

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2374</b>	<b>Date: December 22, 2011</b>
	<b>Change Request 7660</b>

**SUBJECT: Additional Instructions Regarding Demand Bills Under the Home Health Prospective Payment System**

**I. SUMMARY OF CHANGES:** This Change Request provides billing instructions to assist providers in preparing demand bills when the dates of requests by the State Medicaid program do not correspond to dates of existing episodes of care. It also resolves a discrepancy between Medicare instructions for reporting charges and the requirements of the HIPAA transaction standard.

**EFFECTIVE DATE: March 22, 2012**

**IMPLEMENTATION DATE: March 22, 2012**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	10/40.2/HH PPS Claims
R	10/50/Beneficiary-Driven Demand Billing Under HH PPS

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment – Business Requirements

Pub. 100-04	Transmittal: 2374	Date: December 22, 2011	Change Request:7660
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**SUBJECT: Additional Instructions Regarding Demand Bills Under the Home Health Prospective Payment System**

**EFFECTIVE DATE: March 22, 2012**

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## I. GENERAL INFORMATION

**A. Background:** Recent increases in home health demand billing have brought to CMS’ attention certain scenarios that were not adequately addressed in the Medicare Claims Processing Manual, chapter 10, section 50. This Change Request provides additional billing instructions in section 50 to assist providers in preparing demand bills when requests by the State Medicaid program do not correspond to dates of existing episodes of care.

Also, CMS recently discovered that Medicare’s instruction regarding the reporting of the Total Charges field on claims is in conflict with the requirements of the HIPAA standard 837 Institutional claim format. The 837 requires that the Total Charges field (SV203) must always be reported, though zero is an acceptable value. Medicare’s instructions since 2000 have said the field may be zero or blank. This Change Request corrects section 40.2 to resolve this discrepancy.

**B. Policy:** This instruction contains no new policy.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B  M A C	D M  M A C	F I  M A C	C A R  I E R	R H I  S S S	Shared-System Maintainers				OTHE R
		F	M	V	C	I	M	S	W	F	
7660.1	Medicare contractors shall be aware of the revisions to Chapter 10 of the Medicare Claims Processing Manual provided in this transmittal.					X					HH&H MACs

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I  M A C	C A R I E R	R H I  S S	Shared-System Maintainers				OTHE R
						F I S S	M C S	V M S	C W F		
7660.2	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>					X				HH&H MACs	

#### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

**Section B: For all other recommendations and supporting information, use this space:** N/A

#### V. CONTACTS

**Pre-Implementation Contact(s):** Wil Gehne, [wilfried.gehne@cms.hhs.gov](mailto:wilfried.gehne@cms.hhs.gov), 410-786-6148

**Post-Implementation Contact(s):** Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

#### VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: For *Medicare Administrative Contractors (MACs)*:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**Medicare Claims Processing Manual**  
**Chapter 10 - Home Health Agency Billing**

## **40.2 - HH PPS Claims**

*(Rev. 2374, Issued: 12-22-11, Effective: 03-22-12, Implementation: 03-22-12)*

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of “No-RAP” LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net payment on the claim can be easily understood. Detailed RA information is contained in chapter 22.

### **Billing Provider Name, Address, and Telephone Number**

**Required** – The HHA’s minimum entry is the agency’s name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. Medicare contractors use this information in connection with the provider identifier to verify provider identity.

### **Patient Control Number and Medical/Health Record Number**

**Required** - The patient’s control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

The HHA may enter the number assigned to the patient’s medical/health record. If this number is entered, the Medicare contractor must carry it through their system and return it on the remittance record.

### **Type of Bill**

**Required** - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a “frequency” code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

3 - Home Health

## 2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

**NOTE:** While the bill classification of 3, defined as “Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)” may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

## 3rd Digit-Frequency - Definition

7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or “new” bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.

8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

9 - Final Claim for an HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8.

HHAs must submit HH PPS claims with the frequency of “9.” These claims may be adjusted with frequency “7” or cancelled with frequency “8.” Medicare contractors do not accept late charge bills, submitted with frequency “5,” on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

## Statement Covers Period

**Required** - The beginning and ending dates of the period covered by this claim. The “from” date must match the date submitted on the RAP for the episode. For continuous care episodes, the “through” date must be 59 days after the “from” date. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal discharge procedures as the “through” date. If the beneficiary has died, the HHA reports the date of death in the “through date.”



Any NUBC approved patient status code may be used in these cases. The HHA may submit claims for payment immediately after the claim “through” date. It is not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

### **Patient Name/Identifier**

**Required** – The HHA enters the patient’s last name, first name, and middle initial.

### **Patient Address**

**Required** - The HHA enters the patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

### **Patient Birth Date**

**Required** - The HHA enters the month, day, and year of birth of patient. If the full correct date is not known, leave blank.

### **Patient Sex**

**Required** - “M” for male or “F” for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

### **Admission/Start of Care Date**

**Required** - The HHA enters the same date of admission that was submitted on the RAP for the episode.

### **Point of Origin for Admission or Visit**

**Required** - The HHA enters the same point of origin code that was submitted on the RAP for the episode.

### **Patient Discharge Status**

**Required** - The HHA enters the code that most accurately describes the patient’s status as of the “Through” date of the billing period. Any applicable NUBC approved code may be used.

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

In cases where an HHA is changing the Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status code 06. Billing for the beneficiary is being "transferred" to the new contractor.

In cases where the ownership of an HHA is changing and the CMS certification number (CCN) also changes, the service dates on the claims must fall within the effective dates of the terminating CCN. To ensure this, RAPs for all episodes with "from" dates before the termination date of the CCN must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. In changes of ownership which do not affect the CCN, billing for episodes is also unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date. The claim should be coded with patient status 06. Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

If HHAs require guidance on OASIS assessment procedures in these cases, they should contact the appropriate state OASIS education coordinator.

### **Condition Codes**

**Conditional** – The HHA enters any NUBC approved code to describe conditions that apply to the claim.

If the RAP is for an episode in which the patient has transferred from another HHA, the HHA enters condition code 47.

HHAs that are adjusting previously paid claims enter one of the condition codes representing Claim Change Reasons (code values D0 through E0). If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" indicating the reason for the HIPPS code change. HHAs use D9 if multiple changes are necessary.

When submitting a HH PPS claim as a demand bill, HHAs use condition code 20. See §50 for more detailed instructions regarding demand billing.

When submitting a HH PPS claim for a denial notice, HHAs use condition code 21. See §60 for more detailed instructions regarding no-payment billing.

**Required** - If canceling the claim (TOB 3X8), HHAs report the condition codes D5 or D6 and enter “Remarks” indicating the reason for cancellation of the claim.

**Occurrence Codes and Dates**

**Conditional** - The HHA enters any NUBC approved code to describe occurrences that apply to the claim.

**Occurrence Span Code and Dates**

**Conditional** - The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission during an episode.

**Value Codes and Amounts**

**Required** - Home health episode payments must be based upon the site at which the beneficiary is served. For episodes in which the beneficiary’s site of service changes from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

**NOTE:** Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in the Medicare contractor’s online claim history and on remittances.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Contractors always place condition code 61 on the claim along with this value code.)
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 32X, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will not change the TOB and will return the claim to CWF with RIC code U.

### **Revenue Code and Revenue Description**

#### **Required**

HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. The fifth position of the code represents the

non-routine supply (NRS) severity level. This fifth position may differ to allow the HHA to change a code that represents that supplies were provided to a code that represents that supplies were not provided, or vice versa. However, the fifth position may only change between the two values that represent the same NRS severity level. Section 10.1.9 of this chapter contains the pairs of corresponding values. If these criteria are not met, Medicare claims processing systems will return the claim.

HHAs enter only one 0023 revenue code per claim in all cases.

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 042X, 043X, 044X, 055X, 056X and 057X) must be reported as a separate line. Any of the following revenue codes may be used:

027X	<p>Medical/Surgical Supplies (Also see 062X, an extension of 027X)</p> <p>Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623.</p> <p>Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount.</p> <p><b>NOTE:</b> Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills</p>
042X	<p>Physical Therapy</p> <p>Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
043X	<p>Occupational Therapy</p> <p>Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

044X	<p>Speech-Language Pathology</p> <p>Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
055X	<p>Skilled Nursing</p> <p>Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
056X	<p>Medical Social Services</p> <p>Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>
057X	<p>Home Health Aide (Home Health)</p> <p>Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.</p>

**NOTE:** Contractors do not accept revenue codes 058X or 059X when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

**Revenue Codes for Optional Billing of DME**

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their Medicare contractor processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20.

0274	<p>Prosthetic/Orthotic Devices</p> <p>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.</p>
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029X	<p>Durable Medical Equipment (DME) (Other Than Renal)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one.</p> <p>Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.</p>
060X	<p>Oxygen (Home Health)</p> <p>Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.</p>

**Revenue Code for Optional Reporting of Wound Care Supplies**

0623	<p>Medical/Surgical Supplies - Extension of 027X</p> <p>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.</p>
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HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation “surg dressings,” HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, defines routine vs. nonroutine supplies. HHAs use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

HHAs can assist CMS’ future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

**Validating Required Reporting of Supply Revenue Code**

The HH PPS includes a separate case-mix adjustment for non-routine supplies. Non-routine supply severity levels are indicated on HH PPS claims through a code value in the 5th position of the HIPPS code. The 5th position of the HIPPS code can contain two sets of values. One set of codes (the letters S through X) indicate that supplies were provided. The second set of codes (the numbers 1 through 6) indicate the HHA is intentionally reporting that they did not provide supplies during the episode. See section 10.1.9 for the complete composition of HIPPS under the HH PPS.

HHAs must ensure that if they are submitting a HIPPS code with a 5<sup>th</sup> position containing the letters S through X, the claim must also report a non-routine supply revenue with covered charges. This revenue code may be either revenue code 27x, excluding 274, or revenue code 623, consistent with the instructions for optional separate reporting of wound care supplies.

Medicare systems will return the claim to the HHA if the HIPPS code indicates non-routine supplies were provided and supply charges are not reported on the claim. When the HHA receives a claim returned for this reason, the HHA must review their records regarding the supplies provided to the beneficiary. The HHA may take one of the following actions, based on the review of their records:

- If non-routine supplies were provided, the supply charges must be added to the claim using the appropriate supply revenue code.
- If non-routine supplies were not provided, the HHA must indicate that on the claim by changing the 5th position of the HIPPS code to the appropriate numeric value in the range 1 through 6.

After completing one of these actions, the HHA may return the claim to the Medicare contractor for continued adjudication.

### **HCPCS/Accommodation Rates/HIPPS Rate Codes**

**Required** - On the 0023 revenue code line, the HHA must report the HIPPS code that was reported on the RAP. The first four positions of the code must be identical to the value reported on the RAP. The fifth position may vary from the letter value reported on the RAP to the corresponding number which represents the same non-routine supply severity level but which reports that non-routine supplies were not provided.

HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code.

To report HH visits on episodes beginning before January 1, 2011, the HHA reports a single HCPCS code to represent each HH care discipline. These codes are:

G0151 Services of physical therapist in home health or hospice setting, each 15 minutes.

G0152 Services of an occupational therapist in home health or hospice setting, each 15 minutes.

G0153 Services of a speech language pathologist in home health or hospice setting, each 15 minutes.



G0154 Services of skilled nurse in the home health or hospice settings, each 15 minutes.

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports one of the following HCPCS code to represent each HH care discipline:

Physical Therapy (revenue code 042x)

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.

G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.

G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

Occupational Therapy (revenue code 043x)

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.

G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.

G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Skilled Nursing (revenue code 055x)

G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

G0163 Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Medical Social Services (revenue code 056x)

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (revenue code 057x)

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding all skilled nursing and skilled therapy visits

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.

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, we would expect the HHA to report the G-code which reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code which reflects the service for which most of the time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

**Service Date**

**Required** - On the 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

## Service Units

**Required** - Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the claim. For line items detailing all services within the episode period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes.

For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

## Total Charges

**Required** - The HHA must report zero charges on the 0023 revenue code line (the field *must contain* zero).

For line items detailing all services within the episode period, the HHA reports charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). Medicare claims processing systems will not make any payments based upon submitted charge amounts.

## Non-covered Charges

**Required** – The *HHA reports* the total non-covered charges pertaining to the related revenue code here. *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*

## Payer Name

**Required** - See chapter 25.

## Release of Information Certification Indicator

**Required** - See chapter 25.

## National Provider Identifier – Billing Provider

**Required** - The HHA enters their provider identifier.

**Insured's Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Patient's Relationship To Insured**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Unique Identifier**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Group Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Insured's Group Number**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

**Treatment Authorization Code**

**Required** - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

<b>Position</b>	<b>Definition</b>	<b>Format</b>
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X

12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

**NOTE:** The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

This is an example of a treatment authorization code created using this format:

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

In cases of billing for denial notice, using condition code 21, this code may be filled with a placeholder value as defined in section 60.

The investigational device (IDE) revenue code, 0624, is not allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

The claims-OASIS matching key on the claim will match that submitted on the RAP.

### **Document Control Number (DCN)**

**Required** - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims processing systems will match all HH PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically. Providers do not need to submit a DCN on all HH PPS claims, only on adjustments to paid claims.

### **Employer Name**

**Required only if MSP involved.** See Pub. 100-05, Medicare Secondary Payer Manual.

### **Principal Diagnosis Code**

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-CM code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

The principal diagnosis code on the claim will match that submitted on the RAP.

### **Other Diagnosis Codes**

**Required** - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may **not** duplicate the principal diagnosis as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both

forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

### **Attending Provider Name and Identifiers**

**Required** - The HHA enters the name and provider identifier of the attending physician that has signed the plan of care.

### **Remarks**

**Conditional** - Remarks are required only in cases where the claim is cancelled or adjusted.

## **50 - Beneficiary-Driven Demand Billing Under HH PPS**

*(Rev. 2374, Issued: 12-22-11, Effective: 03-22-12, Implementation: 03-22-12)*

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in a Home Health Advance Beneficiary Notice (HHABN), which also must be signed by the beneficiary or appropriate representative. Instructions for the HHABN are found in Chapter 30 of this manual, §60.

Beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the “demand bill” are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA’s judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the Medicare contractor determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is an episode of care, usually 60 days in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care, and (2) at least one service must have been provided to the beneficiary, so that a request for anticipated payment (RAP) can be sent to Medicare and create a record of an episode in Medicare claims processing

systems. Therefore, demand billing under HH PPS must conform to ALL of the following criteria:

- Situations in which disputed services are called for under a plan of care, but the HHA believes the services do not meet Medicare criteria for coverage;
- Claims sent to Medicare with TOB 32X; and
- Episodes on record in Medicare claims processing systems (at least one service in episode).

### **A - Interval of Billing**

Under HH PPS, the interval of billing is standard. At most, a RAP and a claim are billed for each episode. Providers may submit a RAP after the delivery of the first service in the 60-day episode, and they must submit a claim either after discharge or after the end of the 60-day episode. This does not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

### **B - Timeliness of Billing**

The CMS requests that HHAs submit demand bills promptly. Timely filing requirements were not changed by HH PPS (see Chapter 1 for information on timely filing). CMS has defined “promptly” for HH PPS to mean submission at the end of the episode in question. The beneficiary must also be given either a copy of the claim or a written statement of the date the claim was submitted. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments are automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §40.3.

### **C - Claim Requirements**

Original HH PPS claims are submitted with *Type of Bill (TOB) 329*, and provide all other information required on that claim for the HH PPS episode, including all visit-specific detail for the entire episode (the HHA must NOT use *TOB 3X0*). When such claims also serve as demand bills, the following information must **also** be provided: condition code “20” and the services in dispute shown as noncovered line items. Demand bills may be submitted with all noncovered charges. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 327, may also be submitted but must have been preceded by the submission of a *TOB 329* claim for the same episode. RAPs are not submitted as demand bills, but must be submitted for any episode for which a demand bill will be submitted. Such RAPs should not use condition code 20, only the claim of the episode uses this code.

Cases may arise in which the services in dispute are visits for which an HHA has physician’s orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of



these visits that is not covered by Medicare may be covered by another payer (e.g., an 8 hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as a single line item, representing the portion potentially covered by Medicare with a covered charge amount and the portion to be submitted for consideration by other insurance with a noncovered charge amount on the same line. Units reported on this line item should represent the entire elapsed time of the visit (the sum of the covered and noncovered portions), represented in 15 minute increments.

*Cases may also arise in which a State Medicaid program requests the demand bill on the beneficiary's behalf regarding services which have been billed to Medicaid. In these cases, the dates of service for which the State requests the demand bill may not correspond exactly to the episode periods billed to Medicare. These cases require special instructions:*

*Request begins during non-Medicare episode:*

*A Medicare-Medicaid dually-eligible patient may be admitted to home care with the expectation that no services will be billed to Medicare. Later, the State may request demand bills beginning during the course of that episode. This may occur when requests correspond to a calendar year. For example, the patient may be admitted in December and the request for demand bills is effective January 1. In this case, the HHA should submit a demand bill to Medicare with episode dates corresponding to the OASIS assessment that began in December. All services in the episode should be submitted as non-covered line items. As with any demand bill, condition code 20 should be reported on this claim.*

*Request applies to services immediately following Medicare discharge:*

*A dually-eligible patient may be discharged from Medicare home health services before the end of a 60-day episode due to the patient meeting their treatment goals. The patient may remain under the care of the HHA receiving services billed to Medicaid. If the State requests a demand bill for the services within the original Medicare 60-day episode, the HHA should submit an adjustment to their previously paid Medicare claim, using TOB 3x7. The HHA should add condition code 20 to the adjustment claim, change the statement "Through" date to reflect the full 60-day period and add the services provided during the demand bill request period as non-covered line items. The HHA should then submit claims with condition code 20 and all non-covered line items for any episodes of continuous care within the demand bill request period.*

## **D - Favorable Determinations and Medicare Payment**

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will change only with the addition of covered visits if one or more of the following conditions apply:

- An increase in the number of therapy visits results in *a change in the payment group for the episode* - in such cases, the payment group of the episode would be changed by the contractor in medical review;
- An increase in the number of overall visits that either:
  1. Changes payment from a low-utilization payment adjustment to a full episode; or
  2. Results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode).
- A favorable ruling on a demand bill adds days to an episode that received a partial episode payment (PEP) adjustment.

If a favorable determination is made, contractors will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

## **E - Appeals**

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims. HH PPS RAPs do not have appeal rights; rather, appeals rights are tied to the claims that represent all services delivered for the entire episode unit of payment.

## **F – Specific Demand Billing Scenarios**

**1. Independent Assessment.** Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all such cases, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. HHABNs can be used for this purpose.

**2. Billing in Excess of the Benefit.** In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, an HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and an HHABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an HHABN. Billing services in excess of the benefit is discussed in C in this section.

**3. One-Visit Episodes.** Since intermittent skilled nursing care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, an HHA should still give the beneficiary an HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in Chapter 1 of this manual, Section 60. Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in 1. immediately above.