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CHANGE 3
6010.61-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), APRIL 2015

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: **REIMBURSEMENT & CODING UPDATES 17-002**

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PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: July 31, 2017.

This change is made in conjunction with Apr 2015 TPM, Change No. 4 and Apr 2015 TSM, Change No. 3.

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 3
6010.61-M
JUNE 30, 2017

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER	
Table of Contents, pages 1 through 4	Table of Contents, pages 1 through 3
Section 1, pages 3 through 8	Section 1, pages 3 through 8
Section 4, pages 1, 2, 27 - 30, and 33 - 35	Section 4, pages 1, 2, 27 - 30, and 33 - 35
Section 6, pages 35 through 44	Section 6, pages 35 through 44
Section 7, pages 3 through 11	Section 7, pages 3 through 11
Addendum K (CY 2014), pages 1 through 5	★ ★ ★ ★ ★ ★
★ ★ ★ ★ ★ ★	Addendum K (CY 2017), pages 1 through 5
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SUMMARY OF CHANGES

CHAPTER 12

1. This change updates the HHA PPS for CY 2017 and updates the OPPS for CY 2017. EFFECTIVE DATE: 01/01/2017.

Chapter 12

Home Health Care (HHC)

Revision: C-3, June 30, 2017

- Services at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring home, but not including transportation of the individual in connection with any such item or service.

3.2.1.2 Services that can be paid in addition to the prospective payment amount when the beneficiary is receiving home health services under a POC:

- Durable Medial Equipment (DME);
- U.S. Food and Drug Administration (FDA) approved injectable drugs for osteoporosis;
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines;
- Oral cancer drugs and antiemetics;
- Orthotics and prosthetics;
- Ambulance services operated by the HHA;
- Enteral and parenteral supplies and equipment; and
- Other drugs and biologicals administered by other than oral method.
- Effective January 1, 2017, disposable Negative Pressure Wound Therapy (NPWT) devices shall be paid outside the HHA PPS. Payment for disposable NPWT devices is set to equal the amount of the payment that would be made under the Outpatient Prospective Payment System (OPPS) using Healthcare Common Procedure Coding System (HCPCS) codes 97607 and 97608. If NPWT is the sole purpose of the home health visit, payment shall not be made under the HHA PPS, and instead will be based on the OPPS amount, which includes payment for both the device as well as the furnishing of the service. In this case the HHA shall bill these visits under Type of Bill (TOB) 34X, along with the appropriate HCPCS code. If NPWT using a disposable device is performed during the course of an otherwise covered HHA visit, the HHA shall not include the time spent furnishing the NPWT in their visit charge or in the length of time reported for the visit. Instead, NPWT utilizing a disposable device will be separately paid based on OPPS under TOB 34X with the appropriate HCPCS code. The same visit should also be reported on the HHA PPS claim (TOB 32X), but only the time spent furnishing the services unrelated to the provision of NPWT using an integrated, disposable device. The amount paid to the HHA would be equal to the lesser of the actual charge or the payment amount as determined by the OPPS, less applicable cost-shares or deductibles.

3.2.2 Conditions for Coverage

3.2.2.1 HHA services are covered under the TRICARE Program when the following criteria are met:

3.2.2.1.1 The person to whom the services are provided is an eligible TRICARE beneficiary;

3.2.2.1.2 The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program; and

3.2.2.1.3 The beneficiary qualifies for coverage of home health services. To qualify for TRICARE coverage of any home health services, the beneficiary must meet each of the criteria specified below:

- Be confined to the home;
- Services are provided under a POC established and approved by a physician;
- Is under the care of the physician who signs the POC and the physician certification;
- Needs skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or has continued need for occupational therapy;
- TRICARE is the appropriate payer; and
- The services for which payment is claimed are not otherwise excluded from HHA PPS payment.

3.2.3 Subsystems and Coding Requirements

3.2.3.1 HHA PPS will operate on the platform of existing TRICARE claims processing systems.

3.2.3.2 HHA PPS will employ claims formats such as the paper and electronic Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 and related transaction formats -- no new fields will be added to either the remittance or the claim form.

3.2.3.3 Episode, as the payment unit, will also become the unit of tracking in claims systems.

3.2.3.4 Some new subsystems will be created and others modified to mesh with existing claims processing systems.

3.2.3.4.1 The contractor's authorization process (including data entering screens) will be used in designating primary provider status and maintaining and updating the episode information/history of each beneficiary. The managed care authorization system will be used in lieu of Medicare's remote access inquiry system [Health Insurance Query for HHAs (HIQH)]. The data requirements for tracking beneficiary episodes over time are found in Section 5.

3.2.3.4.2 Home Health Resource Groups (HHRGs) for claims will be determined at HHAs by inputting OASIS data (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment) into a Home Assessment Validation and Entry (HAVEN) System. The HAVEN software package contains a Grouper module that will generate a HHRG for a particular 60-day episode of care based upon the beneficiary's condition, functional status and expected resource consumption. Updated versions of this software package may be downloaded from the CMS web site. An abbreviated assessment will be conducted for eligible TRICARE beneficiaries who are under the age of eighteen or receiving maternity care from a Medicare certified HHA. This will require the manual completion and scoring of a HHRG Worksheet for pricing and payment under the HHA PPS. OASIS assessments are not required for authorized care in non-Medicare certified HHAs that qualify for corporate services provider

status under TRICARE (i.e., HHAs which have not sought Medicare certification due to the specialized beneficiary categories they service, such as patients receiving maternity care and beneficiaries under the age of 18).

3.2.3.4.3 All HHA PPS claims will run through Pricer software, which, in addition to pricing Health Insurance Prospective Payment System (HIPPS) codes for HHRGs, will maintain six national standard visit and unit rates to be used in outlier and Low Utilization Payment Adjustment (LUPA) determinations.

3.2.3.4.4 Episodes paid under HHA PPS will be restricted to homebound beneficiaries under existing POCs; i.e., CMS 1450 UB-04 TOB 032X and 033X. However, 034X bills will be used by HHAs for services not bundled into HHA PPS rates.

3.2.3.4.5 Requests for Anticipated Payment (RAP) will be submitted using TOB 0322 only.

3.2.3.4.6 The claim for an episode (TOB 0329) will be processed in the claims processing system as an adjustment to the RAP triggering full or final episode payment, so that the claim will become the single adjusted or finalized claim for an episode in claims history -- claims will be able to be adjusted by HHAs after submission.

3.2.3.4.7 There will not be late charge bills (TOB 0325 or 0335) under HHA PPS -- services can only be added through adjustment of the claim (TOB 0327 or 0337).

3.2.3.4.8 New codes will appear on standard formats under HHA PPS.

3.2.3.4.9 The TOB frequency code of "9" has been created specifically for HHA PPS billing.

3.2.3.4.10 A 0023 revenue code will appear on both RAPs and claims, with new HIPPS codes for HHRGs in the Healthcare Common Procedure Codes (HCPCs) field of a line item.

3.2.3.4.11 Source of Admission codes **B** (transfer from another HHA) and **C** (discharge and readmission to the same HHA) have been created for HHA PPS billing.

3.2.3.5 The wage indexes used for the HHA PPS are the same as those used in calculation of acute inpatient hospital DRG amounts, except they lag behind by one full year.

3.2.3.6 CMS 1450 UB-04 line itemization will have to be expanded to 450 lines for the reporting of services and supplies rendered during the extended 60-day episode period.

3.2.3.7 HHA PPS claims will be exempt from commercial claim auditing software.

3.2.4 Reimbursement

The adoption of the Medicare HHA PPS will replace the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the PPS, the TRICARE Program will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's POC. Other health services including, but not limited to, DME and osteoporosis drugs may receive reimbursement outside of the PPS. A fixed case-mix and wage

adjusted 60-day episode payment will also be paid to Medicare-certified HHAs providing home health services to beneficiaries who are under the age of 18 and/or receiving maternity care. However, this payment amount will be determined through the manual completion and scoring of an abbreviated assessment form. The 23 items in this assessment will provide the minimal amount of data necessary for generating a HIPPS code for payment under the HHA PPS (see Section 4, paragraph 3.6 for more details regarding this abbreviated assessment process). HHAs for which there is no Medicare-certification due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of beneficiaries under the age of 18 or receiving maternity care) will be reimbursed in accordance with payment provisions established under the corporate services provider class (see the TRICARE Policy Manual (TPM), Chapter 11, Section 12.1 for payment provisions that apply to HHAs qualifying for coverage under this class of provider).

3.2.5 Authorized Providers

3.2.5.1 Bachelor of Science (BS) Medical Social Workers (MSWs), social worker assistants, and home health aides that are not otherwise authorized providers under the Basic Program may provide home health services to TRICARE beneficiaries that are under a home health POC authorized by a physician. The services are part of a package of services for which there is a fixed case-mix and wage-adjusted 60-day episode payment.

3.2.5.2 HHAs must be Medicare certified and meet all Medicare conditions of participation [Sections 1861(o) and 1891 of the Social Security Act and Part 484 of the Medicare regulation (42 CFR 484)] in order to receive payment under the HHA PPS for home health services under the TRICARE program.

Note: The HHA will be responsible for assuring that all individuals rendering home health services meet the qualification standards specified in Section 2. The contractor will not be responsible for certification of individuals employed by or contracted with a HHA.

3.2.5.3 HHAs for which Medicare-certification is not available due to the specialized beneficiary categories they serve (e.g., those HHAs specializing solely in the treatment of TRICARE eligible beneficiaries that are under the age of 18 or receiving maternity care) must meet the qualifying conditions for corporate services provider status as specified in the TPM, Chapter 11, Section 12.1. Those specialized HHAs qualifying for corporate services provider status will be reimbursed in accordance with the provisions outlined in Section 4, paragraph 3.6.3.2.

3.2.6 Transition to HHA PPS

3.2.6.1 As of the first day of health care delivery of the new contract, all HHAs must bill all services delivered to homebound eligible TRICARE beneficiaries under a home health POC under HHA PPS. The HHA PPS applies to claims billed on a CMS 1450 UB-04, with Form Locator (FL) 4 TOB 032X or 033X. HHAs will still occasionally bill using TOB 034X, but these claims will not be subject to PPS payment. If an HHA has beneficiaries already under an established POC prior to this date, the open claims for services on or before (TBD) must be closed and submitted for payment under the standard fee-for-service allowable charge methodology. Claims for services on or after (TBD) will be processed and paid under the HHA PPS. Under no circumstances should a HHA claim span payment systems. Claims for services dates spanning payment systems will be returned to the provider for splitting.

3.2.6.2 The contractors will identify all beneficiaries receiving HHC services 60 days prior to implementation of the HHA PPS and notify them and the HHA of any change in their benefit (i.e., changes in coverage of services or reimbursement), with the exception of beneficiaries that were under the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) on or before December 28, 2001, and those grandfathered under the HHC Demonstration. The contractors will be expected to work with the HHAs and beneficiaries toward a smooth transition to the new HHA PPS.

3.2.6.3 The HHA PPS will apply in all 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam.

3.2.7 Implementing Instructions

Since this issuance only deals with a general overview of the HHC benefit and reimbursement methodology, the following cross-reference is provided to facilitate access to specific implementing instructions within Chapter 12:

IMPLEMENTING INSTRUCTIONS	
POLICIES	
General Overview	Section 1
Benefits and Conditions for Coverage	Section 2
Assessment Process	Section 3
Reimbursement Methodology	Section 4
Primary Provider Status and Episodes of Care	Section 5
Claims and Billing Submission Under HHA PPS	Section 6
Pricer Requirements and Logic	Section 7
Medical Review Requirements	Section 8
ADDENDA	
Acronym Table	Addendum A
Home Health Consolidated Billing Code List - Non-Routine Supply (NRS) Codes	Addendum B
Home Health Consolidated Billing Code List - Therapy Codes	Addendum C
CMS Form 485 - Home Health Certification And Plan Of Care Data Elements	Addendum D
Primary Components of Home Health Assessment	Addendum E
Outcome and Assessment Information Set (OASIS-B1) OASIS Items Used for Assessments Of 60-Day Episodes	Addendum F
ICD-9-CM Diagnosis Codes for Home Health Resource Group (HHRG) Assignment	Addendum G
Home Health Resource Group (HHRG) Worksheet	Addendum H
HIPPS Tables for Pricer	Addendum I
Home Assessment Validation and Entry (HAVEN) Reference Manual	Addendum J

IMPLEMENTING INSTRUCTIONS (CONTINUED)	
Annual HHA PPS Rate Updates Calendar Year 2015 Calendar Year 2016 Calendar Year 2017	 Addendum K (CY 2015) Addendum K (CY 2016) Addendum K (CY 2017)
Annual HHA PPS Wage Index Updates - CY 2015 - CY 2017	Addendum L
Diagnoses Associated with Diagnostic Categories Used in Case-Mix Scoring	Addendum M
Diagnoses Included with Diagnostic Categories for Non-Routine Supplies (NRS) Case-Mix Adjustment Model	Addendum N
Code Table for Converting Julian Dates to Two Position Alphabetic Values	Addendum O
Examples of Claims Submissions Under Home Health Agency Prospective Payment System (HHA PPS)	Addendum P
Input/Output Record Layout	Addendum Q
Decision Logic Used By The Pricer For Episodes Beginning On Or After January 1, 2008	Addendum R

- END -

Chapter 12 Section 4

Home Health Benefit Coverage And Reimbursement - Prospective Payment Methodology

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 payment methodology for services rendered to a TRICARE eligible beneficiary under a home health Plan Of Care (POC) established by a physician.

3.0 POLICY

3.1 General Overview

3.1.1 Under the Prospective Payment System (PPS), the TRICARE Program shall reimburse Home Health Agencies (HHAs) a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and Non-Routine (medical) Supplies (NRS) provided under the beneficiary's POC. Durable Medical Equipment (DME) orthotics, prosthetics, certain vaccines, injectable osteoporosis drugs, ambulance services operated by the HHA, other drugs and biologicals administered by other than oral method, and Negative Pressure Wound Therapy (NPWT) utilizing disposable devices will be allowed outside the bundled Episode Of Care (EOC) payment rates.

3.1.2 The variation in reimbursement among beneficiaries receiving Home Health Care (HHC) under this newly adopted PPS will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day EOC, with special reimbursement provisions for major intervening events, Significant Changes In Condition (SCIC), and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using Outcome and Assessment Information Set (OASIS) selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of the Home Health Resource Groups (HHRGs) groups, based on their average expected resource costs relative to other HHC patients.

3.1.3 The HHRG classification determines the cost weight; i.e., the appropriate case-mix weight adjustment factor that indicates the relative resources used and costliness of treating different patients. The cost weight for a particular HHRG is then multiplied by a standard average prospective payment amount for a 60-day episode of HHC. The case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount. Examples of the above calculations will be provided below in order to get a better understanding of the HHA PPS being adopted in this rule, along with the home health benefit structure and applicable reporting requirements.

3.2 Episodes Of Care (EOCs)

3.2.1 The ordinary unit of payment is based on an authorized 60-day EOC. This episode spans a 60-day period which begins with the start of care date (i.e., with the first billable service date) furnished to a beneficiary and ending 60 days later. Payment covers the entire EOC regardless of the number of days of care actually provided during the 60-day period. The only exceptions to this standard payment period are when the following conditions exist: 1) Partial Episode Payment (PEP) adjustment; 2) SCIC adjustment for episodes beginning prior to January 1, 2008; 3) Low Utilization Payment Adjustment (LUPA); 4) additional outlier payment; or 5) medical review determination. There is also downward adjustment in those situations in which the number of therapy services delivered during an episode beginning prior to January 1, 2008, does not meet the anticipated 10 therapy visits threshold. Reduced or additional amounts will be paid under the above situations.

3.2.2 If the beneficiary is still in treatment at the end of the initial 60-day EOC, a decision has to be made regarding recertification for another 60-day EOC; i.e., a physician must certify that the beneficiary is correctly assigned to one of the HHRGs. If the decision is to recertify, a new episode will begin on Day 61 regardless of whether a billable visit is rendered on that day, and ends 60 days later. The HHA will be required to obtain an authorization for the new episode. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.) as long as the beneficiary was receiving services under a HHA's POC. Extension of the HHA benefit beyond the 60th day will require the HHA to fill out a new assessment (OASIS) in order to assign an appropriate HHRG (case-mix category) for the next 60-day EOC. A revised OASIS, along with the physician's POC and certification, is required before the HHA submits a bill for the next 60-day EOC. The timely submission of this information is essential in determining whether the HHRG rate to be paid is appropriate and accurately reflects the beneficiary's clinical condition. There are currently no limits on the number of medically necessary consecutive 60-day episodes that beneficiaries may receive under the HHA PPS. Allowing multiple episodes is intended to assure continuity of care and payment.

3.2.3 Consecutive authorized episodes will be paid at the full prospective rate as long as there are no intervening events or costs which would affect overall resource utilization under the initially designated case-mix assignment.

3.2.4 More than one episode for a single beneficiary may be authorized for the same or different dates of service. This will occur particularly in situations where there is a transfer to another HHA, or discharge and readmission to the same HHA.

3.2.5 Payment will be prorated when an episode ends before the 60th day in the case of a transfer to another HHA, or in the case of a discharge and readmission within the same 60-day period. Claims for episodes may also be submitted prior to the 60th day if the beneficiary has been discharged

FIGURE 12.4-16 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX

NON-STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS	STANDARDIZATION FACTOR FOR WAGE INDEX AND CASE-MIX	BUDGET NEUTRALITY FACTOR	OUTLIER ADJUSTMENT FACTOR	STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS
$2,416.01	0.96184	0.88423	1.05	$2,115.30

3.8.1.3.1 The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in Addendums K (CY 2015), K (CY 2016), and K (CY 2017).

3.8.1.3.2 The standardized prospective payment amount per 60-day EOC is case-mix and wage-adjusted in determining payment to a specific HHA for a specific beneficiary. The wage adjustment is made to the labor portion (0.77668) of the standardized prospective payment amount after being multiplied by the beneficiary's designated HHRG case-mix weight. For example, a HHA serves a TRICARE beneficiary in Denver, CO. The HHA determines the patient is in HHRG C2F1S2 with a case-mix weight of 1.8496. The following steps are used in calculating the case-mix and wage-adjusted 60-day episode payment amount:

Step 1: Multiply the standard 60-day prospective payment amount by the applicable case-mix weight.

(1.8496 x $2,115.30) = $3,912.46

Step 2: Divide the case-mix adjustment episode payment into its labor and non-labor portions.

Labor Portion = (0.77668 x $3,912.46) = $3,038.73

Non-Labor Portion = (0.22332 x $3,912.46) = $873.73

Step 3: Adjust the labor portion by multiplying by the wage index factor for Denver, CO.

(1.0190 x $3,038.73) = $3,096.47

Step 4: Add the wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted episode payment.

($873.73 + $3,096.47) = **$3,970.20**

3.8.1.4 Since the initial methodology used in calculating the case-mix and wage-adjusted 60-day episode payment amounts has not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in Addendums K (CY 2015), K (CY 2016), K (CY 2017), and L.

3.8.1.5 Annual Updating of HHA PPS Rates and Wage Indexes.

3.8.1.5.1 In subsequent fiscal years, HHA PPS rates (i.e., both the national 60-day episode amount and per-visit rates) will be increased by the applicable home health market basket index change.

3.8.1.5.2 Three iterations of these rates will be maintained in Addendums K (CY 2015), K (CY 2016), and K (CY 2017). These rate adjustments are also integral data elements used in updating the Pricer.

3.8.1.5.3 Three iterations of wage indexes will also be maintained in Addendum L, for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

3.8.2 Calculation of Reduced Payments

Under certain circumstances, payment will be less than the full 60-day episode rate to accommodate changes of events during the beneficiary's care. The start and end dates of each event will be used in the apportionment of the full-episode rate. These reduced payment amounts are referred to as: 1) PEP adjustments; 2) SCIC adjustments; 3) LUPAs; and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

Note: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs, and therapy thresholds) has not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in Addendum K (CY 2015), K (CY 2016), K (CY 2017), and L.

3.8.2.1 PEP Adjustment

The PEP adjustment is used to accommodate payment for EOCs less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day EOC; or 2) beneficiary discharged after meeting all treatment goals in the original POC and subsequently readmitted to the same HHA before the end of the 60-day EOC. The PEP adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original POC must be terminated with no anticipated need for additional home health services. A new 60-day EOC would have to be initiated upon return to a HHA, requiring a physician's recertification of the POC, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day EOC. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on Day 28 of a 60-day EOC and subsequently returned to the same HHA on Day 40. However, the first billable visit (i.e., a physician ordered visit under a new POC) did not occur until Day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original POC were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on Day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient was in treatment. Day 42 of the original episode becomes Day 1 of the new certified 60-day episode. The following steps are used in calculating the PEP adjustment:

Step 1: Calculate the proportion of the 60 days that the beneficiary was under treatment.

(28/60)= 0.4667

Step 2: Multiply the beneficiary assigned 60-day episode payment amount by the proportion of days that the beneficiary was under treatment.

($3,970.20 x 0.4667) = **$1,852.90**

3.8.2.2 SCIC Payment Adjustment

For Episodes Beginning On Or After January 1, 2008. The refined HH PPS no longer contains a policy to allow for adjustments reflecting SCICs. Episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Claims submitted with additional HIPPS codes reflecting SCICs will be returned to the provider; i.e., claims for episodes beginning on or after January 1, 2008, that contain more than one revenue code 0023 line.

3.8.2.3 LUPA

3.8.2.3.1 For Episodes Beginning Prior To January 1, 2008

3.8.2.3.1.1 The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day EOC. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in Figure 12.4-1 plus additional amounts for: 1) NRS paid under a home health POC; 2) NRS possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in Figure 12.4-17.

FIGURE 12.4-17 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS

HOME HEALTH DISCIPLINE TYPE	AVERAGE COST PER VISIT				STANDARDIZATION FACTOR FOR WAGE INDEX	OUTLIER ADJUSTMENT FACTOR	PER VISIT PAYMENT AMOUNTS PER 60-DAY EPISODE FOR FY 2001
	FROM THE PPS AUDIT SAMPLE	FOR NON-ROUTINE MEDICAL SUPPLIES*	FOR ONGOING OASIS ADJUSTMENT COSTS	FOR ONE-TIME OASIS SCHEDULING CHANGE			
Home Health Aide	$41.75	$1.94	$0.12	$0.21	0.96674	1.05	$43.37
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

* Combined average cost per-visit amounts for NRS reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.

3.8.2.3.1.2 The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a

Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from Figure 12.4-3) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final LUPA. The following steps are used in calculating the LUPA:

Note: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and Fixed Dollar Loss (FDL) amounts in Addendums K (CY 2015), K (CY 2016), K (CY 2017), and L.

Step 1: Multiple the per-visit rate per discipline by the number of visits and add them together to get the total unadjusted low-utilization payment amount.

Skilled nursing visits	1 x $95.79	=	$ 95.79
Physical therapy visits	1 x $104.74	=	$104.74
Home health aide visits	2 x $43.37	=	$ 86.74
Total unadjusted payment amount			$287.27

Step 2: Multiply the unadjusted payment amount by its labor and non-labor related percentages to get the labor and non-labor portion of the payment amount.

Labor Portion	= ($287.27 x 0.77668)	=	$223.12
Non-Labor Portion	= ($287.27 x 0.22332)	=	$64.15

Step 3: Multiply the labor portion of the payment amount by the wage index for Denver, CO.

($223.12 x 1.0190) = $227.36

Step 4: Add the labor and non-labor portions together to arrive at the LUPA.

($227.36 + $64.15) = **$291.51**

3.8.2.3.2 For Episodes Beginning On Or After January 1, 2008

LUPA may be subject to an additional payment adjustment. If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only EOC the beneficiary received and the Source of Referral and Admission or Visit Code is not **B** (Transfer From Another HHA) or **C** (Readmission to Same HHA), an additional add-on payment will be made. A lump-sum established in regulation and updated annually will be added to these claims. The additional amount for CY 2008 is $87.93.

3.8.2.4 Therapy Threshold Adjustment

3.8.2.4.1 For Episodes Beginning Prior To January 1, 2008

There is a downward adjustment in the 60-day episode payment amount if the number of therapy services delivered during an episode does not meet the 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

3.8.3.2.3 Calculation of Wage-Adjusted Imputed Cost of 60-Day Episode

Step 1: Multiply the total number of visits by the national average cost per visit for each discipline to arrive at the imputed costs per discipline over the 60-day episode.

Skilled Nursing Visits	(54 x $95.79)	=	$5,172.66
Home Health Aide Visits	(48 x $43.37)	=	$2,081.76
Physical Therapy Visits	(6 x $104.74)	=	$628.44

Step 2: Calculate the wage-adjusted imputed costs by dividing the total imputed cost per discipline into their labor and non-labor portions and multiplying the labor portions by the wage index for Missoula, MT (0.9086) and adding back the non-labor portions to arrive at the total wage-adjusted imputed costs per discipline.

1. Skilled Nursing Visits

- Divide total imputed costs into their labor and non-labor portions.

Labor Portion	=	(0.77668 x $5,172.66)	=	$4,017.50
Non-Labor Portion	=	(0.22332 x $5,172.66)	=	$1,155.16

- Wage-adjusted labor portion of imputed costs.

  ($4,017.50 x 0.9086) = $3,650.30

- Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for skilled nursing visits.

  ($3,650.30 + $1,155.16) = $4,805.46

2. Home Health Aide Visits

- Divide total imputed costs into their labor and non-labor portions.

Labor Portion	=	(0.77668 x $2,081.76)	=	$1,616.86
Non-Labor Portion	=	(0.22332 x $2,081.76)	=	$464.90

- Wage-adjusted labor portion of imputed costs.

  ($1,616.86 x 0.9086) = $1,469.08

- Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

  ($1,469.08 + $464.90) = $1,933.98

3. Physical Therapy Visits

- Divide total imputed costs into their labor and non-labor portions.

  Labor Portion = (0.77668 x $628.44) = $488.10
  Non-Labor Portion = (0.22332 x $628.44) = $140.34

- Wage-adjusted labor portion of imputed costs.

  ($488.10 x 0.9086) = $443.49

- Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

  ($443.49 + $140.34) = **$583.83**

Step 3: Add together the wage-adjusted imputed costs for the skilled nursing, home health aide and physical therapy visits to obtain the total wage-adjusted imputed costs of the 60-day episode.

($4,805.46 + $1,933.98 + $583.83) = **$7,323.27**

3.8.3.2.4 Calculation of Outlier Payment

Step 1: Subtract the outlier threshold amount from the total wage-adjusted imputed costs to arrive at the costs in excess of the outlier threshold.

($7,323.27 - $6,058.92) = $1,264.35

Step 2: Multiply the imputed cost amount in excess of the HHRG threshold amount by the loss sharing ratio (80%) to arrive at the outlier payment.

($1,264.35 x 0.80) = **$1,011.48**

3.8.3.2.5 Calculation of Total Payment to HHA

Add the outlier payment amount to the case-mix and wage-adjusted 60-day episode payment amount to obtain the total payment to the HHA.

($3,838.30 + $1,011.48) = **$4,849.78**

3.8.3.3 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.

3.9 Other Health Insurance (OHI) Under HHA PPS

Payment under the HHA PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see Section 6). However, if the beneficiary has OHI which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing HHA claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

- END -

3.1.2.21.5.9.4 The electronic RA, including a claim for a SCIC-adjusted episode, will show the total claim reimbursement and separate segments showing the reimbursement for each HIPPS code.

3.1.2.21.5.9.5 There is no limit on the number of SCIC adjustments 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, with two exceptions:

- One - If the patient is re-assessed and there is no change in the HIPPS code, the same HIPPS does not have to be submitted twice, and no SCIC adjustment will apply.

- Two - If the HIPPS code weight increased but the proration of days in the SCIC adjustment would result in a financial disadvantage to the HHA, the SCIC is not required to be reported.

3.1.2.21.5.9.6 Exceptions are not expected to occur frequently, nor is the case of multiple SCIC adjustments (i.e., three or more HIPPS for an episode).

3.1.2.21.5.9.7 Payment will be made based on six HIPPS, and will be determined by contractor medical review staff, if more than six HIPPS are billed.

3.1.2.21.6 Outlier Payments. There are cost outliers, in addition to episode payments.

3.1.2.21.6.1 HHA 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, the TRICARE Program 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.

3.1.2.21.6.2 Outlier determinations will be made comparing the summed wage-adjusted imputed costs for each discipline (i.e., the summed products of each wage-adjusted per-visit rate for each discipline multiplied by the number of visits of each discipline on the claim) with the sum of: the case-mix adjusted episode payment plus a wage-adjusted fixed loss threshold amount.

3.1.2.21.6.3 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.

3.1.2.21.6.4 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.

3.1.2.21.6.5 Outlier payment amounts are wage index adjusted to reflect the MSA or CBSA in which the beneficiary was served.

3.1.2.21.6.6 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.

3.1.2.21.6.7 Separate outliers will not be calculated for different HIPPS codes in a SCIC situation, but rather the outlier calculation will be done for the entire claim.

3.1.2.21.6.8 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 on a remittance, but it will be identified separately on the claim in history with a value code 17 in CMS 1450 UB-04 FLs 39-41, with an attached amount, and in condition code 61 in CMS 1450 UB-04 FLs 18-28. Outlier payments will also appear on the electronic RA in a separate segment.

3.1.2.22 Exclusivity and Multiplicity of Adjustments

3.1.2.22.1 Episode payment adjustments only apply to claims, not RAPs.

3.1.2.22.2 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.

3.1.2.22.3 For other HHA PPS claims, multiple adjustments may apply on the same claim, although some combinations of adjustments are unlikely (i.e., a SCIC and therapy threshold adjustment in a shortened episode (PEP adjustment)).

3.1.2.22.4 All claims except LUPA claims will be considered for outlier payment.

3.1.2.22.5 Payment adjustments are calculated in Pricer software.

3.1.2.22.6 Payments are case-mix and wage adjusted employing Pricer software (a module that will be attached to existing TRICARE contractor's claims processing systems) used by the contractor when processing TRICARE Program home health claims.

3.1.2.22.7 The contractor must designate the primary provider of home health services through its established authorization process. Only one HHA - the primary or the one establishing the beneficiary's POC - can bill for home health services other than DME under the home health benefit. If multiple agencies are providing services simultaneously, they must take payment under arrangement with the primary agency.

3.1.2.22.8 Payment for services remains specific to the individual beneficiary who is homebound and under a physician's POC.

3.1.2.23 Chart Representation of Billing Procedures

3.1.2.23.1 One 60-day Episode, No Continuous Care (Patient Discharged):

RAP	CLAIM
Contains one HIPPS Code and OASIS Matching Key output from Grouper software linked to OASIS	Submitted with Patient Status Code 01 and contains same HIPPS Code as RAP
Does not give any line item detail for TRICARE but can include line item charges for other carrier	Gives all line item detail for the entire home health episode
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date of Discharge or Day 60
Creates home health episode in automated authorization system (authorization screen)	Closes home health episode automated authorization system (authorization screen)
Triggers initial percentage payment for 60-day home health episode	Triggers final percentage payment

3.1.2.23.2 Initial Episode in Period of Continuous Care:

FIRST EPISODE		NEXT EPISODE(S)
RAP	**CLAIM**	**RAP(S) & CLAIM(S)**
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.	Contains same HIPPS Code as RAP with Patient Status Code 30	Unlike previous RAP in Code period, Admission Date will be the same as that opening the period, and will stay the same on RAPS and claims throughout the period of continuous 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. Claims submitted at the end of each 60 day period.
Does not give any other line item detail for TRICARE use.	Gives all line item detail for entire home health episode.	
From and Through Dates match first service delivered.	From Date same as RAP, Through Date, Day 60 of home health episode.	The RAP and claim From and Through Dates in a period of continuous care are first day of home health episode, w/ or w/o service (i.e., Day 61, 121, 181, etc.).
Creates home health episode in authorization system.	Closes home health episode in authorization system.	
Triggers initial percentage payment.	Triggers final percentage payment for 60-day home health episode.	Creates or closes home health episode.

3.1.2.23.2.1 The above scenarios are expected to encompass most episode billings.

3.1.2.23.2.2 For RAPs, Source of Admission Code **B** is used to receive transfers from other agencies; **C**, if readmission to same agency after discharge.

3.1.2.23.2.3 There is no number limit on medically necessary episodes in continuous care periods.

3.1.2.23.3 A Single LUPA Episode:

RAP	CLAIM
Contains one HIPPS Code and Claims-OASIS Matching Key output from Grouper software linked to OASIS. Does not give any other line item detail for TRICARE use	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 home health episode - line item detail will not show more than four visits for entire episode.
From and Through Dates match date of first service delivered.	From Date same as RAP, Through Date Discharge or Day 60.
Creates home health episode in authorization system.	Closes home health episode in authorization system.
Triggers initial percentage payment.	Triggers final percentage payment for 60-day home health episode.

3.1.2.23.3.1 Though less likely, a LUPA can also occur in a period of continuous care.

3.1.2.23.3.2 While also less likely, a LUPA, though never prorated, can also be part of a shortened episode or an episode in which the patient condition changes.

3.1.2.23.4 "No-RAP" LUPA Episode. When a HHA knows from the outset that an episode will be four visits or less, the agency may choose to bill only a claim for the episode. Claims characteristics are the same as the LUPA final claim on the previous page.

PROs	CONS
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) and less paperwork.	No payment until claim is processed

3.1.2.23.5 Episode with a PEP Adjustment - Transfer to Another Agency 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.	Submitted after discharge with Patient Status Code of 06.
Does not contain other line item detail for TRICARE use.	Contains same HIPPS Code as RAP, and gives all line item detail for entire home health episode.
From and Through Dates match date of first service delivered.	From Date same as RAP, Through Date is discharge.
Creates home health episode in authorization system.	Closes home health episode in authorization system at date of discharge, not 60 days.

RAP	CLAIM
Triggers initial percentage payment.	Triggers final percentage payment, and total payment for the episode will be cut back proportionately (x/60), **x** being the number of days of the shortened home health episode.

3.1.2.23.5.1 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.

3.1.2.23.5.2 A PEP can also occur in a period of otherwise continuous care.

3.1.2.23.5.3 A PEP episode can contain a change in patient condition.

3.1.2.23.6 Episode with a PEP Adjustment - Discharge and "Unknown" Re-Admit, Continuous Care:

FIRST EPISODE (RAP)	CLAIM	START OF NEXT EPISODE (RAP)
Contains one HIPPS and Claim-OASIS Matching Key output from Grouper software linked to OASIS	Submitted after discharge or 60 days with Patient Status 01 - agency submitted claim before the patient was re-admitted in the same 60-day episode.	Unlike previous RAP in Code period, Admission Date will be the same as that opening 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 TRICARE use	Contains same HIPPS Code as RAP, and gives all line item detail for the entire episode.	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 Episode will begin and previous episode automatically shortened.
Creates home health episode in authorization system	Closes home health episode in authorization system 60 days initially, and then revised to less than 60 days after next RAP received.	
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60 of home health episode.	From and Through Dates, equal first episode day with service or Day 60 of home health episode without service (i.e., Day 61, 121, 181).
Triggers initial percentage payment	Triggers final payment, may be total payment for home health episode at first, will be cut back proportionately (x/60) to the number of the shortened episode when next billing received.	Opens next Episode in authorization system. Triggers initial payment for new home health episode.

3.1.2.23.7 Episode with a SCIC Adjustment:

RAP	CLAIM
Contains one HIPPS Code and Claim-OASIS Matching Key output from Grouper	Submitted after discharge with Patient Status Code software linked to OASIS as appropriate (01, 30, etc.). Carries Matching Key and diagnoses consistent with last OASIS assessment.
Does not contain other line item for TRICARE 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 the entire home health episode.

RAP	CLAIM
From and Through Dates match date of first service delivered	From Date same as RAP, Through Date Discharge or Day 60.
Creates home health episode in authorization system	Closes home health episode in authorization system.
Triggers initial percentage payment	Triggers final percentage payment.

3.1.2.23.8 General Guidance on Line Item Billing Under HHA PPS - Quick Reference on Billing Most line items on HHA PPS RAPs and Claims:

TYPE OF LINE ITEM	EPISODE	SERVICES/VISITS	OUTLIER
Claim Coding	New 023 revenue code with new HIPPS on HCPCS 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 HHA PPS).	Determined by Pricer - Not billed by HHAs.
TOB	Billed on 32X only (have 485, patient homebound).	Billed on 32X only if POC; 34X* if no 485.	Appears on remittance only for HHA PPS (via Pricer)
Payment Bases	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*.	Addition to PPS episode rate payment only, not LUPA, paid on claim basis, not line item.
PPS Claim?	**Yes**, RAPs and Claims	**Yes**, Claims only [34X*; no 485/non-PPS]	**Yes**, Claims only

Note: For HHA 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 home health visit/services on this chart will not be paid separately if a home health episode for same beneficiary is open on the system (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	VACCINE	OTHER OUTPUT ITEMS (ANTIGENS, SPLINTS & CASTS)
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, and voluntary use of 623 for wound care supplies.	Current revenue code 636 & HCPCs.	Current revenue codes 636 (drug) and HCPCs, 771 (administration).	Current revenue code 550 & HCPCs.
TOB	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed to Contractor on 32X if 485; 34X*, if no 485.	Billed on 32X if 485; or 34X*, if no 485.	Billed on 34X* only.	Billed on 34X* only.	Billed on 34X* only.
Payment Basis	Lower of total rental cost or reasonable purchase cost.	Allowable charge methodology. Oxygen concentrator - rental or purchase.	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	Average wholesale cost, and paid separately with or without open HHA PPS episode.	
PPS Claims?	**Yes**, Claim only [34X*, no 485/ non-PPS]	**Yes**, Claim only [34X*; if no 485/ non-PPS]	**Yes**, Claim only [34X*, if no POC/non-PPS]	**No** (34X*; claims only)	**No** (34X*; claims only)	**No** (34X*; claims only)

Note: For HHA PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).
* 34X claims for home health services, except as noted for specific items above, will not be paid separately if a home health episode for the same beneficiary is open on the system.
** Other than DME treated as routine supplies according to TRICARE.
*** Routine supplies are not separately billable or payable under TRICARE Home Health Care (HHC). When billing on TOB 32X, catheters and ostomy supplies are considered non-routine supplies and are billed with revenue code 270.

3.1.2.24 Other Billing Considerations.

3.1.2.24.1 Billing for Nonvisit Charges. Under HHA PPS, all services under a POC must be billed as a HHA PPS episode. All services within an EOC must be billed on one claim for the entire episode.

- TOB 329 and 339 are not accepted without any visit charges. Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.

- Nonvisit charges incurred after termination of the POC are payable under medical and other health services on TOB 34X.

3.1.2.24.2 Billing for Use of Multiple Providers. 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 RAP.

- 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 EOC. When the system indicates an EOC is open for a beneficiary, deny the RAP on any other agency billing within the episode unless the RAP indicates a transfer or discharge and readmission situation exists.

3.1.2.24.3 Home Health Services Are Suspended or Terminated and Then Reinstated. A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health service. When the suspension is temporary (does not extend beyond the end 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 POC 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 023 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 POC and submit a RAP for a new episode. The admission date would match the episode from date, as the admission is under a new POC and care was not continuous.

3.1.2.24.4 Preparation of a Home Health Billing Form in No-Payment Situations. HHAs must report all non-covered charges on the CMS 1450 UB-04, including no-payment claims as described below. HHAs must report these non-covered charges for all home health services, including both Part A (TOB 0339) and Part B (TOB 0329 or 034X) service. Non-covered charges must be reported only on HHA PPS claims. RAPs do not require the reporting of non-covered charges. HHA no-payment bills submitted with types of bill 0329 or 0339 will update any current home health benefit period on the system. Per CMS transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used.

3.1.2.24.5 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. (Provider should not report the non-payment codes outlined below). On the CMS 1450 UB-04 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 CMS 1450

UB-04 report these charges in 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 on to other payers.

3.1.2.24.6 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 system record for these claims. Total the charges on the system under revenue code 0001 (total and non-covered). Non-payment codes are required in the system records where no payment is made for the entire claim. Utilize non-payment codes in §3624. These codes alert the TRICARE Program to bypass edits in the systems processing that are not appropriate in non-payment cases. Enter the appropriate code in the "Non-Payment Code" field of the system record if the nonpayment situation applies to all services covered by the bill. When payment is made in full by an insurer primary to the TRICARE Program, 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 system record.

3.1.2.24.7 No-Payment Billing and Receipt of Denial Notices Under HHA PPS. HHAs may seek denials for entire claims from the TRICARE Program in cases where a provider knows all services will not be covered by the TRICARE Program. Such denials are usually sought because of the requirements of other payers (e.g., Medicaid) for providers to obtain TRICARE Program denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

3.1.2.24.7.1 Submission and Processing. In order to submit a no-payment bill to the TRICARE Program under HHA PPS, providers must:

3.1.2.24.7.2 Use TOB 03x0 in FL 4 and condition code 21 in FL 18-28 of the CMS 1450 UB-04 claim form.

3.1.2.24.7.3 The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported.

3.1.2.24.7.4 Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line.

3.1.2.24.7.5 In order for these claims to process through the subsequent HHA PPS edits in the system, providers are instructed to submit a 023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, an 18-digit string of the number 1, **111111111111111111**, for the OASIS Claim-Matching Key in FL 63, and meet other minimum TRICARE Program requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching Key output should be used.

3.1.2.24.7.6 The TRICARE Program standard systems will bypass the edit that required a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems must also ensure that a matching RAP has not been paid for that billing period.

3.1.2.24.7.7 FL 15, source of admission, and treatment authorization code, FL 63, should be unprotected for no-pay bills.

3.1.2.24.8 Simultaneous Covered and Non-Covered Services. In some cases, providers may need to obtain a TRICARE Program denial notice for non-covered services delivered in the same period as covered services that are a part of an HHA PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, and submit the appropriate HHA PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. TRICARE contractor's claims processing systems and automated authorization files will allow such duplicate claims to process when all services on the claim are non-covered.

3.2 Reporting Requirements

Reimbursement will follow Medicare's HHA PPS methodology. With the implementation of HHA PPS, revenue code 023 must be present on all HHA PPS TEDs in addition to all other revenue code information pertinent to the treatment. See the TRICARE Systems Manual (TSM), Chapter 2, Addendum H for a list of valid revenue codes. In addition, under HHA PPS all HHA TEDs must be coded with special rate code **V** Medicare Reimbursement Rate or Special Rate Code **D** for a Discount Rate Agreement.

- END -

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 -

Chapter 12 Addendum K (CY 2017)

Annual Home Health Agency Prospective Payment System (HHA PPS) Rate Updates - CY 2017

Revision: C-3, June 30, 2017

(Final payment amounts per 60-day episodes ending on or after January 1, 2017, and before January 1, 2018 - Continuing Calendar Year (CY) update.)

Home Health Agency Prospective Payment System (HHA PPS) - Determination of Standard HHA PPS amounts

Section 1895(b)(3)(B) of the Act, as amended by section 5201 of the Deficit Reduction Act (DRA), requires for CY 2017 that the standard prospective payment amount be increased by a factor equal to the applicable Home Health (HH) market basket update for HHAs.

Rebasing of 60-Day Episode Payment Amount, National Per-Visit Rates, and the Non-Routine Medical Supplies (NRS) Conversion Factor

Beginning in CY 2014, as required by section 3131(a)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS), and described in their Final Rule published December 2, 2013, rebased the national, standardized 60-day episode payment amount, the national per-visit rates, and the NRS conversion factor. 2017 is the final year of the rebasing adjustment. For CY 2017 the rebasing adjustment is $80.95.

National 60-Day Episode Payment Amounts - CY 2017

In order to calculate the CY 2017 national standardized 60-day episode, the CY 2016 estimated average payment per 60-day episode of $2,965.12 is adjusted by the wage-index budget neutrality factor, a case-mix weights budget neutrality factor, an adjustment for nominal case-mix growth, the rebasing adjustment, and the home health market basket update, as reflected in Figure 12.K.2017-1.

FIGURE 12.K.2017-1 CY 2017 NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNTS

CY 2017 National Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	Nominal Case-Mix Growth Adjustment	CY 2017 Rebasing Adjustment	CY 2017 HH Payment Update Percentage	CY 2017 National, Standardized 60-Day Episode Payment
$2,965.12	x 0.9996	x 1.0214	x0.9903	- $80.95	x 1.025	= $2,989.97

National Per-Visit Amounts Used to Pay Low Utilization Payment Adjustments (LUPAs) and Compute Costs of Outlier - CY 2017

To calculate the CY 2017 national per-visit rates, the 2016 national per-visit rates are adjusted by a wage index budget neutrality factor, and are then increased by the rebasing adjustments described in the December 2, 2013, CMS Final Rule. Finally, the rates are updated by the CY 2017 HH market basket update. National per-visit rates are not subjected to the nominal increase in case-mix. The final updated CY 2017 national per-visit rates per discipline are reflected in Figure 12.K.2017-2:

FIGURE 12.K.2017-2 CY 2017 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAs

HH Discipline Type	CY 2016 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2017 Rebasing Adjustment	CY 2017 HH Payment Update Percentage	CY 2017 Per-Visit Payment
HH Aide	$60.87	x 1.0000	+ $1.79	x 1.025	$64.23
Medical Social Services (MSS)	215.47	x 1.0000	+ 6.34	x 1.025	227.36
Occupational Therapy (OT)	147.95	x 1.0000	+ 4.35	x 1.025	156.11
Physical Therapy (PT)	146.95	x 1.0000	+ 4.32	x 1.025	155.05
Skilled Nursing (SN)	134.42	x 1.0000	+ 3.96	x 1.025	141.84
Speech-Language Pathology (SLP)	159.41	x 1.0000	+ 4.70	x 1.025	168.52

Payment of LUPA Episodes

For CY 2017, as described in the December 2, 2013, CMS Final Rule, the per-visit payment amount for the first SN, PT, and SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes is multiplied by the LUPA add-on factors, which are: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP.

NRS Conversion Factor Update

Payments for the NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2017, the 2016 NRS conversion factor was adjusted using the 2.82 rebasing adjustment factor, as described in the December 2, 2013, CMS Final Rule, and then updated by the CY 2017 HH market basket. See Figure 12.K.2017-3.

FIGURE 12.K.2017-3 CY 2017 NRS CONVERSION FACTOR

CY 2016 NRS Conversion Factor	CY 2017 Rebasing Adjustment	CY 2017 HH Payment Update Percentage	CY 2017 NRS Conversion Factor
$52.71	x 0.9718	x 1.025	= $52.50

The payment amounts, using the above computed CY 2017 NRS conversion factor ($52.50), for the various severity levels based on the updated conversion factor are calculated in Figure 12.K.2017-4.

FIGURE 12.K.2017-4 CY 2017 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM

Severity Level	Points (Scoring)	Relative Weight	CY 2017 NRS Payment Amounts
1	0	0.2698	$14.16
2	1 to 14	0.9742	51.15
3	15 to 27	2.6712	140.24
4	28 to 48	3.9686	208.35
5	49 to 98	6.1198	321.29
6	99+	10.5254	552.58

Labor And Non-Labor Percentages

For CY 2017, the labor percent is 78.535%, and the non-labor percent is 21.465%.

Outlier Payments

Under the HHA PPS, outlier payments are made for episodes for which the estimated cost exceeds a threshold amount. The wage adjusted Fixed Dollar Loss (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. The FDL ratio, which is used in calculating the FDL amount, for CY 2017 is 0.55.

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 episode of care.

FIGURE 12.K.2017-5 CY 2017 COST-PER-UNIT PAYMENT RATES FOR THE CALCULATION OF OUTLIER PAYMENTS

Visit Type	CY 2017 National Per-Visit Payment Rates	Average Minutes-per-visit	Cost-per-unit (1 unit = 15 minutes)
HH aide	$64.23	63.0	$15.29
MSS	227.36	56.5	60.36
OT	156.11	47.1	49.72
PT	155.05	46.6	49.91
SN	141.84	44.8	47.49
SLP	168.52	48.1	52.55

Outcome and Assessment Information Set (OASIS)

HHAs must collect OASIS data in order to participate in the TRICARE program. See Addendum F for the OASIS.

Temporary 3% Rural Add-On for the HHA PPS

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173, enacted on December 8, 2003, and as amended by Section 3131(c) of the Affordable Care Act) provides an increase of 3% of the payment amount otherwise made under Section 1895 of the Social Security Act for HH services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. The 3% rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor when HH services are provided in rural (non-Core Based Statistical Area (CBSA)) areas. The applicable case-mix and wage index adjustments are subsequently applied. Episodes that qualify for the 3% rural add-on will be identified by a CBSA code that begins with '999'.

National 60-Day Episode Payment Amounts for Rural, Non-CBSA Areas

In order to calculate the national standardized 60-day episode payment for beneficiaries residing in a rural area, the CY 2017 national standardized 60-day episode payment of $2,989.97 was increased by 3% to $3,079.67.

Per-Visit Amounts For Services Provided In A Rural Area, Before Wage Index Adjustment

The CY 2017 national per-visit amounts were increased by 3% for beneficiaries who reside in rural areas. See Figure 12.K.2017-6.

FIGURE 12.K.2017-6 CY 2017 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

HH Discipline Type	CY 2017 Per-Visit Rate	Multiplied by the 3% Rural Add-On	CY 2017 Rural Per-Visit Rate
HH Aide	$64.23	x 1.03	$66.16
MSS	227.36	x 1.03	234.18
OT	156.11	x 1.03	160.79
PT	155.05	x 1.03	159.70
SN	141.84	x 1.03	146.10
SLP	168.52	x 1.03	173.58

CY 2017 NRS Conversion Factor For Services Provided In A Rural Area

The CY 2017 NRS Conversion Factor was multiplied by the 3% rural add-on to result in a NRS Conversion Factor of $54.08 for CY 2017.

CY 2017 NRS Payment Amounts For Services Provided In Rural Areas

The CY 2017 NRS payment amounts for services provided in rural areas are summarized in Figure 12.K.2017-7:

FIGURE 12.K.2017-7 CY 2017 RELATIVE WEIGHTS FOR THE SIX-SEVERITY NRS SYSTEM FOR BENEFICIARIES RESIDING IN A RURAL AREA

Severity Level	Points (Scoring)	Relative Weight	CY 2017 NRS Payment Amounts
1	0	0.2698	$14.59
2	1 to 14	0.9742	52.68
3	15 to 27	2.6712	144.46
4	28 to 48	3.9686	214.62
5	49 to 98	6.1198	330.96
6	99+	10.5254	569.21

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Chapter 12 Addendum L

Annual Home Health Agency Prospective Payment System (HHA PPS) Wage Index Updates - CY 2015 - CY 2017

Revision: C-3, June 30, 2017

In 2013, the Office of Management and Budget (OMB) issued changes in the delineation of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combined Statistical Areas. Centers for Medicare and Medicaid Services (CMS) finalized changes to the wage index based on the revised Core Based Statistical Area (CBSA) delineations for the Calendar Year (CY) 2015 HH PPS wage index. These changes are made to the wage index using a blended wage index for a one-year transition. For each county, a blended wage index is calculated as 50% of the CY 2015 wage index using the current OMB delineations and 50% of the CY 2015 wage index using the revised OMB delineations.

The CY 2015 transitional wage index is available for download at http://www.health.mil/rates.

Beginning January 1, 2016, the wage index for all HH PPS payments will be fully based on the new OMB delineations. In CY 2016, CMS updated the HH wage index using solely the new geographic delineations.

The CY 2016 and 2017 wage indexes are available for download at http://www.health.mil/rates.

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