CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11966	**Date: April 21, 2023**
	Change Request 13150

SUBJECT: Adding Claim Through Date to Home Health Grouper interface

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify the interface to the home health Grouper, adding the claim Through date. This will allow for more accurate diagnosis code editing in the program.

EFFECTIVE DATE: October 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2023

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	10/80.1/HH Grouper Input/Output Record Layout

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: 11966	Date: April 21, 2023	Change Request: 13150

SUBJECT: Adding Claim Through Date to Home Health Grouper interface

EFFECTIVE DATE: October 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to revise the interface of the home health (HH) Grouper program to include the claim Through date. Currently, the interface to the HH Grouper includes only the claim From date, which is used to determine which version of the HH Grouper applies to a given claim. The absence of the claim Through date means that the Grouper logic must use the From date plus 29 days to determine whether a claim spans the effective date (October 1 or April 1) of new diagnosis codes. In cases such as transfers or discharges with treatment goals met, the claim Through date may be less an 29 days after the From date. This creates the possibility of some inaccuracy in editing of valid diagnosis codes or of determining predecessor codes for case-mix scoring. Adding the Through date will allow the Grouper logic to be revised to address these limitations.

B. Policy: This Change Request contains no new policy. It revised Medicare systems to more accurately implement existing payment policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13150.1	The contractor shall revise the interface with the Home Health Grouper to add the claim Through date, as shown in Pub. 100-04, chapter 10, section 80.1.					X				
13150.1.1	The contractor shall test the revised interface using the Home Health Grouper pre-release which shall be available by June 28, 2023. Note: The pre-release will include the interface changes, but not the October 2023 logic and diagnosis code changes. Logic and code changes will be implemented under the October 2023 recurring update to the Home Health Grouper.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): 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

80.1 – HH Grouper Input/Output Record Layout

(Rev. 11966; Issued: 04-21-23; Effective: 10-01-23; Implementation: 10-02-23)

The required data and format for the HH Grouper input/output record for periods of care beginning on or after January 1, 2020 are shown below:

File Position	Format	Title	Description
1 - 24	X(24)	Claim ID	Input item: Document control number of the claim record.
25-32	X(8)	From Date	Input item: The Statement Covers "From" date from the claim, in format CCYYMMDD
33	9	Period Timing	Input item: Set to 1 when claim From date matches Admission date or when a CWF sequence edit is received. Otherwise, set to 2.
34 - 35	9(2)	Referral Source	Input item: If occurrence code 61 or 62 are present on the claim, the code value is moved to this field. The occurrence date is not moved.
36 - 42	X(8)	Principal Diagnosis	Input item: The principal diagnosis code from the claim.
43 - 50	X(8)	Secondary Diagnosis	Input item: The first secondary diagnosis code from the claim.
51 - 235	Defined above	Additional Secondary Diagnosis data	Input items: 23 additional occurrences of secondary diagnoses from the claim.
236-275	X(40)	Filler	For future use.
276	9	M1033-HOSP-RISK-HSTRY-FALLS	Input item: Moved from the M1033-HSTRY-FALL field on the QIES/OASIS screen in FISS. Valid values: 0,1
277	9	M1033-HOSP-RISK-WEIGHT-LOSS	Input item: Moved from the M1033-WEIGHT-LOSS field on the QIES/OASIS screen in FISS. Valid values: 0,1
278	9	M1033-HOSP-RISK-MLTPL-HOSPZTN	Input item: Moved from the M1033-MLTPL-HOSPZTN field on the QIES/OASIS screen in FISS. Valid values: 0,1
279	9	M1033-HOSP-RISK-MLTPL-ED-VISIT	Input item: Moved from the M1033-MLTPL-ED-VISIT field on the QIES/OASIS screen in FISS. Valid values: 0,1
280	9	M1033-HOSP-RISK-MNTL-BHV-DCLN	Input item: Moved from the M1033-MNTL-BHV-DCLN on the QIES/OASIS screen in FISS. Valid values: 0,1
281	9	M1033-HOSP-RISK-COMPLIANCE	Input item: Moved from the M1033-COMPLIANCE on the QIES/OASIS screen in FISS. Valid values: 0,1

File Position	Format	Title	Description
282	9	M1033-HOSP-RISK-5PLUS-MDCTN	Input item: Moved from the M1033-5PLUS-MDCTN on the QIES/OASIS screen in FISS. Valid values: 0,1
283	9	M1033-HOSP-RISK-CRNT-EXHSTN	Input item: Moved from the M1033-CRNT-EXHSTN on the QIES/OASIS screen in FISS. Valid values: 0,1
284	9	M1033-HOSP-RISK-OTHR-RISK	Input item: Moved from the M1033-OTHER-RISK on the QIES/OASIS screen in FISS. Valid values: 0,1
285	9	M1033-HOSP-RISK-NONE-ABOVE	Input item: Moved from the M1033-NONE-ABOVE on the QIES/OASIS screen in FISS. Valid values: 0,1
286-287	9(2)	M1800-CRNT-GROOMING	Input item: Moved from the M1800-CRNT-GROOMING on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
288-289	9(2)	M1810-CRNT-DRESS-UPPER	Input item: Moved from the M1810-DRESS-UPPER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
290-291	9(2)	M1820-CRNT-DRESS-LOWER	Input item: Moved from the M1820-DRESS-LOWER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
292-293	9(2)	M1830-CRNT-BATHG	Input item: Moved from the M1830-CRNT-BATHG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06
294-295	9(2)	M1840-CRNT-TOILTG	Input item: Moved from the M1840-CRNT-TOILTG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04
296-297	9(2)	M1850-CRNT-TRNSFRNG	Input item: Moved from the M1850-CRNT-TRNSFRNG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05
298-299	9(2)	M1860-CRNT-AMBLTN	Input item: Moved from the M1860-CRNT-AMBLTN on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06
300-349	*X(50)*	Filler	For future use.
350	*X(8)*	*Through Date*	*Input item: Beginning October 1, 2023, the Statement Covers "Through" date from the claim, in format CCYYMMDD*
358-599	*X(242)*	*Filler*	*For future use.*
600	*X(1)*	*Filler*	*For Internal Use Only*

File Position	Format	Title	Description
601-607	X(7)	Version Used	Output item: The version of the HH Grouper which grouped the current claim. Informational only.
608-612	X(5)	HIPPS Code	Output item: The HIPPS code determined by grouping the input items above. Moved to the HCPCS code field of revenue code 0023 line of the claim.
613-614	9(2)	Validity Flag	Output item: Beginning April 1, 2023, the specific diagnosis coding issue that requires a claim to be returned to the provider.
615-616	9(2)	Grouper Return Code	Output item: Identified technical issues that may cause no HIPPS code to be assigned.
617-700	X(84)	Filler	For future use.

If the return code is 05, the claim will be returned to the provider for correction because the principal diagnosis is not assigned to a clinical group.

If the return code is 03, the claim will be returned to the provider for correction because of a diagnosis coding issue that is indicated by the validity flag.