CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12291	**Date: October 5, 2023**
	Change Request 13244

Transmittal 12147 issued July 20, 2023, is being rescinded and replaced by Transmittal 12291, dated October 5, 2023, to restore subsections in the Benefit Policy Manual update that were accidentally omitted. This correction does not make any revisions to the companion Pub. 100-04; all revisions are associated with Pub. 100-02. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 02, 2023. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Prospective Payment System Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement section 4136 of the Consolidated Appropriations Act of 2023, which requires separate payment of disposable negative pressure wound therapy devices on the type of bill most commonly used by home health agencies.

EFFECTIVE DATE: January 1, 2024 - Claim "Through" Dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/10.1/National 30-Day Payment Rate
R	7/10.9/Discharge Issues
R	7/10.11/Consolidated Billing
R	7/50.4.4/Negative Pressure Wound Therapy Using a Disposable Device

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12291	Date: October 5, 2023	Change Request: 13244

Transmittal 12147 issued July 20, 2023, is being rescinded and replaced by Transmittal 12291, dated October 5, 2023, to restore subsections in the Benefit Policy Manual update that were accidentally omitted. This correction does not make any revisions to the companion Pub. 100-04; all revisions are associated with Pub. 100-02. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 02, 2023. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Prospective Payment System Claims

EFFECTIVE DATE: January 1, 2024 - Claim "Through" Dates on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to implement division FF, section 4136 of the Consolidated Appropriations Act of 2023, which requires separate payment of disposable negative pressure wound therapy (dNPWT) devices on the type of bill most commonly used by home health agencies.

B. Policy: Division FF, section 4136 of the Consolidated Appropriations Act of 2023 (CAA, 2023) (Pub. L.117-328) mandates that for CY 2024, the separate payment amount for an applicable dNPWT device would be set equal to the supply price used to determine the relative value for the service under the physician fee schedule (PFS) under section 1848 as of January 1, 2022 (CY 2022) updated by the specified adjustment described in subparagraph (B) for such year. Division FF section 4136 of the CAA, 2023 also adds a new subparagraph 1834(s)(3)(B), which requires that the separate payment amount to be adjusted by the percent increase in the CPI–U for the 12-month period ending with June of the preceding year minus the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) for such year. Accordingly, this may result in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year. For 2025 and each subsequent year, the CAA, 2023 requires that the separate payment amount will be set equal to the payment amount established for the device in the previous year, updated by the specified adjustment described in subparagraph (B) for such year.

Section 1834(s)(3)(C) of the Act, as added by Division FF, section 4136 of the CAA, 2023, specifies that the separate payment amount for applicable devices furnished on or after January 1, 2024, would no longer include payment for nursing or therapy services described in section 1861(m). Payment for such nursing or therapy services would now be made under the prospective payment system established under section 1895, the HH PPS, and is no longer separately billable. Additionally, beginning in CY 2024 and each subsequent year, claims for the separate payment amount of an applicable dNPWT device would now be accepted and processed on claims submitted using the type of bill that is most commonly used by home health agencies to bill services under a home health plan of care (TOB 032x). That is, claims with a date of service on or after January 1, 2024 for an applicable dNPWT device will no longer be submitted on TOB 034x.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13244 - 04.1	The contractor shall allow HCPCS code A9272 to be submitted with Type of Bill 032x.			X						
13244 - 04.2	The contractor shall require HCPCS code A9272 to be submitted with revenue code 027x (other than 0274) on Type of Bill 032x.			X						
13244 - 04.3	The contractor shall return to provider claims with Type of Bill 034x with HCPCS codes 97607 or 97608 and claim Through dates on or after January 1, 2024.			X		X				
13244 - 04.4	The contractor shall return to provider claims with any Type of Bill other than 032x with HCPCS code A9272.	X		X		X				
13244 - 04.5	The contractor shall pay revenue code 027x (other than 0274) lines with HCPCS A9272 on Type of Bill 032x separately from the HH PPS amount, applying the national fee amount provided in the HHH abstract file. Note: All other services reported with revenue code 027x other than 0274 continue to be bundled into the HH PPS amount returned from the HH Pricer.					X				
13244 - 04.5.1	The contractor shall apply deductible and coinsurance to payments for HCPCS A9272 on TOB 032x.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13244 - 04.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
4.5	For each year beginning calendar year 2024 and for all subsequent years, this fee amount will be published in the HH PPS annual payment update recurring CR.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carla Douglas, carla.douglas@cms.hhs.gov , Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 7 - Home Health Services

Table of Contents

(Rev. 12291, Issued:10-05-23)

10.1 - National 30-Day Period Payment Rate

(Rev. 12291, Issued: 10-05-23, Effective: 01-01-24, Implementation: 01-02-24)

A. Services Included

The law requires the 30-day period to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 30-day period payment rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 30-day period payment rate are:

1. Skilled nursing services;
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 30-day period payment rate also includes amounts for nonroutine medical supplies and therapies that could have been unbundled to Part B prior to HH PPS. (See §10.11.C for those services.)

B. Excluded Services

The law specifically excludes durable medical equipment (DME) from the 30-day period payment rate and consolidated billing requirements. DME continues to be paid the fee schedule amounts or through the DME competitive bidding program outside of the HH PPS rate.

Certain injectable osteoporosis drugs which are covered where a woman is postmenopausal and has a bone fracture are also excluded from the 30-day period payment rate, but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of these osteoporosis drugs. These osteoporosis drugs continue to be paid on a reasonable cost basis.

Negative pressure wound therapy using a disposable device (dNPWT) that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy (in lieu of a conventional NPWT DME system), is also excluded from the 30-day period payment rate, but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of NPWT using a disposable device.

Furnishing NPWT using a disposable device means the application of a new applicable disposable device, as that term is defined in §1834 of the Social Security Act (the Act), *which includes only the device paid separately (specified by the assigned HCPCS code) and does not include payment for the professional services.*

10.9 - Discharge Issues

(Rev. 12291, Issued: 10-05-23, Effective: 01-01-24, Implementation: 01-02-24)

A. Hospice Election Mid-Period

If a patient elects hospice before the end of the 30-day period and there was no *partial payment adjustment* or LUPA adjustment, the HHA will receive a full 30-day period payment. The 30-day period with visits less than the LUPA threshold for the payment group would be paid at the low utilization payment adjusted amount.

B. Patient's Death

The documented event of a patient's death would result in a full 30-day period payment, unless the death occurred in a low utilization payment adjusted 30-day period. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death occurred during a low utilization adjusted 30-day payment period, the period would be paid at the low utilization payment adjusted amount. In the event of a patient's death during an adjusted 30-day period, the total adjusted period would constitute the full 30- day period payment.

C. Patient is No Longer Eligible for Home Health (e.g., no longer homebound, no skilled need)

If the patient is discharged because he or she is no longer eligible for the Medicare home health benefit and has received visits meeting the LUPA threshold for the payment group, then the HHA would receive the full 30-day period payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same 30- day period and transferred to another HHA or returned to the same HHA, then this would result in a partial payment adjustment.

D. Discharge Due to Patient Refusal of Services or is a Documented Safety Threat, Abuse Threat or is Noncompliant

If the patient is discharged because he or she refuses services or becomes a documented safety, abuse, or noncompliance discharge and has received visits meeting the LUPA threshold for the payment group, then the HHA would receive full period payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same 30-day period and transferred to another HHA or returned to the same HHA, then this would result in a *partial payment adjustment.*

E. Patient Enrolls in Managed Care Mid-Period

If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective mid period, the 30-day period payment will be proportionally adjusted with a partial payment adjustment since the patient is receiving coverage under MA. Beginning with the effective date of enrollment, the MA plan will receive a capitation payment for covered services.

F. Submission of Final Claims Prior to the End of the 30-day Period

The claim may be submitted upon discharge before the end of the 30-day period. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a partial payment adjustment or other adjustment.

G. Patient Discharge and Financial Responsibility for Part B Bundled Medical Supplies and Services

As discussed in detail under §10.11, below, the law governing the Medicare HH PPS requires the HHA

to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under an open home health plan of care during an open episode. Once the patient is discharged, the HHA is no longer responsible for providing home health services including the bundled Part B medical supplies and therapy services.

H. Discharge Issues Associated With Inpatient Admission Overlapping Into Subsequent 60-Day Recertifications

1. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there is no recertification assessment of the patient, then the new certification begins with the new start of care date after inpatient discharge.

2. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay on day 61, if the home health resource group (HHRG) remains the same then the 30-day period of care following the inpatient stay would be considered continuous and thus be considered a recertification. However, if the HHRG is different, this would result in a new start of care OASIS and thus be considered a new certification and begins with the new start of care date after inpatient discharge.

3. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay after day 61 (after the first day of the next 60-day recertification of care), then a new certification begins with the new start of care date after inpatient discharge.

10.10 - Consolidated Billing

(Rev. 12291, Issued: 10-05-23, Effective: 01-01-24, Implementation: 01-02-24)

For individuals under a home health plan of care, payment for all services and supplies, with the exception of certain injectable osteoporosis drugs, DME, and furnishing NPWT using a disposable device is included in the HH PPS base payment rates. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.
Payment must be made to the HHA.

A. Home Health Services Subject to Consolidated Billing Requirements

The home health services included in the consolidated billing governing the HH PPS are:
• Part-time or intermittent skilled nursing services;
• Part-time or intermittent home health aide services;
• Physical therapy;
• Speech-language pathology services;
• Occupational therapy;
• Medical social services;
• Routine and nonroutine medical supplies;
• Covered osteoporosis drug as defined in §1861(kk) of the Act, but excluding other drugs and biologicals;
• Furnishing NPWT using a disposable device as that term is defined in §1834 of the Act, *which includes only the device paid separately (specified by the assigned HCPCS code) and does not include payment for the professional services.*
• Medical services provided by an intern or resident-in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with

a hospital with an approved teaching program; and
• Home health services defined in §1861(m) of the Act provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

B. Medical Supplies

The law requires that all medical supplies (routine and nonroutine) be provided by the HHA while the patient is under a home health plan of care. The agency that establishes the 30-day period is the only entity that can bill and receive payment for medical supplies during a 30-day period for a patient under a home health plan of care. Both routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the 30-day period

Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to HH PPS. See §50.4 for detailed discussion of medical supplies.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled into the HHA 30-day period payment rate. Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

DME, including supplies covered as DME, are paid separately from the HH PPS and are excluded from the consolidated billing requirements governing the HH PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient.

Certain injectable osteoporosis drugs are included in consolidated billing under the home health benefit. However, payment is not bundled into the HH PPS payment rates. HHAs must bill for the osteoporosis drug in accordance with billing instructions. Payment is in addition to the HH PPS payment.

Furnishing NPWT using a disposable device is included in consolidated billing under the home health benefit. However, payment *for the device* is not bundled into the HH PPS payment rates. HHAs must bill for NPWT using a disposable device in accordance with billing instructions. Payment is in addition to the HH PPS payment.

C. Relationship Between Consolidated Billing Requirements and Part B Supplies and Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to HH PPS That No Longer Can Be Unbundled

The HHA is responsible for the services provided under arrangement on their behalf by other entities. Covered home health services at §1861(m) of the Act (except DME) are included in the baseline HH PPS rates and subject to the consolidated billing requirements while the patient is under a plan of care of the HHA. The time the services are bundled is while the patient is under a home health plan of care.

Physician services or nurse practitioner services paid under the physician fee schedule are not recognized as home health services included in the PPS rates. Supplies incident to a physician service or

related to a physician service billed to the Medicare contractor are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DME Medicare contractor in this situation.

Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are included in the baseline rates and subject to the consolidated billing requirements. In addition to therapies that had been paid on a cost basis under home health, CMS has included in the rates additional amounts for Part B therapies that could have been unbundled prior to PPS. These therapies are subject to the consolidated billing requirements. There are revenue center codes that reflect the ranges of outpatient physical therapy, occupational therapy, and speech language pathology services and Healthcare Common Procedure Coding System (HCPCS) codes that reflect physician supplier codes that are physical therapy, occupational therapy, and speech-language pathology services by code definition and are subject to the consolidated billing requirements. Therefore, the above-mentioned therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care and cannot be separately billed to Part B during an open 30-day period of care.

D. Freedom of Choice Issues

A beneficiary exercises his or her freedom of choice for the services under the home health benefit listed in §1861(m) of the Act, including medical supplies, but excluding DME covered as a home health service by choosing the HHA. Once a home health patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the Medicare home health benefit during the certified episode.

E. Knowledge of Services Arranged for on Behalf of the HHA

The consolidated billing requirements governing HH PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of the services provided during the 30-day period. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient's plan of care must reflect the physician or allowed practitioner ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physician or allowed practitioner orders) of the services provided by an entity during a 30-day period to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during a 30-day period in which the patient is under the HHA's home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during a 30-day period in an effort to resolve any misunderstanding and avoid such situations in the future.

50.4.4 - Negative Pressure Wound Therapy Using a Disposable Device

(Rev. 12291, Issued: 10-05-23, Effective: 01-01-24, Implementation: 01-02-24)

For services furnished on or after January 1, 2017 and before January 1, 2024, sections 1834 and 1861(m)(5) of the Act *required* a separate payment to an HHA for an applicable disposable device, to an individual who *received* home health services for which payment *was* made under the Medicare home health benefit. Section 1834 of the Act defines an applicable device as a disposable NPWT

device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy used in lieu of a conventional NPWT DME system. As required by §1834 of the Act, the separate payment amount for a disposable NPWT device *was* set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I HCPCS code, otherwise referred to as Current Procedural Terminology (CPT) codes, for which the description for a professional service includes the furnishing of such a device.

Payment for HH visits related to wound care, but not requiring the furnishing of an entirely new disposable NPWT device, *were* covered by the HH PPS *period* payment and *were* billed using the HH claim. Where a home health visit *was* exclusively for the purpose of furnishing NPWT using a disposable device, the HHA *submitted* only a type of claim that *was* paid for separately outside the HH PPS (TOB 34x). Where, however, the home health visit *included* the provision of other home health services in addition to, and separate from, furnishing NPWT using a disposable device, the HHA *submitted* both a home health claim and a TOB 34x— the home health claim for other home health services and the TOB 34x for furnishing NPWT using a disposable device.

EXAMPLE:

A patient requires dNPWT for the treatment of a wound. On Monday, a nurse assesses a patient's wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient's condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device. In this scenario, the billing procedures are as follows:

For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with CPT code 97607 or 97608. None of the services should be reported on the HH claim.

For the Thursday visit, the nurse checked the wound, but did not apply a new disposable NPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.

For services furnished on or after January 1, 2024, Division FF, section 4136 of the Consolidated Appropriations Act of 2023 (CAA, 2023) (Pub. L.117-328) requires that beginning in CY 2024, there will be a separate payment amount for an applicable dNPWT device only and does not include payment for the nursing and therapy services. Payment for the device is equal to the supply price used to determine the relative value for the service under the Medicare Physician Fee Schedule (as of January 1, 2022) for the applicable disposable device and updated by the consumer price index for all urban consumers minus the productivity adjustment for each future year.

Payment for nursing or therapy services, described in section 1861(m), to apply a disposable NPWT device would now be made under the prospective payment system established under section 1895, the HH PPS, and is no longer separately billable. Additionally, beginning in CY 2024 and each subsequent year, claims for the separate payment amount of an applicable dNPWT device would now be accepted and processed on claims submitted using the type of bill that is most commonly used by home health agencies to bill services under a home health plan of care (TOB 032x). That is, claims with a date of

service on or after January 1, 2024 for an applicable dNPWT device will no longer be submitted on TOB 034x.

EXAMPLE:

A patient requires dNPWT for the treatment of a wound. On Monday, a nurse assesses a patient's wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nursing visit is reported on the home health claim as a home health visit using the appropriate G-code, revenue code and units of time on TOB 032x. Payment for these services are included in the overall HH PPS payment rate for the 30-day period of care if the LUPA threshold has been met for the period. The HHA would report the Healthcare Common Procedure Coding System (HCPCS) code A9272 (for the device only) on the home health type of bill TOB 032x. A separate payment is made for the device only. The nurse returns on Thursday for follow up teaching and assessment of the device. The nurse does not replace the dNPWT device at this visit. Only the nursing visit is reported on the home health claim using TOB 032x. No separate reporting for the device would be included on the claim since the device was not replaced during this visit.

For instructions on billing for NPWT using a disposable device, see Pub. 100-04, Medicare Claims Processing Manual, chapter 10, Section 90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services.