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National Government Services

Home Health Billing Basics

5/10/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Welcome

National Government Services Provider Outreach & Education Home Health & Hospice Team

Today's Presenter

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Objectives

- Provide an explanation of the Home Health Prospective Payment System (HH PPS) and educate on basic billing of the Notice of Admission (NOA) and period of care claim for HH providers
- Review specific billing guidelines for NOA and claim billing

Agenda

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

Home Health Certification Period

- Up to 60 days
  - Recertification if required

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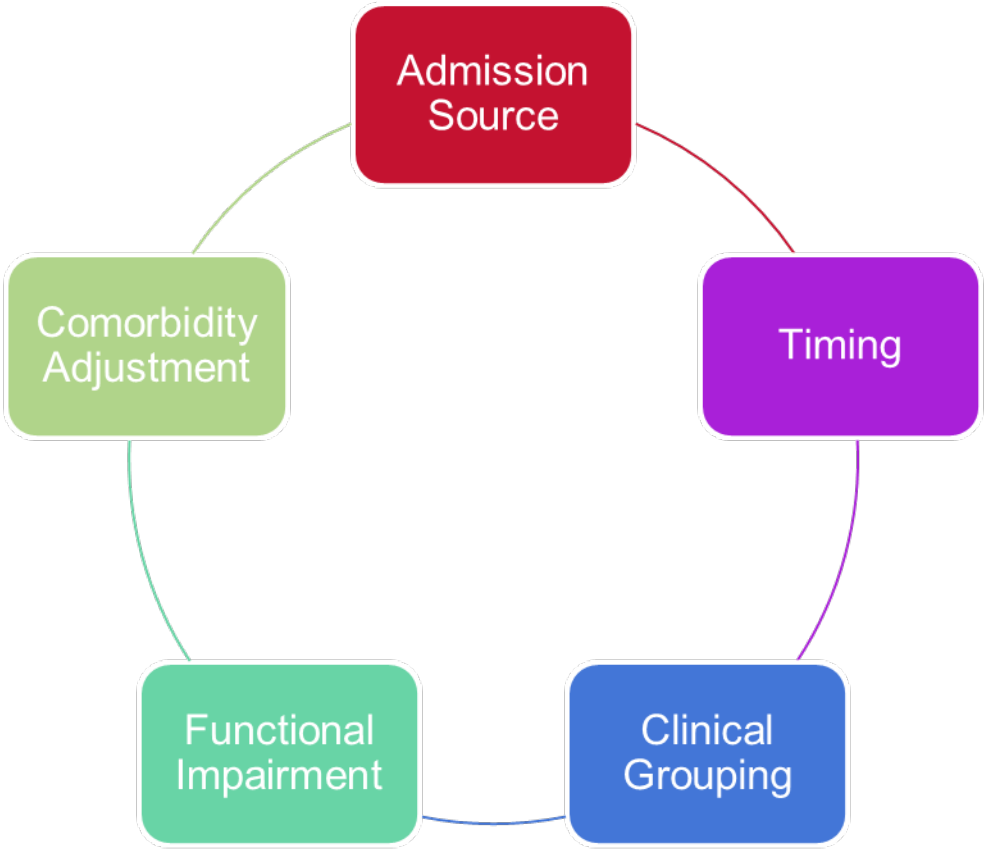
Patient-Driven Groupings Model (PDGM)

- PDGM effective 1/1/2020
- Payment model for HH PPS
  - 60-day certification/plan of care
  - Billed in two 30-day periods

PDGM Payment Groupings



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Admission Source

Institutional

- Acute or post-acute admission within 14 days of “From” date

Community

- No acute or post-acute admission within 14 days of “From” date

Timing

Early Period

- First 30-day period

Late Period

- Second and later 30-day periods

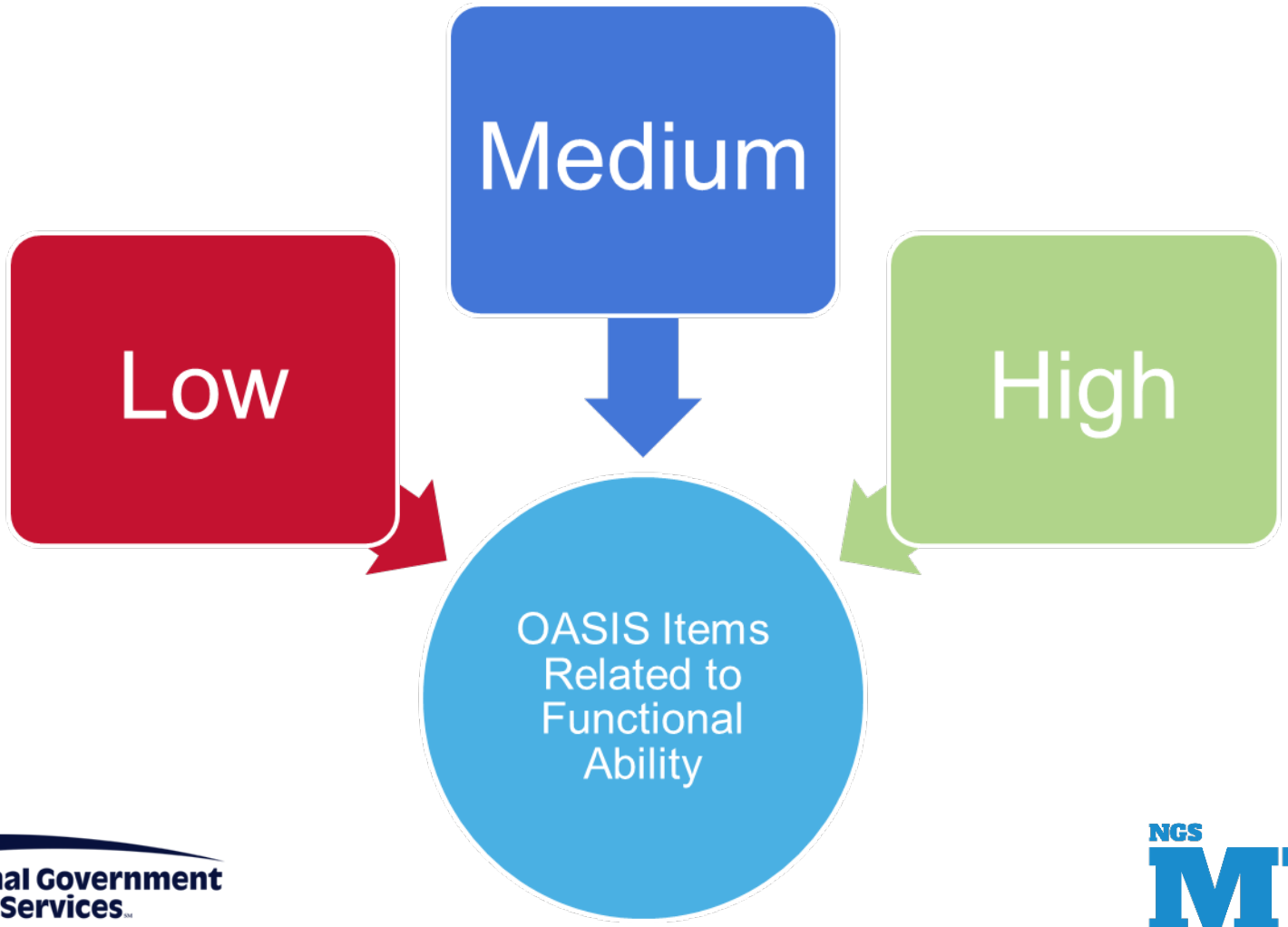
Admission Source and Timing

- Late 30-day periods always classified as community admission unless there is an acute hospitalization 14 days prior to the period
  - HHAs have the option whether or not to discharge the patient if the patient is hospitalized for a short period of time
- Post-acute stay 14 days prior to late home health 30-day period only considered institutional if HHA discharged patient prior to post-acute stay
- HHAs have the option to include an occurrence code (61 or 62) on the claim to identify institutional admission source

Clinical Groups

- Primary Reason for Home Health Care
- Based on Principal Diagnosis Code
- 12 Total Clinical Groups in PDGM Case-mix

Functional Impairment Levels



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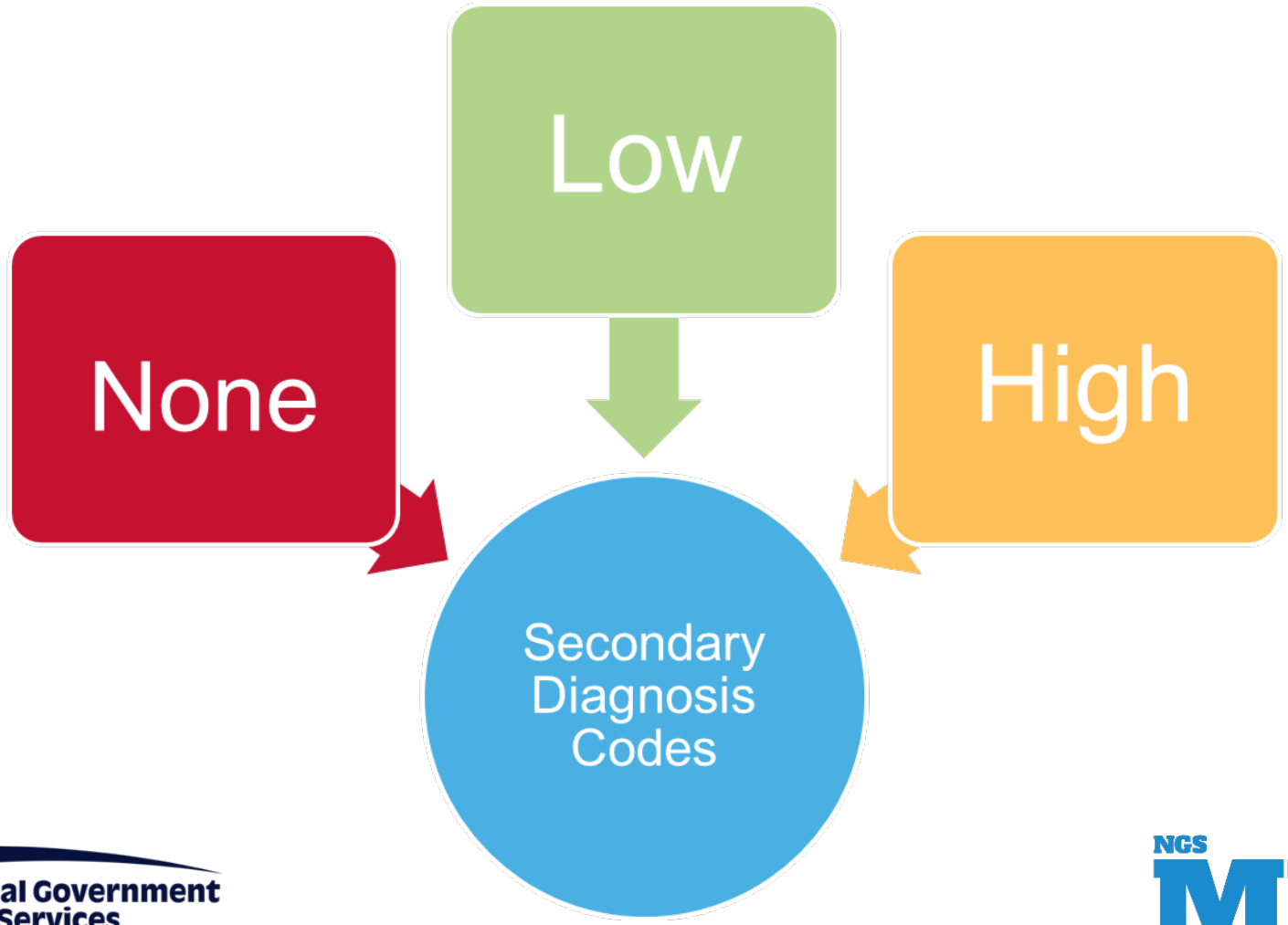
Comorbidity Adjustment



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			

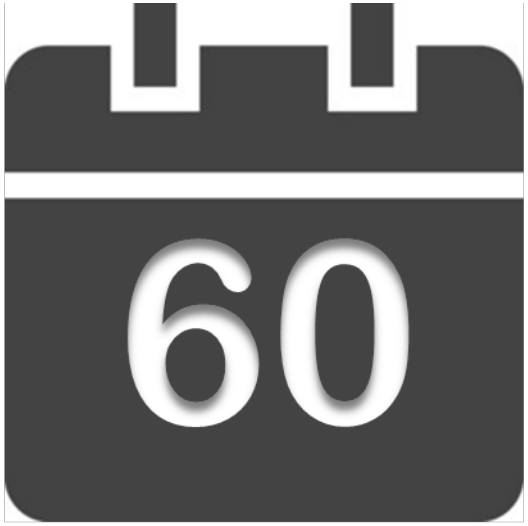
PDGM 30-day Periods

- Payment made for each 30-day period
  - Based on information submitted on period of care claim
  - NOA required at start of care to open home health admission period

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

Period of Care Sequence/Timing

- First 30-day period classified as early
- All subsequent periods classified as late
- Periods 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

NOA

- Must be submitted for any period of care that starts on or after 1/1/2022
- Purpose: open a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission

When to Submit the NOA

- HHA has received the appropriate physician's written or verbal order that contains the services required for an initial visit, and
- HHA has conducted the initial visit at the start of care and admitted patient to HH care
- NOA must be submitted within five calendar days from the start of care

Non-Timely Submission Reduction

- Payment reduction applies if HHA does not submit NOA within five calendar days from the start of care date

Note: The “From” date is day zero. Count five calendar days starting the day after the “From” date to determine timely NOA 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 for all applicable periods of care until the date the HHA submits the NOA
  - The reduction would include any outlier payment
  - The reduction amount will be displayed with value code QF on the claim

Exception to Late NOA Penalty

Fires, floods, earthquakes

CMS or MAC system issue

Late certification

Circumstances determined by CMS or MAC

Exception to Late NOA 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 NOA penalty
  - Providing sufficient information in the remarks section of the claim to allow the MAC to research the exception request

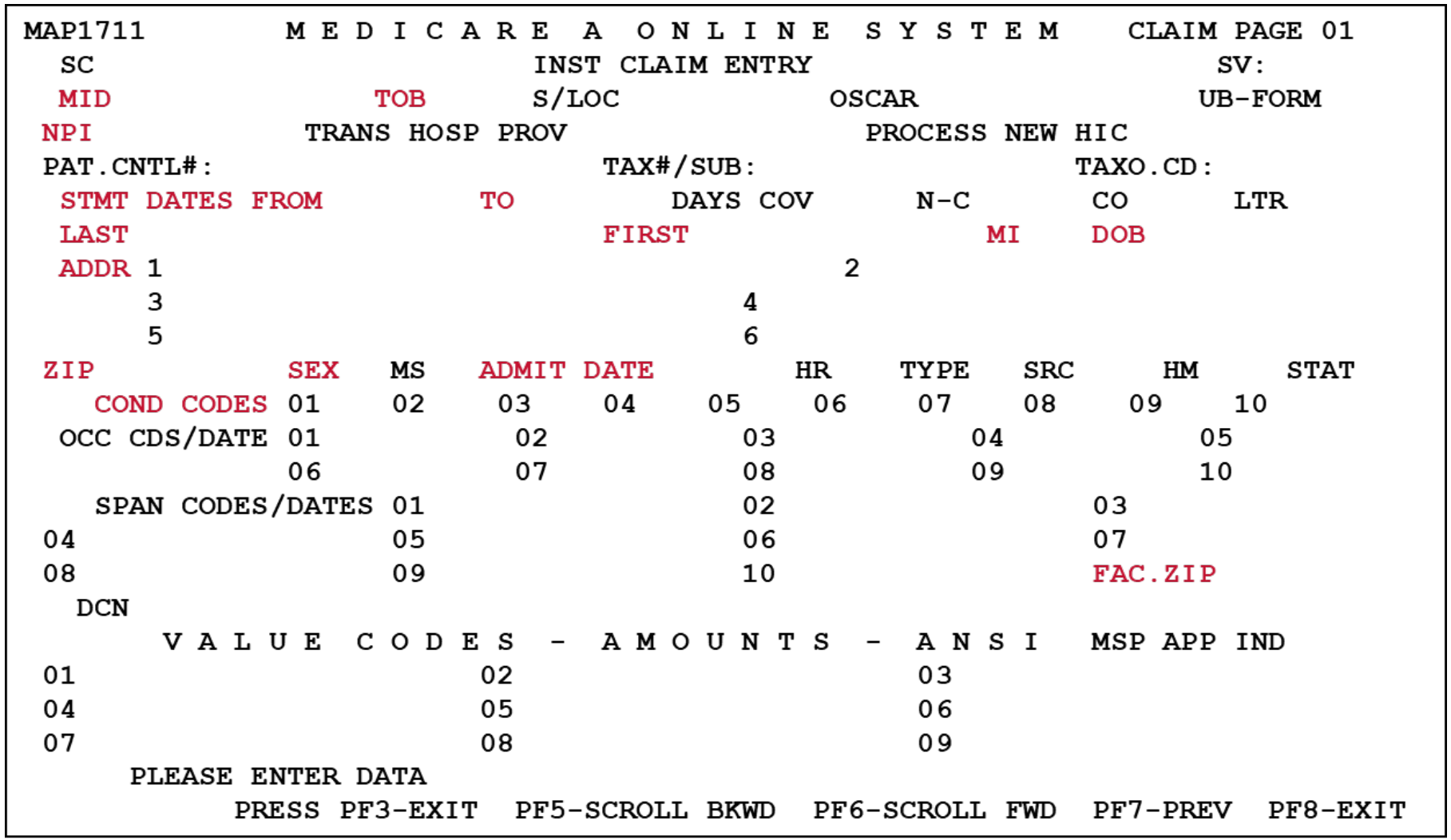
Required Fields: NOA Claim Page 1 (DDE)

Field	Description/Notes
MID Medicare Identification	Enter the beneficiary's Medicare number.
TOB Type of Bill	32A – Notice of Admission 32D – Cancellation of Admission
NPI National Provider Identifier	Enter the home health agency's NPI number.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Report the date of the first visit provided in the admission as the "From" date. The "To" or "Through" date on the NOA must always match the "From" date.
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: NOA Claim Page 1 (DDE)

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). The Admission date on the NOA must always match the “From” date.
COND CODES Condition Codes	Enter condition code 47 for a patient transferred from another HHA. HHAs can also use cc 47 when the patient has been discharged from another HHA, but the discharge claim has not been submitted or processed at the time of the new admission.
FAC. ZIP	Facility ZIP Code of the provider or subpart (9 digit code).

NOA Claim Page 1



Final Period Claim

Submitted

- at end of 30-day period, or
- when patient transferred, or
- when patient discharged

All services for the period must 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 must be submitted and accepted in the state repository (iQIES)

Claims processing system uses information from OASIS and claim to assign the HIPPS for full HH PPS payment

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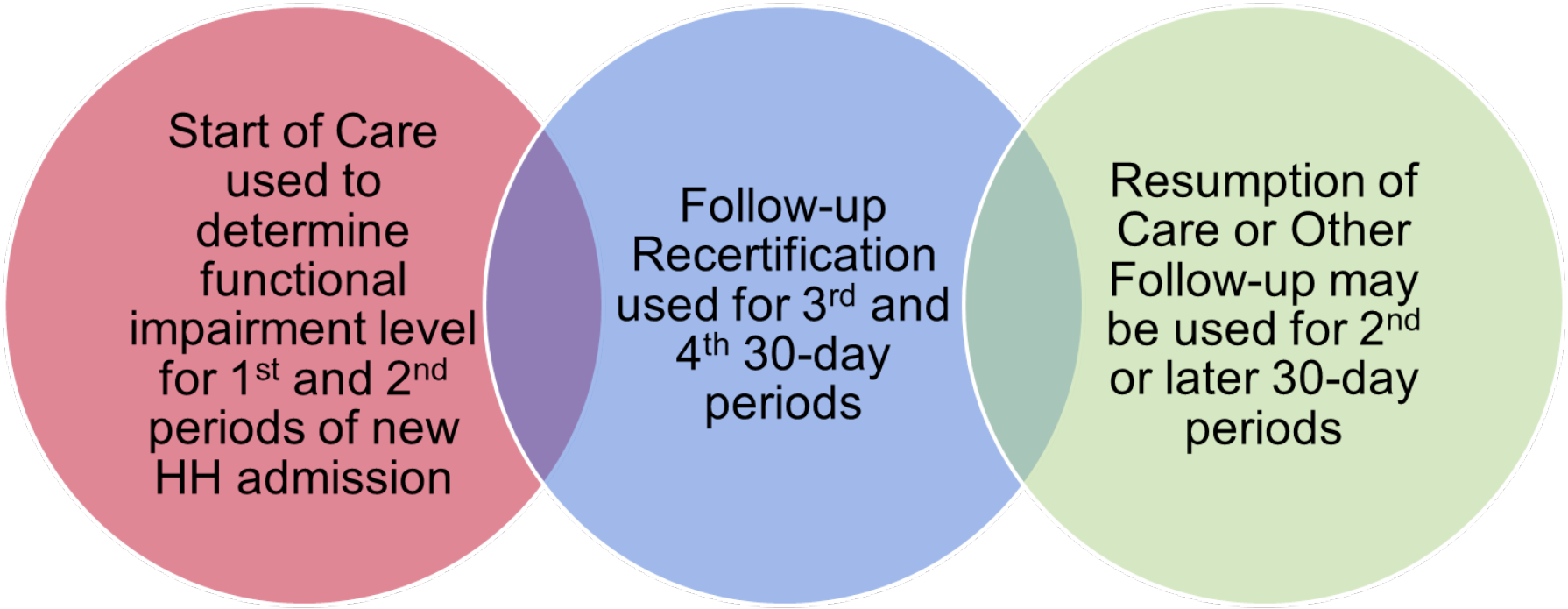
How OASIS Data is Used

- System looks at “From” date to find most recent OASIS



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
- Information 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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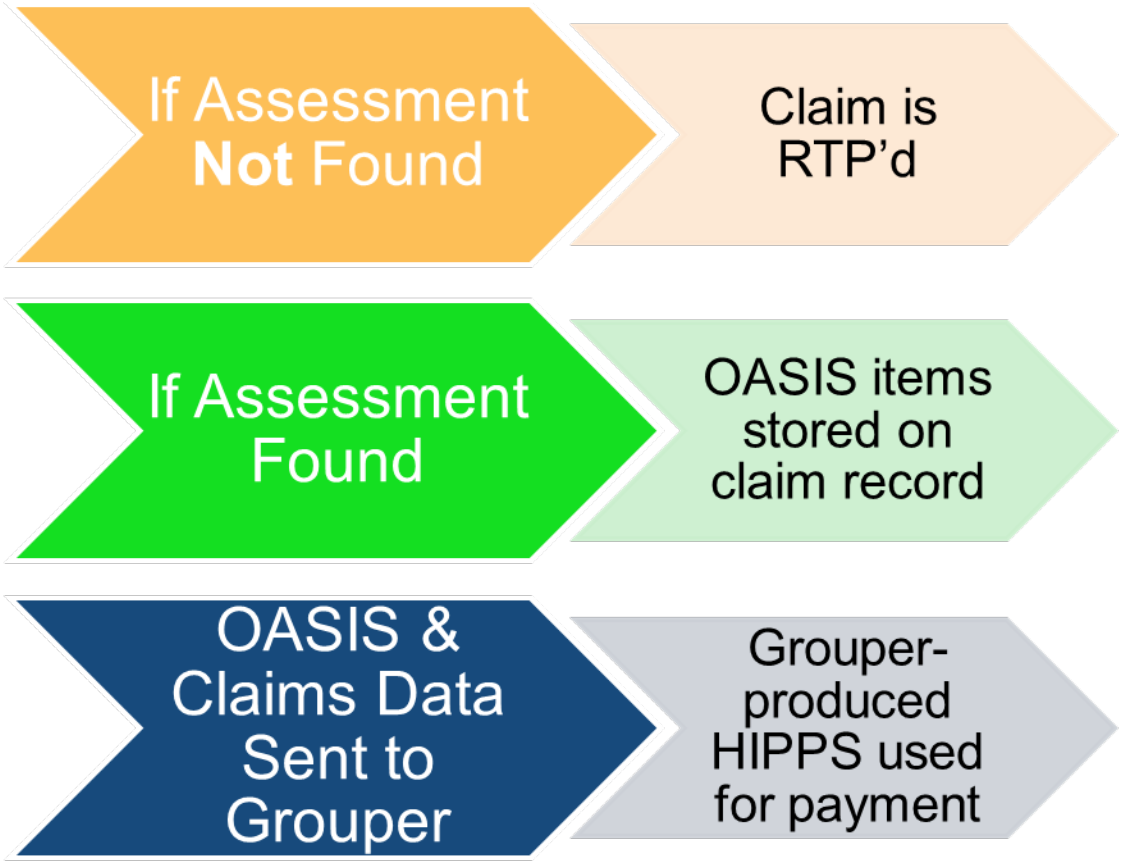
OASIS Corrections and Claim Adjustments

- OASIS information may be corrected after submitting a claim to Medicare
- No need to adjust claims every time a correction is made
- Only 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



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Required Fields: HH Period Claim Page 1

Field	Description/Notes
MID Medicare Identification	Enter the beneficiary's Medicare number.
TOB Type of Bill	329 – Home Health Final Claim for an HH PPS Period
NPI National Provider Identifier	Enter the HHA's NPI 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 NOA for the initial 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

Required Fields: HH Period Claim Page 1

Field	Description/Notes
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)
ADMIT DATE	The HHA enters the same date of admission that was submitted on the NOA for all periods until the patient is discharged (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 (Condition 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	Dates entered in must be in 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
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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 — 1/20/2022
  - Inpatient hospital discharge date — 1/10/2022 (ten days prior)
  - SNF discharge date — 1/18/2022 (two days prior)
  - Report occurrence code 62 with 1/18/2022 date
- Claims with both occurrence code 61 and 62 will be returned

Required Fields: HH Period Claim Page 2

Field	Description/Notes
REV Revenue Code	Claims must report a Revenue Code line 0023 with a HIPPS code. Also required to report revenue lines for all services provided to the patient within the period of care.
HCPCS	Enter the Grouper produced HIPPS code or any valid HIPPS code under PDGM for the 0023 revenue line. For all other revenue lines, report HCPCS codes as appropriate for each revenue code.
SERV DT Service Date	For initial periods of care, report the date of the first covered visit provided during the period on the 0023 revenue line. For subsequent periods, report the date of the first visit provided during the period on the 0023 revenue line, regardless of whether the visit was covered or non-covered. Report all other service dates for additional revenue codes as appropriate. MMDDYY format.
TOT UNITS Total Service 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.

Optional Field: HH Period Claim Page 2

Field	Description/Notes
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.
NCOV CHARGE Non-covered 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

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

Variety of services

Only one G-code per visit

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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 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 visit reported on the claim, 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

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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 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
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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 Other Physician	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

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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
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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
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Claim Variations

- Transfers
- Discharges and readmissions
- Low Utilization Payment Adjustment (LUPA)

Partial Payment Adjustment

- Beneficiary transfers from one HHA to another, or
- Beneficiary discharged and readmitted to the same agency within 30 days of the original 30-day period start date
- Case-mix adjusted payment for 30-day period pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission

Transfers

Receiving agency coordinates with initial HHA

- Contact and coordinate transfer date
- Document communication
- Submit NOA with cc 47

Transferring agency submits discharge claim showing transfer status "06"

* This claim will receive the partial payment adjustment

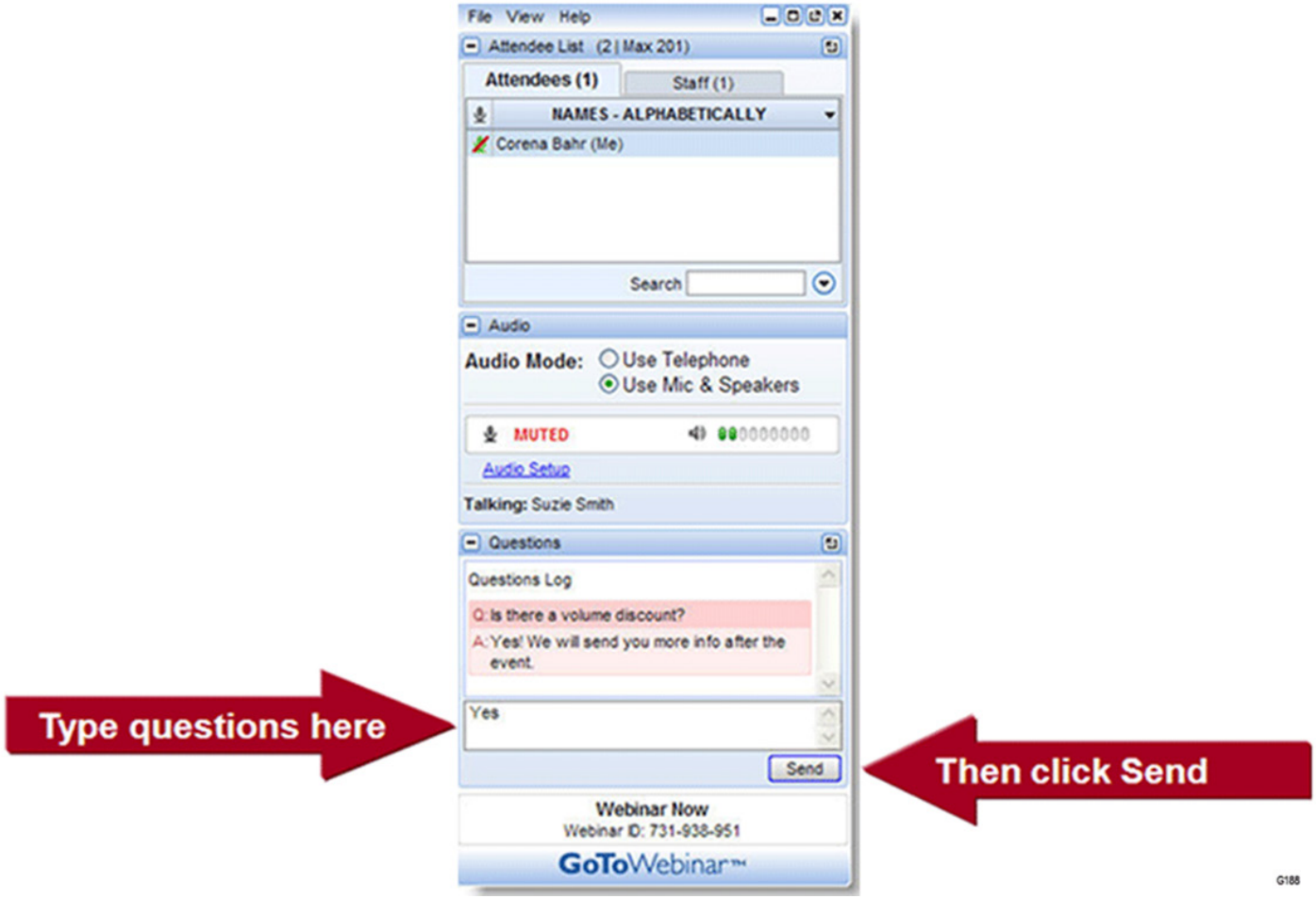
Discharge and Readmission

- 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 NOA date

LUPA

- 30-day periods with low number of visits paid on a per-visit basis using the national per-visit rates
- Each of the 432 different PDGM payment groups has a threshold that determines if the receives a LUPA (range is 2-6 visits in a 30-day period)
- LUPA periods that occur as the only period or the first period in a sequence of adjacent periods receive an increased payment for the front-loading of assessment costs and administrative costs (LUPA add-on)

Ask a Question Using the Question Box



National Government Services Web Resources

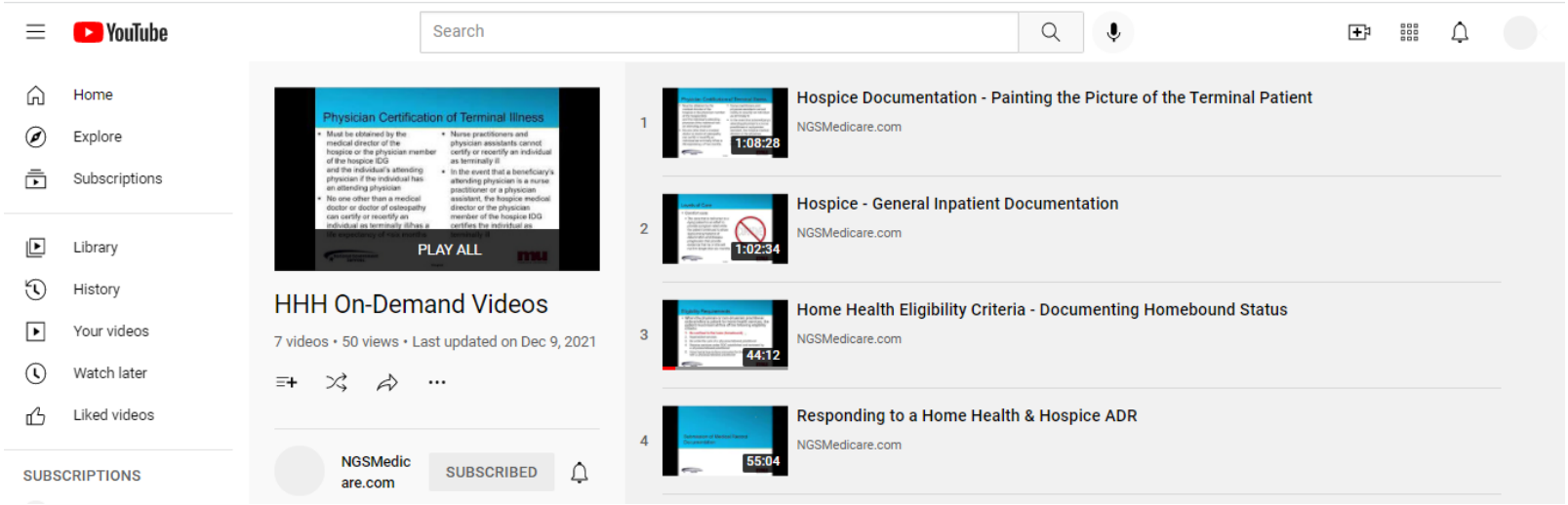
- NGS website
- Events
  - Upcoming education sessions
  - Past events material
- Education
  - Medicare Topics
    - Home Health Billing (job aids)
- Medicare University
    - HH+H CBT courses

Provider Contact Center

- Resources > Contact Us > Provider Contact Center

State/Region	Toll-Free Number	IVR	PCC Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY Contact Information	866-277-7287	Monday-Friday* 8:00 a.m.-4:00 p.m. PT *Closed for training on the 2nd and 4th Friday of the month 9:00 a.m.-1:00 p.m. PT
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-289-0423 TTY Contact Information	866-275-7396	Monday-Friday* 8:00 a.m.-4:00 p.m. ET *Closed for training on the 2nd and 4th Friday of the month. 12:00-4:00 p.m. ET
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-590-6728 TTY Contact Information	866-275-3033	Monday-Friday* 8:00 a.m.-4:00 p.m. CT 9:00 a.m.-5:00 p.m. ET *Closed for training on the 2nd and 4th Friday of the month. 11:00 a.m.-3:00 p.m. CT 12:00-4:00 p.m. ET

NGS HHH On-Demand Videos



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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