



## Enhancements to Home Health (HH) Consolidated Billing Enforcement – JA6911

**Note:** This Job Aid was revised to reflect the revised Change Request (CR) 6911 that was issued on June 14, 2010. In this article, the CR release date and transmittal number were revised. Also, the Web address for accessing CR6911 was revised. All other information remains the same.

Related CR Release Date: June 14, 2010 **Revised**

Date Job Aid Revised: June 18, 2010

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

<b>Key Words</b>	MM6911, CR6911, R1988CP, HH, Consolidated, Billing, Enforcement, Enhancements
<b>Contractors Affected</b>	<ul style="list-style-type: none"> <li>• Medicare Carriers</li> <li>• Fiscal Intermediaries (FIs)</li> <li>• Part A/B Medicare Administrative Contractors (A/B MACs)</li> <li>• Regional Home Health Intermediaries (RHHIs)</li> <li>• Durable Medical Equipment Medicare Administrative Contractors (DME MACs)</li> </ul>
<b>Provider Types Affected</b>	Provider types affected are physicians, providers, and suppliers submitting claims to Medicare Carriers, FIs, A/B MACs, RHHIs, and/or DME MACs for services provided to Medicare beneficiaries during an episode of HH care.



- The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the HH Prospective Payment System (HH PPS).
- It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing.

<b>Provider Needs to Know...</b>	<ul style="list-style-type: none"> <li>• Medicare instructions, regarding delivery of supplies intended for use over an extended period of time, have changed.</li> <li>• Currently, suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.</li> </ul>
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- Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began.
  - Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the 'from' date on the supply line item falls within the HH episode of care.
  - Chapter 10, Section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers, whose services are subject to HH consolidated billing, to determine before providing their services whether a beneficiary is currently in a HH episode of care.
  - CMS will create a new file which will store and display certifications of HH plans of care.
  - Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care.
  - Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care.
  - Medicare pays physicians for this service using the following two codes:
    - **G0179** - Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care; and
    - **G0180** - Physician Certification For Medicare-covered Home Health Services Under A Plan of Care.
  - Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's (HHA's) billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves.
  - HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60 percent or 50 percent payment for that episode.
  - But there may be instances in which the physician claim for the certification service is received before any HHA billing, and this claim is the earliest indication Medicare systems have that a HH episode will be provided.
  - As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid.
  - Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file.
  - When the provider enters an inquiry date on Medicare's Common Working File query screens, Medicare systems will display all certification code dates within 9 months before the date entered.
  - When the provider does not enter an inquiry date, Medicare systems will display all
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certification code dates within 9 months before the current date as the default response.

**NOTE:** Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40 percent of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's HH status.

Background

- Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the HHA and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, Chapter 10, Section 20.2.1. (The revised chapter is attached to CR6911.)
- If the date of service for a non-routine supply Healthcare Common Procedure Coding System code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems.
- Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.
- When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates.
- This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.'
- Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed.

Operational Impact N/A

Reference Materials

The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6911.pdf> on the CMS website.

The official instruction (CR6911) issued regarding this change may be found at <http://www.cms.gov/Transmittals/downloads/R1988CP.pdf> on the CMS website.