Home Health Billing Basics

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Today's Presenter

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Objectives

- Provide an explanation of the HH PPS and educate on basic billing of the RAP and period of care claim for HH providers
- Review specific billing guidelines for RAP and claim billing

Agenda

- HH PPS Overview
- Billing the HH RAP
- Billing the HH Claim
- Claim Variations
- References and Resources
- Questions

HH Certification Period

- Certification for home health care is for a period of up to 60 days in which a HHA provides care for a Medicare beneficiary for whom a HH plan of care has been established by the beneficiary's physician
  - The certification may be shorter than, but cannot exceed 60 days in length
  - If there is a continuing need for HH care, the beneficiary's physician may re-certify the need for home health care
    - There is no limit to the number of times a physician may recertify the patient's needs to receive care in the home

Patient-Driven Groupings Model

- PDGM took effect for initial certifications and recertifications that started on or after 1/1/2020
- PDGM is a payment model for the HH PPS that:
  - Relies more on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories, and
- Implemented a change in the unit of home health payment from a 60-day episode to a 30-day period

Patient-Driven Groupings Model

- Case-mix adjusted payment groups
  - Former HH PPS had 153 possible case-mix adjusted payment groups
  - PDGM has 432 possible case-mix adjusted payment groups
- PDGM is designed to “better align payments with patient needs” and to ensure that clinically complex patients have adequate access to care

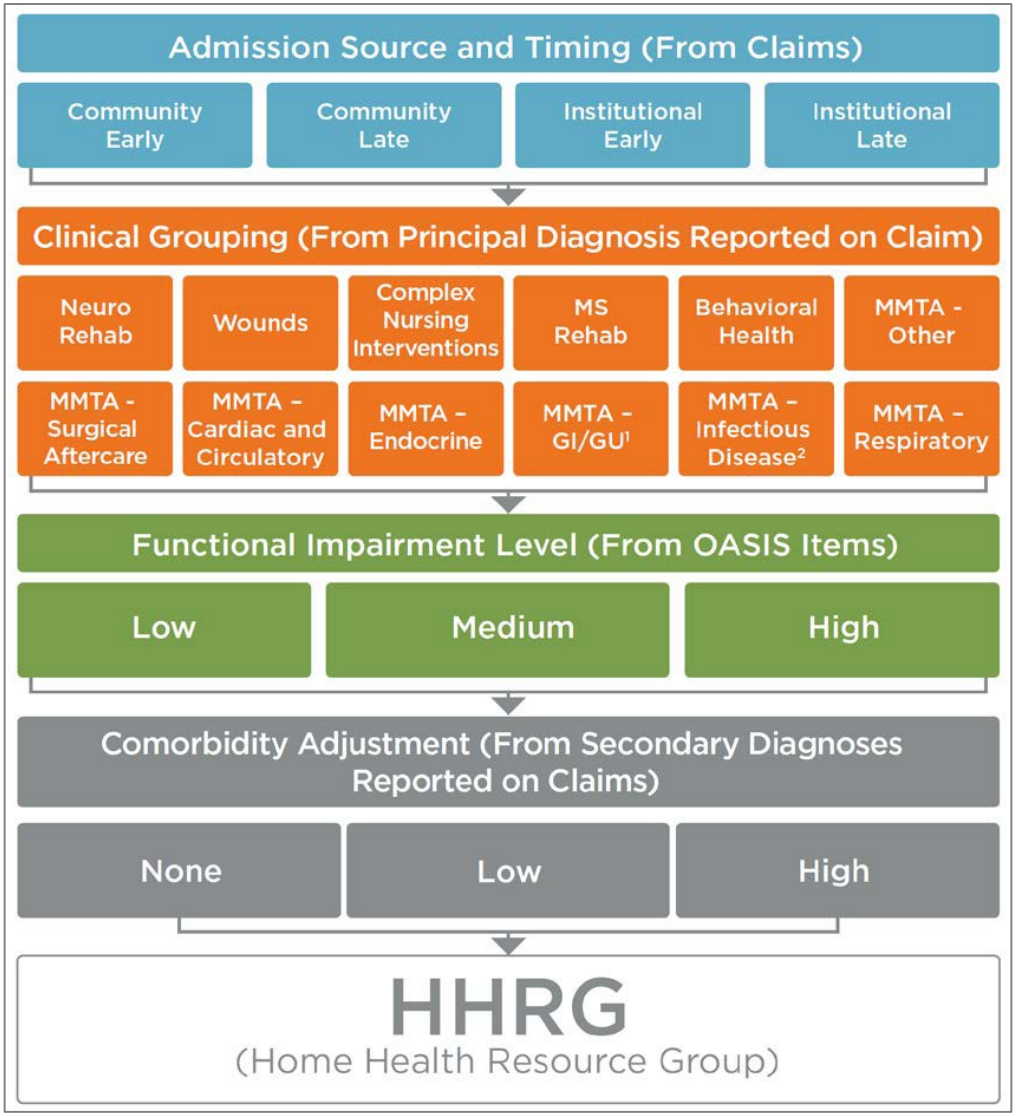
PDGM Payment Groupings

- The PDGM groups home health periods of care for payment based on:
  - Admission source (two subgroups): community or institutional admission source
  - Timing of the 30-day period (two subgroups): early or late
  - Clinical grouping (twelve subgroups): based on principle diagnosis
  - Functional Impairment Level (three subgroups): low, medium or high
  - Comorbidity adjustment (three subgroups): none, low or high – based on secondary diagnoses

Billing for the Certification Period

- The HH PPS payment for each 60-day certification period is determined by two separate 30-day billing periods
  - OASIS, certification/recertification and plan of care based on 60 days

PDGM HHRGs


Admission Source and Timing (From Claims)
Community Early
Community Late
Institutional Early
Institutional Late
Clinical Grouping (From Principal Diagnosis Reported on Claim)
Neuro Rehab
Wounds
Complex Nursing Interventions
MS Rehab
Behavioral Health
MMTA - Other
MMTA - Surgical Aftercare
MMTA – Cardiac and Circulatory
MMTA – Endocrine
MMTA – GI/GU[1]
MMTA – Infectious Disease[2]
MMTA – Respiratory
Functional Impairment Level (From OASIS Items)
Low
Medium
High
Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)
None
Low
High
HHRG
(Home Health Resource Group)

Admission Source

- Institutional – admission within 14 days of the "From" date of the home health claim
  - Acute – inpatient care hospitals, or
  - Post-acute –SNF, IRF, LTCH or IPF
- Community – no acute or post-acute care admission within 14 days of the "From" date of the home health claim

Timing

- Definition of sequence, or subsequent, claims has not changed:
  - Periods considered sequential when there are no more than 60 days between the end of one period and the start of the next period
- Early Period – the first 30-day period in a sequence of home health periods
- Late Period – the second and later 30-day periods in a sequence of home health periods

Admission Source and Timing

- Late 30-day periods always classified as community admission unless there is an acute hospitalization 14 days prior to the late home health 30-day period
  - HHAs have the option whether or not to discharge the patient if the patient is hospitalized for a short period of time
- A post-acute stay 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay
- Information from Medicare systems during claims processing will automatically assign admission source and timing categories
- HHAs have the option to include an occurrence code (61 or 62) on the claim to identify an institutional admission source

Clinical Groups

- Each 30-day period grouped by primary reason for home health care
- Intended to reflect primary reason for services
- Based on the principal diagnosis reported on the claim
- Twelve total groups in PDGM case-mix

ICD-10 Codes Determine Clinical Group

- 30-day period assigned to clinical group based on principal diagnosis code on the claim
- Average resource use of all 30-day periods within a clinical group varies across clinical groups and differences reflected in payment
- If a diagnosis code is used that does not fall into a clinical group (e.g., dental codes or other uncovered/invalid codes), claim is returned to the provider for more definitive coding
- Additional adjustments made for other health conditions

Functional Impairment Levels

- Grouped into Low, Medium, or High based on OASIS items
  - Determined based on OASIS responses to M1800 (grooming), M1810 (ability to dress upper body), M1820 (ability to dress lower body), M1830 (bathing), M1840 (toilet transferring), M1850 (transferring), M1860 (ambulation/locomotion), and M1032 (hospitalization risk)

Functional Impairment Levels

- PDGM uses responses to seven OASIS items associated with functions and one for hospitalization risk
  - Responses to each element of the OASIS items will be assigned points and drive the categorization of functional impairment

Comorbidity Adjustment

- The principal HHA-reported diagnosis determines the PDGM clinical group
  - Secondary diagnoses also impact resource use and should be taken into account
- A comorbidity is defined as a medical condition coexisting in addition to a principal diagnosis
  - Comorbidity is tied to poorer health outcomes, more complex medical need and management, and higher care costs

Comorbidity Adjustment

- The comorbidity adjustment category is based on the presence of secondary diagnoses on the 30-day period claim
- Low comorbidity adjustment: there is a reported secondary diagnosis that is associated with higher resource use
- High comorbidity adjustment: there are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately, i.e., the two diagnoses may interact with one another resulting in higher resource use
- No comorbidity adjustment: there is no reported secondary diagnosis that falls in either the low or high comorbidity adjustment

Case-mix HIPPS Coding

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1- Community Early	A- MMTA Other	A- Low	1- None	1
2- Institutional Early	B- Neuro Rehab	B- Medium	2- Low	
3- Community Late	C- Wounds	C- High	3- High	
4- Institutional Late	D- Nursing Complex Interv.			
	E- MS Rehab			
	F- Behavioral Health			
	G- MMTA Surgical Aftercare			
	H- MMTA Cardiac & Circulatory			
	I- MMTA Endocrine			
	J- MMTA GI/GU			
	K- MMTA Infectious Disease			
	L- MMTA Respiratory			

30-day Periods

- Under the PDGM, payment is made for each 30-day period
- HH PPS payment made in two installments
  - RAP (initial payment)
    - Only providers who were Medicare-certified prior to 1/1/2019 and are submitting periods of care with DOS prior to 1/1/2021 will receive 20% payment on RAPs
  - Period of care claim (final payment)

Note: OASIS, certification/recertification and plan of care still based on 60 days

Period of Care Sequence/Timing

- First 30-day period classified as early
- All subsequent periods classified as late
- Periods are considered subsequent as long as there are no more than 60 days between claims

Consolidated Billing

- HHA must bill for all home health services which include
  - Part-time or intermittent skilled nursing services
  - Skilled therapy services (PT, OT, SLP)
  - Routine and nonroutine medical supplies
  - Part-time or intermittent home health aide services
  - Medical social services
  - NPWT furnished using a disposable device
  - Covered osteoporosis drugs as defined in Section 1861(kk) of the Act
- All home health services paid on a cost basis included in PPS rate
- Payment made to primary HHA regardless of whether or not items or services were furnished by the HHA

RAP

- Part of the original purpose was to request the initial split percentage payment for HH PPS period
  - All periods beginning on or after 1/1/2021 receive 0 (zero) percent up-front payment
- Main purpose still remains: the RAP establishes the HHA as primary HHA and opens new home health certification period in CWF
  - Enforces consolidated billing edits
- All HHAs will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period
  - Must be submitted within 5 calendar days of the “From” date
- HIPPS may be produced by Grouper software or be any valid HIPPS code
- Submitted after receiving physician’s orders for home care and after delivering the initial visit to the beneficiary

RAP

- All HHAs need to submit a RAP at the beginning of each 30-day period to establish the home health period of care
  - These RAPs will be processed but not paid
  - No special coding is required on no-pay RAPs
- Full payment for each period of care will be made on the final claim

When to Submit the Initial RAP

- HHAs are to submit the RAP when:
  - The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented
  - The initial visit within the 60-day certification period has been made and the individual is admitted to HH care

Billing Multiple RAP Periods

- HHAs may submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time to help further reduce provider administrative burden
- For subsequent periods of care in calendar year 2021, the HHA may submit these RAPs with the first day of the period of care as the service date on the 0023 revenue code line
  - This allows for the submission of RAPs for two 30-day periods of care immediately after the start of a 60-day certification period

Non-Timely Submission Reduction

- A payment reduction applies if a HHA does not submit the RAP within five calendar days from the start of care date for the first 30-day period of care in a 60-day certification period and within five calendar days of the "from" date for the second 30-day period of care in the 60-day certification period.

Note: The "From" date is day zero. Count five calendar days starting the day after the "From" date to determine timely RAP submission.

Non-Timely Submission Reduction

- Reduction in payment will be equal to a 1/30th reduction to the wage and case-mix adjusted 30-day period payment amount, or “from” date for subsequent 30-day periods, until the date the HHA submits the RAP
- The reduction would include any outlier payment
- The reduction amount will be displayed with value code QF on the claim

Exception to Late RAP Penalty

- The four circumstances that may qualify the HHA for an exception to the consequences of filing a late RAP:
- Fires, floods, earthquakes, or other unusual events
- An event that produces a data filing problem due to a CMS or MAC systems issue
- A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
- Other circumstances determined by the MAC or CMS

Exception to Late RAP Penalty

- An HHA may submit an exception request on the claim by:
  - Reporting the KX modifier with the HIPPS code on the revenue code 0023 line of Type of Bill 032x (other than 0322 and 0320) to indicate the HHA requests an exception to the late RAP penalty
  - Providing sufficient information in the remarks section of the claim to allow the MAC to research the exception request

Required Fields: RAP Claim Page 1

Field	Description/Notes
MID	Medicare Identification (Beneficiary's Medicare Number)
TOB	Type of Bill – 322
NPI	National Provider Identifier Number
PAT. CNTL#	Patient Control Number – enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	INITIAL RAP: Enter the first Medicare billable visit in the "From" field. Enter the same date in the "To" field. MMDDYY format SUBSEQUENT RAP: Enter the first date of the next period of care in the "From" field. Enter the same date in the "To" field. MMDDYY format
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)

Required Fields: RAP Claim Page 1

Field	Description/Notes
ADMIT DATE	Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC (Source of Admission)	Enter the appropriate NUBC code for the source of admission.
STAT	Patient Status – Enter patient status code 30. No other patient status code is acceptable on the RAP.
FAC. ZIP	Facility ZIP Code of the provider or subpart (9 digit code).

Required Fields: RAP Claim Page 1

Field	Description/Notes
VALUE CODES	Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes. Enter Value Code 85 with the appropriate Federal Information Processing Standards (FIPS) code. The five-digit FIPS code must also be entered with two trailing zeroes. NOTE: Value codes 61 and 85 are optional for RAPs with “From” dates on and after January 1, 2021; however, these value codes are required on the period of care claim.

RAP Claim Page 1

```
MAP1711    PAGE 01          NATIONAL GOVERNMENT SERVICES
  SC                              INST CLAIM ENTRY
MID XXXXXXXXXXX   TOB 322  S/LOC S B0100 OSCAR XXXXXX          SV:     UB-FORM
NPI XXXXXXXXXXX  TRANS HOSP PROV                    PROCESS NEW MID
PAT.CNTL#: XX-XXXXXX              TAX#/SUB:                  TAXO.CD:
STMT DATES FROM 0217XX  TO 0217XX   DAYS COV      N-C       CO       LTR
LAST BENE                        FIRST IMA           MI    DOB XXXXXXXX
ADDR 1 1234 HOPE LANE                                 2 ANYWHERE, ST
     3                                   4                                CARR:
     5                                   6                                 LOC:
ZIP XXXXXXXXX SEX X MS   ADMIT DATE 0217XX HR    TYPE X SRC X D HM      STAT 30
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                   02                  03
04                  05                   06                  07
08                  09                   10                  FAC.ZIP XXXXX XXXX
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 61 XXXXX.00           02 85 XXXXX.00           03
04                       05                       06
07                       08                       09
     PLEASE ENTER DATA
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV   PF8-NEXT
```

Required Fields: RAP Claim Page 2

Field	Description/Notes
REV	Revenue Codes – Enter Revenue Code 0023, which indicates a HIPPS code will be reported for HHPPS.
HCPC	Enter the HIPPS code in this field (This can be any valid HIPPS code for billing in this field; the actual HIPPS code for HH PPS payment will be determined by the Medicare system based on the information submitted on the 30-day period claim).
SERV DT	Service Date – Initial Period of Care: Report the date of the first billable service provided under the HIPPS code on the 0023 revenue line. Subsequent Period(s) of Care: Report the date of the first service provided under the HIPPS code on the 0023 revenue line, or the first day of the period if billing immediately after the start of care. MMDDYY format.
TOT UNITS	Total service units – No units of service are required on the 0023 revenue line.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line must be zero.

RAP Claim Page 2

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MAP1712        M E D I C A R E   A   O N L I N E   S Y S T E M     CLAIM PAGE 02
  SC                          INST CLAIM ENTRY                    REV CD PAGE 01

  MID XXXXXXXXXXX       TOB 322   S/LOC S B0100      PROVIDER XXXXXX

 CL   REV   HCPC   MODIFS    RATE     UNIT    UNIT    TOT CHRG    COV CHRG   NCOV CHRG SERV DT
  1 0023   2BB11                                        0.00                          0217XX
  2 0001




PLEASE ENTER DATA
            PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD   PF7-PREV   PF8-EXIT
```

Required Fields: RAP Claim Page 3

Field	Description/Notes
PAYER	Payer Identification – Enter “Medicare” on line A with payer code ‘Z’. Medicare does not make secondary payments or conditional payments on RAPs; the RAP should always be submitted as Medicare primary. If Medicare is the secondary payer, enter MSP information on the period claim.
RI	Release of Information – Entering “Y”, “R” or ‘’N” “Y” – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims “R” – Indicates the release is limited or restricted “N” – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code. This is the only diagnosis code required on RAPs with “From” dates on or after 1/1/21. Other diagnosis codes are optional.
ATT PHYS	Attending Physician – Enter NPI and name (last name, first name, middle initial) of the attending physician that established the plan of care with orders - this must be the individual physician’s NPI, not a group NPI.

RAP Claim Page 3

```
MAP1713        M E D I C A R E   A   O N L I N E   S Y S T E M     CLAIM PAGE 03
  SC                           INST CLAIM ENTRY
  MID XXXXXXXXXX     TOB 322   S/LOC S B0100    PROVIDER XXXXXX

   CD   ID     PAYER                      OSCAR       RI AB   PRIOR PAY   EST AMT DUE
  A Z          MEDICARE                                Y
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                          COST RPT DAYS       NON COST RPT DAYS
  DIAGNOSIS CODES   1 XXXXX    2 XXXXX    3           4            5
                    6          7          8           9
  ADMITTING DIAGNOSIS              E CODE            HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES  1                    2
   3                    4                    5                    6

  ESRD HOURS 00   ADJUSTMENT REASON CODE FC   REJECT CODE          NONPAY CODE
  ATT PHYS          NPI XXXXXXXXXX     L SMITH              F ROBERT     M S   SC XX
  OPR PHYS          NPI                L                    F            M     SC
  OTH PHYS          NPI                L                    F            M     SC
  REN PHYS          NPI                L                    F            M     SC
  REF PHYS          NPI                L                    F            M     SC

          PLEASE ENTER DATA
                PF3-EXIT   PF7-PREV   PF8-NEXT   PF9-UPDT
```

Required Fields: RAP Claim Page 5

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card.
CERT/SSN/ HIC/MBI	Enter the Medicare Number as it appears on the Medicare card if it does not automatically populate.

RAP Claim Page 5

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MAP1715        M E D I C A R E   A   O N L I N E   S Y S T E M     CLAIM PAGE 05
  SC                          INST CLAIM ENTRY
  MID XXXXXXXXXX     TOB 322  S/LOC S B0100    PROVIDER XXXXXX
INSURED NAME REL CERT-SSN-HIC-MBI SEX GROUP NAME    DOB    INS GROUP NUMBER
  A BENE         IMA
                 XXXXXXXXXX
  B

  C

  TREAT. AUTH. CODE



  TREAT. AUTH. CODE



  TREAT. AUTH. CODE

       PLEASE ENTER DATA
      PF3-EXIT   PF7-PREV   PF8-NEXT   PF9-UPDT
```

Periods of Care with No Visits Expected

- If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line
  - This will ensure the HHA remains recorded on Medicare's CWF system as the primary HHA for the beneficiary
  - This will ensure that HH consolidated billing is enforced
  - Only submit claims for 30-day periods in which visits were delivered

Claims Billing Overview

- HHA provides services for up to 30 days, then submits claim with HIPPS code matching the RAP and detailed service information
  - Matching HIPPS remains important to pair the claim with the correct RAP
- Must report line items for all services provided in the period of care

Final Period Claim

- Should be submitted
  - at end of 30-day period, or
  - when a beneficiary is transferred, or
  - when beneficiary is discharged
- Must be submitted after all services for the period have been provided and physician has signed plan of care and all orders
- Face-to-face encounter must have been completed prior to submitting the claim
- The OASIS assessment must be submitted and accepted in the state repository (iQIES) prior to billing the claim
- RAP canceled when final period claim is submitted and 100% payment is made once claim processes

How OASIS Data is Used

- OASIS used in determining HIPPS is based on the most recently completed assessment:
  - Medicare system looks back from the claim “From” date for most recent assessment
  - Start of Care assessment use for determining functional impairment level for first and second 30-day periods of new home health admission
  - Follow-up Recertification assessment used for third and fourth 30-day periods
  - Resumption of Care or Other Follow-up assessments may be used for second or later 30-day period

OASIS data and the claims system

- OASIS items used to determine the PDGM payment group are returned from iQIES and recorded on the claim record:
  - Items M1033 (Hospitalization Risk), M1800, M1810, M1820, M1830, M1840, M1850, M1860 (current functional levels)
  - Eight items but 17 fields of data in all
- This information will be displayed on FISS screen MAP171G

MAP171G: OASIS Items from iQIES

```
MAP171G    PAGE 03    NATIONAL GOVERNMENT SERVICES #06201 UAT      ACMFA722
 KXT2938    SC                 CLAIM INQUIRY                   A2020300 06:45:3

 MID                 TOB 322    S/LOC           PROVIDER

                                QIES/OASIS INFORMATION

 M1033-HSTRY-FALLS     OA      MR          M1033-WEIGHT-LOSS      OA      MR
 M1033-MLTPL-HOSPZTN   OA      MR          M1033-MLTPL-ED-VISIT   OA      MR
 M1033-MNTL-BHV-DCLN   OA      MR          M1033-COMPLIANCE       OA      MR
 M1033-5PLUS-MDCTN     OA      MR          M1033-CRNT-EXHSTN      OA      MR
 M1033-OTHER-RISK      OA      MR          M1033-NONE-ABOVE       OA      MR
 M1800-CRNT-GROOMING   OA      MR          M1810-DRESS-UPPER      OA      MR
 M1820-DRESS-LOWER     OA      MR          M1830-CRNT-BATHG       OA      MR
 M1840-CRNT-TOILTG     OA      MR          M1850-CRNT-TRNSFRNG    OA      MR
 M1860-CRNT-AMBLTN     OA      MR

                              PROCESS COMPLETED  --   PLEASE CONTINUE
                         PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT
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OASIS Corrections and Claim Adjustments

- OASIS information may be corrected by an HHA after submitting a claim to Medicare
- No need to adjust claims every time a correction is made
- Only the eight functional items (below) are used by the claims system, so claims only need to be adjusted if these items are corrected and the HHA believes the changes will have an impact on payment
  - M1033, M1800, M1810, M1820, M1830, M1840, M1850, M1860

Claim Match with OASIS

- When the 30-day period claim is received Medicare claims system checks iQIES for assessment
  - If assessment is not found, claim is RTP'd
  - If assessment is found, answers to eight OASIS items are returned and stored on claim record
- Medicare system combines OASIS and claims data and sends to Grouper
- Grouper-produced HIPPS code is used for payment (replaces provider-submitted HIPPS code)

Required Fields: HH Period Claim Page 1

Field	Description/Notes
MID	Medicare Identification (Beneficiary's Medicare Number)
TOB	Type of Bill – 329
NPI	National Provider Identifier Number
PAT. CNTL#	Patient Control Number – enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Enter the beginning and ending date of the period covered by the claim. The "From" date must match the date submitted on the RAP for the same period. MMDDYY format. The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)

Required Fields: HH Period Claim Page 1

Field	Description/Notes
ADMIT DATE	The HHA enters the same date of admission that was submitted on the RAP for the period (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC (Source of Admission)	Enter the appropriate NUBC code for the source of admission.
STAT	Patient Status – Enter the code that most accurately describes the patient's status as of the "To" date of the billing period. Any applicable NUBC approved code may be used.
COND CODES (Optional field)	Some period claims may be billed with condition code 54 if there are no skilled services being billed, but there is a policy exception that allows billing covered services (e.g., home health aide services, medical social worker visits).

Required Fields: HH Period Claim Page 1

Field	Description/Notes
OCC CDS/DATE	Occurrence Codes and corresponding date (MMDDYY format): Enter Occurrence Code 50 with OASIS completion date (OASIS item M0090). Enter Occurrence Code 61 if there is a hospital discharge date within 14 days of HHA admission. Enter Occurrence Code 62 if there is an other institutional discharge date (SNF, IRF, LTCH, or IPF) within 14 days of HHA admission.
FAC. ZIP	Facility ZIP Code of the provider or subpart (nine-digit code).
VALUE CODES	Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes. Enter Value Code 85 with the appropriate Federal Information Processing Standards (FIPS) code. The five-digit FIPS code must also be entered with two trailing zeroes.

HH Period Claim Page 1

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MAP1711        M E D I C A R E   A   O N L I N E   S Y S T E M     CLAIM PAGE 01
  SC                          INST CLAIM ENTRY                          SV:
 MID XXXXXXXXXX     TOB 329   S/LOC S B0100    OSCAR XXXXXX           UB-FORM
 NPI XXXXXXXXXX   TRANS HOSP PROV                   PROCESS NEW HIC
 PAT.CNTL#: XX-XXXXXX              TAX#/SUB:                    TAXO.CD:
  STMT DATES FROM 0217XX  TO 0317XX  DAYS COV       N-C        CO       LTR
  LAST  BENE                        FIRST IMA              MI     DOB XXXXXXXX
  ADDR 1    1234 HOPE LANE                  2 ANYWHERE, ST
       3                                    4
       5                                    6
 ZIP XXXXXXXXX SEX M MS   ADMIT DATE 0217XX HR    TYPE X SRC X    HM    STAT XX
    COND CODES 01    02    03    04    05    06    07    08    09    10
  OCC CDS/DATE 01 50 XXXXXX  02 61 XXXXXX 03          04          05
               06            07           08          09          10
    SPAN CODES/DATES 01                   02                  03
 04                  05                   06                  07
 08                  09                   10                FAC.ZIP XXXXX XXXX
   DCN
        V A L U E   C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
 01   61    XXXXX.00       02 85 XXXXX.00          03
 04                        05                      06
 07                        08                      09
      PLEASE ENTER DATA
        PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT
```

Reporting Occurrence Codes 61 and 62

- Determining “within 14 days of the ‘From’ date” of the HH claim
  - Include the “From” date, then count back using the day before the “From” date as day one
  - If “From” date = 1/20/2021, then 1/19/2021 is day one
  - Counting back from 1/19/2021, the 14-day period is 1/6/2021 – 1/19/2021
- Use occurrence codes to report discharge dates in this period
  - LTCH discharge date of 1/6/2021 would be reported on an admission HH claim with occurrence code 62
  - An acute hospital discharge date of 1/18/2021 would be reported with occurrence code 61

Reporting Occurrence Codes 61 and 62

- Report only one occurrence code 61 or 62 on a claim – if two inpatient discharges occur during the 14-day window, report the later discharge date, for example:
  - HH claim “From” date — 1/20/2021
  - Inpatient hospital discharge date — 1/10/2021 (ten days prior)
  - SNF discharge date — 1/18/2021 (two days prior)
  - Report occurrence code 62 with 1/18/2021 date
- Claims with both occurrence code 61 and 62 will be returned

Institutional Discharge

- What if an HHA is not aware of an institutional discharge when they submit the claim?
  - If the inpatient claim has been processed by Medicare before the HH claim is received, Medicare systems will identify it and group the HH claim into an institutional payment group automatically
  - If the inpatient claim has not been processed yet when the HH claim is received, Medicare systems will group the HH claim into a community payment group
  - When the inpatient claim is processed later, Medicare systems will automatically adjust the paid HH claim and pay it using an institutional payment group instead

Adjustments for Institutional Discharge

- Automatic adjustments to change community payment groups to institutional will be identified on the remittance advice:
  - TOB 032G
  - CARC 186
  - RARC N69
- Institutional payment groups will not be automatically adjusted to community if no inpatient claim is found after the timely filing period closes
  - Inpatient stay may have been in a non-Medicare facility (e.g., Veteran's Administration)
  - Non-Medicare facilities can **only** be identified through occurrence codes

Required Fields: HH Period Claim Page 2

Field	Description/Notes
REV	Revenue Codes – Claims must report a Revenue Code line 0023 matching the one submitted on the RAP for the period. Also report all services provided to the patient within the period of care.
HCPCS	Enter the HIPPS code for the 0023 revenue line. For all other revenue lines, report HCPCS codes as appropriate for each revenue code.
SERV DT	Service Date – Report the date of the first billable service provided under the HIPPS code reported on the 0023 revenue line (same as the RAP). Report all other service dates for additional revenue codes as appropriate. MMDDYY format.
TOT UNITS	Total service units – No units of service are required on the 0023 revenue line. Units of service for all other revenue codes are reported as appropriate.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line must be zero. Total charges for all other revenue codes are reported as appropriate.

Optional Field: HH Period Claim Page 2

UB-04 Field	Description/Notes
NCOV CHARGE	Noncovered Charges – Report total noncovered charges related to the revenue line. Examples of noncovered charges on HH PPS claims may include: • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments

Service Visit Codes

Revenue Code	Description
027X	Medical/Surgical Supplies
0274 (Optional Billing of DME)	Prosthetic/Orthotic Devices
029X (Optional Billing of DME)	DME (Other than Renal)
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech-Language Pathology
055X	Skilled Nursing
056X	Medical Social Services

Service Visit Codes

Revenue Code	Description
057X	Home Health Aide
060X (Optional Billing of DME)	Oxygen
0623	Medical/Surgical Supplies - Extension of 027X Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027X to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.

HCPCS Codes

Discipline/Revenue Code	Applicable HCPCS Code
Physical Therapy (042X)	G0151, G0157, G0159
Occupational Therapy (043X)	G0152, G0158, G0160
Speech-Language Pathology (044X)	G0153, G0161
Skilled Nursing (055X)	G0299, G0300, G0162, G0493, G0494, G0495, G0496
Medical Social Services (056X)	G0155
Home Health Aide (057X)	G0156

Note: In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

Time Reporting Units

Units	Minutes (< means less than)
1	< 23 minutes
2	= 23 minutes to < 38 minutes
3	= 38 minutes to < 53 minutes
4	= 53 minutes to < 68 minutes
5	= 68 minutes to < 83 minutes
6	= 83 minutes to < 98 minutes
7	= 98 minutes to < 113 minutes
8	= 113 minutes to < 128 minutes
9	= 128 minutes to < 143 minutes
10	= 143 minutes to < 158 minutes

Site of Service Codes

- Required to be billed with first billable service on final period claim
- Revenue line with site of service Q-code should use the same revenue code and date of service as the first billable service, one unit, and a nominal charge (e.g., a penny)
- If location changes during the period, new site of service code billed with first visit in new location

Site of Service Codes

HCPCS Code	Definition
Q5001	Hospice or Home Health Care Provided in Patient's Home/Residence
Q5002	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5009	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)

HH Period Claim Page 2

```
MAP1712        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 02
  SC                          INST CLAIM ENTRY                  REV CD PAGE 01

  MID XXXXXXXXXX     TOB 329   S/LOC S B0100   PROVIDER XXXXXX

                                      TOT     COV
  CL   REV   HCPC MODIFS        RATE  UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
   1 0023   2BBA1                                         0.00                0217XX
   2 0421   G0151                      00005   00005      150.00                0217XX
   3 0421   Q5001                      00001   00001        0.01                0217XX
   4 0421   G0151                      00004   00004      150.00                0223XX
   5 0421   G0151                      00004   00004      150.00                0301XX
   6 0421   G0151                      00004   00004      150.00                0303XX
   7 0421   G0151                      00004   00004      150.00                0308XX
   8 0421   G0151                      00004   00004      150.00                0310XX
   9 0421   G0151                      00004   00004      150.00                0315XX
  10 0421   G0151                      00004   00004      150.00                0317XX
  13 0431   G0152                      00005   00005      100.00                0302XX
  14 0001                                              1500.01

          PLEASE ENTER DATA
   PRESS PF2-171D   PF3-EXIT   PF5-UP   PF6-DOWN   PF7-PREV   PF8-NEXT   PF11-RIGHT
```

Required Fields: HH Period Claim Page 3

Field	Description/Notes
PAYER	Payer Identification – If Medicare is the primary payer, enter “Medicare” on line A with payer code ‘Z’. Enter appropriate payer information for MSP situations.
RI	Release of Information – Entering “Y”, “R” or ‘’N” “Y” – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims “R” – Indicates the release is limited or restricted “N” – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code and any other diagnosis codes (up to 24 additional codes) to accurately record what is driving patient care. The diagnosis codes on the period claim may not always match the OASIS.

Required Fields: HH Period Claim Page 3

Field	Description/Notes
ATT PHYS	Attending Physician – Enter the NPI and name (last name, first name, middle initial) of the attending physician signed the plan of care – this must be the individual physician's NPI, not a group NPI. The physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.
OTH PHYS	Name and NPI of the physician who certifies/recertifies the patient's eligibility for home health care (this field only needs to be completed if the physician who certifies/recertifies is different than the physician who signs the plan of care). The individual physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.

HH Period Claim Page 3

```
MAP1713        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 03
  SC                            INST CLAIM ENTRY
  MID XXXXXXXXXX     TOB 329   S/LOC S B0100    PROVIDER XXXXXX

   CD   ID     PAYER                      OSCAR       RI AB   PRIOR PAY   EST AMT DUE
  A Z          MEDICARE                                Y
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                        COST RPT DAYS       NON COST RPT DAYS
  DIAGNOSIS CODES   1 XXXXX    2 XXXXX    3 XXXXX    4 XXXXX     5
                    6          7          8          9
  ADMITTING DIAGNOSIS              E CODE            HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES  1                    2
   3                    4                    5                    6

  ESRD HOURS 00   ADJUSTMENT REASON CODE FC   REJECT CODE          NONPAY CODE
  ATT PHYS          NPI XXXXXXXXXX     L SMITH              F ROBERT     M S   SC XX
  OPR PHYS          NPI                L                    F            M     SC
  OTH PHYS          NPI XXXXXXXXXX     L JONES              F SARAH      M R   SC XX
  REN PHYS          NPI                L                    F            M     SC
  REF PHYS          NPI                L                    F            M     SC

           PLEASE ENTER DATA
                PF3-EXIT   PF7-PREV   PF8-NEXT   PF9-UPDT
```

Required Fields: HH Period Claim Page 5

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card (or the information for the primary insurer in MSP situations).
CERT/SSN/HIC/ MBI	Enter the Beneficiary's Medicare number (or insured information for MSP claims) as it appears on the Medicare card if it does not automatically populate.

HH Period Claim Page 5

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MAP1715        M E D I C A R E   A   O N L I N E   S Y S T E M     CLAIM PAGE 05
  SC                           INST CLAIM ENTRY
  MID XXXXXXXXXX     TOB 329   S/LOC S B0100    PROVIDER XXXXXX
INSURED NAME REL CERT-SSN-HIC-MBI   SEX GROUP NAME    DOB    INS GROUP NUMBER
  A BENE          IMA
                  XXXXXXXXXX
  B

  C

  TREAT. AUTH. CODE


  TREAT. AUTH. CODE



  TREAT. AUTH. CODE


           PLEASE ENTER DATA
PF3-EXIT   PF7-PREV   PF8-NEXT   PF9-UPDT
```

Claim Variations

- Transfers
- Discharges and readmissions
- LUPA
  - No-RAP LUPA

Partial Payment Adjustment

- Payments adjusted if a beneficiary transfers from one home health agency to another or is discharged and readmitted to the same agency within 30 days of the original 30-day period start date
- The case-mix adjusted payment for 30-day periods of that type is pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission, resulting in a partial period payment

Transfers

- Receiving agency coordinates with initial HHA
  - Contact and coordinate transfer date
  - Document communications between agencies
  - Submit RAP indicating transfer (condition code 47)
- Transferring agency submits discharge claim showing transfer status “06” – this claim will receive the partial payment adjustment due to the shortened period

Discharge and Readmission

- Patient discharged before end of 30-day period and same agency readmits in the same 30 days
- Prorated first period – this is the claim with the partial payment adjustment (billed with “06” patient status code)
- New 30-day period begins based on readmission RAP date

LUPA

- Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates
- LUPA periods that occur as the only period or the first period in a sequence of adjacent periods for a patient will receive an increased payment for the front-loading of assessment costs and administrative costs (LUPA add-on)
- Each of the 432 different PDGM payment groups has a threshold that determines if the 30-day period receives a LUPA
  - For each payment group, the 10th percentile value of visits is used to create a payment group specific LUPA threshold with a minimum threshold of at least two for each group (range is 2-6 visits in a 30-day period)
  - LUPA thresholds for each of the 432 case-mix groups can be found on the CMS HHA Center page

No-RAP LUPA

- Advance knowledge of LUPA for 30-day period
- HHA chooses to not submit RAP
- Claim may be adjusted later if visits are added that exceed LUPA threshold
  - Remember to submit RAP before adjusting claim
- If a RAP was submitted for a LUPA and it was late:
  - No LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP
  - The payment reduction cannot exceed the total payment of the claim

National Government Services Web Resources

- NGS website
- Education Mega Tab
  - Education > Webinars, Teleconferences & Events
    - Upcoming education sessions
  - Education > Medicare University Course List
    - HH+H CBT courses
  - Education > Past Events
    - Event materials and training summaries
  - Education > Job Aids & Manuals
    - Home health billing job aids
  - YouTube
- Provider Resources
  - Calculators & Tools > Reason Code Look Up Tool for Top Claim Errors

Provider Contact Center

- Provider Contact Center numbers, IVR numbers and hours of availability found under Contact Us > Provider Contact Center
  - NGSConnex
  - Written Inquiries

CMS Resources

- CMS website
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
    - Chapter 7 (Home Health Services)
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 1, Section 70 (Claim Processing Timeliness)
    - Chapter 10, Sections 40.1 and 40.2 (Home Health Agency Billing)
  - Medicare Learning Network
    - Resource Materials
    - Training
    - MLN Matters Articles

CMS Resources

- Home Health Agency Center
  - Coding and Billing Information
  - HH PPS Regulations and Notices
  - HH Change Requests/Transmittals
  - HHA Email Updates
  - Links to OASIS information

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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