

Home Health Billing Part Two: The Period of Care Claim

3/20/2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

Today's Presenter

- Christa Shipman
 - Provider Outreach and Education Consultant





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Objective

Attendees will understand the information needed prior to billing the home health period of care claim, and the billing requirements for the claim.



Agenda

- [Patient-Driven Groupings Model Overview](#)
- [Submitting the Period of Care claim](#)
- [Claim Variations](#)
- [Resources](#)
- [Q&A](#)

Patient-Driven Groupings Model

PDGM

- Payment model for HH PPS
- Reimbursement calculated based on clinical characteristics and other patient information across payment categories
- OASIS, plan of care, and certification/recertification based on 60 days
 - Billed under two 30-day payment periods
- Reimbursement driven by the resource grouping assigned

PDGM Payment Groupings

- Admission Source
 - Institutional
 - Community
- Timing
 - Early period
 - Late period
- Clinical Grouping
 - Primary reason for home care
 - Principal diagnosis
 - 12 total clinical groups
- Functional Impairment
 - Low/Medium/High
- Comorbidity Adjustment
 - None/Low/High

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			

Period of Care Claim

What to Know Prior to Billing

- Period of care claim is submitted:
 - At the end of the 30-day period, or
 - When the patient is transferred, or
 - When the patient is discharged
- All services for the period must have been provided and the physician or allowed practitioner has signed the plan of care and all orders
- Face-to-face encounter completed
- OASIS submitted and accepted in the state repository (iQIES)
- All services reported (covered and noncovered)
- NOA processed to open admission

Consolidated Billing

- HHA must bill for all home health services provided as part of the patient's plan of care, including
 - Part-time or intermittent skilled nursing services
 - Skilled therapy services (PT, OT, SLP)
 - Routine and non-routine medical supplies
 - Part-time or intermittent home health aide services
 - Medical social services
 - dNPWT
 - Covered osteoporosis drugs

How OASIS Data is Used

- System looks at “From” date to find most recent OASIS
 - Start of care used to determine functional impairment level for 1st and 2nd periods of new HH admission
 - Follow-up Recertification used for 3rd and 4th 30-day periods
 - Resumption of Care or Other Follow-up may be used for 2nd or later 30-day periods
- When OASIS is found, OASIS items are stored on the claim record
 - OASIS and claims data sent to the Grouper and the Grouper produces a HIPPS code for claim payment
- If OASIS is not found, the claim is RTPd for correction

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 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

Institutional Admissions

- Occurrence Code 61 reported with discharge date when hospital discharge is within 14 days of HHA admission
- Occurrence code 62 reported with discharge date when SNF, IRF, LTCH, or IPF discharge is within 14 days of HHA admission
- 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
 - Claims with both occurrence code 61 and 62 will be returned

Site of Service Codes

- Required to be billed with first service on final period claim
- Site of service Q-code revenue line uses same revenue code and date of service as the first visit reported on the claim, along with 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

Period of Care Claim Submission – 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")	<p>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.</p> <p>The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format</p>
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.

Period of Care Claim Submission – Page 1 (cont.)

Field	Description/Notes
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).
OCC CDS/DATE: Occurrence Codes and corresponding date	<p>Dates entered in must be in MMDDYY format: Enter Occurrence Code 50 with OASIS completion date (OASIS item M0090).</p> <p>Enter Occurrence Code 61 if there is a hospital discharge date within 14 days of HHA admission.</p> <p>Enter Occurrence Code 62 if there is an other institutional discharge date (SNF, IRF, LTCH, or IPF) within 14 days of HHA admission.</p>
FAC. ZIP	Facility ZIP Code of the provider or subpart (nine-digit code).
VALUE CODES	<p>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.</p> <p>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.</p>

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 XXXXXXXXXXXX  TOB 329  S/LOC S B0100  OSCAR XXXXXX          UB-FORM
NPI XXXXXXXXXXXX  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 XXXXXXXXXXXX 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
  VALUE CODES - AMOUNTS - ANS 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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Period of Care Claim Submission – 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.
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 (Optional field)	Report total non-covered charges related to the revenue line. Examples of non-covered charges on HH PPS claims may include: <ul style="list-style-type: none"> • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments

G-code Unit Reporting

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

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			
CL	REV	HCPC	MODIFS	RATE	TOT UNIT	COV 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

Period of Care Claim Submission – 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.
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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 (Optional field)	<p>Report total non-covered charges related to the revenue line. Examples of non-covered charges on HH PPS claims may include:</p> <ul style="list-style-type: none"> • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments

HH Period Clam 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  C L A I M  P A G E  0 3
SC              INST CLAIM ENTRY
MID XXXXXXXXXXXX  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 XXXXXXXXXXXX  L SMITH          F ROBERT  M S  SC XX
OPR PHYS          NPI          L          F          M  SC
OTH PHYS          NPI XXXXXXXXXXXX  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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Period of Care Claim Submission – Page 4

Field	Description/Notes
REMARKS	Remarks are not required on the claim; however, remarks are recommended when adjusting or canceling the claim, or when submitting a request for late NOA penalty exception.

Period of Care Claim Submission – 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/SSI/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.

Claim Variations

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 the initial HHA
 - Contact and agree upon transfer date
 - Document communication
 - Submit NOA with cc 47
- Transferring agency submits discharge claim with transfer patient status code '06'
 - This claim will receive 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 PDGM payment group has a threshold that determines if it is 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)

Resources

Ask a Question Using the Question Box

The screenshot displays the GoToWebinar interface. At the top, there is a menu bar with 'File', 'View', and 'Help'. Below it, a window titled 'Attendee List (2 | Max 201)' shows a list of attendees, including 'Corena Bahr (Me)'. The 'Audio' section is visible, with 'Audio Mode' set to 'Use Mic & Speakers' and a 'MUTED' indicator. The 'Questions' section is highlighted, showing a 'Questions Log' with a question: 'Q: Is there a volume discount?' and an answer: 'A: Yes! We will send you more info after the event.' Below the log is a text input field containing the word 'Yes' and a 'Send' button. Two red arrows are overlaid on the image: one pointing to the input field with the text 'Type questions here', and another pointing to the 'Send' button with the text 'Then click Send'.

National Government Services Web Resources

- [NGS website](#)
- Events
 - Upcoming education sessions
 - Past events material
- Education
 - Medicare topics
 - Home health billing (job aids)
- Medicare University
 - CBT courses

Provider Contact Center

- First option when contacting National Government Services
 - Required to log and track all incoming inquiries
- Tiered system to respond accurately to all provider inquiries
- Contact number and hours available on our website
 - Contact Us > Provider Contact Center

CMS Resources

- [CMS website](#)
- 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
- [Home Health Agency \(HHA\) Center](#)

Listen to our Podcast



Navigating Medicare: Home Health & Hospice Insights for Providers

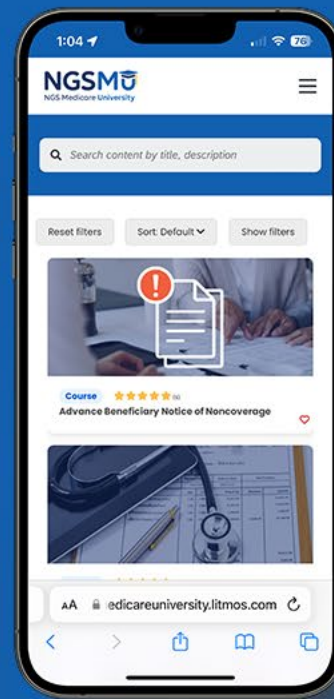
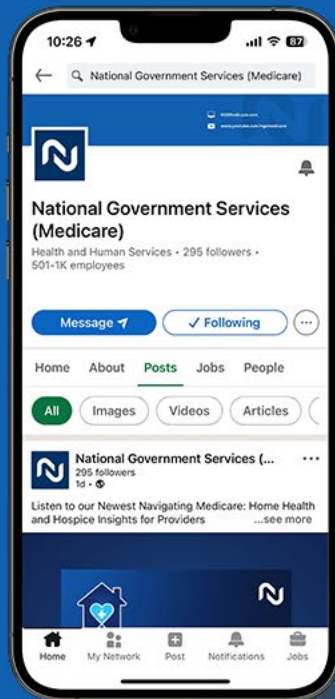
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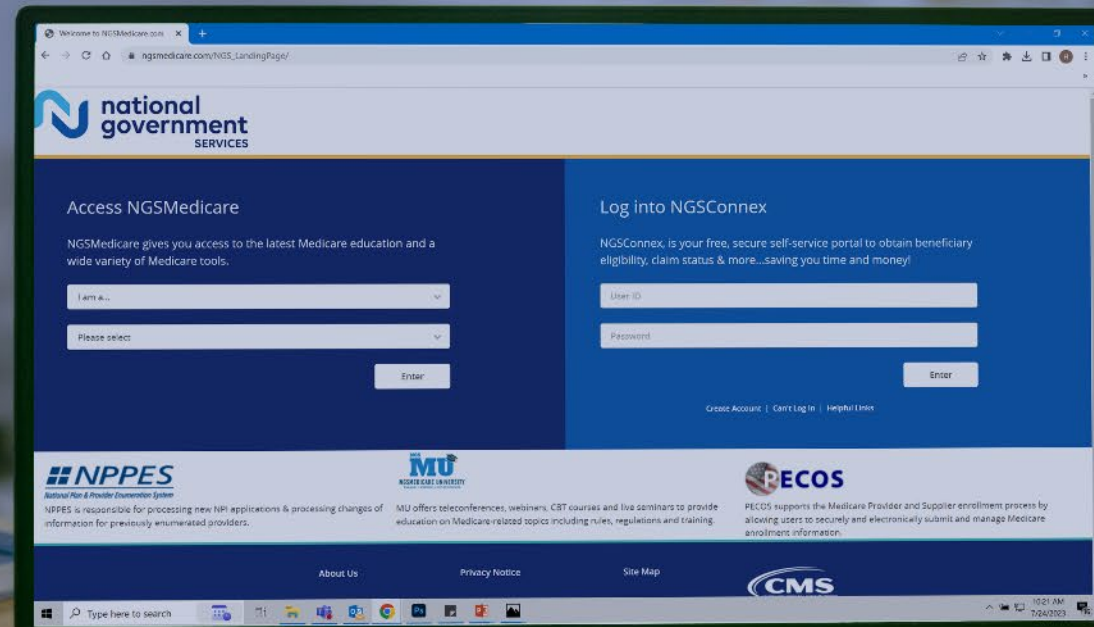


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Online resources, event calendar, LCD/NCD, and tools



[IVR System](#)

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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Questions?

Thank you!