

Chapter 12

Addendum P

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

Revision: C-31, January 31, 2019

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

Chapter 12, Addendum P

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

NUBC[®] National Uniform
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FIGURE 12.P-2 RAP - NON-TRANSFER SITUATION WITH LINE ITEM SERVICE ADDED

[illegible]

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

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

FIGURE 12.P-3 RAP - TRANSFER SITUATION

Note: **Point of Origin** [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 STATE B		18	
19 OCCURRENCE CODE 0023		20 DATE 0001		21 OCCURRENCE CODE 0001		22 DATE 0001		23	
24		25		26		27		28	
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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	
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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	
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879		880		881		882		883	
884		885		886		887		888	
889		890		891					

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

Your Agency Name										3a PAY CNTL #		b MED REC #		5 TYPE OF BILL							
Address														3X2							
City										ST		Zip									
										5 FED. TAX NO		6 STATEMENT COVERS PERIOD		7							
												10162000		10162000							
8 PATIENT NAME										a		Doe Jane M									
9 PATIENT ADDRESS										a		123 Main Street		Anywhere ST SU000							
b										c		d		e							
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DRG		17 STAT		18 19 20 21		CONDITION CODES 22 23 24 25 26 27 28		29 ADJ STATE 30					
03151920		F		10162000		C		30													
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		42 CODE		VALUE CODES AMOUNT		43 CODE		VALUE CODES AMOUNT	
										a		61		1900 00							
										b											
										c											
										d											
43 PAY 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		10162000				0 00		0 00									
0001																					
PAGE ____ OF ____										CREATION DATE		TOTALS									
50 PAYER		51 HEALTH PLAN ID		52 REL INFO		53 ASG 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		67		68																	
66 1629																					
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73													
74 PRINCIPAL PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		A12345		QUAL							
										LAST		Green		FIRST							
										LAST				FIRST							
										77 OPERATING NPI				QUAL							
										LAST				FIRST							
										78 OTHER NPI				QUAL							
										LAST				FIRST							
										79 OTHER NPI				QUAL							
										LAST				FIRST							
80 REMARKS		BTCL a		b		c		d													

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

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

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																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
8 PATIENT NAME a Doe Jane M										9 PATIENT ADDRESS a 123 Main Street Anywhere ST 50000										5 FED. TAX NO										6 STATEMENT FROM 10012000										7 COVERS PERIOD THROUGH 10012000																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
10 BIRTHDATE 03151920										11 SEX F										12 DATE OF ADMISSION 10012000										13 TYPE C										14 DRG 30										15 STAT D5										16 CONDITION CODES										17										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																																																																																																																																																																																																																	
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42 REV CD 0023										43 DESCRIPTION HH Services										44 HCPCS / RATE / HIPPS CODE HAEJ1										45 SERV. DATE 10012000										46 SERV. UNITS										47 TOTAL CHARGES 0.00										48 NON-COVERED CHARGES 0.00										49																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
50 PAYER 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										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																																																																																																			
58 INSURED'S NAME Doe, Jane M										59 PREL. 60 INSURED'S UNIQUE ID 123456789A										61 GROUP NAME										62 INSURANCE GROUP NO.										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																																																																																																																																																																																													
63 TREATMENT AUTHORIZATION CODES 200010012000093001										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME										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																																																																																																																																																																																																																																					
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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-6 CLAIM - NON-TRANSFER SITUATION

1 Your Agency Name		2		3a PAT CNTL #		3b MED REC #		3c TYPE OF BILL	
Address		City ST Zip		5 FED. TAX NO		6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
						10012000		11292000	
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	
15 SRC		16 DRG		17 STAT		18		19	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM	
								THROUGH	
36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38		41 CODE		VALUE CODES AMOUNT	
						61		1900 00	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV DATE		46 SERV UNITS	
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	
23		PAGE 1 OF 1		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		56 NPI		57 OTHER PRV ID		58 INSURED'S NAME		59 PREL	
						Doe, Jane M		60 INSURED'S UNIQUE ID	
						123456789A		61 GROUP NAME	
								62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		67	
A 200010012000093001						1629		68	
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	
				LAST		Green		FIRST	
				LAST		Mark		FIRST	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL		QUAL	
80 REMARKS		B1CC		LAST		FIRST		QUAL	
		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.

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

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

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

Note: Point of Origin (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		3a PAT CNTRL # 3b MED REC #		4 TYPE OF BILL 329	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 11292000		7	
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		14 TYPE B		15 SRC 30	
16 DRG		17 STAT		18 19 20 21	
22 23 24 25 26 27 28 29 ACCT STATE		30			
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE	
34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE CODE DATE	
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TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

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		2		3a PAT CNTL #		3b MED REC #		3c TYPE OF PPS	
Address		City ST Zip		5 FED TAX NO		6 STATEMENT FROM		7 COVERS PERIOD THROUGH	
8 PATIENT NAME a Doe Jane M		9 PATIENT ADDRESS a 123 Main Street		Anywhere ST		10012000		11292000	
10 BIRTHDATE 03151920		11 SEX F		12 DATE 10012000		13 HR 1		14 TYPE 30	
15 SRC		16 DRG		17 STAT		18		19	
20		21		22		23		24	
25		26		27		28		29 ACOT 39	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38		39	
40		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT		43		44	
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TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

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																																																																																																																																																																																																							
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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																																																																																																																																	
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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.

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015

Chapter 12, Addendum P

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	
86		87		88	
89		90		91	
92		93		94	
95		96		97	
98		99		100	

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Chapter 12, Addendum P

FIGURE 12.P-11 CLAIM - CANCELLATION

Your Agency Name										3a PAY CNTL #		4 TYPE OF PROC																																					
Address										b. MED REC #		328																																					
City ST Zip										5 FED. TAX NO		6 STATEMENT FROM																																					
										10012000		COVERS PERIOD THROUGH 11292000																																					
8 PATIENT NAME a Doe Jane M					9 PATIENT ADDRESS a 123 Main Street																																												
					Anywhere					ST 50000																																							
b																																																	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DRG		17 STAT		CONDITION CODES		18 19 20 21 22 23 24 25 26 27 28		29 ACCT 39																																	
03151920		F		10012000				1		30		D6																																					
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 CODE		OCCURRENCE DATE		34 CODE		OCCURRENCE SPAN FROM		THROUGH		36 CODE		OCCURRENCE SPAN FROM																																	
										2002332340508																																							
38																																																	
41 CODE VALUE CODES AMOUNT														41 CODE VALUE CODES AMOUNT																																			
a 61 1900 00																																																	
b																																																	
c																																																	
d																																																	
42 REV. CD.		43 DESCRIPTION				44 HCPCS / RATE / NPPS CODE				45 SERV. DATE				46 SERV. UNITS				47 TOTAL CHARGES				48 NON-COVERED CHARGES				49																							
0023		HH Services				HAEJ1				10012000								0 00																															
0550		Skilled Nurse Visit				G0154				10012000				2				150 00																															
0570		HH Aide				G0156				10012000				3				75 00																															
0550		Skilled Nurse Visit				G0154				10102000				2				150 00																															
0570		HH Aide				G0156				10102000				2				75 00																															
0420		Physical Therapy				G0151				10152000				3				200 00																															
0550		Skilled Nurse Visit				G0154				10202000				2				150 00																															
0570		HH Aide				G0156				10202000				2				75 00																															
0420		Physical Therapy				G0151				10252000				3				200 00																															
0550		Skilled Nurse Visit				G0154				10302000				2				150 00																															
0570		HH Aide				G0156				10302000				2				75 00																															
0420		Physical Therapy				G0151				11042000				3				200 00																															
0550		Skilled Nurse Visit				G0154				11102000				1				150 00																															
0570		HH Aide				G0156				11102000				2				75 00																															
0420		Physical Therapy				G0151				11142000				3				200 00																															
0550		Skilled Nurse Visit				G0154				11202000				2				150 00																															
0570		HH Aide				G0156				11202000				3				75 00																															
0420		Physical Therapy				G0151				11242000				3				200 00																															
0550		Skilled Nurse Visit				G0154				11292000				2				150 00																															
0570		HH Aide				G0156				11292000				2				75 00																															
0270		Supplies				G0156				11292000				11				132 58																															
0001														43				2707 58																															
PAGE OF										CREATION DATE										TOTALS																													
50 PAYER					51 HEALTH PLAN ID					52 REL INFO					53 ASG BEN					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI																			
Medicare					167999					Y																				57 OTHER PRV ID																			
58 INSURED'S NAME										59 PREL 60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																			
Doe, Jane M										123456789A																																							
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																													
200010012000093001																																																	
66 1629																				68																													
69 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI										73									
74 PRINCIPAL PROCEDURE CODE										OTHER PROCEDURE CODE										OTHER PROCEDURE CODE										75																			

UB-04 CMS-1450

APPROVED OMB NO.

NUBC[®] National Uniform
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