CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10919	**Date: August 6, 2021**
	Change Request 12315

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 8, 2021. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Low Utilization Payment Adjustment (LUPA) Add-on Amounts for Home Health (HH) Occupational Therapy Visits and Corrections to Payment Grouping Processes

I. SUMMARY OF CHANGES: This change request makes changes to Original Medicare systems to allow for LUPA add-on payments to apply if an occupational therapy visit is the first visit in a period of care.

EFFECTIVE DATE: January 1, 2022 - Claim Through dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.17/Payment Adjustments - Low Utilization Payment Adjustments (LUPAs)
R	10/70.2/Input/Output Record Layout
R	10/70.4/Decision Logic Used by the Pricer on Claims

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10919	Date: August 6, 2021	Change Request: 12315

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I. GENERAL INFORMATION

A. Background: Under the Consolidated Appropriations Act, 2021 (CAA 2021), the regulations at §§ 484.55(a)(2) and 484.55(b)(3) were revised to allow Occupational Therapists (OTs) to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health benefit when the plan of care does not initially include skilled nursing care. That is, occupational therapists may conduct the initial assessment and complete the comprehensive assessment, but only when occupational therapy is on the home health plan of care with either physical therapy and/or speech therapy and skilled nursing services are not initially on the plan of care. Because of this change, CMS must establish a LUPA add-on factor in calculating the LUPA add-on payment amount for the first skilled occupational therapy visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care.

This change request also contains requirements to ensure consistent and accurate processing of HH claims under the Patient-Driven Groupings Model.

All HH claims are matched to their associated Outcomes and Assessment Information System (OASIS) assessment during processing and use certain OASIS items to determine the Health Insurance Prospective Payment System (HIPPS) code used for payment. Medicare Administrative Contractors (MACs) have reported intermittent failures in the claims-OASIS matching process. When MACs observe unusually high volumes of HH claims in suspense locations awaiting a match, they may recycle the claims to the assessment system a second time. Per instructions in publication 100-04, chapter 10, section 10.1.10.1, MACs may take this action at their discretion or when notified by CMS. Requirements four and five ensure the recycled claims process correctly in all cases.

Similarly, on all HH claims, the HH Grouper program must calculate the HIPPS code used for payment. MACs have reported intermittent cases where HH claims bypass the HH Grouper and have paid using the provider-submitted HIPPS code. Requirement six creates a safeguard to prevent this.

B. Policy: Currently, there are no sufficient data regarding the average excess of minutes for the first visit in LUPA periods where the initial and comprehensive assessments are conducted by OTs. Therefore, in the Calendar Year (CY) 2020 HH Prospective Payment System (PPS) final rule, CMS finalized to utilize the Physical Therapy (PT) LUPA add-on factor of 1.6700 as a proxy for the OT LUPA add-on factor for CY 2022 until we have CY 2022 data to establish the OT add-on factor for the LUPA add-on payment amounts in future years. The similarity in the per-visit payment rates for both PT and OT make the PT LUPA add-on factor the most appropriate proxy until CMS has sufficient data to establish the OT LUPA add-on factor.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12315.1	The contractor shall send the earliest line item date on HH claims (Type of Bill (TOB) 032x other than 0320) to the HH Pricer in the field shown in the record layout in the Medicare Claims Processing Manual, chapter 10, section 70.2 if revenue code 043x is present on the earliest date and Healthcare Common Procedure Coding System (HCPCS) code is G0152 or G0160.					X				HH Pricer
12315.2	The contractors shall apply the add-on visit amount returned by the HH Pricer in the add-on amount field corresponding to revenue code 043x to the earliest line item with revenue code 043x, when the Pricer return code is 14.					X				HH Pricer
12315.3	The contractor shall compare the earliest line item dates for revenue codes 042x, 043x, 044x and 055x and select the revenue code with the earliest date to apply an add-on factor.									HH Pricer
12315.3.1	Medicare contractors shall select revenue code 055x, if the earliest date for revenue codes 042x, 043x or 044x match the revenue code 055x date.									HH Pricer
12315.3.2	Medicare contractors shall select revenue code 042x, if the earliest date for revenue codes 042x and 043x match and revenue code 055x is not present.									HH Pricer
12315.3.3	Medicare contractors shall select revenue code 043x, if the earliest date for revenue codes 043x and 044x match and revenue code 055x is not present.									HH Pricer
12315.4	The LUPA add-on visit amount shall be the national per-visit amount for that visit multiplied by 1.6700, if the selected revenue code is 043x.									HH Pricer
12315.5	For HH claims and adjustments received on or after 1/3/2022, the contractor shall ensure in all cases that if claims are moved from hold locations awaiting responses from the Internet Quality Improvement and Evaluation System (iQIES) (SMFRX1 - SMFRX4) to location SB0100, the claims will set reason code 37071 and be included in a new iQIES finder file. Note: Intermittent failures in this process can result in claims looping between the Common Working File					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(CWF) edits U524P and U524Q.									
12315.6	For HH claims and adjustments (other than RAC adjustments) received on or after 1/3/2022, the contractor shall ensure that HH Grouper output is present on a HH claim (Grouper return code GRTC is not spaces) before sending the claim to the HH Pricer.					X				
12315.6.1	The contractor shall recycle the claim back through the HH Grouper, when a GRTC of spaces is received for the first time on a HH claim and OASIS data is present on claim page 43.					X				
12315.6.2	The contractor shall suspend the claim, when a GRTC of spaces is received for the second or greater time on a HH claim and OASIS data is present on claim page 43. NOTE: Repeated failure to receive Grouper output requires research into a system error. Claims shall be suspended to prevent pricing and paying in error based on the provider-submitted HIPPS code.			X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12315.7	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
.1	This requirement mirrors the existing process for revenue codes 042x, 044x and 055x, created by BR 8380.1.1.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carla Douglas, carla.douglas@cms.hhs.gov , Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

10.1.17 - Payment Adjustments - Low Utilization Payment Adjustments (LUPAs)

(Rev.10919, Issued: 08-06-21, Effective:01-01-22, Implementation:01-03-22)

If an HHA provides fewer than the threshold of visits specified for the period's HHRG, they will be paid a standardized per visit payment. Such payment adjustments are called Low Utilization Payment Adjustments (LUPAs).

On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. If the claim for the LUPA is later adjusted such that the number of visits is equal to or greater than the threshold for the HHRG, payments will be adjusted to an HHRG basis, rather than a visit basis.

If the LUPA period is the first in a sequence of adjacent periods or is the only period of care the beneficiary received, Medicare will make an additional add-on payment. Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy, *occupational therapy (after January 1, 2022),* or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if claims are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated period in the same sequence.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

70.2 - Input/Output Record Layout

(Rev.10919, Issued: 08-06-21, Effective:01-01-22, Implementation:01-03-22)

The required data and format for the HH Pricer input/output record for periods of care beginning on or after January 1, 2021 are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value from field 18 of the provider specific file. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2%
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.

File Position	Format	Title	Description
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for periods of care ending during the current calendar year.
46-56	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for periods of care ending during the current calendar year.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period "From" date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to 'B' when condition code 47 is present on the claim. The indicator is set to '1' in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to '2' when a LUPA add-on claim is identified as not being the first or only period in a sequence. The indicator is set to '0' in all other cases.
96	X	PEP-IND	Input item: A single Y/N character to indicate if a claim must be paid a partial period payment adjustment. Medicare claims processing systems set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared 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.
105-110	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
111-119	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.

File Position	Format	Title	Description
120-123	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
124-126	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
127-131	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. Medicare claims processing 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.
132-139	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.
140-148	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA.
149-157	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA.
158-166	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 1.8451. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700. *If revenue code 043x and the Through date is on or after January 1, 2022, then this is the national per-visit amount multiplied by 1.6700.* If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.
168-401	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.
402-403	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.
			Payment return codes:
			00 Final payment where no outlier applies

File Position	Format	Title	Description	
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Not used.
			04	Not used.
			05	Not used.
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, partial period payment
			11	Final payment, partial period payment with outlier
			12	Not used.
			13	Not used.
			14	LUPA payment, add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
404-408	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
409-417	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. Added to the claim as a value code 17 amount.	
418-426	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
427-435	S9(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.	
436-444	9(7)V9(2)	PPS-STD-VALUE	Output item: 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.	

File Position	Format	Title	Description
445-452	X(8)	RECEIPT-DATE	Input item: The receipt date of the corresponding NOA for this claim. Date format must be CCYYMMDD.
453	X	OVERRIDE-IND	Input item: An indicator of whether an exception request to the late filing penalty has been granted by the MAC. Valid values: Y = Exception has been granted, no late filing penalty will be calculated N = No exception applies, calculate late filing penalty, if applicable.
454-462	9(7)V9(2)	LATE-SUB-PENALTY-AMT	Output item: The late submission penalty amount, determined by subtracting the total payment after the late submission penalty from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QF amount.
463-650	X(188)	FILLER	

Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The Medicare claims processing system 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 the HIPPS code will be placed in the revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount. If the return code is 06 or 14 (indicating a low utilization payment adjustment), the Medicare claims processing system 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. If the return code is 14, the Medicare claims processing system will apply the H-HHA-REVENUE-ADD-ON-VISIT-AMT to the earliest line item with the corresponding revenue code.

70.4 - Decision Logic Used by the Pricer on Claims

(Rev.10919, Issued: 08-06-21, Effective:01-01-22, Implementation:01-03-22)

On input records with TOB 329, 327, 32F, 32G, 32H, 32I, 32J, 32K, 32M, 32Q, 33Q or 32P (that is, all provider submitted claims and provider or A/B MAC (HHH) initiated adjustments), Pricer will perform the following calculations in the numbered order.

If the "SERV-FROM-DATE" is on or after January 1, 2020, the Pricer shall perform the following:

Prior to these calculations, determine the applicable Federal standard rate to apply by reading the value in "INIT-PAY-QRP-INDICATOR." If the value is 0, use the full standard rate in subsequent calculations. If the value is 2, use the standard rate which has been reduced by 2 percent due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

    1.1 If the "REVENUE-SUM1-6-QTY-ALL" is less than the LUPA threshold associated with the "HRG-INPUT-CODE" (e.g. threshold is 6, sum is 5 or less), read the national standard per visit rates 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.

1.2 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 a 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, *043x (CY 2022 and after)* 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.

For claims with Through dates on or after January 1, 2022:

If the earliest date for revenue codes 042x and 043x match and revenue code 055x is not present, select revenue code 042x.

If the earliest date for revenue codes 043x and 044x match and revenue code 055x is not present, select revenue code 043x.

1.3 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 043x, 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.

1.4 Return the sum of all "REVENUE-COST" amounts and the "REVENUE-ADD-ON-VISIT-AMT" amount, if applicable, in 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. No further calculations are required.

1.5 If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to the LUPA threshold associated with the "HRG-INPUT-CODE", proceed to the HRG payment calculation in step 2.

2. HRG payment calculations.

2.1. If the "PEP-IND" is an N:

Find the weight for the "HRG-INPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the applicable period of care rate for the calendar year in which the "SERV-THRU-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 nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage

index and case-mix adjusted payment for this HRG. Proceed to the outlier calculation in step 3.

2.2. If the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG amount, as in 3.1. Determine the proportion to be used to calculate this PEP by dividing the "PEP-DAYS" amount by 30. Multiply the case-mix and wage index adjusted payment by this proportion. The result is the partial period payment due on the claim. Proceed to the outlier calculation in step 3.

3. Outlier calculation:

3.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-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 the HRG payment calculation. This is the outlier threshold for the period.

3.2. 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 imputed cost for the period.

3.3. Subtract the outlier threshold from the imputed cost.

3.4. If the result determined in step 3.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

3.5. 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 percent 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 step 3.4, return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from HRG payment calculation. 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 step 3.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

a. If the result determined in step 3.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment. Return zeroes in the "OUTLIER-PAYMENT" field. Return the HRG payment amount in the "TOTAL-PAYMENT" field, with return code 00.

4. Late-filed NOA payment penalty:

4.1 If the value in “OVERRIDE-IND” is equal to Y, continue to step 5.

4.2 If the span of days between the “FROM-DATE” and “RECEIPT-DATE” is greater than five and the value in“OVERRIDE-IND” is equal to N, reduce the “HRG-PAY” and “OUTLIER-PAYMENT” amounts by the span of days/30.

4.3 Subtract the sum of the“HRG-PAY” and “OUTLIER-PAYMENT” amounts reduced by the late-filed NOA penalty from step 4.2 from the sum of the “HRG-PAY” and “OUTLIER-PAYMENT” amounts before the penalty. Return the result in “LATE-SUB-PENALTY-AMT.” Continue to step 5.

5. Value-Based Purchasing Adjustment:

Multiply all payment amounts by adjustment factor in “PROV-VBP-ADJ-FAC.” Return the results as the final Medicare payment amounts in all appropriate output fields.

Subtract the total payments calculated in steps 2 through 4 from the total VBP-adjusted payments calculated in step 5. Return the difference in the “VBP-ADJ-AMT” field.