Chapter 12 Section 7

Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic

Issue Date:
Authority: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)
Revision: C-3, June 30, 2017

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

To describe the Pricer requirements for reimbursement of home health services under the Home Health Prospective Payment System (HHA PPS).

3.0 POLICY

3.1 HHA PPS Pricer Requirements

All home health services billed on Type Of Bill (TOB) 32X or 33X will be reimbursed based on calculations made by the Home Health (HH) Pricer. The HH Pricer operates as a call module within contractors' systems. The HH Pricer makes all reimbursement calculations applicable under HHA PPS, including percentage payments on Requests for Anticipated Payment (RAPs), claim payments for full Episodes Of Care (EOCs), and all payment adjustments, including Low Utilization Payments (LUPAs), Significant Change In Condition (SCIC) adjustments and outlier payments. Contractors' systems must send an input record to Pricer for all claims with covered visits, and Pricer will send the output record back to the contractors' system.

3.1.1 General Requirements

3.1.1.1 Pricer will return the following information on all claims: Output (Health Insurance Prospective Payment System (HIPPS) codes, weight used to price each HIPPS code, payment per HIPPS code, total payment, outlier payment and return code. If any element does not apply to the claim, Pricer will return zeros.

3.1.1.2 Pricer will wage index adjust all PPS payments based on the Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) reported in value code 61 on the claim.

3.1.1.3 Pricer will return the reimbursement amount for the HIPPS code in the 023 line of the claim for the RAPs and paid claims.

3.1.1.4 If input is invalid, Pricer will return one of a set of error return codes to indicate the invalid element.

3.1.1.5 Pricer must apply the fiscal year rate changes to through date on claim.

3.1.2 Pricing of RAPs

3.1.2.1 Pricer will employ RAP logic for TOB 322 and 332 only.

3.1.2.2 On the RAP, Pricer will multiply the wage index adjusted rate by 0.60 if the claim from date and admission date match and the initial payment indicator is = 0.

3.1.2.3 On the RAP, Pricer will multiply the wage index adjusted rate by 0.50 if the claim from date and admission date do not match and the initial payment indicator is = 0.

3.1.2.4 On the RAP, Pricer will multiply the wage index adjusted rate by 0.00 if the initial payment indicator equals 1.

3.1.2.5 Pricer will return the payment amount on RAP with return code **03** for 0%, **04** for 50% payment and **05** for 60% payment.

3.1.3 Pricing of Claims

3.1.3.1 Pricer will employ claim logic for TOB 329, 339, 327, 337, 32G, 33G, 32I, 33I, 32J, 33J, 32M, and 33M only.

3.1.3.2 Pricer will make payment determinations for claims in the following sequence:

- LUPA
- Therapy threshold
- HHRG payments [including Partial Episode Payment (PEP) and SCIC]
- Outlier, in accordance with logic in the pricer

3.1.3.3 Pricer will pay claims as LUPAs when there are less than 5 occurrences of all HH visit revenue codes: 42X, 43X, 44X, 55X, 56X, and 57X.

3.1.3.4 Pricer will pay visits on LUPA claims at national standardized rates, and the total visit amounts will be final payment for the episode.

3.1.3.5 If Pricer determines the claim to be a LUPA, all other payment calculations will be bypassed.

3.1.3.6 Pricer will return claim LUPA payments, with return code **06**.

3.1.3.7 DHA will supply Pricer with a table of "fall back" HIPPS codes so HIPPS can be downcoded when thresholds are not met.

3.1.3.8 If one of the 320 HIPPS codes that indicate therapy is present, Pricer will check for the presence of 10 therapy visits by revenue code (42X, 43X, 44X). Ten therapies in total for an episode is the threshold.

3.1.3.9 If 10 occurrences of therapy revenue codes are not found when HIPPS code indicates therapies, Pricer will reprice the claim based on the table of "fall back" HIPPS codes.

3.1.3.10 Pricer will return both the input HIPPS code and an output HIPPS code. The output code will be different from the input code only if the therapy threshold is not met.

3.1.3.11 If the PEP indicator is **Y**, Pricer will multiply the wage index adjusted rate by the number of HHRG days over 60 (days divided by 60).

3.1.3.12 If the PEP indicator is **Y** and there are two or more HIPPS codes on the claim, Pricer will multiply each HHRG payment by the number of PEP days/60. Each result will then be multiplied by the number of HHRG days/the number of PEP days. The sum of these amounts is the total HHRG payment for the episode.

3.1.3.13 If a SCIC, Pricer will prorate the episode in accordance with the multiple HHRG lines that come in on the claim.

3.1.3.14 Pricer will perform the outlier calculations on all claims unless the claim is a LUPA.

3.1.3.15 Pricer passes back to the system a single outlier amount, no matter how many HIPPS codes are on the claim.

3.1.3.16 Pricer will perform an outlier calculation that requires total number of visits per discipline to be multiplied by national standard per visit rates. Effective January 1, 2017, the methodology to calculate the outlier payment will utilize a cost-per-unit approach rather than a cost-per-visit approach. The national per-visit rates are converted into per 15 minute unit rates. The per-unit rate by discipline will be used along with the visit length data reported on the home health claim to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an EOC. The amount of time per day used to estimate the cost of an episode for the outlier calculation is limited to eight hours or 32 units per day (care is not limited, only the number of hours/units eligible for inclusion in the outlier calculation). For rare instances when more than one discipline of care is provided and there is more than eight hours of care provided in one day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline shown in Addendum K (CY 2017), Figure 12.K.2017-5. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of episode cost in order to cap the estimation of an episode's cost at eight hours of care per day. The total result is compared to an outlier threshold which is determined by adding the rate for the HIPPS code to a standard fixed-loss amount. If the total result is greater than the threshold, Pricer will pay 80% of the difference between the two amounts in addition to the episode rate determined by the HIPPS code.

3.1.3.17 Pricer will return claim payment with no outlier payment with return code **00**.

3.1.3.18 Pricer will return claim payments with outlier payment with return code **01**.

3.1.3.19 Pricer will return the following additional information on claims:

- The dollar rate used to calculate revenue code costs, and
- The costs calculated for each revenue code.

3.1.3.20 If any revenue code is submitted with zeros, Pricer will return zeros in these fields.

3.1.3.21 Annual Updates: DHA will annually update the following information used by Pricer:

- Federal episode rate
- Outlier threshold amount
- Outlier loss-sharing ratio
- RAP payment percentage
- Labor and non-labor percentages
- Hospital wage index
- HHRG weight table
- National per visit rate table

3.1.4 Interface with Pricer

3.1.4.1 Provide specification for a 450-byte Pricer input record layout.

3.1.4.2 Contractor's claims processing system will pass the following claim elements to Pricer for all claims:

- National Provider Identifier (NPI)
- Health Insurance Claim (HIC) number
- Provider number
- TOB
- Statement from and through dates
- Admission date and HIPPS codes

3.1.4.3 System will place the return code passed back from Pricer on the header of all claims.

3.1.4.4 If the claim is a LUPA, the system will apportion the payment amounts returned from Pricer to the visit lines.

3.1.4.5 The system will pass a **Y** medical review indicator to Pricer if a HIPPS code is present in the panel field on a line, and the line item pricing indicator shows that the change came from medical review (MR). In all other cases an **N** indicator will be passed.

3.1.4.6 The system will assure all claims with covered visits will flow to Pricer, but only covered visits will be passed to Pricer.

3.1.4.7 The system will pass Pricer all six home health visit revenue codes sorted in ascending order, with a count of how many times each code appears on the claim, and those that do not appear on claims will be passed with a quantity of zero.

3.1.4.8 If there is one HIPPS code on the claim and the patient status is **06**, **SS** will pass 60 days of service for the HIPPS code, regardless of visit dates on the claim.

3.1.4.9 If the claim is a PEP, **SS** will calculate the number of days between the first service date and the last service date and pass that number of days for the HIPPS code.

3.1.4.10 If the claim is a SCIC, **SS** will calculate the number of days for all HIPPS codes from the inclusive span of days between first and last service dates under the HIPPS code.

3.1.4.11 The system will pass a **Y/N** medical review indicator to Pricer for each HIPPS code on the claim.

3.1.4.12 The system will pass Pricer a **Y** PEP indicator if the claim shows a patient status of **06**. Otherwise, the indicator will be **N**.

3.1.4.13 The system will place the payment amount returned by Pricer in the total charge and the covered charge field on the 023 line.

3.1.4.14 The system will place any outlier amount on the claim as value code **17** amount and plug condition code **61** on the claim.

3.1.4.15 When Pricer returns an 06 return code (LUPA payment), the system will place it on the claim header in the return code field and create a new **L** indicator in the header of the record.

3.1.4.16 Pricer will be integrated into the system for customer service and create a new on-line screen to do it.

3.1.5 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 NPI when it is implemented.
11-22	X(12)	HIC	**Input Item:** The HIC number of the beneficiary, copied from Form Locator (FL) 60 of the claim form.
23-28	X(6)	PRO-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 TOB 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 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.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
36	X	INIT-PAY-INDICATOR	**Input Item:** A single character to indicate if normal percentage payments should be made on RAP, or whether payment should be based on data drawn by the 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.
44-46	X(3)	FILLER	Blank.
47-50	X(4)	MSA	**Input Item:** The MSA or CBSA 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)	SER-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 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 023 revenue code line. If an ANSI code on the line indicates medical review involvement, standard systems must copy the additional HIPPS code placed on the 023 revenue code line by the medical reviewer.
83-87	X(5)	HRG-OUTPUT-CODE	**Output Item:** The HIPPS code used by 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(7)V9 (2)	HRG-WGTS	**Output Item:** The weight used by Pricer to determine the reimbursement amount on the claim.
97-105	9(7)V9 (2)	HRG-PAY	**Output Item:** The reimbursement amount calculated by Pricer for each HIPPS code on the claim.
106-250	Defined above	Additional HRG data	Five more occurrences of all HRG/HIPPS related fields defined above, since up to 6 HIPPS codes can be automatically processed for payment on any one episode.
251-254	X(4)	REVENUE-CODE	**Input Item:** One of the six home health disciplines 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.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
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 Pricer to calculate the reimbursement for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar rates used by 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 Pricer to be the reimbursement for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by 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 circumstance 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% **Error return codes:** 10 = Invalid TOB 15 = Invalid PEP Days 20 = PEP indicator invalid 25 = Med review indicator invalid 30 = Invalid MSA or CBSA code 35 = Invalid Initial Payment Indicator 40 = Dates are _____ or are invalid 70 = Invalid HRG code 75 = No HRG present in first 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 therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input with revenue codes 42X, 43X, and 44X.
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 LUPA. This amount will be the total of all the covered visit quantities input with all six home health discipline revenue codes.
413-421	9(7)V9 (2)	OUTLIER-PAYMENT	**Output Item:** The outlier payment determined by 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 Pricer to be due on the RAP or claim.
431-450	X(20)	FILLER	Blank.

3.1.5.1 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

and 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 zeros.

3.1.5.2 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 023 line.
- The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount.
- If the return code is **06** (indicating a LUPA), 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.

3.1.6 Decision Logic Used by Pricer on RAPs

On input records with TOB 322 or 332, Pricer will perform the following calculations in the numbered order:

3.1.6.1 **1.a.** Find weight for "HRG-INPUT-CODE" from the table of weight 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 "SER-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 DHA. Multiply the case-mix adjusted rate by 0.77668 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 0.22332 to determine the non-labor portion.

3.1.6.2 **2.a.** If the "INIT-PYMNT-INDICATOR" equals **0**, perform the following: Determine if the "SERV-FROM-DATE" is equal to the "ADMIT-DATE." If yes, multiply the wage index and case-mix adjusted payment by 0.6. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENT" with return code **05**.

3.1.6.3 **2.b.** If the "INIT-PAYMNT-INDICATOR" equals **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**.

3.1.7 Decision Logic Used By 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:

3.1.7.1 LUPA Calculations

3.1.7.1.1 **1.a.** If the "REVENUE-SUM1-6-QTY-ALL" (the total of the six revenue code quantities, representing the total number of visits on the claim) is less than 5, read the national standard per-visit

rate 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 products. The result is the total payment for the episode. Return amount in the "TOTAL-PAYMENT" field with return code **06**.

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

3.1.7.2 Therapy Threshold Determination

3.1.7.2.1 **2.a.** 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 "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 Pricer is arranged in two columns. The first column lists 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 the first column matches the code in the second column (indicating the threshold does not need to be met 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.

3.1.7.2.2 **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 calculation. Use the weights associated with the codes in the "HRG-OUTPUT-CODE" fields for the further calculations involving each HRG.

3.1.7.3 HRG Payment Calculations

3.1.7.3.1 **3.a.** If the "HRG-OUTPUT-CODE" occurrences are less than two, and the "PEP-INDICATOR" is **N**:

- Find the weight for the "HRG-OUTPUT-CODE" from weight tables for the Federal fiscal year in which the "SER-THRU-DATE" falls.

- Multiply the weight times the Federal standard episode rate for the Federal fiscal year in which the "SER-THRU-DATE" falls. The product is the case-mix adjusted rate.

- Multiply the case-mix adjusted rate by 0.77668 to determine the labor portion.

- Multiply the labor portion by the wage index corresponding to **MSA1**.

- Multiply the case-mix adjusted rate by 0.22332 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 paragraph 3.1.7.4).

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

- Perform the calculation of the case-mix and wage adjusted payment for the HRG, as above. Determine the proportion to be used to calculate this 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 paragraph 3.1.7.4).

3.1.7.3.3 3.c. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to two, 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 the code divided by sixty. Repeat this for up to six occurrences of the "HRG-OUTPUT-CODE." These amounts will be returned in separate occurrence of the "HRG-PAY" fields, so that the standard systems can associate them with the claim's 023 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 paragraph 3.1.7.4).

3.1.7.3.4 3.d. If the "HRG-OUTPUT-CODE" occurrences are greater than or equal to two, 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 be returned separately in the corresponding "HRG-PAY" fields.

- Sum all resulting dollar amounts. This is the total HRG payment for the episode.
- Proceed to the outlier calculations (see paragraph 3.1.7.4).

3.1.7.4 Outlier Calculations

3.1.7.4.1 **4.a.** Wage adjust the outlier fixed loss amount for the Federal fiscal year in which the "SER-THRU-DATE" falls, using the **MSA** or **CBSA** 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.

3.1.7.4.2 **4.b.** For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per-visit rate from the revenue code table for the Federal fiscal year in which the "SER-THRU-DATE" falls.

- Multiply each quantity by the corresponding rate.
- Sum the six results and wage index adjust the sum as described above, using the MSA or CBSA code in the **MSA1** field. The result is the wage index adjusted imputed cost for the episode.

Note: See paragraph 3.1.3.16 for outlier calculations on or after January 1, 2017.

3.1.7.4.3 **4.c.** Subtract the outlier threshold for the episode from the imputed cost for the episode (4.d.).

- If the result is greater then $0.00, calculate 0.80 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 to the "TOTAL-PAYMENT" field, with return code **00**.

- END -