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National Government Services

J6: Home Health Billing Basics

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Acronyms

- Please access the Acronyms page on the NGSMedicare.com Web site to view any acronym used within this presentation.

Objective

- Provide an explanation of the HH PPS and educate on basic billing of the RAP and episode claim for HH providers

Agenda

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

HH Episode

- A HH episode is 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
  - Episodes may be shorter than, but cannot exceed 60 days in length
  - If there is a continuing need for HH care, the beneficiary may receive care for an unlimited number of 60-day episodes

HH PPS

- Pays HHAs a predetermined base payment for each 60-day episode of care for each Medicare beneficiary
  - Adjusted for health condition and care needs of the beneficiary
  - Adjusted for geographic difference in wages for HHAs across the country
    - Case-mix adjustment
  - Outliers ensure payment for beneficiaries with expensive care needs and unusually high costs

HH PPS

- Case-mix group assigned to a patient's episode also referred to as an HHRG determined by data from the OASIS
  - HHRG reflected on HHA claim as a HIPPS code
- HH PPS payment made in two installments
  - RAP (initial payment)
  - Episode claim (final payment)

HIPPS

- HIPPS Coding
  - Position 1: Episode Sequence & Therapy Threshold
  - Position 2-4: Clinical, Functional & Service Domains
  - Position 5: Non-Routine Supply

1 A F K S

HIPPS

	Position 1	Position 2	Position 3	Position 4	Position 5		
	Grouping Step	Clinical Domain	Functional Domain	Service Domain	Supplies Provided	Supplies Not Provided	Domain Levels
Early Episodes (1st & 2nd)	1 0-13 Visits	A HHRG: C1	F HHRG: F1	K HHRG:S1	S Severity Level: 1	1 Severity Level: 1	= MIN
	2 14-19 Visits	B HHRG: C2	G HHRG: F2	L HHRG:S2	T Severity Level: 2	2 Severity Level: 2	= LOW
Late Episodes (3rd & later)	3 0-13 Visits	C HHRG: C3	H HHRG: F3	M HHRG:S3	U Severity Level: 3	3 Severity Level: 3	= MOD
	4 14-19 Visits			N HHRG:S4	V Severity Level: 4	4 Severity Level: 4	= HIGH
Early or Late Episodes	5 20+ Visits			P HHRG:S5	W Severity Level: 5	5 Severity Level: 5	= MAX
					X Severity Level: 6	6 Severity Level: 6	

Episode Sequence

- Episode Sequencing
  - Early: First or second episode in a sequence of adjacent episodes*
  - Later: Third or later episode in a sequence of adjacent episodes*
    - *"Adjacent Episodes" are defined as being separated by no more than 60 days between claims

Therapy Thresholds

- Number of therapy visits projected on the OASIS at the start of the episode is confirmed by therapy visits entered on final episode claim
- Three Thresholds
  - 6 Visits
  - 14 Visits
  - 20 Visits
- Claims will be recoded based on actual number of therapy services provided

Supply Groups

- Supplies bundled into HH PPS payment
  - Routine supplies: used in small quantities for patients during usual course of home care
  - Non-routine: needed to treat patient's specific illness or injury according to plan of care
- Non-routine supplies grouped based on if supplies were (or were not) provided and further scaled down into severity levels

Note: A list of non-routine supplies can be found in the Home Health Consolidated Billing Master Code List on the CMS Web site: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html

Did You Know…

- Grouper software will always output a code that says supplies are provided. Provider will change 5th position of HIPPS prior to claim submission, if supplies were not utilized.

Consolidated Billing

- HHA must bill for all home health services which includes:
  - Nursing and therapy services
  - Routine and non-routine medical supplies
  - HH aide services
  - Medical social services
- 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

- Requests initial split percentage payment for HH PPS episode
  - Initial episode = 60% split (40% for final claim)
  - Subsequent episode = 50% split (50% for final claim)
- Submitted after receiving physician's verbal orders and after delivering at least one service to the beneficiary
- Establishes agency as primary HHA
- Opens new home health episode on CWF

Home Health
Prospective Payment System: RAP

- RAP can be submitted when all of the following conditions are met:
  - OASIS completion
  - Physician's verbal orders
  - Plan of care sent to physician
  - First service delivered
- Submitted on TOB 322

Did You Know…

- The NUBC maintains the coding information for all medical billing including the UB-04 data elements. The most common valid values used in home health billing represented in this presentation do not represent an all-inclusive list of codes that may be used when billing home health RAPs and claims. Visit the NUBC Web site for subscription to the UB-04: http://www.nubc.org

Required Fields: RAP Claim Page 1

Field	Description/Notes
HIC	Beneficiary's Medicare Health Insurance Claim (HIC) Number
TOB	Type of Bill – 322
NPI	National Provider Identifier (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")	INITIAL RAP: Enter the first Medicare billable visit in the "From" field. Enter the same date in the "To" field. MMDDYY format SUBSEQUENT EPISODE RAP: Enter the first date of the newly certified episode 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)	**Code**	**Definition**
	1	Physician Referral
	2	Clinic Referral
	3	Medicare Advantage Organization (MAO) Referral
	4	Transfer from Hospital
	5	Transfer from SNF (Skilled Nursing Facility)
	6	Transfer from another health care facility
	9	Information Not Available
	A	Transfer from CAH (Critical Access Hospital)

Required Fields: RAP Claim Page 1

Field	Description/Notes
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).
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.

RAP 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:
  HIC 123456789A    TOB 322  S/LOC S B0100     OSCAR XX7XXX         UB-FORM
 NPI XXXXXXXXXX TRANS HOSP PROV                PROCESS NEW HIC
 PAT.CNTL#: XXXXXXXX             TAX#/SUB: 39XXXXXXX       TAXO.CD:
  STMT DATES FROM 021714  TO 021714  DAYS COV      N-C       CO      LTR
  LAST DAVISON                    FIRST JOHN            MI    DOB 12091929
  ADDR 1 12345 HOPE LANE                  2 LOS ANGELES CA
       3                                  4
       5                                  6
 ZIP 92885     SEX M MS   ADMIT DATE 021714 HR 00 TYPE 9 SRC 5 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 98765 4321
   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    66780.00       02                  03
 04                      05                  06
 07                      08                  09
 37185                                                <== REASON CODES
       PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT
```

Required Fields: RAP Claim Page 2

Field	Description/Notes
REV	Revenue Codes – Enter Revenue Code **0023**, which indicates a Health Insurance Prospective Payment System (HIPPS) code will be reported for HHPPS.
HCPC	Enter the HIPPS code in this field (This is the HHRG from the OASIS).
SERV DT	Service Date – Report the date of the first billable service provided under the HIPPS code reported on the 0023 revenue line. 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

```
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

 HIC 123456789A    TOB 322  S/LOC S B0100  PROVIDER XX7XXX

                                TOT    COV
 CL  REV  HCPC MODIFS       RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE SERV DT
  1 0023 1AFKS                   00001 00001        0.00             021714
  2 0001


 37185                                                    <== REASON CODES
      PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

Required Fields: RAP Claim Page 3

Field	Description/Notes
PAYER	Payer Identification – If Medicare is the primary payer, enter “Medicare” on line A. Medicare does not make secondary payments or conditional payments on RAPs.
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-9-CM code for the principal diagnosis code and any other diagnosis codes for conditions that coexisted when the plan of care was established.
ATT PHYS	Attending Physician – Enter the NPI and name (last name, first name, middle initial) of the attending physician that established the plan of care with verbal 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
HIC 123456789A    TOB 322  S/LOC S B0100  PROVIDER XX7XXX
                                                    OFFSITE ZIPCD:
 CD  ID    PAYER                    OSCAR        RI AB  PRIOR PAY  EST AMT DUE
A         MEDICARE                  XX7XXX        Y Y         0.00        0.00
B                                                             0.00        0.00
C                                                             0.00        0.00
DUE FROM PATIENT        0.00        0.00
MEDICAL RECORD NBR 000XXXXX           COST RPT DAYS      NON COST RPT DAYS
DIAGNOSIS CODES  1 7812    2 4019    3 2900    4 V1588    5
                 6         7         8         9
ADMITTING DIAGNOSIS 7812      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    LN SMITH               FN ROBERT    MI S
OPR PHYS        NPI 0000000000    LN                     FN           MI
OTH PHYS        NPI 0000000000    LN                     FN           MI

37185                                                     <== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

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	Enter the Medicare Health Insurance Claim Number as it appears on the Medicare card if it does not automatically populate.
TREAT. AUTH. CODE	Treatment Authorization Code – Enter the OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported on claim page 2.

RAP Claim Page 5

```
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
 HIC 123456789A     TOB 322  S/LOC S B0100  PROVIDER XX7XXX
 INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME    DOB    INS GROUP NUMBER
 A DAVISON           JOHN          M             12091929
                  123456789A
 B

 C

 TREAT. AUTH. CODE
 14BV14BV11DDICAGJF


 TREAT. AUTH. CODE



 TREAT. AUTH. CODE

37185                                                    <== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

OASIS Matching Key

- Treatment Authorization Code Field
  - First nine positions: dates used
    - Two-digit dates and alpha codes for Julian dates
    - One-digit code for reason for assessment
  - Last nine positions: episode sequence, clinical & functional scores, and case-mix equations

Treatment Authorization From OASIS

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start of Care) – 2 digit year	**2014**	**14**
3-4	M0030 (Start of Care) – code for Julian date	**048**	**BV**
5-6	M0090 (Date Assessment Complete) – 2 digit year	**2014**	**14**
7-8	M0090 (Date Assessment Complete) – code for Julian Date	**048**	**BV**
9	M0100 (Reason for Assessment)	**01**	**1**
10	M0100 (Episode Timing)	**01**	**1**
11	Clinical Severity Points – under Equation 1	**4**	**D**
12	Functional Severity Points – under Equation 1	**4**	**D**
13	Clinical Severity Points – under Equation 2	**9**	**I**
14	Functional Severity Points – under Equation 2	**3**	**C**
15	Clinical Severity Points – under Equation 3	**1**	**A**
16	Functional Severity Points – under Equation 3	**7**	**G**
17	Clinical Severity Points – under Equation 4	**10**	**J**
18	Functional Severity Points – under Equation 4	**6**	**F**

Final Episode Claim

- Submitted at end of 60-day period, when a beneficiary is transferred or when beneficiary is discharged
- Must be submitted after all services for the episode have been provided and physician has signed plan of care and all verbal orders
- Face-to-face encounter must have been completed prior to submitting the claim
- RAP payment recouped when final episode claim is submitted and 100% payment is made once claim processes

Required Fields: HH Claim Page 1

Field	Description/Notes
HIC	Beneficiary's Medicare Health Insurance Claim 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 episode. MMDDYY format. For continuous care episodes, the "To" date must be 59 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 Claim Page 1

Field	Description/Notes	
ADMIT DATE	The HHA enters the same date of admission that was submitted on the RAP for the episode (MMDDYY).	
TYPE	Enter the appropriate NUBC code for the admission type.	
SRC (Source of Admission)	**Code**	**Definition**
	1	Physician Referral
	2	Clinic Referral
	3	MAO Referral
	4	Transfer from Hospital
	5	Transfer from SNF (Skilled Nursing Facility)
	6	Transfer from another health care facility
	9	Information Not Available
	A	Transfer from CAH (Critical Access Hospital)

Required Fields: HH Claim Page 1

Field	Description/Notes
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.
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.

HH 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:
  HIC 123456789A     TOB 329  S/LOC S B0100      OSCAR XX7XXX          UB-FORM
 NPI XXXXXXXXXX TRANS HOSP PROV                  PROCESS NEW HIC
 PAT.CNTL#: XXXXXXXX             TAX#/SUB: 39XXXXXXX       TAXO.CD:
  STMT DATES FROM 021714  TO 041714  DAYS COV      N-C       CO      LTR
  LAST DAVISON                    FIRST JOHN            MI    DOB 12091929
  ADDR 1 12345 HOPE LANE                  2 LOS ANGELES CA
       3                                  4
       5                                  6
 ZIP 92885     SEX M MS    ADMIT DATE 021714 HR 00 TYPE 9 SRC 5 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 98765 4321
   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    66780.00        02                       03
 04                       05                       06
 07                       08                       09
 37185                                                <== REASON CODES
       PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT
```


Required Fields: HH 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 episode. Also report all services provided to the patient within the episode.
HCPC	Enter the HIPPS code for the 0023 revenue line. For all other revenue lines, report CPT/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 other revenue codes are reported as appropriate.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line will be zero. Total charges for other Revenue Codes are reported as appropriate.

Service Visit Codes

Revenue Code	Description
027X	Medical/Surgical Supplies
0274 (Optional Billing of DME)	Prosthetic/Orthotic Devices
029X (Optional Billing of DME)	Durable Medical Equipment (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)	G0154, G0162, G0163, G0164
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 episode claim
- If location changes during the episode, new site of service code billed with first visit in new location
- 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)

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 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

 HIC 123456789A    TOB 329  S/LOC S B0100  PROVIDER XX7XXX

                                 TOT    COV
 CL  REV  HCPC MODIFS       RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE SERV DT
   1 0023 1AFK1                  00060 00060        0.00             021714
   2 0421 G0151                  00005 00005      150.00             021714
   3 0421 Q5001                  00001 00001        0.01             021714
   4 0421 G0151                  00004 00004      150.00             022314
   5 0421 G0151                  00004 00004      150.00             030114
   6 0421 G0151                  00004 00004      150.00             030314
   7 0421 G0151                  00004 00004      150.00             030814
   8 0421 G0151                  00004 00004      150.00             031014
   9 0421 G0151                  00004 00004      150.00             031514
  10 0421 G0151                  00004 00004      150.00             031714
  11 0421 G0151                  00003 00003      150.00             032214
  12 0421 G0151                  00003 00003      150.00             032414
  13 0421 G0151                  00003 00003      150.00             032914
  14 0431 G0152                  00003 00003      150.00             030214


37186                                                    <== REASON CODES
     PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```


Required Fields: HH Claim Page 3

Field	Description/Notes
PAYER	Payer Identification – If Medicare is the primary payer, enter “Medicare” on line A.
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-9-CM code for the principal diagnosis code and any other diagnosis codes for conditions that coexisted when the plan of care was established.
ATT PHYS	Attending Physician – Enter the NPI and name (last name, first name, middle initial) of the attending physician that established the plan of care with verbal orders – this must be the individual physician’s NPI, not a group NPI.

HH 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
HIC 123456789A    TOB 322  S/LOC S B0100  PROVIDER XX7XXX
                                                    OFFSITE ZIPCD:
 CD  ID    PAYER                    OSCAR        RI AB  PRIOR PAY  EST AMT DUE
A         MEDICARE                  XX7XXX        Y Y         0.00        0.00
B                                                             0.00        0.00
C                                                             0.00        0.00
DUE FROM PATIENT        0.00        0.00
MEDICAL RECORD NBR 000XXXXX           COST RPT DAYS      NON COST RPT DAYS
DIAGNOSIS CODES  1 7812    2 4019    3 2900    4 V1588    5
                 6         7         8         9
ADMITTING DIAGNOSIS 7812      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    LN SMITH               FN ROBERT    MI S
OPR PHYS        NPI 0000000000    LN                     FN           MI
OTH PHYS        NPI XXXXXXXXXX    LN SMITH               FN ROBERT    MI S
```

Remember, with episodes beginning on or after July 1, 2014, the certifying physician NPI and NPI of the physician who signs the plan of care must be reported on your claim.

Required Fields: HH Claim Page 5

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card.
CERT/SSN/HIC	Enter the Medicare Health Insurance Claim Number as it appears on the Medicare card if it does not automatically populate.
TREAT. AUTH. CODE	Treatment Authorization Code – Enter the OASIS matching key output by the Grouper software. This is the same code as was entered on the RAP for the same episode.

HH Claim Page 5

```
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
 HIC 123456789A    TOB 329  S/LOC S B0100  PROVIDER XX7XXX
 INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB   INS GROUP NUMBER
 A DAVISON          JOHN          M             12091929
                 123456789A
 B

 C

 TREAT. AUTH. CODE
14BV14BV11DDICAGJF


 TREAT. AUTH. CODE



 TREAT. AUTH. CODE

37185                                                  <== REASON CODES
           PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Claim Variations

- Transfers
- Discharges and Readmissions
- LUPA
- No-RAP LUPA

Partial Episode Payment

- Proportional payment based on number of days of service provided
  - Total number of days counted from first billable service to last billable service
- Applied when patient is transferred to another HHA within 60-day episode
- Applied when patient is discharged and readmitted to same HHA within same 60-day episode

Transfer

- Transfers happen when a beneficiary changes from one HHA to another within a 60-day episode
- Responsibilities for receiving HHA and transferring HHA:
  - Receiving agency:
    - Checks beneficiary eligibility for home health care; verifies services not already provided by another HHA
    - Informs beneficiary
    - Coordinates with initial HHA
    - Submits properly coded RAP
  - Transferring agency submits properly coded discharge claim

Transfer Process

- Inform beneficiary
  - No further services from the initial HHA
  - No further payments received by initial HHA
  - You are now primary HHA responsible for all services outlined in the plan of care
- Document beneficiary was notified of transfer process

Transfer Process

- Receiving agency coordinates with initial HHA
  - Contact and coordinate transfer date
  - Document communications between agencies
  - Submits RAP indicating transfer (condition code 47)
- Transferring agency submits discharge claim showing transfer status ’06’ – this claim will receive a PEP adjustment due to the shortened episode

Discharge & Readmission

- Patient discharged before end of 60-day episode
- Same agency readmits in the same 60 days
  - Pro-rated first episode
  - New 60-day clock
- This scenario MUST be billed with a shortened first episode (PEP adjusted claim with patient status code ’06’) and a new RAP that shows the readmission

Did You Know…

- If an agency discharges a patient from HH care because there is no expectation they will return after an inpatient hospital stay, the HHA should NOT bill for discharge and readmission (i.e., a PEP claim and new RAP) if the patient does return to HH care within the original 60-day episode.
  - CMS IOM Pub. 100-04, Chapter 10, Section 10.1.14

LUPA

- Standardized per visit payment made in lieu of HH PPS payment
  - Applied to claims with four or less visits in the entire episode
  - Per-visit rates published in HH PPS rate update calendar year final rule
    - Click here for the Final rule for Calendar Year 2013
    - Click here for the Final rule for Calendar Year 2014

No-RAP LUPA

- Advance knowledge of LUPA for episode
- 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

National Government Services Web Resources

- Top Claims Submission Errors
- Home Health Job Aids
- FISS/DDE Provider Online Manual
- Training Events Calendar
- Education Session Material
- E-mail Updates
  - New Medicare information (billing and coverage)
  - Provider education and training announcements

Top Claims Submission Errors

- Includes the top error codes and helpful hints on how to resolve the top errors
  - http://www.NGSMedicare.com/
  - Select Go to Home Page link for appropriate Medicare contract/state combination from start page
  - Select Accept on the HCPCS/CPT attestation page
  - Select Top Claims Submission Errors subnavigation under Claims
  - Reason code reports are listed by workload and type

Home Health Job Aids

- Contains resources and tools for home health providers
  - http://www.NGSMedicare.com/
  - Select Go to Home Page link for appropriate Medicare contract/state combination from start page
  - Select Accept on the HCPCS/CPT attestation page
  - Select Tools and Materials subnavigation under Resources
    - Hyperlinks to the Home Health Job Aids can be found on this page

FISS/DDE Provider Online Manual

- Contains detailed instructions for using the FISS/DDE Online System
  - http://www.NGSMedicare.com/
  - Select Go to Home Page link for appropriate Medicare contract/state combination from start page
  - Select Accept on the HCPCS/CPT attestation page
  - Select Manuals subnavigation under Publications
  - Select Fiscal Intermediary Standard System/Direct Data Entry Provider Online Manual index link

Training Events Calendar

- All past and upcoming training sessions can be found here—this is also where providers register for upcoming sessions
  - http://www.NGSMedicare.com/
  - Select Go to Home Page link for appropriate Medicare contract/state combination from start page
  - Select Accept on the HCPCS/CPT attestation page
  - Select Training Events Calendar subnavigation under Education and Training

Education Session Materials

- Training sessions may have an event summary including any questions and answers asked during the Q&A portion
  - http://www.NGSMedicare.com/
  - Select Go to Home Page link for appropriate Medicare contract/state combination from start page
  - Select Accept on the HCPCS/CPT attestation page
  - Select Training Summaries subnavigation under Education and Training

Provider Contact Center

State/Region	Interactive Voice Response System	Toll-free Number	Hours Available
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-277-7287	866-590-6724 TTY: 877-753-8124	Monday-Friday, 8:00 a.m.-5:00 p.m. PT 9:00 a.m.-6:00 p.m. MT Thursday, closed for training 10:00 a.m.-12:00 p.m. PT 11:00 a.m.-1:00 p.m. MT
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-275-3033	866-590-6728	Monday-Friday, 8:00 a.m.-5:00 p.m. CT 9:00 a.m.-6:00 p.m. ET Thursday, closed for training 1:00-3:00 p.m. CT 2:30-4:00 p.m. ET

CMS Resources

- http://www.cms.gov
  - 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 1, Section 80.2 (Clean Claim Submission)
    - Chapter 10, Sections 40.1 & 40.2 (Home Health Agency Billing)
    - Chapter 25 (UB-04 Instructions)

CMS Resources

- http://www.cms.gov/center/hha.asp
  - Home Health Agency Center
    - Coding and Billing Information
    - HH PPS Regulations and Notices
    - HH Change Requests/Transmittals
    - HHA Email Updates
    - Links to OASIS information
      - Providers may also e-mail OASIS questions to: CMSOASISquestions@oasisanswers.com

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Thank You!

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES