Home Health Benefit Coverage And Reimbursement - Pricer Requirements And Logic

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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)

1.0 APPLICABILITY

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

2.0 ISSUE

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

3.0 POLICY

3.1 HHA PPS Pricer Requirements

All home health services billed on type of bill (TOB) 32X will be reimbursed based on calculations made by the Home Health (HH) Pricer. Per Centers for Medicare & Medicaid Services (CMS) transmittal 2694, effective October 1, 2013, the TOB 033X will no longer be used. The HH Pricer operates as a call module within TRICARE's standard systems. The HH Pricer makes all reimbursement calculations applicable under HHA PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full Episodes Of Care (EOCs), and all payment adjustments, including low utilization payments (LUPAs), partial episode payment (PEP) adjustment, therapy threshold adjustments, and outlier payments. Standard systems must send an input record to Pricer for all claims with covered visits, and Pricer will send the output record back to the standard systems. The following sections describe the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make payment determinations.

3.1.1 General Requirements

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

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

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

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

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

3.1.2 Pricing of RAPs

3.1.2.1 Pricer will employ RAP logic for TOB 322 only.

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

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

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

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

3.1.3 Pricing of Claims

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

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

- LUPA
- Recoding of claims based on episode sequence and therapy thresholds
- Home Health Resource Group (HHRG) payments [including PEP]
- Outlier, in accordance with logic in TRICARE paper

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

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

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

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

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

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

3.1.3.15 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 episode of care. 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 L (CY 2017). 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.

3.1.3.16 Pricer will return claim payment with no outlier payment with return code "00".

3.1.3.17 Pricer will return claim payments with outlier payment with return code "01".

3.1.3.18 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.

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

3.1.3.20 Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Following are the annual updated items:

- The Federal standard episode amount;
- The Federal conversion factor for non-routine supplies;
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights to be used for each Health Resource Group (HRG);
- A table of supply weights to be used to adjust the non-routine supply conversion factor;
- A table of national standardized per visit rates and per unit rates;
- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the RAP payment percentages, the outlier loss-sharing percentage and the labor and non-labor percentages.

3.1.4 Interface with Pricer

3.1.4.1 Provide specification for a 650-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 The 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, the standard systems 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, the standard systems 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, the standard systems 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 650 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 if it is sent to the HH Pricer in the future.
11-22	X(12)	HIC	**Input Item:** The HIC number of the beneficiary, copied from the claim form.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
23-28	X(6)	PRO-NO	**Input Item:** The six digit OSCAR system provider number, copied from the claim form.
29-31	X(3)	TOB	**Input Item:** The TOB code, copied from the claim form.
32	X	PEP-INDICATOR	**Input Item:** A single Y/N character to indicate if a claim must be paid a PEP adjustment. Standard systems must set a "Y" if the discharge status code on the claim is 06. An "N" is set in all other cases.
33-35	9(3)	PEP-Days	**Input Item:** The number of days to be used for PEP payment calculation. 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.
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 Medicare's provider specific file. **Valid Values:** 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0%
37-46	X(9)	FILLER	Blank.
47-50	X(5)	CBSA	**Input Item:** The CBSA code, copied from the value code 61 amount on 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 the claim form. Date format must be CCYYMMDD.
61-68	X(8)	SERV-THRU-DATE	**Input Item:** The statement covers period "Through" date, copied from the claim form. Date format must be CCYYMMDD.
69-76	X(8)	ADMIT-DATE	**Input Item:** The admission date, copied from the claim form must be CCYYMMDD.
77	X	HRG-MED-REVIEW INDICATOR	**Input Item:** A single Y/N character to indicate if a HIPPS code has been changed by medical review. Standard systems must set a "Y" if an ANSI code on the line item indicates medical review change. 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 change, 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 unless the claim is recoded due to therapy thresholds or changes in episode sequence. If recoded, standard systems stores this output item in the APC-HIPPS field on the claim record.
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 by 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.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
91-96	9(2)V9 (4)	HRG-WGTS	**Output Item:** The weight used by Pricer to determine the payment 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	Fields for five more occurrences of all HRG/HIPPS code related fields defined above. **NOT USED**.
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.
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.
258-262	9(5)	REVENUE-QTY-OUTLIER-UNITS	**Input Item:** The sum of the units reported on all covered lines corresponding to each of the six revenue codes. The standard systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.
263-270	9(8)	REVENUE-EARLIEST-DATE	**Input Item:** The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
271-279	9(7)V9 (2)	REVENUE-DOLL-RATE	**Output Item:** The dollar rates used by Pricer to calculate the payment 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.
280-288	9(7)V9 (2)	REVENUE-COST	**Output Item:** The dollar amount determined by Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA. Otherwise, the dollar amounts used by Pricer to impute the costs of the claim for purposes of calculating an outlier payment, if any.
289-297	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	**Output Item:** The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055X, then this is the national per-visit amount multiplied by 1.8714. If revenue code 042X, then this is the national per-visit amount multiplied by 1.6841. If revenue code 044X, then this is the national per-visit amount multiplied by 1.6293.
298-532	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
533-534	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 02 = Final payment where outlier applies, but is not payable due to limitation 03 = Initial percentage payment, 0% 04 = Initial percentage payment, 50% 05 = Initial percentage payment, 60% 06 = LUPA payment only 07 = Not used 08 = Not used 09 = Final payment, PEP 11 = Final payment, PEP with outlier 12 = Not used 13 = Not used 14 = LUPA payment, first episode add-on payment applies **Error return codes:** 10 = Invalid TOB 15 = Invalid PEP Days 16 = Invalid HRG days, greater than 60 20 = PEP indicator invalid 25 = Med review indicator invalid 30 = Invalid MSA/CBSA code 35 = Invalid Initial Payment Indicator 40 = Dates before October 1, 2000 or 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
535-539	9(5)	REVENUE-SUM 1-3-QTY-THR	**Output Item:** The total therapy visits used by the Pricer to determine if the therapy threshold was met for the claim. This amount will be the total of the covered visit quantities input with revenue codes 42X, 43X, and 44X.
540-544	9(5)	REVENUE-SUM 1-6-QTY-All	**Output Item:** The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six home health discipline revenue codes.
545-553	9(7)V9 (2)	OUTLIER-PAYMENT	**Output Item:** The outlier payment amount determined by Pricer to be due on the claim in addition to any HRG payment amounts.
554-562	9(7)V9 (2)	TOTAL- PAYMENT	**Output Item:** The total reimbursement determined by Pricer to be due on the RAP or claim.
563-567	9(3)V9 (2)	LUPA-ADD-ON-PAYMENT	**Output Item:** For claim "Through" dates before January 1, 2014, the add-on amount to be paid for LUPA claims that are the first episode in a sequence. This amount is added by the standard systems to the payment for the first visit line on the claim. **For claim "Through" dates on or after January 1, 2014, zero filled.**

FILE POSITION	FORMAT	TITLE	DESCRIPTION
568	X	LUPA-SRC-ADM	**Input Item:** Standard systems set this indicator to 'B' when condition code 47 is present on the RAP or claim. The indicator is set to '1' in all other cases.
569	X	RECODE-IND	**Input Item:** A recoding indicator set by standard systems in response to identifying that the episode sequence reported in the first position of the HIPPS code must be changed. Valid values: 0 = Default value 1 = HIPPS code shows later episode, should be early episode 2 = HIPPS code shows early episode, but this is not a first or only episode 3 = HIPPS code shows early episode, should be later episode
570	9	EPISODE-TIMING	**Input Item:** A code indicating whether a claim is an early or late episode. Standard systems copy this code from the 10th position of the treatment authorization code. Valid values: 1 = Early episode 2 = Late episode
571	X	CLINICAL-SEV-EQ1	**Input Item:** A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 1 of the case-mix system. The standard systems copy this code from the 11th position of the treatment authorization code.
572	X	FUNCTION-SEV-EQ1	**Input Item:** A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 1 of the case-mix system. The standard systems copy this code from the 12th position of the treatment authorization code.
573	X	CLINICAL-SEV-EQ2	**Input Item:** A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 2 of the case-mix system. The standard systems copy this code from the 13th position of the treatment authorization code.
574	X	FUNCTION-SEV-EQ2	**Input Item:** A hexavigesimal code that converts to a number representing the functional score for this patient calculated under equation 2 of the case-mix system. The standard systems copy this code from the 14th position of the treatment authorization code.
575	X	CLINICAL-SEV-EQ3	**Input Item:** A hexavigesimal code that converts to a number representing the clinical score for this patient calculated under equation 3 of the case-mix system. The standard systems copy this code from the 15th position of the treatment authorization code.
576	X	FUNCTION-SEV-EQ3	**Input Item:** A hexavigesimal code that converts to a number representing the functional score for this patient calculate under equation 3 of the case-mix system. The standard systems copy this code from the 16th position of the treatment authorization code.
577	X	CLINICAL-SEV-EQ4	**Input Item:** A hexavigesimal code that converts to a number representing the clinical score for this patient calculate under equation 4 of the case-mix system. The standard systems copy this code from the 17th position of the treatment authorization code.
578	X	FUNCTION-SEV-EQ4	**Input Item:** A hexavigesimal code that converts to a number representing the functional score for this patient calculate under equation 4 of the case-mix system. The standard systems copy this code from the 18th position of the treatment authorization code.

FILE POSITION	FORMAT	TITLE	DESCRIPTION
579-588	9(8)V99	PROV-OUTLIER-PAY-TOTAL	**Input Item:** The total amount of outlier payments that have been made to this HHA for episodes ending during the current calendar year.
589-599	9(9)V99	PROV-PAYMENT-TOTAL	**Input Item:** The total amount of HH PPS payments that have been made to this HHA for episodes ending during the current calendar year.
600-604	9V9(5)	PROV-VBP-ADJ-FAC	**Input Item:** The standard systems move this information from field 30 of the provider specific file.
605-613	9(7)V9 (2)	VBP-ADJ-AMT	**Output Item:** The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.
614-622	9(7)V9 (2)	PPS-STD-VALUE	**Output Item:** The standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.
623-650	X(28)	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, Pricer will perform the following calculations in the numbered order:

3.1.6.1 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 TRICARE. Multiply the case-mix adjusted rate by the current labor related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to "CBSA." Multiply the Federal adjusted rate by the current non-labor related

percentage to determine the non-labor portion. Sum the labor and non-labor portions. The sum is the case-mix and wage index adjusted payment for this HRG.

3.1.6.2 Find the non-routine supply weight corresponding to the fifth positions of the "HRG-INPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. Sum the HRG payment and non-routine supply payments.

3.1.6.2.1 If the "INIT-PYMNT-INDICATOR" equals 0 or 2, 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". If no, multiply the wage index and case-mix adjusted payment by 0.5. Return the resulting amount as "HRG-PAY" and as "TOTAL-PAYMENTS" with return code 04.

3.1.6.2.2 If the "INIT-PAYMNT-INDICATOR" equals 1 or 3, 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, 327, 32F, 32G, 32H, 32I, 32J, 32K, 32M, 32P, 32Q, or 33Q (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 Prior to these calculations, determine the applicable Federal standard episode rate to apply by reading the value in "INIT-PAYMENT-INDICATOR." If the value is 0 or 1, use the full standard episode rate in subsequent calculations. If the value is 2 or 3, use the standard episode rate which has been reduced by 2% due to the failure of the provider to report required quality data.

Note: Since the TRICARE Program is not following Medicare's requirement for a 2% reduction in the standard episode rate due to the failure of the provider to report required quality data, all four values (0, 1, 2, or 3) appearing in "INIT-PAYMENT-INDICATOR" will result in full payment of standard episode rate.

3.1.7.2 LUPA Calculations

3.1.7.2.1 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 calendar year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

3.1.7.2.2 If the following conditions are met, calculate an additional LUPA add-on payment:

- The dates in the "SERV-FROM'DATE" and "ADMIT-DATE" fields match;
- The first position of the HIPPS code is a 1 or a 2;
- The value in "LUPA-SRC-ADM" is not a B; and
- The value in "RECODE-IND" is not 2.

Compare the earliest line item dates for revenue codes 042X, 044X, and 055X and select the revenue code with the earliest date. If the earliest date for revenue codes 042X or 044X match the revenue code 055X date, select revenue code 055X. If the earliest date for revenue codes 042X and 044X match and revenue code 055X is not present, select revenue code 042X.

3.1.7.2.3 Apply the appropriate LUPA add-on factor to the selected earliest dated line.

- If revenue code 055X, multiply the national per-visit amount by 1.8451.
- If revenue code 042X, multiply the national per-visit amount by 1.6700.
- If revenue code 044X, multiply the national per-visit amount by 1.6266.

Return the resulting payment amount in the “REVENUE-ADD-ON-VISIT-AMT” field.

3.1.7.2.4 Return the sum of all “REVENUE-COST” amounts and the “REVENUE-ADD-ON-VISIT-AMT”, if applicable, the “TOTAL-PAYMENT” field. If the LUPA payment includes LUPA add-on amount, return 14 in the “PAY-RTC” field. Otherwise, return 06 in the “PAY-RTC” field. These distinct return codes assist the standard systems in apportioning visit payments to claim lines. No further calculations are required. If “REVENUE-SUM1-6-QTY-ALL” is greater than or equal to 5, proceed to the recoding process in paragraph 3.1.7.3.

3.1.7.3 Recoding of claims based on episode sequence and therapy thresholds.

- Read the “RECODE-IND.” If the value is 0, proceed to paragraphs 3.1.7.3.2 and 3.1.7.3.4 below (therapy visit recoding) based on the claim “Through” date.

- If the value in “RECODE-IND” is 1, find the number of therapy services reported in “REVENUE-SUM1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

- If the value in “RECODE-IND” is 3, find the number of therapy services reported in “REVENUE-SUM1-3-QTY-THR.” If the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

- Read the alphabetic values in the “CLINICAL-SEV-EQ” field and “FUNCTION-SERV-EQ” field for which the number at the end of the field names corresponds to the recoded first position of the HIPPS code determined above. Translate the alphabetic value from a hexavigesimal code to its corresponding numeric valve. These are the severity scores in the clinical and functional domains of the case mix model under the payment equation that applies to the claim.

3.1.7.3.1 For claims with “Through” dates on or after January 1, 2016 and before January 1, 2017, use the following translation:

- If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity levels and the number of therapy visits in the “REVENUE-SUM1-3-QTY-THR” field to recode the second, third, and fourth

positions of the HIPPS code as follows:

- Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 - CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A
C through D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

- Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 - FUNCTION-SEV-EQ1 value	FUNCTION-EQ1 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through O	0 - 14	F1 (Min)	F
P	15	F2 (Low)	G
Q+	16+	F3 (Mod)	H

- Recode the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K
6	L
7 - 9	M
10	N
11 - 13	P

- If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:

  - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 - CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A
C through H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 - FUNCTION-SEV-EQ2 value	FUNCTION-EQ2 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through G	0 - 6	F1 (Min)	F
H through N	7 - 13	F2 (Low)	G
Q+	14+	F3 (Mod)	H

- Recode the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
14 - 15	K
16 - 17	L
18 - 19	M

- If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:

  - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 - CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A	0	C1 (Min)	A
B	1	C2 (Low)	B
C+	2+	C3 (Mod)	C

  - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 - FUNCTION-SEV-EQ3 value	FUNCTION-EQ3 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through G	0 - 6	F1 (Min)	F
H through K	7 - 10	F2 (Low)	G
L+	11+	F3 (Mod)	H

  - Recode the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K
6	L
7 - 9	M

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
10	N
11 - 13	P

- If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:
  - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 - CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through D	0 - 3	C1 (Min)	A
E through M	4 - 12	C2 (Low)	B
N+	13+	C3 (Mod)	C

  - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 - FUNCTION-SEV-EQ4 value	FUNCTION-EQ4 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A	0	F1 (Min)	F
B through H	1 - 7	F2 (Low)	G
I+	8+	F3 (Mod)	H

  - Recode the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
14 - 15	K
16 - 17	L
18 - 19	M

- Move the resulting recoded HIPPS code to the HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations

3.1.7.3.2 Recoding steps for claims with "Through" dates on or after January 1, 2016 and before January 1, 2017:

- If the first position of the HIPPS code submitted in "HRG-INPUT-CODE" is 5 and the number of therapy services in "REVENUE-SUM1-3-QTY-THR" is less than 20, read the value in the "EPISODE-TIMING" field.

- If the value in the "EPISODE-TIMING" field is a 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code as 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

- If the value in the "EPISODE-TIMING" field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

- Return to the start of paragraph 3.1.7.3.1 and recode the remaining positions of the HIPPS code as described above.

- In all cases, read only the "REVENUE-SUM1-3-QTY-THR" field and recode the fourth positions of the HIPPS code according to the table below, if possible.

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 and 4	
REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K	14 - 15	K
6	L	16 - 17	L
7 - 9	M	18 - 19	M
10	N		
11 - 13	P		

- Move the resulting recoded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weight associated with the code in the "HRG-OUTPUT-CODE field for all further calculations.

- If the HIPPS code begins with 1 and the value in "REVENUE-SUM1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS as described above.

- If the HIPPS code begins with 3 and value in "REVENUE-SUM1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the "RECODE-IND" to 3. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS as described above.

- If the HIPPS code begins with 2 and the value "REVENUE-SUM1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-IND" to 1. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS code as described above.

- If the HIPPS code begins with 4 and the value in "REVENUE-SUM1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS code as described above.

- If the HIPPS code begins with 1 or 2 and the value in "REVENUE-SUM1-3-QTY-THR" is 20 or more:

    - Change the first position of the HIPPS code to 5 and recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 - CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through D	0 - 3	C1 (Min)	A
E through Q	14 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

    - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 - FUNCTION-SEV-EQ2 value	FUNCTION-EQ2 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through C	0 - 2	F1 (Min)	F
D through G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

    - Change the fourth position of the HIPPS code to K.

- If the HIPPS code begins with 3 or 4 and the value in "REVENUE-SUM1-3-QTY-THRU" is 20 or more.

    - Change the first position of the HIPPS code to 2 and recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 - CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through D	0 - 3	C1 (Min)	A
E through Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

    - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 - FUNCTION-SEV-EQ4 value	FUNCTION-EQ4 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through C	0 - 2	F1 (Min)	F
D through G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

    - Change the fourth position of the HIPPS code to K.

3.1.7.3.3 For claims with "Through" dates on or after January 1, 2017, use the following translation:

- If the recoded first position of the HIPPS code is 1, use the numeric values for the clinical and functional severity level and the number of therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS as follows:
    - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 11 - CLINICAL-SEV-EQ1 value	CLINICAL-SEV-EQ1 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A
C through D	2 - 3	C2 (Low)	B
E+	4+	C3 (Mod)	C

- Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 12 - FUNCTION-SEV-EQ1 value	FUNCTION-EQ1 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through N	0 - 13	F1 (Min)	F
O	14	F2 (Low)	G
P+	15+	F3 (Mod)	H

- Change the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K
6	L
7 - 9	M
10	N
11 - 13	P

- If the recoded first position of the HIPPS code is 2, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:
    - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 - CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A

Treatment Authorization Code position 13 - CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
C through H	2 - 7	C2 (Low)	B
I+	8+	C3 (Mod)	C

- Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 - FUNCTION-SEV-EQ2 value	FUNCTION-EQ2 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through G	0 - 6	F1 (Min)	F
H through N	7 - 13	F2 (Low)	G
Q+	14+	F3 (Mod)	H

- Change the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
14 - 15	K
16 - 17	L
18 - 19	M

- If the recoded first position of the HIPPS code is 3, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:

  - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 15 - CLINICAL-SEV-EQ3 value	CLINICAL-SEV-EQ3 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A
C	2	C2 (Low)	B
D+	3+	C3 (Mod)	C

  - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 16 - FUNCTION-SEV-EQ3 value	FUNCTION-EQ3 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through G	0 - 6	F1 (Min)	F
H through K	7 - 10	F2 (Low)	G
L+	11+	F3 (Mod)	H

- Change the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K
6	L
7 - 9	M
10	N
11 - 13	P

- If the recoded first position of the HIPPS code is 4, use the numeric values for the clinical and functional severity levels and the number therapy visits in the "REVENUE-SUM1-3-QTY-THR" field to recode the second, third, and fourth positions of the HIPPS code as follows:

  - Recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 - CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through B	0 - 1	C1 (Min)	A
C through J	2 - 9	C2 (Low)	B
K+	10+	C3 (Mod)	C

  - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 - FUNCTION-SEV-EQ4 value	FUNCTION-EQ4 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through B	0 - 1	F1 (Min)	F
C through J	2 - 9	F2 (Low)	G
K+	10+	F3 (Mod)	H

  - Change the fourth position of the HIPPS code according to the table below:

REVENUE-SUM-1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
14 - 15	K
16 - 17	L
18 - 19	M

- Move the resulting recoded HIPPS code to the HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weights associated with the code in the "HRG-OUTPUT-CODE" field for all further calculations.

3.1.7.3.4 Recoding steps for claims with "Through" dates on or after January 1, 2016 and before January 1, 2017:

- If the first position of the HIPPS code submitted in "HRG-INPUT-CODE" is a 5 and the number of therapy services in "REVENUE-SUM1-3-QTY-THR" is less than 20, read the value in the "EPISODE-TIMING" field.

- If the value in the "EPISODE-TIMING" field is 1, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 1. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 2.

- If the value is the "EPISODE-TIMING" field is a 2, and the number of therapy services is in the range 0-13, recode the first position of the HIPPS code to 3. If the number of therapy services is in the range 14-19, recode the first position of the HIPPS code to 4.

- Return to paragraph 3.1.7.3.3 and recode the remaining positions of the HIPPS code as described above.

- In all cases, read only the "REVENUE-SUM1-3-QTY-THR" field and recode the fourth positions of the HIPPS code according to the table below, if possible.

HIPPS codes beginning with 1 or 3		HIPPS codes beginning with 2 and 4	
REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value	REVENUE-SUM 1-3-QTY-THR value	Resulting HRG-OUTPUT-CODE fourth position value
0 - 5	K	14 - 15	K
6	L	16 - 17	L
7 - 9	M	18 - 19	M
10	N		
11 - 13	P		

- Move the resulting recoded HIPPS code to the "HRG-OUTPUT-CODE" fields. Proceed to HRG payment calculations. Use the weight associated with the code in the "HRG-OUTPUT-CODE field for all further calculations.

- If the HIPPS code begins with 1 and the value in "REVENUE-SUM1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 2, and set the "RECODE-IND" to 1. Recode the remaining positions of the HIPPS as described above.

- If the HIPPS code begins with 3 and value in "REVENUE-SUM1-3-QTY-THR" is greater than 13 and less than 20, change the first position of the HIPPS code to 4, and set the "RECODE-IND" to 3. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS as described above.

- If the HIPPS code begins with 2 and the value "REVENUE-SUM1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 1, and set the "RECODE-

IND" to 1. Return to paragraph 3.1.6.1 and recode the remaining positions of the HIPPS code as described above.

- If the HIPPS code begins with 4 and the value in "REVENUE-SUM1-3-QTY-THR" is less than 14, change the first position of the HIPPS code to 3, and set the "RECODE-IND" to 3. Return to paragraph 3.1.6.1 an recode the remaining positions of the HIPPS code as described above.

- If the HIPPS code begins with 1 or 2 and the value in "REVENUE-SUM1-3-QTY-THR" is 20 or more:

  - Change the first position of the HIPPS code to 5 and recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 13 - CLINICAL-SEV-EQ2 value	CLINICAL-SEV-EQ2 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through D	0 - 3	C1 (Min)	A
E through Q	14 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

  - Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 14 - FUNCTION-SEV-EQ2 value	FUNCTION-EQ2 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through C	0 - 2	F1 (Min)	F
D through G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

  - Change the fourth position of the HIPPS code to K.

- If the HIPPS code begins with 3 or 4 and the value in "REVENUE-SUM1-3-QTY-THRU" is 20 or more.

  - Change the first position of the HIPPS code to 5 and recode the second position of the HIPPS code according to the table below:

Treatment Authorization Code position 17 - CLINICAL-SEV-EQ4 value	CLINICAL-SEV-EQ4 converted point value	Clinical Severity Level	Resulting HRG-OUTPUT-CODE second position value
A through D	0 - 3	C1 (Min)	A
E through Q	4 - 16	C2 (Low)	B
R+	17+	C3 (Mod)	C

- Recode the third position of the HIPPS code according to the table below:

Treatment Authorization Code position 18 - FUNCTION-SEV-EQ4 value	FUNCTION-EQ4 converted point value	Functional Severity Level	Resulting HRG-OUTPUT-CODE third position value
A through C	0 - 2	F1 (Min)	F
D through G	3 - 6	F2 (Low)	G
H+	7+	F3 (Mod)	H

- Change the fourth position of the HIPPS code to K.

3.1.7.4 HRG Payment Calculations

3.1.7.4.1 If the "PEP-INDICATOR" is an "N":

- If the weight for the first four positions the "HRG-OUTPUT-CODE" from the weight table for the calendar year in with the "SERV-THRU-DATE" falls. Multiply the weight times the Federal standard episode rate for the calendar year in which the "SERV-THR-DATE" falls. The product is the case-mix adjusted rate. Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to the "CBSA" field. Multiply the case-mix adjusted rate by the current non-labor-related percentage 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 the HRG.

- Find the non-routine supply weight corresponding to the fifth positions of the "HRG-OUTPUT-CODE" from the supply weight table for the calendar year in which the "SERV-THR-DATE" falls. Multiply the weight times the Federal supply conversion factor for the calendar year in which the "SERV-THRU-DATE" falls. The result is the case-mix adjusted payment for non-routine supplies.

- Sum the payment results for both portions of the "HRG-OUTPUT-CODE" and proceed to the outlier calculations in paragraph 3.1.7.6.

3.1.7.4.2 If the "PEP-INDICATOR" is a "Y":

- Perform the calculation of the case-mix and wage adjusted payment for the HRG and supply amount 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 3.1.7.5).

3.1.7.5 Outlier Calculations

3.1.7.5.1 Wage adjust the outlier fixed loss amount for the Federal fiscal year in which the "SER-THRU-DATE" falls, using the CBSA code in the CBSA 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.

3.1.7.5.2 Claims with "Through" dates before January 1, 2017: For each quantity in the six "REVENUE-QTY-COV-VISITS" fields, read the national standard per visit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the **CBSA** code in the "CBSA" field. The result is the wage index adjusted imputed cost for the episode.

- Claims with "Through" dates on or after January 1, 2017: For each quantity in the six "REVENUE-QTY-OUTLIER-UNITS" fields, read the national standard per unit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the **CBSA** code in the "CBSA" field. The result is the wage index adjusted cost for the episode.

3.1.7.5.3 Subtract the outlier threshold for the episode from the imputed cost for the episode.

3.1.7.5.4 If the result determined in paragraph 3.1.7.6.3 is greater than $0.00, calculate 0.80 times the result. This is the outlier payment amount.

3.1.7.5.5 Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:

- Multiply the amount in the "PROV-PAYMENT-TOTAL" field by 10% to determine the HHA's outlier limitation amount.
- Deduct the amount in the "PROV-OUTLIER-PAY-TOTAL" from the outlier limitation amount. This result is the available outlier pool for the HHA.
- If the available outlier pool is greater than or equal to the outlier payment amount calculated in paragraph 3.1.7.5.4 return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from all HRG payment calculations. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.
- If the available outlier pool is less than the outlier payment amount calculated in paragraph 3.1.7.5.4, return no payment amount to the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

3.1.7.5.6 If the result determined in paragraph 3.1.7.6.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment for the episode. Return zeros in the "OUTLIER-PAYMENT" field. Return the total of all HRG payment amounts in the "TOTAL-PAYMENT" field, with return code 00.

3.1.7.6 Home Health Value-Based Purchasing (HH VBP) Model

3.1.7.6.1 In the Calendar Year (CY) 2016 HH PPS Final Rule, CMS finalized its proposal to implement the HH VBP Model in nine states representing each geographic area in the nation. For all Medicare-certified HHAs that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each

HHA's total performance score on a set of measures already reported via Outcome and Assessment Information Set (OASIS) and Hospital Consumer Assessment of Healthcare Providers and Systems (HHCHAHPS) for all patients serviced by the HHA, or determined by claims data, plus three new measures where performance points are achieved for reporting data.

3.1.7.6.2 Revisions have been made to the HH Pricer program to accept the necessary adjustment factor to apply the HH VBP adjustment and to capture the adjusted amount on the claim record. The HH VBP adjustment amount will be placed on the claim as a value code **QV** amount.

- Effective January 1, 2018, the HH VBP adjustment factor will be reported in the "PROV-VBP-ADJ-FAC" field.

- If no factor is provided, enter 1.00000.

3.1.7.6.3 The HHAs in the nine HH VBP states will have their payments adjusted (upward or downward) in the following manner:

- A maximum payment adjustment of 3% in CY 2018;
- A maximum payment adjustment of 5% in CY 2019;
- A maximum payment adjustment of 6% in CY 2020;
- A maximum payment adjustment of 7% in CY 2021; and
- A maximum payment adjustment of 8% in CY 2022.

Note: Since the TRICARE Program is not following Medicare's payment performance adjustment process (HH VBP Model), 1.00000 will be reported in field "PROV-VBP-ADJ-FAC" for all HH claims resulting in full payment of standard episode rates.

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