				80 REMARKS		QUAL			
														LAST		FIRST			
														81 OTHER NPI		QUAL			

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-8 CLAIM - SIGNIFICANT CHANGE IN CONDITION (SCIC) SITUATION

Note: Two HIPPS Codes appear on this claim due to a SCIC.

1 Your Agency Name Address City ST Zip		2		3a PAY CNTL # b. MED REC #		4 TYPE OF PPS 329	
5 FED TAX NO		6 STATEMENT FROM 10012000		7 COVERS PERIOD THROUGH 11292000		8	
9 PATIENT NAME a Doe Jane M				9 PATIENT ADDRESS a 123 Main Street Anywhere ST 30000			
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000		13	
14 TYPE 1		15 SRC 30		16 DRG		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		100		101	
102		103		104		105	
106		107		108		109	
110		111		112		113	
114		115		116		117	
118		119		120		121	
122		123		124		125	
126		127		128		129	
130		131		132		133	
134		135		136		137	
138		139		140		141	
142		143		144		145	
146		147		148		149	
150		151		152		153	
154		155		156		157	
158		159		160		161	
162		163		164		165	
166		167		168		169	
170		171		172		173	
174		175		176		177	
178		179		180		181	
182		183		184		185	
186		187		188		189	
190		191		192		193	
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222		223		224		225	
226		227		228		229	
230		231		232		233	
234		235		236		237	
238		239		240		241	
242		243		244		245	
246		247		248		249	
250		251		252		253	
254		255		256		257	
258		259		260		261	
262		263		264		265	
266		267		268		269	
270		271		272		273	
274		275		276		277	
278		279		280		281	
282		283		284		285	
286		287		288		289	
290		291		292		293	
294		295		296		297	
298		299		300		301	
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306		307		308		309	
310		311		312		313	
314		315		316		317	
318		319		320		321	
322		323		324		325	
326		327		328		329	
330		331		332		333	
334		335		336		337	
338		339		340		341	
342		343		344		345	
346		347		348		349	
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458		459		460		461	
462		463		464		465	
466		467		468		469	
470		471		472		473	
474		475		476		477	
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482		483		484		485	
486		487		488		489	
490		491		492		493	
494		495		496		497	
498		499		500		501	
502		503		504		505	
506		507		508		509	
510		511		512		513	
514		515		516		517	
518		519		520		521	
522		523		524		525	
526		527		528		529	
530		531		532		533	
534		535		536		537	
538		539		540		541	
542		543		544		545	
546		547		548		549	
550		551		552		553	
554		555		556		557	
558		559		560		561	
562		563		564		565	
566		567		568		569	
570		571		572		573	
574		575		576		577	
578		579		580		581	
582		583		584		585	
586		587		588		589	
590		591		592		593	
594		595		596		597	
598		599		600		601	
602		603		604		605	
606		607		608		609	
610		611		612		613	
614		615		616		617	
618		619		620		621	
622		623		624		625	
626		627		628		629	
630		631		632		633	
634		635		636		637	
638		639		640		641	
642		643		644		645	
646		647		648		649	
650		651		652		653	
654		655		656		657	
658		659		660		661	
662		663		664		665	
666		667		668		669	
670		671		672		673	
674		675		676		677	
678		679		680		681	
682		683		684		685	
686		687		688		689	
690		691		692		693	
694		695		696		697	
698		699		700		701	
702		703		704		705	
706		707		708		709	
710		711		712		713	
714		715		716		717	
718		719		720		721	
722		723		724		725	
726		727		728		729	
730		731		732		733	
734		735		736		737	
738		739		740		741	
742		743		744		745	
746		747		748		749	
750		751		752		753	
754		755		756		757	
758		759		760		761	
762		763		764		765	
766		767		768		769	
770		771		772		773	
774		775		776		777	
778		779		780		781	
782		783		784		785	
786		787		788		789	
790		791		792		793	
794		795		796		797	
798		799		800		801	
802		803		804		805	
806		807		808		809	
810		811		812		813	
814		815		816		817	
818		819		820		821	
822		823		824		825	
826		827		828		829	
830		831		832		833	
834		835		836		837	
838		839		840		841	
842		843		844		845	
846		847		848		849	
850		851		852		853	
854		855		856		857	
858		859		860		861	
862		863		864		865	
866		867		868		869	
870		871		872		873	
874		875		876			

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-9 CLAIM - NO-RAP-LOW UTILIZATION PAYMENT ADJUSTMENT (LUPA) CLAIM

In this example, the beneficiary transferred to another HHA. Your HHA provided two services and had not yet submitted the RAP when the beneficiary transferred; therefore, you have a No-RAP-LUPA Claim situation.

1 Your Agency Name Address City ST Zip										2										3a PAT. CNTL. # b. MED. REC. # 5 FED. TAX NO.										4 TYPE OF BILL 329																																																																																																																																																																																			
6 STATEMENT FROM 10012000										7 COVERS PERIOD THROUGH 10032000																																																																																																																																																																																																							
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000																																																																																																																																																																																																							
10 BIRTHDATE 03151920										11 SEX F										12 DATE 10012000										13 HR 1										14 TYPE 06										15 SRC										16 DRG										17 STAT										18										19										20										21										22										23										24										25										26										27										28										29 ACOT										30 STATE									
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE										35 CODE										OCCURRENCE SPAN FROM THROUGH										36 CODE										OCCURRENCE SPAN FROM THROUGH										37																																																																																																																																	
38										41 CODE										VALUE CODES AMOUNT										41 CODE										VALUE CODES AMOUNT										41 CODE										VALUE CODES AMOUNT																																																																																																																																																					
42 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																																																											
0023										HH Services										HAEJ1										10012000										2										01 00																																																																																																																																																															
0550										Skilled Nurse Visit										G0154										10012000										3										150 00																																																																																																																																																															
0570										HH Aide										G0156										10012000										3										75 00																																																																																																																																																															
0001																														5										225 00																																																																																																																																																																									
PAGE 1 OF 1										CREATION DATE										TOTALS																																																																																																																																																																																													
50 PAYER										51 HEALTH PLAN ID										52 REL INFO										53 ASG BEN										54 PRIOR PAYMENTS										55 EST. AMOUNT DUE										56 NPI										57 OTHER PRV ID																																																																																																																																											
A Medicare										167999										Y																																																																																																																																																																																													
58 INSURED'S NAME										59 PREL										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																																																																																																																																																																									
A Doe, Jane M																				123456789A																																																																																																																																																																																													
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																																																																																																																																													
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66 1629																																																																																																																																																																																																																	
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI										73																																																																																																																																																																									
74 PRINCIPAL PROCEDURE CODE										75 OTHER PROCEDURE CODE										76 ATTENDING NPI A12345										77 OPERATING NPI										78 OTHER NPI										79 OTHER NPI										80 REMARKS																																																																																																																																																					
LAST Green										FIRST Mark										LAST										FIRST										LAST										FIRST																																																																																																																																																															
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UB-04 CMS-1450

APPROVED OMB NO.

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-10 CLAIM ADJUSTMENT

The TOB changes to end in a 7, a Claim Change Reason Code (e.g., D9) is included, and the RHHI's ICN that identifies the original claim is included. Remarks are noted in FL 80 at the bottom of the claim.

1 Your Agency Name Address City ST Zip		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF CLAIM 327	
5 FED. TAX NO.		6 STATEMENT FROM 10012000		7 COVERS PERIOD THROUGH 11292000	
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000			
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000	
13 HR 1		14 TYPE 1		15 SRC 1	
16 DRG 30		17 STAT D9		18 19 20 21	
22 23 24		25 26 27 28		29 ACCT 39	
30 OCCURRENCE DATE 03151920		31 OCCURRENCE DATE 10012000		32 OCCURRENCE DATE 11292000	
33 OCCURRENCE DATE 11292000		34 OCCURRENCE DATE 11292000		35 OCCURRENCE DATE 11292000	
36 OCCURRENCE DATE 11292000		37 OCCURRENCE DATE 11292000		38 OCCURRENCE DATE 11292000	
39 OCCURRENCE DATE 11292000		40 OCCURRENCE DATE 11292000		41 OCCURRENCE DATE 11292000	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE	
45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
48 NON-COVERED CHARGES		49			
50 PAYER A Medicare		51 HEALTH PLAN ID 167999		52 REL. INFO Y	
53 ASG. BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	
56 NPI		57 OTHER PRV ID		58 INSURED'S NAME A Doe, Jane M	
59 PREL		60 INSURED'S UNIQUE ID 123456789A		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES A 200010012000093001		64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME		66		67	
68		69 ADMIT DK		70 PATIENT REASON DK	
71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 ATTENDING NPI A12345	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
80 REMARKS Adjusted line item date of service on last therapy visit - from 11/24 to 11/25/2000, and changed 15-minute increments from 3 to 4.		81 CC a		82	
83		84		85	
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89		90		91	
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95		96		97	
98		99		100	

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Chapter 12, Addendum P

Examples Of Claims Submission Under Home Health Agency Prospective Payment System (HHA PPS)

FIGURE 12.P-11 CLAIM - CANCELLATION

The TOB changes to end in an 8, a Claim Change Reason Code (e.g., D6) is included, and the RHHI's ICN that identified the original claim is included.

1 Your Agency Name Address City ST Zip										2										3a PAY CNTL # b MED REC #										3 TYPE OF PPS 328																																																	
5 FED. TAX NO										6 STATEMENT FROM 10012000										7 COVERS PERIOD THROUGH 11292000																																																											
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000																																																																					
10 BIRTHDATE 03151920										11 SEX F										12 DATE ADMISSION 10012000										13 HR 14 TYPE 15 SRC 16 DRG 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT 30																																																	
31 OCCURRENCE CODE 00										32 OCCURRENCE DATE 000000										33 OCCURRENCE CODE 00										34 OCCURRENCE DATE 000000										35 OCCURRENCE SPAN FROM THROUGH 000000 000000										36 OCCURRENCE SPAN FROM THROUGH 000000 000000										37																			
38										41 CODE 61										42 VALUE CODES AMOUNT 1900 00										43 CODE 00										44 VALUE CODES AMOUNT										45 CODE 00										46 VALUE CODES AMOUNT																			
42 REV CD										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49									
1 0023										HH Services										HAEJ1										10012000										2										0 00																				1									
2 0550										Skilled Nurse Visit										G0154										10012000										2										150 00																				2									
3 0570										HH Aide										G0156										10012000										3										75 00																				3									
4 0550										Skilled Nurse Visit										G0154										10102000										2										150 00																				4									
5 0570										HH Aide										G0156										10102000										2										75 00																				5									
6 0420										Physical Therapy										G0151										10152000										3										200 00																				6									
7 0550										Skilled Nurse Visit										G0154										10202000										2										150 00																				7									
8 0570										HH Aide										G0156										10202000										2										75 00																				8									
9 0420										Physical Therapy										G0151										10252000										3										200 00																				9									
10 0550										Skilled Nurse Visit										G0154										10302000										2										150 00																				10									
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