Chapter 12 Addendum Q

Input/Output Record Layout

Revision:

The Home Health (HH) Pricer input/output file is 450 bytes in length. The require data and format are shown below:

FILE POSITION	FORMAT	TITLE	DESCRIPTION
FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008			
1-10	X(10)	NPI	This field will be used for National Provider Identifier (NPI) when it is implemented.
11-22	X(12)	HIC	Input item: The Health Insurance Claim (HIC) number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit OSCAR system provider number, copied from the claim.
29-31	X(3)	TOB	Input item: The Type of Bill (TOB) code, copied from the claim form.
32	X	PEP-INDICATOR	Input item: A single Y/N character to indicate if a claim must be paid a Partial Episode Payment (PEP) adjustment. The contractors' claims processing systems must set a Y if the patient discharge status code on 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. The contractors' claims processing systems determine this number by the span of days from and including the first line item service date on the claim to and including the last line item service date on the claim.
36	X	INIT-PAY-INDICATOR	Input item: A single character to indicate if normal percentage payment should be made on Request for Anticipated Payment (RAP) or whether payment should be based on data drawn by the contractors' claims processing 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
44-46	X(2)	FILLER	Blank
47-50	X(5)	CBSA	Input item: The Core Based Statistical Area (CBSA) code, copied from the value code 61 amount on the claim form.
51-52	X(2)	FILLER	Blank
53-60	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU-DATE	Input item: The statement covers period "Through" date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008			
77	X	HRG-MED-REVIEW	Input item: A single Y/N character to indicate if a Health Insurance Prospective Payment System (HIPPS) code has been changed my medical review. Contractors' claims processing systems must set a y if an ANSI code on the line indicates a medical review change. An N must be set in all other cases.
78-82	X(5)	HRG-INPUT-CODE	Input item: Contractors' claims processing systems must copy the HIPPS code reported by the provider on each 0023 revenue code line. If an ANSI code on the line item indicates a medial review change, the contractors' claims processing systems must copy the additional HIPPS code place on the 0023 revenue code line by the medical reviewer.
83-87	X(5)	HRG-OUPUT-CODE	Output item: The HIPPS code used by the Pricer to determine the payment amount on the claim.
88-90	9(3)	HRG-NO-OF-DAYS	Input item: A number of days calculated by the system for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under the HIPPS code to and including the last item service date provided under the HIPPS code.
91-96	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
97-105	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Five more occurrences of all Health Resource Group (HRG)/HIPPS code related fields identified above, since up to six HIPPS codes can be automatically processed for payment in any one episode.
251-254	X(4)	REVENUE-CODE	Input item: One of the six home health discipline revenue codes (042X, 043X, 044X, 055X, 056X 057X). All six revenue codes must be passed by the contractors' claims processing systems even if the revenue codes are not present on the claim.
255-257	9(3)	REVENUE-QTY-COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Contractors' claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
258-266	9(7)V9(2)	REVENUE-DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a Low Utilization Payment Adjustment (LUPA). Otherwise, the dollar rates used by the Pricer to impute the costs of the claim for purposed of calculating an outlier payment, if any.
267-275	9(7)V9(2)	REVENUE-COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by the Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
276-400	Defined above	Additional REVENUE data PAY-RTC	Five more occurrences of all REVENUE related data defined above.

FILE POSITION	FORMAT	TITLE	DESCRIPTION	
FOR EPISODES BEGINNING PRIOR TO JANUARY 1, 2008				
401-402	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			03	Initial percentage payment, 0%
			04	Initial percentage payment, 50%
			05	Initial percentage payment, 60%
			06	LUPA payment only
			07	Final payment, Significant Change In Condition (SCIC)
			08	Final payment, SCIC with outlier
			09	Final payment, PEP
			11	Final payment, PEP with outlier
			12	Final payment, SCIC within PEP
			13	Final payment, SCIC with PEP with outlier
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, > 60
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid Metropolitan Statistical Area (MSA)/CBSA code
			35	Invalid Initial Payment Indicator
			40	Dates < October 1, 2000 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on 3x9 or adjustment TOB
403-407	9(5)	REVENUE-SUM 1-3-QTY-THR	Output item: The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input in association with revenue codes 042x, 043x,.and 044x.	
408-412	9(5)	REVENUE- SUM 1-6- QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH 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.	

FILE POSITION	FORMAT	TITLE	DESCRIPTION
FOR EPISODES BEGINNING ON OR AFTER JANUARY 1, 2008			
431-435	9(3)V9(2)	LUPA-ADD-ON PAYMENT	Output item: The add-on amount to be paid for LUPA claims that are the first episode in a sequence.
436	X	LUPA-SRC-ADM	Input item: The source of admission code on the RAP or claim.
437	X	RECODE-IND	Input item: A recoding indicator set by the contractors' claims processing systems in response to the identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0=default value 1=HIPPS code shows later episode, should be early episode 3=HIPPS code shows early episode, should be later episode
438	9	EPISODE-TIMING	Input item: A code indicating whether a claim is an early or late episode. Contractors' systems copy this code from the 10th position of the treatment authorization code. Valid values: 1=early episode 2=late episode
439	X	CLINICAL-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 11th position of the treatment authorization code.
440	X	FUNCTION-SEV-EQ1	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. Contractors' systems copy this code from the 12th position of the treatment authorization code.
441	X	CLINICAL-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 13th position of the treatment authorization code.
442	X	FUNCTION-SEV-EQ2	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. Contractors' systems copy this code from the 14th position of the treatment authorization code.
443	X	CLINICAL-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 15th position of the treatment authorization code.
444	X	FUNCTION-SEV-EQ3	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 3 of the case-mix system. Contractors' systems copy this code from the 16th position of the treatment authorization code.
445	X	CLINICAL-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the clinical score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 17th position of the treatment authorization code.
446	X	FUNCTION-SEV-EQ4	Input item: A hexivigesimal code that converts to a number representing the functional score for this patient calculated under equation 4 of the case-mix system. Contractors' systems copy this code from the 18th position of the treatment authorization code.
447-450	X	FILLER	

- Input records on RAPs will include all input items except for "REVENUE" related items, and input records on RAPs will never report more than one occurrence of "HHRG" 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 claims contractors' claims processing systems will move the following Pricer output items to the claim record.

- 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.

- If the return code is 06 (indicating a LUPA), the contractors' claims processing systems will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payment be accurately reflected on the remittance advice.

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