national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Continuing Home Health Billing: The Period of Care Claim

10/26/2023

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.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenter: Christa Shipman

What to Know Before Billing Medicare

Submitting the Period of Care Claim

Claim Variations

Questions & Answers

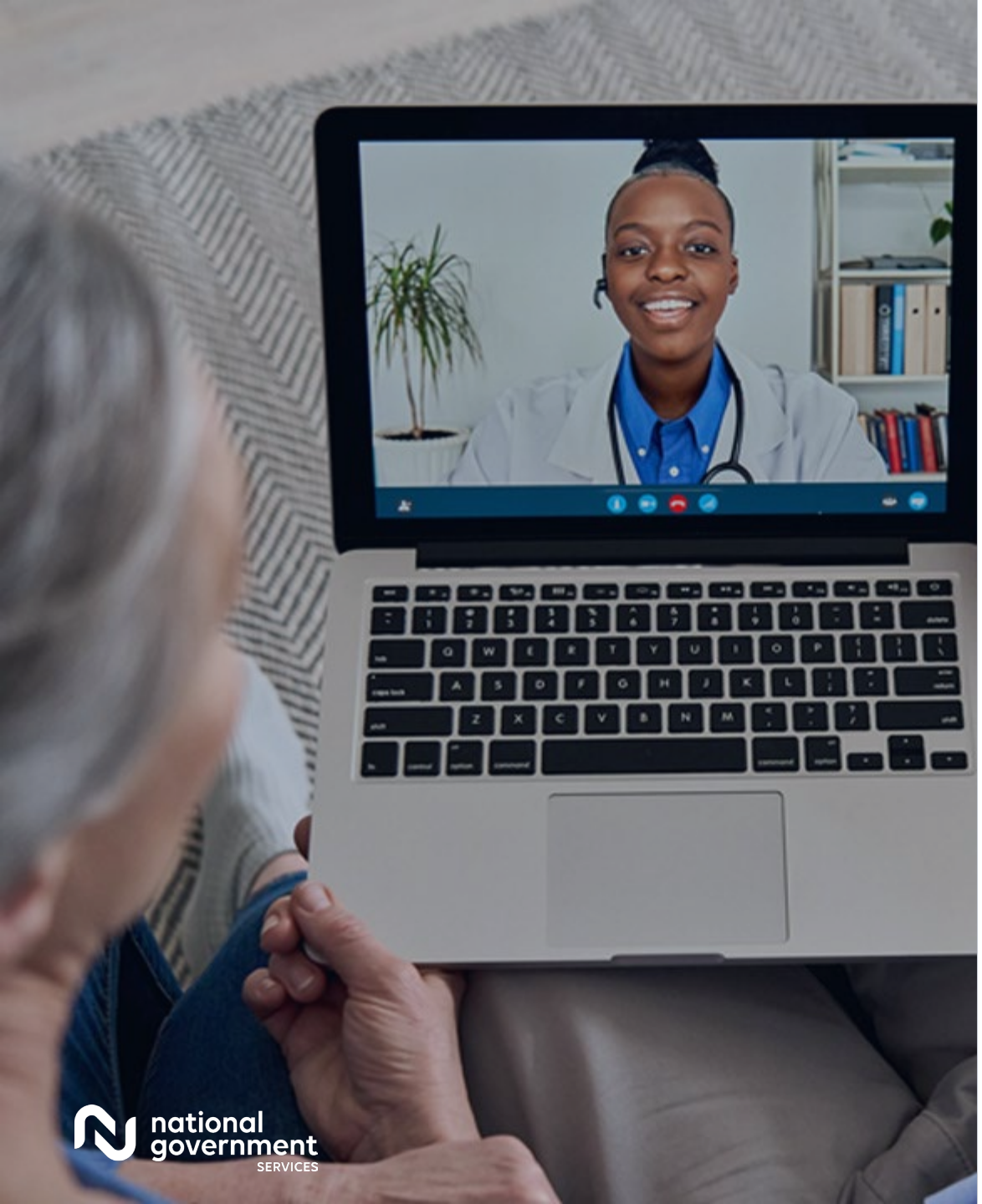
national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

NGSMU

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.



Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

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

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

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
  - NPWT using a disposable device
  - Covered osteoporosis drugs

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)
- NOA processed to open admission

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
- 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

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")	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
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	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

```
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
```

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: • 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

                                          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
```

Period of Care Claim Submission – 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.
ATT PHYS Attending Physician	Enter the NPI and name (last name, first name, middle initial) of the attending physician who 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 Clam 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
```

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

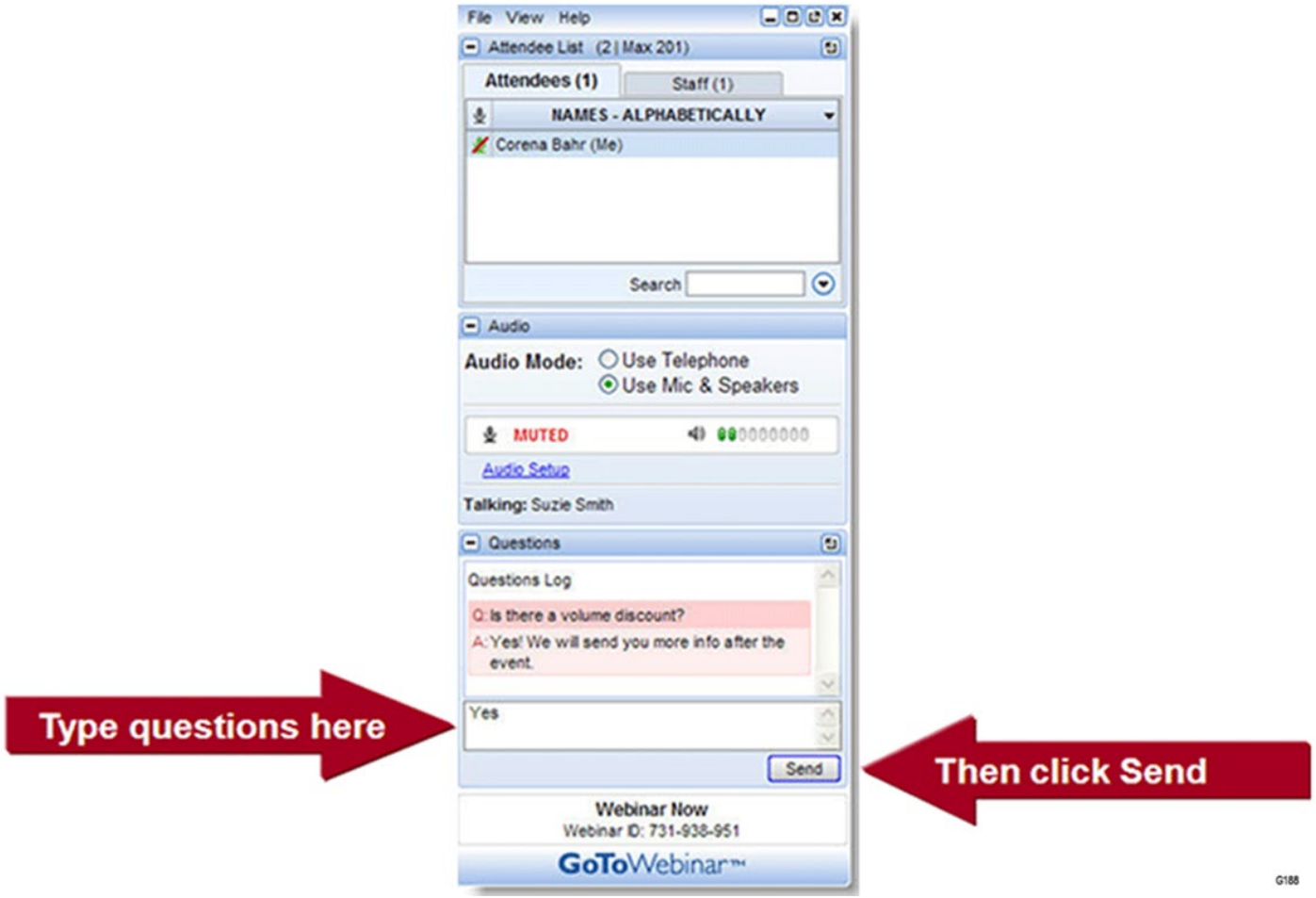
LUPA

- 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



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

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

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
- Home Health Agency (HHA) Center

Connect with us on Social Media

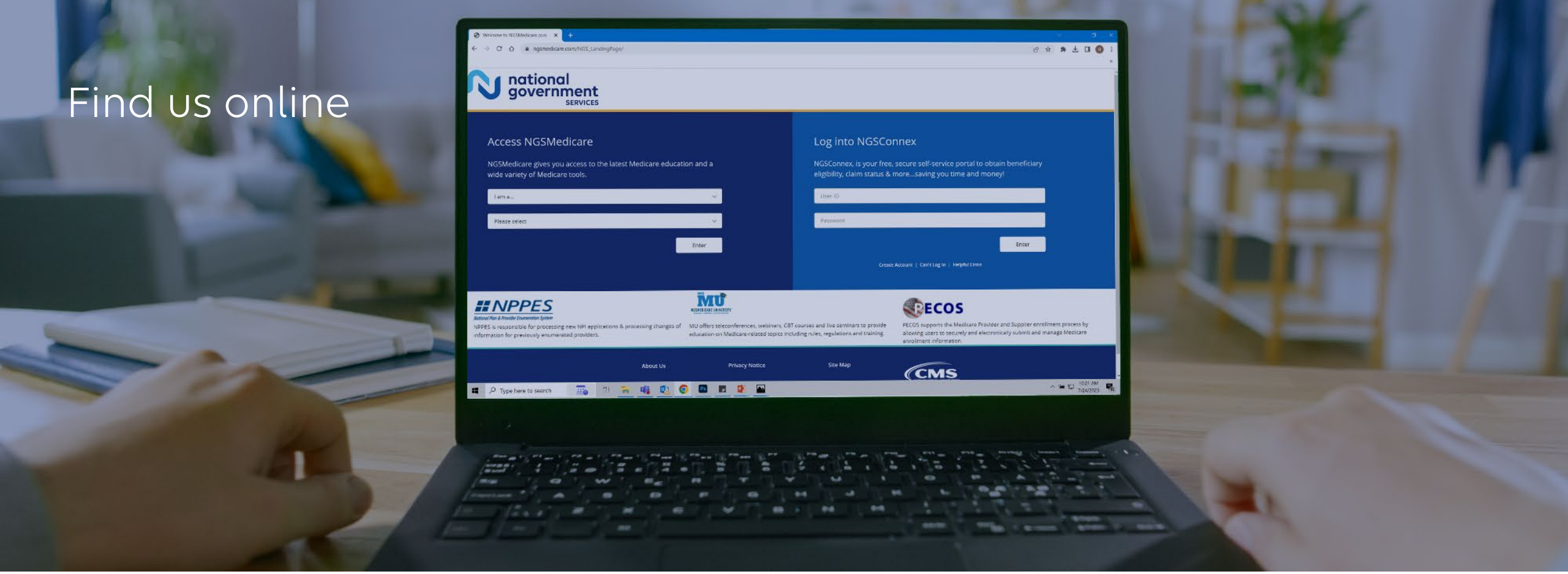
YouTube Channel
Educational Videos

medicare mobile
Text NEWS to 37702; Text GAMES to 37702

www.MedicareUniversity.com
Self-paced online learning

LinkedIn
Educational Content

Find us online



www.NGSMedicare.com
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

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.