1.   Introduction to the HH PPS PC Pricer

1.1   Background on HH PPS

The Balanced Budget Act of 1997 and subsequent legislation called for the creation of a prospective payment system (PPS) for home health agencies.   The law required that all payments for home health services under a physician's plan of care on or after October 1, 2000 be made under this system.   Among other provisions, the law:

- Required payment be made on the basis of a prospective amount;

- Allowed the Secretary of the Department of Health and Human Services to determine a new unit of payment;

- Required the new unit of payment to reflect different patient-related conditions (case mix) and wage adjustments;

- Allowed for cost outliers (supplemental payment for exceptional high-cost cases); and

- Required proration of the payment when a beneficiary chooses to transfer among home health agencies (HHAs) within an episode.

In July 2000, the Centers for Medicare and Medicaid Services (CMS), then known as the Health Care Financing Administration (HCFA), published the final regulations for the home health prospective payment system (HH PPS). These regulations provided for the following:

- The unit of payment that is a 60 day episode;

- Each episode is expected to be paid in two split payments, one billed on a Request for Anticipated Payment (RAP) at the beginning of the episode and one on a claim at the end of the episode;

- Only claims provide line-items detailing the individual services delivered;

- Home Health Resources Groups (HHRGs), represented by HIPPS coding on claims, are the basis of payment for each episode; HHRGs are produced through publicly available Grouper software that determines the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input in this software;

- HHRGs can be changed mid-episode if there is a significant change in a patient's condition (SCIC adjustment);

- Episodes can be truncated and given partial episode payments (PEP adjustment) if beneficiaries choose to transfer among HHAs or if a patient is discharged and subsequently readmitted during the same 60 day period;

- There are also reducing adjustments in payment when the number of visits provided during the episode fall below a certain threshold (low utilization payment adjustments: LUPAs);

- There are downward adjustments in HHRGs if the number of therapy services delivered during an episode does not meet anticipated thresholds-- therapy threshold;

- There are cost outliers, in addition to episode payments; and

- Payments are case-mix and wage adjusted.

In August 2007, CMS issued final regulations refining the HH PPS system. These regulations are effective for HH PPS episodes beginning in calendar year 2008. Key features of these refinements included:

- a new set of HHRGs based on a four-equation case-mix model, with a corresponding new set of HIPPS codes;

- a separate payment adjustment to account for variations in non-routine supply costs;

- multiple therapy thresholds, with payment adjustments to account for both increases and decreases from the expected number of therapies;

- an add-on payment for LUPA claims that are the first or only episodes in a sequence of episodes; and

- the elimination of the significant change in condition (SCIC) policy.

All of the HH PPS payment adjustments that were defined in this final regulation are calculated in a Pricer software module that is executed in the claims processing system of the Medicare contractors responsible for home health claims. This manual assumes users of the PC Pricer have a basic familiarity with HH PPS payment policies. For more complete background information on HH PPS payment policies and claims processing, refer to the Medicare Claims Processing Manual, Chapter 10. For more detailed information on the mainframe Pricer, refer to section 70 of that chapter.

1.2   Purpose and Features of the HH PPS PC Pricer

The HH PPS PC Pricer is a tool to assist home health agencies (HHAs) and other interested parties in determining the Medicare payment for a particular episode of home health care. HHAs may wish to use this software to:

- predict the payment for services they plan to provide,
- calculate the payment they will receive for a particular claim, in order to accurately post accounts receivable, or
- to validate that they have received correct payment for a claim upon receipt of their Medicare remittance advice.

An advantage of the HH PC Pricer for these functions is that it contains and applies precisely the same logic that Medicare contractors use in their claims system.   As a result, HHAs can be sure that the payment calculations reflect current Medicare payment policies exactly.   It should be noted, though, that certain payment adjustments that may occur in the Medicare contractor system are not accounted for in the HH PC Pricer, such as additional payments for Durable Medical Equipment (DME) items, or the calculation of payments if Medicare is the secondary payer.

The HH PC Pricer calculates payments for both RAPs and claims, requiring the key entry of only the limited information required to arrive at an accurate payment. Once this information is entered, the software immediately displays a screen that shows the total payment for the claim, detailed components of the payment including the wage index applied and individual line item payments, and a message explaining the basis of the payment calculation.   The software also creates a printed report of this information if hard copy documentation of a payment calculation is desired.

1.3   Using this manual

The remainder of this manual is divided into three sections, corresponding to three basic questions about how to use this software. Section 2 provides installation instructions. Once the software is installed, most subsections of Sections 3 and 4 are freestanding instructions in how to perform a specific task.   Section 3 contains a subsection that provides definitions of the fields of the screens used to complete the tasks it describes. When first using the manual it may be helpful to familiarize yourself with these field definitions first, and then use the definition sections as a reference as you learn different tasks.   Screen images that display the result of the instructions in each subsection are also provided.

2.   How Do I Install the HH PC Pricer?

2.1   System Requirements

Prior to attempting to install the HH PC Pricer, ensure that your PC is compatible with the software.   The HH PC Pricer requires the Windows 95 operating system or a higher version of Windows (e.g. Windows 98, NT, ME, XP, etc.).

2.2   Downloading from the Internet

The HH PC Pricer is available as a free download from the CMS website. Go to the PC Pricer home page at:
 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/

This page contains a document that provides detailed instructions for downloading and installing PC Pricers to your computer.   Refer to these instructions as needed when you download the HH version.

To access the HH download, click the link on the left-hand sidebar of the page, labeled "Home Health Prospective Payment System (HH PPS) PC Pricer.

2.3   Keeping the software current

Each version of the HH PPS PC Pricer contains software designed to calculate payments for a particular calendar year. Most HHAs will likely want to maintain the PC Pricers applicable to all RAPs or claims within the full Medicare claims timely filing period. Since the timely filing period extends 12 months beyond the service dates of a claim, you may want to maintain two HH PC Pricers at one time. In calendar year 2014, certain claims with dates in 2013 will be timely for Medicare filing.   When calendar year 2015 begins, you will want to download the 2015 HH PC Pricer, but will be able to remove the 2013 version from your PC if you choose.

New HH Pricer versions for a new calendar year are available for download immediately following January 1st of each year. The software is routinely updated each quarter but HHAs will rarely have reason to update the software more frequently than annually. Unless mid-year legislative changes affect Medicare payment rates, these interim updates only affect the providers listed in the provider files contained in the download (see Section 4 for more information on the provider files).

3.   How do I calculate payments?

3.1   Navigating the screens of the PC Pricer

Opening the program:

To launch the PC Pricer, open the HHAPRC*xxx* folder and double click on the file named HHDRV*xxx*.EXE. A CMS masthead screen will appear. The cursor will be blinking in a field in the lower right-hand corner of the screen. Enter the letter indicating the drive on which the program is loaded.

The welcome screen like the one below will be displayed.

```
Screen : HHDRV142

        HHA PC PRICER 2014.2 PSF 01/2014, 01/2014 THRU 12/2014

        WELCOME TO CENTERS FOR MEDICARE & MEDICAID SERVICES

             THIS HHA PC PRICER IS NETWORK COMPATIBLE

        This software is provided by CMS to calculate
        payments for MEDICARE HHA services with THRU
        DATES  01/01/2014 THRU 12/31/2014.  Information
        provided is the most accurate available, however,
        you are responsible for the accuracy and the
        validity of all input parameters used to calculate
        the payment rate.  Report any discrepancies
        to the CMS agency which provided this software.


             UNAUTHORIZED use of this software is
                  strictly prohibited!!!.


             PLEASE SELECT OPTION  BELOW
        -----------------------------------------------------
        (Y = CALCULATE) (V = VIEW A PROVIDER) (Q = QUIT)   ENTER ==> Y
```

There are three options available at the ENTER field in the bottom left corner, to calculate (Y), to view a provider (V) [see Section 4] or to quit. The default setting is a Y to calculate, so press the Enter key on your keyboard to advance to the RAP/claim entry screen.

Basic Navigation:

The primary tool to navigate around the RAP/claim entry screen and other screens in the program is the Tab key on your keyboard. The Tab key jumps the cursor forward from one entry field to the next. You may also advance through fields by pressing the spacebar, but this advances through each position of a field one at a time before advancing to the next field and is much more cumbersome than tabbing.

Pressing the Enter key at any time will initiate the payment calculation. If any information required to calculate a payment is missing when the Enter key is pressed, an error message will be displayed that indicates the missing information.

The fields on all of the screens of the PC Pricer are not sensitive to input from your PC's mouse.   That is, you cannot position the cursor at a particular field by clicking the mouse over that field. Only the title bar at the top of the PC Pricer display is sensitive to the mouse.   Like most Windows screens, clicking and holding the mouse button on this bar allows you to drag the screen around your desktop. The minimize, maximize and exit buttons in the top right-hand corner also respond to the mouse.

Closing the program:

There are two ways to close the program. Using the mouse, you can click the exit button in the title bar. This causes a message box to display "FORCED TERMINATION." Clicking the "Yes" button in this message box completes your exit from the program. Entering "Q" in the ENTER field at the bottom left also closes the program.

3.2   Definition of the fields on the RAP/claim entry screen – Calendar Year 2008 through 2013 Versions

The information provided below defines the information required by each field on the RAP/claims entry screen.   It also indicates whether the field is required or optional for payment calculation, and provides an explanation of each field's purpose. Fields marked "required, with default" are filled automatically by the program with the value most likely to apply. Normally, these fields may be tabbed over, but they may be overwritten with other values as necessary.

HH PROV NO. – Required. Home health agency provider number. Enter your agency's six-digit CMS Certification Number in this field. The PC Pricer contains a file of all the provider numbers that were reported to CMS by a Medicare contractor as an active HHA provider as of the quarter in which your version of the software was created. If your provider number is not this file, your RAP/claim will be calculated with zero payment and you will receive a message reading "No provider number found". If this occurs, or if you are an entity other than an HHA, you may enter a new provider in the provider file (see Section 4).

CBSA – Required. Core-Based Statistical Area. Enter the code that corresponds to the location where the Medicare beneficiary received services. This code is the same code that is entered on the RAP/claim in association with value code 61 in the appropriate form locator of the UB-04. This code is used to determine the wage index value to apply in payment calculations.

PAT-ID NO. – Optional. Patient identification number. This field is designed to accommodate a Medicare health insurance claim (HIC) number (the beneficiary's Social Security Number plus a character suffix).   Any identifying number may be entered in this field. Positions left blank will be filled with zeroes. This item may be useful to the home health agency in associating a printed payment report with a patient's file.

TOB – Required. Type of bill. The type of bill code reported on the RAP/claim submitted to Medicare.   This item is used by the program to determine the type of payment calculation to apply.

   Valid entries: RAPs: 322
                   Claims: 329, adjustment bill types (327, etc.)

INITIAL PAY IND – Required, with default. Initial Payment Indicator. This is an item that is added to a RAP in Medicare processing, to indicate whether a particular provider has been determined ineligible for RAP payments. The default value of this field is zero, which means that normal percentage payments are made on RAPs. If the item is set to 1, all RAP calculations will result in zero.

This field is also used to indicate whether an HHA is paid under the 2% reduction for failing to submit quality data. If the item is set to 2, the payment will be calculated based on the 2% reduction.   If the item is set to 3, all RAP calculations will result in zero and the payment will be calculated based on the 2% reduction.

Valid entries: 0, 1, 2 or 3

PEP IND – Required, with default. Partial episode payment (PEP) indicator. This field is used by the program to determine if a PEP payment calculation should be applied. The default value of N indicates that a PEP is not applied. Change this value to Y if the patient discharge status code on the UB-04 claim would be 06, since these claims are always paid as PEPs. This field will never be changed on RAPs.

Valid entries: Y, N

PEP DAYS – Required, with default. Partial episode payment (PEP) days. This field is no longer used by the program, so tab over this field leaving the default value of zero.

SERV FROM DATE – Required. Service From Date. Enter the date from a RAP or claim that corresponds to the Statement Covers Period "From" field on the UB-04. This field is used by the program to ensure the record falls within the calendar year period that a particular PC Pricer version is designed to calculate. It is also used on RAPs to compare to the ADMIT DATE field (see below) in order to apply the correct percentage payment.

NOTE: The PC Pricer cannot accept dates from a previous calendar year.   This means that episodes spanning January 1 cannot be calculated using the program.

Valid entries: Must use MM/DD/YY date format.

SERV THRU DATE – Required. Service Through Date. Enter the date from a RAP or claim that corresponds to the Statement Covers Period "Through" field on the UB-04. This field is used by the program to ensure the record falls within the calendar year period that a particular PC Pricer version is designed to calculate.

Valid entries: Must use MM/DD/YY date format.

ADMIT DATE-- Required. <u>Admission Date</u>. Enter the date from a RAP or claim that corresponds to the Admission date field on the UB-04.   This field is used by the program on RAPs to compare to the SERV FROM DATE field (see above) in order to apply the correct percentage payment. If these two dates match, a 60% payment is calculated. If they do not match, a 50% payment is calculated.

> Valid entries: Must use MM/DD/YY date format.

SOURCE ADM CODE – Required. <u>Source of Admission Code</u>. On RAPs, always enter 1. On claims, enter 'B' if condition code 47 is reported on the claim.   Otherwise, enter 1. This field is used by the Pricer to determine whether a LUPA add-on amount should be paid.

RECODE IND – Required. <u>Recoding Indicator</u>.   This field is used in Medicare systems when the Common Working File determines that the payment initially calculated for the claim conflicts with the history of prior claims for the beneficiary.   As a result, the claim needs to be recoded and/or recalculated.

> In almost all cases, this information will not be available to a provider using the PC Pricer, so that provider should enter a 0, which indicates no recoding is required.

> An entry of 1 indicates that the HIPPS code reports a RAP or claim is a later episode but it should be an early episode.   An entry of 3 indicates that the HIPPS code reports a RAP or claim is an early episode but it should be a later episode. An entry of 2 indicates that a LUPA add-on payment was calculated but the episode is not a first episode.

> Valid entries: 0, 1, 2, 3

EPISODE TIMING – Required.   <u>Episode Timing Indicator</u>.   Enter the number found in position 10 of the treatment authorization code on the claim.   A 1 indicates the episode is an early episode.   A 2 indicates the episode is a later episode.

> Valid entries: 1 or 2

SEVERITY POINTS– Required. <u>Severity Points for Recoding</u>.   Enter the last 8 positions (positions 11 – 18) of the treatment authorization code on the claim. This value was generated along with the HIPPS code by your HH PPS grouping software (either HAVEN or your commercial product).   This data will be used by the Pricer to re-group the HIPPS code for the episode, if necessary.

> Valid entries: Any letter

HIPPS1--Required.   <u>HIPPS code.</u> Enter the Health Insurance Prospective Payment System (HIPPS) code that corresponds to the revenue code 0023 line on a RAP or

claim. This field is used by the program to determine the appropriate case-mix weight for payment calculations.

MED-IND—Required, with default. Medical Review Indicator. This field was created for use by Medicare contractor medical review or appeals unit staff to indicate a HIPPS code that was changed as a result of adjudication of the claim.   If a value of Y is entered in this field, the program will not change the HIPPS code but will accept the contractor determination for calculation purposes.   Non-contractor users of the program should always leave the default N value in this field.

Valid entries: Y, N

DAYS—Required, with default. Number of Days of Service Provided Under HIPPS Code. This field shows the number of days of service to be paid under each HIPPS code reported on the claim. For claims subject to PEP adjustments, enter the span of days between the first and last visits provided in the episode. For other RAPs or claims, accept the default value of 60 days.

Valid entries: 0 – 60

REV VISITS fields—The following six fields are not required on RAPs. On claims, a number of visits in one or more of the six fields. These fields are used by the program to determine whether a low utilization payment adjustment (LUPA) applies and to calculate any applicable outlier payment amount.

REV1 0420 VISITS -- Physical Therapy Visits. Enter the number of physical therapy visits provided in the episode, which correspond to the number of revenue code 042x lines on a claim.

REV2 0430 VISITS -- Occupational Therapy Visits. Enter the number of occupational therapy visits provided in the episode, which correspond to the number of revenue code 043x lines on a claim.

REV3 0440 VISITS -- Speech-Language Pathology Visits. Enter the number of speech therapy visits provided in the episode, which correspond to the number of revenue code 044x lines on a claim.

REV4 0550 VISITS -- Skilled Nursing Visits. Enter the number of skilled nursing visits provided in the episode, which correspond to the number of revenue code 055x lines on a claim.

REV5 0560 VISITS -- Medical Social Work Visits. Enter the number of medical social worker visits provided in the episode, which correspond to the number of revenue code 056x lines on a claim.
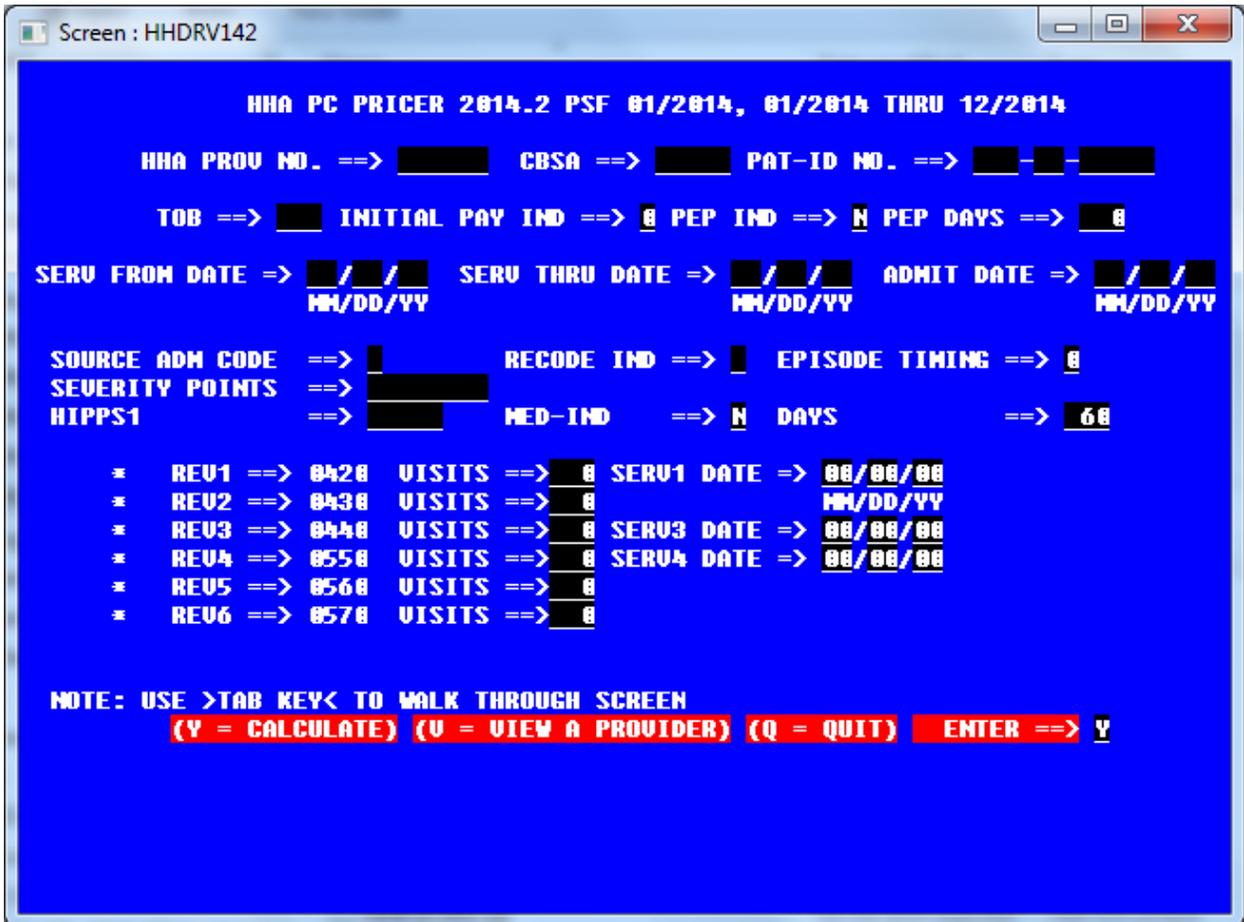
REV6 0570 VISITS -- <u>Home Health Aide Visits</u>. Enter the number of home health aide visits provided in the episode, which correspond to the number of revenue code 057x lines on a claim.

3.3   Definition of the fields on the RAP/claim entry screen – Calendar Year 2014 Version and Later Versions

The information provided below defines the information required by new fields on the RAP/claims entry screen as revised for the Calendar Year 2014 version.   For all other fields, refer to section 3.2.

Note that beginning with the 2014 version, there are date fields required to correspond with certain revenue code entries.   These fields are needed to calculate the revised LUPA add-on payment.

The revised RAP/claims entry screen is shown below:

SERV1 DATE – <u>Earliest Visit Date for Revenue Code 042x</u>. Enter the earliest line item date appearing on the claim with revenue code 042x (physical therapy).

SERV3 DATE – <u>Earliest Visit Date for Revenue Code 044x</u>. Enter the earliest line item date appearing on the claim with revenue code 044x (speech-language pathology).
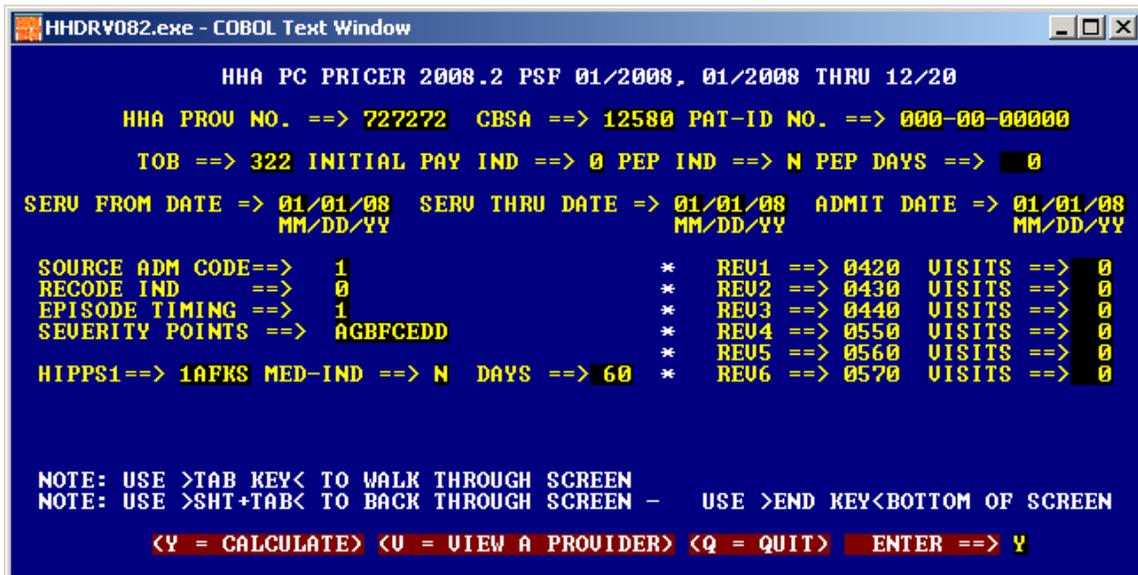
SERV4 DATE – <u>Earliest Visit Date for Revenue Code 055x</u>. Enter the earliest line item date appearing on the claim with revenue code 055x (skilled nursing).

Tab through the Earliest Visit Date fields if no visits for that discipline were provided during the episode, leaving the fields filled with zeroes. When the record calculates, the PC Pricer will fill these fields with 12/31/2099.   User should disregard these 'dummy' dates.

3.4   Entering RAPs

Entry Screen:

The following instructions outline the steps for entering a Request for Anticipated Payment (RAP) for calculation.   A completed RAP entry screen is pictured below.

For episodes beginning before January 1, 2014:

For episodes beginning on or after January 1, 2014:

1. Enter your provider number and the CBSA code representing the beneficiary's site of service (i.e. the value code 61 amount from the claim.)

2. If a patient specific record is desired, enter the beneficiary's Health Insurance Claim number in the PAT-ID NO field. If not, tab over this field.

3. Enter 322 in the TOB field.

4. Tab over the INITIAL PAY IND, PEP IND and PEP DAYS fields, leaving their default values unchanged.

5. Enter the dates in the SERV FROM, SERV THRU and ADMIT DATE fields, corresponding to the RAP. Note: on RAPs the FROM and THRU dates should always match.

6. Always enter 1 in the SOURCE ADM CODE field.

7. Enter 0 in the RECODE IND field.

8. Enter the necessary information from the treatment authorization code on the RAP into the EPISODE TIMING and SEVERITY POINTS fields.
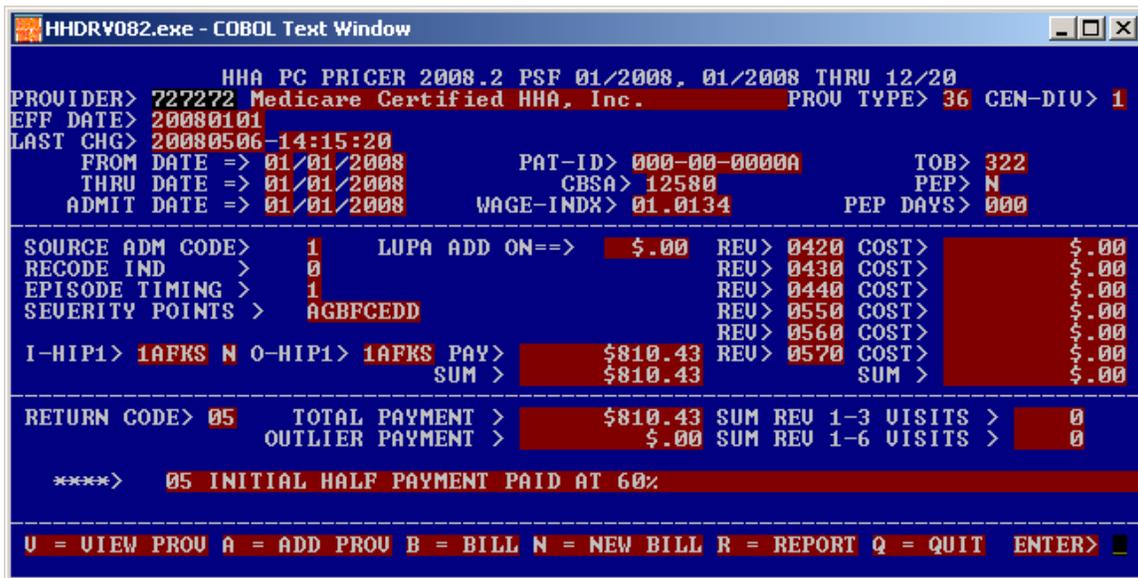
9. Enter the HIPPS code from the revenue code 0023 line on the RAP in the HIPPS1 field.

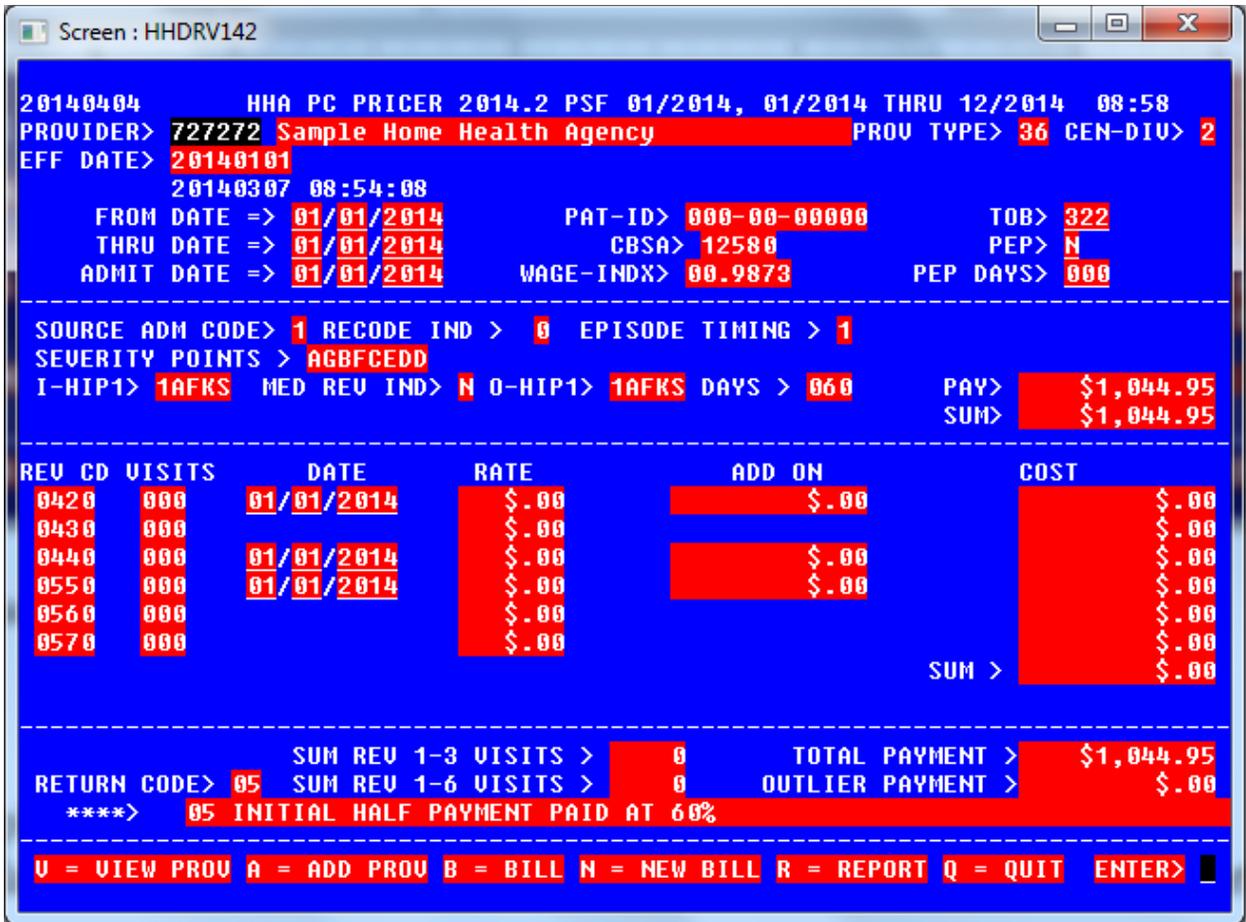10. No further fields need to be changed. Hit the "Enter" key on your keyboard to calculate the payment.

Payment Report:

A payment report screen will be displayed, similar to one of the examples below.

Payments for episodes beginning before January 1, 2014:

Payments for episodes beginning on or after January 1, 2014:

In addition to displaying information you have entered identifying the provider, beneficiary and claim information, three important results fields appear on the report for a RAP:

WAGE-INDX   This field displays the weight value applied to the labor portion of the payment in the wage adjustment calculation.

TOTAL PAYMENT   This field displays the payment for the RAP you have entered. On RAPs this field will also match the results in the PAY and SUM fields immediately above it.

RETURN CODE   This field displays a two digit numeric code that explains the method of payment applied on the record. The code and its definition are displayed after the arrow at the bottom of the screen. Typical return codes for RAPs are 04 (50% payment) and 05 (60% payment).

Next Steps: The flashing cursor will be waiting at the ENTER field in the lower right hand corner of the screen.

Enter B to make changes to the RAP record you have just entered.

Enter N to create a completely new RAP or claim.

Enter R to print a hard copy report of the results of this RAP calculation. The hard copy report includes all the same information available on the payment report screen.   The information is simply re-formatted to print in portrait layout on paper to make a more easily readable record.
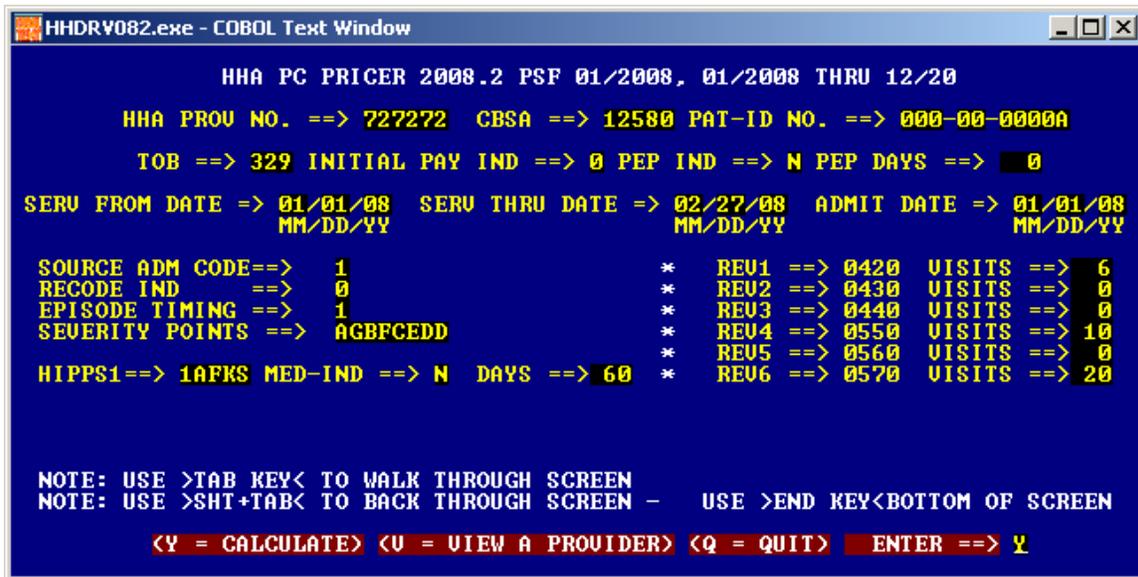
3.5   Entering claims

The next five subsections provide specific instructions for entering claims for each of the HH PPS payment types.
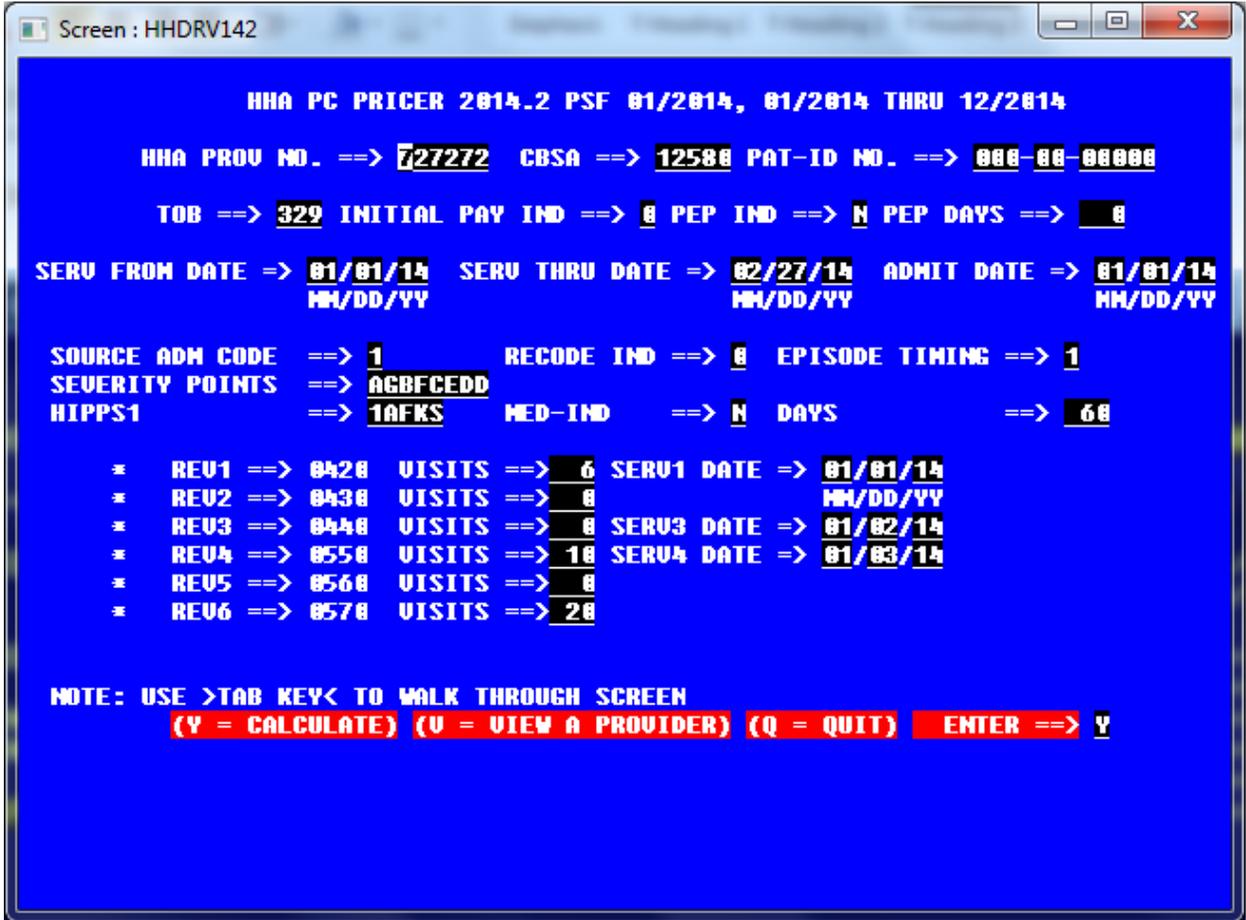
3.5.1 Typical HH PPS claim

Entry Screen:

The following instructions outline the steps for entering a typical claim for calculation. These instructions apply to claims for which no HH PPS payment adjustments apply. Completed claim entry screens are pictured below.

Claims for episodes beginning before January 1, 2014:

Claims for episodes beginning on or after January 1, 2014:

1. Enter your provider number and the CBSA code representing the beneficiary's site of service (i.e. the value code 61 amount from the claim.)

2. If a patient specific record is desired, enter the beneficiary's Health Insurance Claim number in the PAT-ID NO field. If not, tab over this field.

3.   Enter 329 in the TOB field.

4. Tab over the INITIAL PAY IND, PEP IND and PEP DAYS fields, leaving their default values unchanged.

5. Enter the dates in the SERV FROM, SERV THRU and ADMIT DATE fields, corresponding to the claim.

6. If condition code 47 is reported on the claim, enter 'B' in the SOURCE ADM CODE field. Otherwise, enter 1.

7. Enter 0 in the RECODE IND field.

8. Enter the necessary information from the treatment authorization code on the claim into the EPISODE TIMING and SEVERITY POINTS fields.

9. Enter the HIPPS code from the revenue code 0023 line on the claim in the HIPPS1 field.

10. Enter the total numbers of home health discipline visits in the appropriate REV VISITS fields (i.e. the total number of lines with each revenue code).

11. For claims beginning on or after January 1, 2014, enter the earliest visit date for a physical therapy visit (SERV1 DATE), speech language pathology visit (SERV3 DATE) or skilled nursing visit (SERV4 DATE).

12. Tab through any remaining REV VISITS fields until the cursor rests at the ENTER field in the lower right hand corner with the Y default value displayed.   Press the Enter key on your keyboard.
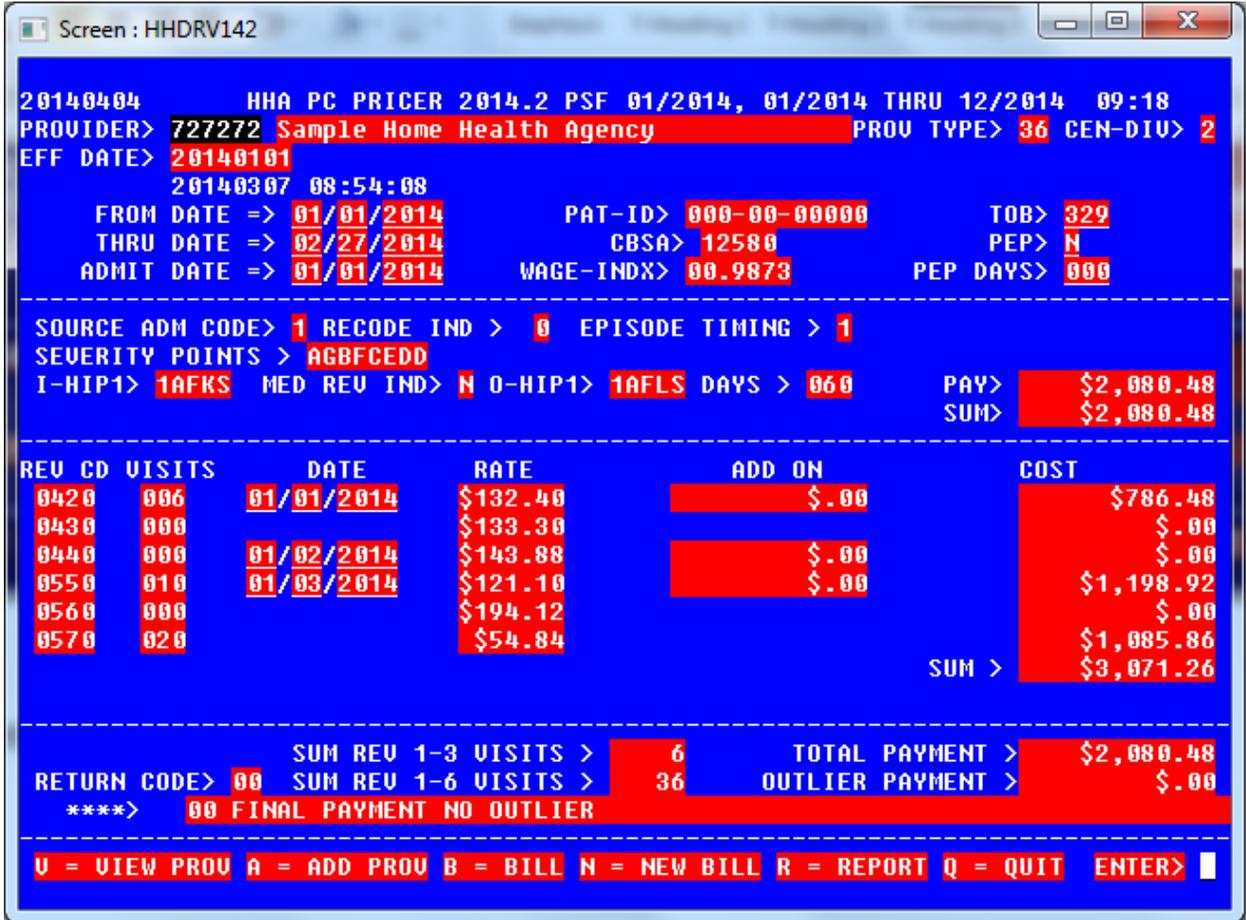
Payment Report:

A payment report screen will be displayed, similar to the examples below.

For payments for episodes beginning before January 1, 2014:

For payments for episodes beginning on or after January 1, 2014:

In addition to displaying information you have entered identifying the provider, beneficiary and claim information, several important results fields appear on the report for a claim:

WAGE-INDX   This field displays the weight value applied to the labor portion of the payment in the wage adjustment calculation.

TOTAL PAYMENT   This field displays the payment for the claim you have entered. On typical claims this field will also match the results in the PAY and SUM fields immediately above it.

RETURN CODE   This field displays a two digit numeric code that explains the method of payment applied on the record. The code and its definition are displayed after the arrow at the bottom of the screen. The return code on a typical claim is 00, final payment with no outlier.

REV COST fields   These fields display the imputed costs for each home health discipline that were used to determine whether an outlier payment applied to the claim.

SUM REV 1-3 VISITS   This field displays the total number of therapy visits that were reported on the claim.   This is the total that was used by the program to determine whether therapy thresholds apply.

SUM REV 1-6 VISITS   This field displays the total number of visits that were reported on the claim.   This is the total that was used by the program to determine whether the LUPA threshold was met.

Next Steps: The flashing cursor will be waiting at the ENTER field in the bottom right hand corner of the screen.

Enter B to make changes to the claim record you have just entered.

Enter N to create a completely new RAP or claim.

Enter R to print a hard copy report of the results of this claim calculation. The hard copy report reproduces the information all the same information available on the payment report screen.   The information is simply re-formatted to print in portrait layout on paper to make a more easily readable record.

3.5.2 Therapy and outlier adjustments

Entry Screen:

Calculations internal to the PC Pricer determine whether claim payments need to be adjusted because of the therapy thresholds that apply to the claim, or because the outlier threshold was exceeded or both. So the entry of these claims is no different from the entry of the typical claim described in 3.5.1 above. However, the results of the payment report will change if these adjustments apply.

Payment Report:

1) If the therapy thresholds that apply to the claim require the claim to be adjusted, the PC Pricer automatically recodes the claim. That is, the PC Pricer changes the HIPPS code you entered to reflect the HIPPS code that properly applies This change appears on the payment report in the following fields:

I-HIP1   This field shows the input HIPPS code.   That is, the field reports back the code you entered on the previous screen.

O-HIP1   This field shows the output HIPPS code. That is, the field reports the code
              that the Pricer used to calculate the payment. The dollar amounts reported
              in the PAY and SUM fields relate to this code.

2) If the outlier threshold is exceeded on a claim, the PC Pricer calculates the additional
outlier payment due over and above the HIPPS code amount. This adjustment appears on
the payment report screen in the following fields.

OUTLIER PAYMENT   This field shows the additional outlier payment calculated. The
                   amount in this field added to the amount in the SUM field
                   above will always equal the amount in the TOTAL PAYMENT
                   field.

RETURN CODE   This field will contain 01, indicating a final payment with an
                   outlier.

It is possible for both of these adjustments to apply to the same claim. The following is a
sample payment report screen demonstrating both adjustments.

3.5.3 Partial episode payments (PEPs)

Entry Screen:

The entry of a claim for which a partial episode payment (PEP) adjustment applies varies from the entry of a typical claim in two ways.

First, the PEP IND field must be entered. Always enter a Y in this field on PEP claims. If you are working from a copy of a submitted claim, enter a Y in this field any time the patient status code in FL 22 of the claim is 06.

Next, after you enter the dates of the claim and its HIPPS code, you must alter the default value of 60 that appears in the DAYS field corresponding to the HIPPS code. Enter the span of days from and including the first visit to and including the last visit in the entire episode in the DAYS field. Enter the remainder of the claim normally.

Payment Report:

The payment report will carry over the PEP IND and DAYS information you entered, but otherwise the payment report will appear similar to a typical claim.

3.5.4 Low utilization payment adjustments (LUPAs)

Entry Screen:

The entry of LUPA claims does not vary from the entry of typical claims.   Enter all the required claim fields, including the HIPPS code of the claim and the numbers of visits.

Payment Report:

Based on the presence of four or fewer visits on a claim record, the PC Pricer will automatically calculate a LUPA payment.   In this case, the payment report screen will reflect the LUPA payment using the following fields:

REV COST   These fields are used on LUPA claims to show the actual payment amounts which are calculated on a per visit basis. The HIPPS PAY fields will show zero. If the LUPA add-on payment applies, the add-on amount will be reported in a separate LUPA ADD-ON field of the payment report.

REV SUM   The separate per visit payments are subtotaled in this field. The SUM field under the HIPPS PAY fields will show zero. This subtotal will match the TOTAL PAYMENT field also.

RETURN CODE   The code in this field will be 06, indicating LUPA payment only, or 14, indicating LUPA payment when the LUPA add-on applies.

Sample LUPA payment report:

3.6   Correcting the RAP/claim you are calculating

You may notice after you have calculated a RAP or claim record that you made an entry error on the RAP or claim and wish to correct the record you have just entered.   In this case, you can go back to that record and correct the errors instead of re-keying the entire screen.   To do this, enter a B in the ENTER field in the lower right-hand corner of the results screen. This will return you to the RAP/Claim entry screen, which will still display the record previously entered.   The cursor will be flashing in the first position of the first field on the entry screen (the provider number field).   Tab forward to the field you wish to correct and key over the erroneous entry.   Repeat this step for as many fields as necessary to correct the complete record.

 Then you can jump the cursor to the ENTER field in the lower right hand corner of the entry screen by using the End key on your keyboard. If the cursor is on the last position of any field in the entry screen, pressing the End key once will jump the cursor to the ENTER field. If the cursor is in any other position of a field, pressing the End key twice

will jump the cursor to the ENTER field.   The default value of Y (for calculate) will be present in this field. Pressing the Enter key on your keyboard will display the results screen for the corrected record.

TIP: If you are calculating a batch of similar records (for instance, same provider number, patient id or billing periods), it may be more convenient to use this correction feature to enter the records than to create entirely new records each time. Only changing the fields that differ between one RAP/claim and the next could save a significant amount of data entry.

4.   How do I add a provider to the provider file?

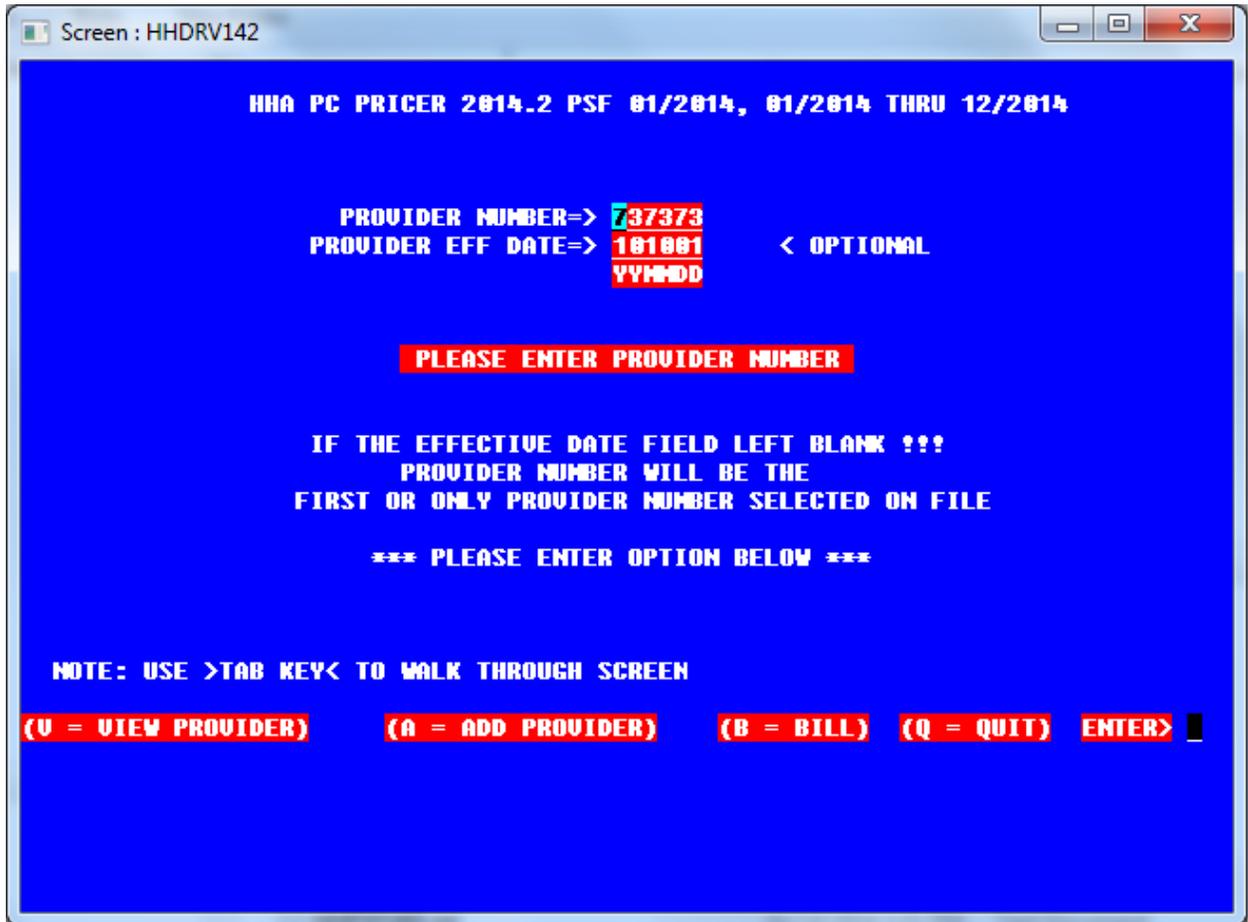## 4.1   Reasons to add a provider record

The PC Pricer contains a provider file with records listing all Medicare certified home health agencies as of the start of the quarter in which the particular version of the software was produced.   These provider listings currently have a very limited impact on the calculation of payments by the program, but may become more important to payment calculations in the future.   They are essential to the calculation of payments only in that a provider number that refers to a valid record in the provider file is required to calculate a RAP or claim.

The great majority of home health agencies will never need to add a provider record to the file, since their number will already be present.   However, agencies who have recently received their Medicare provider number or who have recently undergone a change in ownership which caused their provider number to change may not find their number listed in the provider file.   Rather than await the next quarterly release of the PC Pricer that contains their provider record, such agencies may create their own record using the instructions in 4.2 below.

Additionally, entities that are not Medicare certified home health agencies but are interested in the HH PPS payment calculations may wish to use the PC Pricer software. Such entities may include payment policy researchers, Medicare Advantage plans and others.   These entities may also use the instructions in 4.2 below to create 'dummy' provider records similar to the on used to create the payment examples above.   Medicare Advantage plans should not interpret the absence of a provider record from the file contained in the PC Pricer as evidence that a provider is not Medicare certified.

4.2   Adding a provider record

To begin adding a provider, open the program and enter "V," for View a Provider, at the Welcome screen.   The following screen will appear:

This screen prompts you to enter a provider number (this may be your new Medicare provider number or a dummy number if a non-provider user) and an effective date.   Tab to the ENTER field in the lower right-hand corner.   Enter A to add a provider.

A second screen, like the one below, will appear. This screen requires more detailed information.

```
■ Screen : HHDRV142                                        ⬓ ⬓ ✕

              HHA PC PRICER 2014.2 PSF 01/2014, 01/2014 THRU 12/2014

   PROVIDER NUMBER ==>  737373
   PROVIDER EFF-DATE    20140101 <CCYYMMDD
   PROVIDER NAME ==>     Sample HHA


        PROVIDER TYPE ==> 36            TEMP-RELIEF   ==> Y   Y OR BLANK ONLY
      CENSUS DIVISION ==> 2             PPS FED BLEND ==> 0   0,1 ONLY
   GEO / STAND   CBSA ==> 12580/12580   SPEC PAY INDC ==> 0
    RECL LOCATION CBSA ==>12580  N      SPEC PAY INDX ==> 00.0000
       NUMBER OF BEDS ==>               CAPI PAY CODE ==> A < A,B,C OR BLANK
   (CMIA)FACILITY PAY ==>        .00    HOSP SPEC RATE==>       .00
              COLA ==> 0.000           OLD HARM RATE ==>       .00
    INTERN BED RATIO ==> 0.0000        NEW HARM RATIO==> 0.0000
   FISCAL YEAR BEGIN ==> 20001001<CCYYMMDD CSTCHG RATIO   ==> 0.000
           SSI RATIO ==> .0000          NEW HOSPITAL  ==>    < Y, N, OR BLANK
       MEDICAID RATIO ==> .0000         IME           ==> 0.0000
    OPER CSTCHG RATIO==> 0.000          EXCEPTIONS    ==>      0.00
                    PAY CODE  -- A, B, C, OR BLANK ONLY


     NOTE: USE >TAB KEY< TO WALK THROUGH SCREEN
   --------------------------------------------------------------------
   (B = BILL)  (V = VIEW ANOTHER PROV)  (A = ADD THIS PROV)  (Q = QUIT)  ENTER>
```

Several fields are required, some of which reflect the hospital-oriented nature of Medicare provider files.   Much of this data is not applicable to home health agencies but some data not relevant to HH PPS payments must be entered and many fields may be tabbed over and ignored.

1. The first seven fields in the left hand column must be completed. First enter your provider name (or a dummy name if a non-provider user).

2.   Enter "36" in PROVIDER TYPE. This code indicates an HHA.

3. Enter the CENSUS DIVISION that best describes your location in the country.   The code definitions are:

1   New England
2   Middle Atlantic
3   South Atlantic
4   East North Central
5   East South Central
6   West North Central
7   West South Central

8   Mountain
9   Pacific

4. Next, enter the Core-Based Statistical Area (CBSA) code for your office location in the GEO CBSA, STAND CBSA and RECL LOCATION CBSA fields.

5. Enter an "N" in the one character field that follows the RECL LOCATION CBSA field.

6. Tab through the remaining fields in the left hand column, leaving them blank or zeroes with the exception of the FISCAL YEAR BEGIN field.

7. Enter your fiscal year beginning date in CCYYMMDD format or a default date (i.e. 20xx1001) for non-provider users.

8. Enter a Y in the TEMP RELIEF field, enter an A in the CAPI PAY CODE field, then tab through all the fields in the right hand column, leaving them blank or zeroes.

9. At the ENTER field in the lower right-hand corner, enter A to add the provider information. A message will appear saying "Successful write to provider file" or special messages will appear identifying errors in the data that must be corrected.   The new provider record will be retained in the PC Pricer for this point forward and will not need to be re-entered as long as the particular version of the software is used.

NOTE: New versions of the HH PPS PC Pricer are posted quarterly containing updated provider file information. Unless this information is important to your needs, it is not advisable for users to update their software quarterly.   When you download a new version of the PC Pricer, any provider records you have added manually will need to be re-created.