CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4452	Date: November 8, 2019
	Change Request 11527

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions

I. SUMMARY OF CHANGES: This change request revises additional sections of pulication 100-04, chapter 10, to support the implementation of the HH PDGM.

EFFECTIVE DATE: January 1, 2020
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: December 11, 2019

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	10/10.1.14/Discharge and Readmission Situation Under HH PPS - Payment Effects
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims

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: 4452	Date: November 8, 2019	Change Request: 11527

SUBJECT: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions

EFFECTIVE DATE: January 1, 2020
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: December 11, 2019

I.   GENERAL INFORMATION

A.   Background: In the Calendar Year (CY) 2019 final Home Health Prospective Payment System Rate Update final rule, CMS finalized an alternative case-mix methodology now called the Patient-Driven Groupings Model (PDGM), which includes the payment reform requirements as set forth in the Bipartisan Budget Act (BBA) of 2018 and will be implemented in CY 2020. The manual instructions in this Change Request (CR) are revised to conform to the final policies of the PDGM.

B.   Policy: This CR further implements the policies of the PDGM, as described in the CY 2019 home health final rule and as required by section 51001 of the BBA of 2018. For the complete policy, see the final rule and CRs 11081, 11272 and 11395.

II.   BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H	M A C	F I S S	M C S	V M S	C W F	
11527.1	The contractors shall be aware of the manual changes to publication 100-04, chapter 10, Home Health Agency Billing.			X						

III.   PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
11527.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter			X		

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): 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 Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev.:4452, Issued: 11-08-19)

10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects
(Rev.:4452, Issued: 11-08-19, Effective: 01-01-20, Implementation: 12-11-19)

Under HH PPS, HHAs may discharge beneficiaries before the episode/period has closed if all treatment goals of the plan of care have been met, or if the beneficiary ends care by transferring to another home health agency. Cases may occur in which an HHA has discharged a beneficiary during a episode/period, but the beneficiary is readmitted to the same agency in the same 60 or 30 days. Since no portion of the episode/period can be paid twice, the first payment must be pro-rated to reflect the shortened period (see §10.1.15). A new episode/period can be opened by the HHA. Medicare systems will allow this in cases where the CMS certification number (CCN) on the new RAP matches the CCN on the prior episode/period. The next episode/period will begin the date the first service is supplied under readmission (setting a new 60-day or 30-day "clock").

Note that beneficiaries do not have to be discharged within the episode/period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day or 30-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same period, the discharge is not recognized for Medicare payment purposes. All the HH services provided in the complete episode/period, both before and after the inpatient stay, should be billed on one claim. When discharging, full episode payment would still be made unless the beneficiary received more home care later in the same episode/period.

Discharge should be made at the end of the *60-day certification period* in all cases if the beneficiary has not returned to the HHA. *If the beneficiary returns to HH after an inpatient stay that spans the end of the certification period, a new start of care assessment and a RAP and claim with a new admission date are required.*

For services after January 1, 2020, discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a certification period. The HHA should submit the RAP and claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge. Medicare systems will allow the HH claim to overlap the inpatient claim for dates in which there are no HH visits.

40.1 - Request for Anticipated Payment (RAP)
(Rev.:4452, Issued: 11-08-19, Effective: 01-01-20, Implementation: 12-11-19)

The following data elements are required to submit a RAP under HH PPS. Home health services under a plan of care are paid based on a 60-day episode of care (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit a RAP using the coding described below.

In general, a RAP and a claim will be submitted for each episode or period of care. Each claim must represent the actual utilization over the episode period. If the claim is not received 60 days after the calculated end date of the episode (day 120) or period (day 90) or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the HHA's next remittance advice (RA).

If care continues with the same provider for a second episode or period of care, the RAP for the second episode or period may be submitted even if the claim for the first has not yet been submitted. If a prior episode or period is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the HHA's next RA will be used to recoup the overpaid amount.

While a RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims.

Provider Name, Address, and Telephone Number

Required - The 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. This information is used in connection with the CMS Certification Number to verify provider identity.

Patient Control Number

Required - The patient's control number assigned by the HHA for association and reference purposes.

Type of Bill

Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this particular episode of care. The type of bill accepted for HH PPS requests for anticipated payment is:

032x - Home Health Services under a Plan of Treatment

4th Digit	Definition
2-Interim-First Claim	For HHAs, used for the submission of original or replacement RAPs.
8-Void/Cancel of a Prior Claim	Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP must be submitted for the episode to be paid. If a RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted.

Medicare contractors will allow only provider-submitted cancellations of RAPs or provider-submitted final claims to process as adjustments against original RAPs. Provider may not submit adjustments (frequency code '7') to RAPs.

NOTE: Type of bill 033x is no longer valid, effective October 1, 2013.

Statement Covers Period (From-Through)

Required - Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known.

The RAP contains the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode or period.

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior RAP submission instructions for RAPs with "From" dates before January 1, 2020. The HHA should follow PDGM instructions for RAPs with "From" dates on or after January 1, 2020.

Patient Name/Identifier

Required - Patient's last name, first name, and middle initial.

Patient Address

Required - 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 - Month, day, and year of birth of patient.

Left blank if the full correct date is not known.

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 - Date the patient was admitted to home health care. On the first RAP in an admission, this date should match the statement covers "from" date. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

Point of Origin for Admission or Visit

Required - Indicates the patient's point of origin for the admission.

The HHA enters any appropriate National Uniform Billing Committee (NUBC) approved code.

Patient Discharge Status

Required - Indicates the patient's status as of the "through" date of the billing period. Since the "through" date of the RAP will match the "from" date, the patient will never be discharged as of the "through" date. As a result only one patient status is possible on RAPs, code 30 which represents that the beneficiary is still a patient of the HHA.

Condition Codes

Conditional. - The HHA enters any NUBC approved code to describe conditions that apply to the RAP.

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

If canceling the RAP (TOB 0328), the agency reports a condition code indicating the appropriate claim change reason.

Enter "Remarks" indicating the reason for cancellation.

Occurrence Codes and Dates

Conditional – The HHA enters any NUBC approved code to describe occurrences that apply to the RAP. Occurrence code values are two alphanumeric digits, and the corresponding dates are shown as eight numeric digits.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. To ensure these payment adjusts are applied accurately, the HHA reports the following codes:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	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.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

Conditional - Any NUBC approved Value code to describe other values that apply to the RAP. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00).

Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single HIPPS code that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines if they choose, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023 revenue code. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

NOTE: Revenue codes 058x and 059x are not accepted with covered charges on Medicare home health RAPs under HH PPS. Revenue code 0624 (investigational devices) is not accepted at all on Medicare home health RAPs under HH PPS.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

For RAPs with "From" dates on or after January 1, 2020, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code in order to meet this requirement. The percentage payment for the RAP is based on the HIPPS code as submitted. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Service Date

Required - For initial episodes*/periods of care,* the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode*/period.* For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode*/period,* regardless of whether the visit was covered or non-covered.

The one exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's plan of care requires that the beneficiary is seen every 6 weeks and there is a recertification, the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare's Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

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 RAP. If additional revenue codes are submitted on the RAP, the HHA reports service units as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Total Charges

Required – The HHA reports zero charges on the 0023 revenue code line.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports any necessary charge amounts to meet the requirements of other payers or its billing software. Medicare claims processing systems will not make any payments based upon submitted charge amounts.

Payer Name

Required - See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

Release of Information Certification Indicator

Required - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

Insured's Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - On RAPs with "From" dates before January 1, 2020, 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:

Position	Definition	Format
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.

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2015	15
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2016	16
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	H
12	Functional severity points – under Equation 1	2	C
13	Clinical severity points – under Equation 2	13	N
14	Functional severity points – under Equation 2	4	E
15	Clinical severity points – under Equation 3	3	D
16	Functional severity points – under Equation 3	4	E
17	Clinical severity points – under Equation 4	12	M
18	Functional severity points – under Equation 4	7	H

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

The treatment authorization code that would appear on the claim would be, in this example: 15JK16AA41HCNEDEMH.

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format. If the format is incorrect, the contractor returns the claim to the provider.

On RAPs with "From" dates on of after January 1, 2020, treatment authorization codes are no longer required on RAPs.

Document Control Number (DCN)

Required - If canceling a RAP, HHAs must enter the control number (ICN or DCN) that the contractor assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case.

Principal Diagnosis Code

Required - The HHA enters the ICD code for the principal diagnosis. The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by the HIPAA. The code must be the full diagnosis code, including all five digits for ICD-9-CM or all seven digits for ICD-10 CM where applicable. Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For claim "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

Other Diagnosis Codes

Required - The HHA enters the full diagnosis codes for 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.

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 Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.

Remarks

Conditional - Remarks are necessary when canceling the RAP, to indicate the reason for the cancellation.

40.2 - HH PPS Claims
(Rev.:4452, Issued: 11-08-19, Effective: 01-01-20, Implementation: 12-11-19)

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 (before January 1, 2020) or a 30-day period of care (on or after January 1, 2020). Payment for this episode or period will usually be made in two parts. After a RAP has been paid and an episode or period has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due.

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 RA so the net payment on the claim can be easily understood. Detailed RA information is contained in chapter 22 of this manual.

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. A/B MACs (HHH) 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 A/B MAC (HHH) must carry it through their system and return it on the remittance record.

Type of Bill

Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this particular episode of care. The types of bill accepted for HH PPS claims are:

032x - Home Health Services under a Plan of Treatment

4th Digit - 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 codes 7, or 8.

HHAs must submit HH PPS claims with the 4th digit of "9." These claims may be adjusted with code "7" or cancelled with code "8." A/B MACs (HHH) do not accept late charge bills, submitted with code "5," on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

NOTE: Type of bill 033x is no longer valid, effective October 1, 2013.

Statement Covers Period

The Patient-Driven Groupings Model is effective for periods of care beginning January 1, 2020. The HHA should follow all prior claims submission instructions for claims with "From" dates before January 1, 2020, including episodes that span into 2020. The HHA should follow PDGM instructions for claims with "From" dates on or after January 1, 2020.

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 for a 60-day episode or 29 days after the "From" date for a 30-day period of care

In cases where the beneficiary has been discharged or transferred within the episode or 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."

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 episode or period 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 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 30-day period, 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 episode or period. 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 A/B MAC (HHH) to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each A/B MAC (HHH). To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the A/B MAC (HHH) 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 A/B MAC (HHH).

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.

If the claim is for an episode in which there are no skilled HH visits in billing period, but a policy exception that allows billing for covered services is documented at the HHA, the HHA enters condition code 54.

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

When submitting an 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 0328), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

Required – On claims with "From" dates on or after January 1, 2020, the HHA enters occurrence code 50 and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090). If occurrence code 50 is not reported on a claim or adjustment, the claim will be returned to the provider for correction.

On claims for initial periods of care (i.e. when the From and Admission dates match), the HHA reports an inpatient admission that ended within 14 days of the "From" date by using one of the following codes.

Code	Short Descriptor	Long Descriptor

61	Hospital Discharge Date	The Through date of a hospital stay that ended within 14 days prior to the From date this HHA claim.
62	Other Institutional Discharge Date	The Through date of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days prior to this HHA admission.

On claims for continuing periods of care, the HHA reports an inpatient hospital admission that ended within 14 days of the "From" date by using occurrence code 61.

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent discharge date. Claims reporting more than one of any combination of occurrence codes 61 and 62 will be returned to the provider for correction.

Conditional - The HHA enters any other 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 certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. For episodes in which the beneficiary's site of service changes from one CBSA or county to another within the episode period, HHAs should submit the CBSA code or State and County code corresponding to the site of service at the end of the episode on the claim.

Provider-submitted codes:

Code	Title	Definition
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.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the HHA.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. A/B MACs (HHH) always

Code	Title	Definition
		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.
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 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, 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, 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 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. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used

for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.

For claims with "From" dates before January 1, 2020, the fifth position of the code represents the 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/period. All services must be billed on one claim for the entire episode/period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.

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	Medical/Surgical Supplies (Also see 062x, an extension of 027x) 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. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills
042x	Physical Therapy 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.
043x	Occupational Therapy 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.
044x	Speech-Language Pathology 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.

055x	Skilled Nursing
	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.
056x	Medical Social Services
	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.
057x	Home Health Aide (Home Health)
	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.

NOTE: A/B MACs (HHH) 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 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 A/B MAC (HHH) 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 of this manual.

0274	Prosthetic/Orthotic Devices
	Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.
029x	Durable Medical Equipment (DME) (Other Than Renal)
	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. Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.
060x	Oxygen (Home Health)
	Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

0623	Medical/Surgical Supplies - Extension of 027x
	Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.

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 Medicare's 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

For claims with "From" dates before January 1, 2020, 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 fifth position of the HIPPS code. The fifth 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 fifth position containing the letters S through X, the claim must also report a non-routine supply revenue code 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 fifth 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 A/B MAC (HHH) 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. For claims with "From" dates before January 1, 2020, 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 episodes with "From" dates before January 1, 2020, Medicare may change the HIPPS used for payment of the claim in the course of claims processing, but the HIPPS code submitted by the provider in this field is never changed or replaced. If the HIPPS code is changed, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

For episodes with "From" dates on or after January 1, 2020, Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changed based on medical review or other processes, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

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

To report HH visits, the HHA reports one of the following HCPCS codes to represent a visit by 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.

Note that modifiers indicating services delivered under a therapy plan of care (modifiers GN, GO or GP) are not required on HH PPS claims.

Skilled Nursing (revenue code 055x)

General skilled nursing:

For dates of service before January 1, 2016: G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

For dates of service on or after January 1, 2016: Visits previously reported with G0154 are reported with one of the following codes:

> G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
>
> G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.

Care plan oversight:

For dates of service before January 1, 2017:

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).

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0163 with one of the following codes:

> G0493 Skilled services of a registered nurse (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).
>
> G0494 Skilled services of a licensed practical nurse (LPN) 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).

Training:

For dates of service before January 1, 2017: 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.

For dates of service on or after January 1, 2017, HHAs report visits previously reported with G0164 with one of the following codes:

> G0495 Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.
>
> G0496 Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

<u>Medical Social Services (revenue code 056x)</u>

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

<u>Home Health Aide (revenue code 057x)</u>

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

<u>Regarding all skilled nursing and skilled therapy visits</u>

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, Medicare 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 that 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.

For episodes beginning on or after July 1, 2013, HHAs must report where home health services were provided. The following codes are used for this reporting:

Q5001: Hospice or home health care provided in patient's home/residence

Q5002: Hospice or home health care provided in assisted living facility

Q5009: Hospice or home health care provided in place not otherwise specified

The location where services were provided must always be reported along with the first visit reported on the claim. In addition to reporting a visit line using the G codes as described above, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit and a nominal covered charge (e.g., a penny). If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Service Date

Required - For initial episodes*/periods of care*, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode*/period*. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode*/period*, regardless of whether the visit was covered or non-covered.

For other line items detailing all services within the episode/period, it reports service dates as appropriate to that revenue code. 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.

When the claim Admission Date matches the Statement Covers "From" Date, Medicare systems ensure that the Service Date on the 0023 revenue code line also matches these dates.

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. If any visits report over 96 units (over 24 hours) on a single line item, Medicare systems return the claim returned to the provider.

Effective January 1, 2017, covered and noncovered increments of the same visit must be reported on separate lines. This is to ensure that only covered increments are included in the per-unit based calculation of outlier payments.

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 - On claims with "From" dates before January 1, 2020, the code on the claim will match that submitted on the RAP.

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.

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format. If the format is incorrect, the contractor returns the claim to the provider.

On claims with "From" dates on of after January 1, 2020, treatment authorization codes are no longer required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 0327) 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 code for the principal diagnosis. The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by the HIPAA. The code must be the full

diagnosis code, including all five digits for ICD-9-CM or all seven digits for ICD-10 CM where applicable. Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

For claim "From" dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

For claim "From" dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

Other Diagnosis Codes

Required - The HHA enters the full diagnosis codes for 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.

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 Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).

For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Attending Provider Name and Identifiers

Required - The HHA enters the name and national provider identifier (NPI) of the attending physician who signed the plan of care.

Other Provider (Individual) Names and Identifiers

Required - The HHA enters the name and NPI of the physician who certified/re-certified the patient's eligibility for home health services.

NOTE: Both the attending physician and other provider fields should be completed unless the patient's designated attending physician is the same as the physician who certified/re-certified the patient's eligibility. When the attending physician is also the certifying/re-certifying physician, only the attending physician is required to be reported.

Remarks

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