CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10086	**Date: May 1, 2020**
	Change Request 11721

SUBJECT: New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting

I. SUMMARY OF CHANGES: This Change Request provides home health (HH) billing and processing instructions for new G-codes that describe therapy assistant services. It also makes a correction to the processing of HH claims that receive episode sequence edits.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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	10/10.1.17/Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)
R	10/10.1.19.2/Adjustments of Episode Payment - Early or Later Episodes
R	10/10.1.19.3/Adjustments of Episode Payment – Validation of HIPPS Codes
R	10/10.1.24/Glossary and Acronym List
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: 10086	Date: May 1, 2020	Change Request: 11721

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EFFECTIVE DATE: January 1, 2020
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I. GENERAL INFORMATION

A. Background: Prior to January 1, 2020, the regulations at § 409.44(c)(2)(iii)(C) stated that where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

In the CY 2020 Home Health Prospective Payment System (HH PPS) Rule, we stated that it would be appropriate to allow therapist assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the home health benefit, if acting within the therapy scope of practice defined by state licensure laws. The qualified therapist would still be responsible for the initial assessment; plan of care; maintenance program development and modifications; and reassessment every 30 days, in addition to supervising the services provided by the therapist assistant. This would allow home health agencies more latitude in resource utilization. Furthermore, allowing assistants to perform maintenance therapy would be consistent with other post-acute care settings, including skilled nursing facilities (SNFs). The requirements below revise Original Medicare systems to allow new codes that describe these services.

Additionally, a current limitation in Medicare systems requires the MAC to manually recode claims processed without a corresponding OASIS assessment (claims for beneficiaries under 18 years old or claims with condition code DR) if the claim is subject to the Common Working File (CWF) edits that enforce period of care sequence. The requirements below automate the recoding process. This Change Request (CR) also make various clarifying changes to the Medicare Claims Processing Manual, chapter 10, in order to better reflect the policies of the Patient-Driven Groupings Model.

B. Policy: As finalized in the CY 2020 HH PPS final rule, the regulations at § 409.44(c)(2)(iii)(C) were modified to allow therapist assistants (rather than only therapists) to perform maintenance therapy under the Medicare home health benefit. For analysis purposes, in order to track how much maintenance therapy is being furnished by therapist assistants in response to this regulatory change, effective January 1, 2020, CMS will establish a G-code for the maintenance services furnished by a physical therapist assistant and a G-code for the maintenance services furnished by an occupational therapist assistant.

The payment per visit will remain the same regardless of whether a therapist assistant is furnishing maintenance or other therapy services.

The two new G-codes are:

• G2168: Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes

Short Descriptor: Svs by pt in home health

• G2169: Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes

Short Descriptor: Svs by ot in home health

These codes will be accepted by Medicare systems when submitted after the implementation date of this CR for dates of service on or after January 1, 2020. In the interim, HHAs should continue to report G0157 and G0158 for any therapist assistant services provided in 2020.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11721.1	The contractor shall allow HCPCS code G2168 to be reported with revenue code 042x on home health claims (TOB 032x other than 0322).					X				
11721.2	The contractor shall allow HCPCS code G2169 to be reported with revenue code 043x on home health claims (TOB 032x other than 0322).					X				
11721.3	The contractor shall recode the HIPPS code on an HH claim (TOB 032x other than 0322 and 0320) when the following conditions are met: • the HIPPS code indicates an early period of care (first position is equal to 1 or 2) • the claim is identified during processing to be a late period of care, and • the claim is not subject to OASIS data collection, indicated by OA fields populated with 9s on the OASIS information screen, and • the claim From date is on or after January 1, 2020. NOTE: Claims for beneficiaries under age 18 and claims reporting condition code DR are not subject to OASIS data collection.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11721.3.1	The contractor shall recode the HIPPS code as follows: • if the first position of the HIPPS code is a 1 (indicating early/community), change the first position to 3 (late/community), or • if the first position of the HIPPS code is a 2 (early/institutional), change the first position to 4 (late/institutional)					X				
11721.3.2	The contractor shall put the recoded late HIPPS code in the APC-HIPPS field on the claim, set the payment indicator (IND) to P, and return the recoded claim to CWF.					X				
11721.4	The contractor shall recode the HIPPS code on an HH claim (TOB 032x other than 0322 and 0320) when the following conditions are met: • the HIPPS code indicates a late period of care (first position is equal to 3 or 4) • the claim is identified during processing to be an early period of care, • the claim is not subject to OASIS data collection, indicated by OA fields populated with 9s on the OASIS information screen, and • the claim From date is on or after January 1, 2020. NOTE: Claims for beneficiaries under age 18 and claims reporting condition code DR are not subject to OASIS data collection.					X				
11721.4.1	The contractor shall recode the HIPPS code as follows: • if the first position of the HIPPS code is a 3 (indicating late/community), change the first position to 1 (early/community), or • if the first position of the HIPPS code is a 4 (late/institutional), change the first position to 2 (early/institutional).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11721.4.2	The contractor shall put the recoded early HIPPS code in the APC-HIPPS field on the claim, set the payment indicator (IND) to P, and return the recoded claim to CWF.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11721.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter 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.			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:
.2	This requirement revises the edit created by BR 10167.10, which limited the allowable HCPCS reported on occupational therapy revenue code lines to Q5001, Q5002, Q5009, G0152, G0158 or G0160. G2169 is added to the list of allowable HCPCS codes.
.3	The claims are identified as late by CWF edit 524P.
.4	The claims are identified as early by CWF edit 524Q.

X-Ref Requirement Number	Recommendations or other supporting information:
.1	This requirement revises the edit created by BR 10167.9, which limited the allowable HCPCS reported on physical therapy revenue code lines to Q5001, Q5002, Q5009, G0151, G0157 or G0159. G2168 is added to the list of allowable HCPCS codes.

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 Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 10086, Issued: 05-01-2020)

10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev.10086, Issued: 05-01-2020, Effective: 01-01-2020, Implementation: 10-05-2020)

For episodes of care beginning before January 1, 2020, if an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 60-day period. For periods of care beginning on or after January 1, 2020, if an HHA *provides* fewer than the threshold of visits specified for the period's HHRG, they will be paid a standardized per visit payment instead of a payment for a 30- day period of care. Such payment adjustments are called Low Utilization Payment Adjustments (LUPAs).

On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments. If the claim for the LUPA is later adjusted such that the number of visits becomes five or more, payments will be adjusted to an HHRG basis, rather than a *per* visit basis.

If the LUPA episode/period is the first in a sequence of adjacent episodes/periods or is the only episode/period of care the beneficiary received, Medicare will make an additional add-on payment. Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if claims are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated episode/period in the same sequence.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

10.1.19.2 - Adjustments of Episode Payment - Early or Later Episodes

(Rev.10086, Issued: 05-01-2020, Effective: 01-01-2020, Implementation: 10-05-2020)

For episodes beginning before January 1, 2020*:*

The HH PPS uses a 4-equation case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early episode of care (1st or 2nd episode in a sequence of adjacent covered episodes) or a later episode of care (the 3rd episode and beyond in a sequence of adjacent covered episodes).

Early episodes include not only the initial episode in a sequence of adjacent covered episodes, but also the next adjacent covered episode, if any, that followed the initial episode. Later episodes are defined as all

adjacent episodes beyond the second episode. Episodes are considered to be adjacent if they are separated by no more than a 60-day period between claims.

The 60-day period to determine a gap that will begin a new sequence of episodes is generally counted from the calculated 60-day end date of the episode. That is, in most cases Medicare systems will count from ‘‘day 60’’ of an episode without regard to an earlier discharge date in the episode. The exception is episodes subject to PEP adjustment. In PEP cases, Medicare systems will count 60 days from the date of the last billable home health visit provided in the PEP episode.

Any Original Medicare covered episode for a beneficiary is considered in determining adjacent covered episodes. A sequence of adjacent covered episodes is not interrupted if a beneficiary transfers between HHAs. Episodes covered by Medicare Advantage plans are not considered in determining adjacent episodes.

Example: A patient is admitted to Agency A on July 5th into a payment episode that ends on the date of Sept 2nd. The patient is then recertified on Sept 3rd, with an end of episode date of November 1st. Agency B admits on Jan 1.

When determining if two eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1. Continue counting to, and including, the first day of the next episode.

In this example, November 1st was the last day of the episode and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent.

The episode starting January 1st would be reported by Agency B as “early”. December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “later.”

HHAs report whether an episode is “early” or “later” using OASIS item M0110. This OASIS information is then used to determine the HIPPS code used for billing. The first position of the HIPPS code shows whether an episode is “early” or “later.” Since HHAs may not always have complete information about previous episodes, the HIPPS code is validated by Medicare systems. The Common Working File reads the episode history described in section 30.5 to determine whether an episode has been coded correctly based on the most current information available to Medicare. If the HIPPS code disagrees with Medicare’s episode history, the claim will be recoded.

The receipt of any episode may change the sequence of previously paid claims. For instance, a claim may be paid as “early” because the HHA was not aware of prior episodes and the previous HHA had not billed for the prior episodes. When the earlier dated episodes are received, Medicare systems will initiate an automatic adjustment to recode the previously paid claim and correct its payment.

When claims are recoded, values in the treatment authorization code submitted on the claim will be used to determine the new code. Tables demonstrating how values in the treatment authorization code are converted into new HIPPS code values are included in section 70.4 below.

For periods of care beginning on or after January 1, 2020:

The HH PDGM uses a case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early period of care (1st period in a sequence of adjacent covered periods) or a later episode of care (the 2nd period and beyond in a sequence of adjacent covered periods). Periods of care are considered to be adjacent if they are separated by no more than a 60-day period between claims.

The 60-day period to determine a gap that will begin a new sequence of periods is generally counted from the calculated 30-day end date of the period of care. That is, in most cases Medicare systems will count from ''day 30'' of a period without regard to an earlier discharge date in the episode. The exception is periods of care subject to partial period payment adjustment. In partial period cases, Medicare systems will count 60 days from the date of the last billable home health visit provided in the period of care.

Any Original Medicare covered period for a beneficiary is considered in determining adjacent covered periods, including Medicare Secondary Payer (MSP) periods. A sequence of adjacent covered periods is not interrupted if a beneficiary transfers between HHAs. Periods covered by Medicare Advantage plans or by Federal payers other than Medicare (e.g., Veterans Administration or Department of Defense) are not considered in determining adjacent periods because the claims from these payers are not available to Original Medicare systems.

Example: A patient is admitted to Agency A on July 5 into a payment period that ends on the date of August 3. The patient is then recertified on August 4, with a period end date of September 2. Agency B admits on November 2.

When determining if two periods are adjacent, the HHA should count the number of days from the last day of one period until the first day of the next period. Adjacent periods are defined as those where the number of days from the last day of one period until the first day of the next period is not greater than 60. The first day after the last day of a period is counted as day 1. Continue counting to, and including, the first day of the next period.

In this example, September 2 was the last day of the period and November 2 is the first day of the next period. When counting the number of days from the last day of one period (September 2), September 3 would be day 1, and November 2 would be day 61. Since the number of days from the end of one period to the start of the next is more than 60 days, these two periods are not adjacent.

The period starting November 2 would be considered "early". November 1 represents day 60 in this example. If the next period started November 1 instead of January 2, that period would be considered adjacent since the number of days counted is not greater than 60. The period starting November 1 would be considered "later." Any period beginning between September 3 and November 1 in this example would also be considered as "later."

When the HHA submits a final claim, the period of care is determined to be "early" if the claim From date matches the Admission date. All other claims are considered "later." The first position of the HIPPS code calculated by Medicare's Grouper software shows whether a period of care is "early" or "later." Then Medicare's Common Working File reads the period history described in section 30.5 to determine whether a period has been coded correctly based on the most current information available to Medicare. If the HIPPS code disagrees with Medicare's period history, the claim will be recoded.

The receipt of any claim may change the sequence of previously paid claims. For instance, a claim may be paid as "early" because the claim From and Admission dates matched and the previous HHA had not billed for the prior periods of care. When the earlier dated periods are received, Medicare systems will initiate an automatic adjustment (Type of Bill 032G) to recode the previously paid claim and correct its payment.

10.1.19.3 - Adjustments of Episode Payment – Validation of HIPPS Codes

(Rev.10086, Issued: 05-01-2020, Effective: 01-01-2020, Implementation: 10-05-2020)

Recoding Based on OASIS-calculated HIPPS Codes

The HIPPS code calculated based on the OASIS assessment for an episode is reported on the HH RAP and claim *for episodes beginning before January 1, 2020*. HHAs may calculate the HIPPS code using CMS-provided Grouper software or with their own software that recreates CMS grouping logic. When the OASIS assessment is submitted to the Medicare quality system, the HIPPS code is independently calculated using the CMS-provided Grouper program.

When processing the claim for an episode, Medicare systems compare the provider-submitted HIPPS code with the HIPPS code calculated based on the assessment information in the quality system. If the codes do not match, the OASIS-calculated HIPPS code is used for payment.

Medicare systems display the OASIS-calculated HIPPS code in Direct Data Entry (DDE) in a field named "RETURN-HIPPS1." When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice. In other cases, the HIPPS code in this field will match what the HHA submitted on their claim.

The OASIS-calculated HIPPS code may be re-coded further by Medicare systems. The OASIS-calculated HIPPS code will be sent to the HH PPS Pricer program which may change the code based on changes in therapy services (see section 10.1.19.1) or whether the claim is for an early or later episode (see section 10.1.19.2). In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice. HHAs will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE:

Field in DDE	DDE Map	Represents
HCPC	MAP171E	HHA-submitted HIPPS code
RETURN-HIPPS1	MAP171E	OASIS-calculated HIPPS code
APC-HIPPS	MAP171A	Pricer re-coded HIPPS code

The OASIS-calculated HIPPS code may also be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the HIPPS code determined by medical review will be used for payment and will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

This recoding process applies only to episodes beginning before January 1, 2020. Under the Patient-Driven Grouping Model, payment groups are determined by Medicare systems using OASIS data and the provider-submitted HIPPS code is not used. *The provider-submitted code will be replaced on the claim by the HIPPS code calculated by the HH Grouper program.*

On PDGM claims:

Field in DDE	*DDE Map*	*Represents*
HCPC	*MAP171E*	*Initial Grouper-calculated HIPPS code*
RETURN-HIPPS1	*MAP171E*	*Not used*
APC-HIPPS	*MAP171A*	*Re-coded HIPPS code, if Grouper applied more than once during processing due to updated information.*

When an OASIS Assessment Has Not Been Submitted

Submission of an OASIS assessment is a condition of payment for HH episodes/periods of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30 day period will have elapsed by the time an episode/period of HH services is completed and the final claim for that episode/period is submitted to Medicare. If the OASIS assessment is not found in the quality system upon receipt of a final claim, Medicare systems will return or deny the HH claim.

If the claim is denied, the contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N/A
MSN: 41.17

If the claim is returned, the HHA may correct any errors in the OASIS or claim information to ensure a match and then re-submit the claim. If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period, and
- Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.

Condition code 21 must not be used in these instances, since it would result in inappropriate beneficiary liability.

The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N211
MSN: 41.17

Recoding Based on Inpatient Stay Information

For periods of care beginning on or after January 1, 2020:

The HH PDGM uses a case-mix model that recognizes and differentiates payment for periods of care based on whether a patient is/was referred to home health from the community or from an acute or post-acute care referral source. Patients who were discharged from an acute care hospital or from a skilled nursing facility (SNF) or swing bed, inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days prior to an HHA admission are grouped into 'institutional' payment groups. This applies to the first claim in an admission (e.g., a claim where the From and Admission dates match). Patients who were discharged from an acute care hospital within 14 days prior to any continuing HH period of care are also grouped into 'institutional' payment groups. All other periods of care are considered 'community.'

"Institutional' payment groups are identified in Medicare claims processing systems in one of two ways. The HHA may report the acute care hospital discharge date on the claim using occurrence code 61 or the

post-acute care discharge date using occurrence code 62. If one of these occurrence codes is present on the claim and reports an applicable date for the payment adjustment, the claim will be grouped as 'institutional' using a HIPPS code beginning with 2 or 4. Outpatient hospital stays, including observation stays and ER visits, are not reported using either occurrence code.

If the HHA is unaware of the inpatient discharge or chooses not to report the occurrence code, the institutional grouping may be assigned by Medicare systems. If Medicare has received the inpatient claim before the HH claim is processed, Medicare systems will identify the applicable discharge date during processing and group the claim into an institutional payment group based on our claim history information. If the inpatient facility has not billed yet, the claim will be paid using a community payment group. When Medicare receives the inpatient claim later during the timely filing period, Medicare systems will automatically adjust the paid home health claim using Type of Bill 032G and pay it using an institutional payment group instead. The difference in the payment will be reflected on the home health agency's next Medicare remittance advice. The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so adjustments can be clearly identified.

The contractor shall use the following remittance advice messages and associated codes when automatically adjusting claims under this policy. This CARC/RARC combination is not covered by CAQH CORE Business Scenarios.

Group Code: CO
CARC: 186
RARC: N69
MSN: N/A

Automatic adjustments can only be triggered by Medicare processing the inpatient claim. In certain cases, Medicare may never learn about the inpatient stay during the timely filing period. If the beneficiary was in a non-Medicare facility (e.g., a VA hospital), Medicare will never receive that claim. The HHA must identify stays in non-Medicare facilities by using the appropriate occurrence code for the 'institutional' payment group to be applied correctly.

10.1.24 - Glossary and Acronym List

(Rev.10086, Issued: 05-01-2020, Effective: 01-01-2020, Implementation: 10-05-2020)

ABN - Advance Beneficiary Notice of Non-Coverage

A/B MAC (A) - A/B MACs processing hospital claims.

A/B MAC (HHH) - A/B MACs processing all Home Health and Hospice claims.

CBSA - Core Based Statistical Area

CCN - CMS certification number

Claim - The second of two transactions submitted for a HH PPS episode to receive the second split percentage payment for the episode.

CLIA - Clinical Laboratory Improvement Amendments

CMS - The Center for Medicare & Medicaid Services, the Federal Agency administering the Medicare program.

CWF - Common Working File

DCN - Document Control Number

DME - Durable Medical Equipment.

DME MAC - DME Medicare Administrative Contractor - 4 Medicare contractors nationally processing DME on professional claim formats.

DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics and Supplies.

DOEBA - Date of Earliest Billing Activity

DOLBA - Date of Latest Billing Activity

Episode - The unit of payment for HH PPS, covering up to 60 days of HH services.

Grouper - A software module that "groups" information for payment classification. *Under the HH PDGM, data from the claim and from the OASIS assessment tool is grouped to calculate the HIPPS code used for payment. See section 80.*

HAVEN - Publicly available software that automates the entry and transmission of OASIS assessment information.

HCPCS Code(s) - Healthcare Common Procedure Coding System. Coding for services or items used in the HCPCS/Accommodation Rates/HIPPS Rate Codes field on institutional claim formats. A list of HCPCS is accessible on the CMS Web site.

HH - Home Health

HHA(s) - Home Health Agency(ies)

HH PPS - Home Health Prospective Payment System

HHRG - Home Health Resource Group. One of the case-mix groups that determine HH PPS payment rates.

HICN - Health Insurance Claim Number

HIPAA - Health Insurance Portability and Accountability Act

HIPPS - Health Insurance Prospective Payment System. Coding used in the HCPCS/ Accommodation Rates/HIPPS Rate Codes field on institutional claim formats to represent case-mix groups in certain prospective payment systems.

ICD - International Classification of Diseases

ICN - Internal Control Number

LUPA - Low Utilization Payment Adjustment. An episode of 4 or less visits paid by national standardized per visit rates instead of by the HH PPS case-mix system.

MAC - Medicare Administrative Contractor, one of the contractors processing Medicare claims.

MSA - Metropolitan Statistical Area

National Standard Per Visit Rates - National rates for each of the 6 home health disciplines based on historical claims data. These rates are used in payment of LUPAs and calculation of outliers.

No-RAP LUPAs - A billing scenario in which only a claim, not a RAP, is submitted for an episode by an HHA because the HHA is aware from the outset that the episode will be four visits or less.

NRS - Non-Routine Supplies

NUBC - National Uniform Billing Committee

OASIS - Outcome and Assessment Information Set. The HH patient assessment instrument.

Outlier - An addition to a full episode payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold. Pricer computes HH PPS outliers as part of Medicare claims payment for all non-LUPA episodes.

Patient Status Code - a code in the Patient Discharge Status field on institutional claims which describes patient status at discharge or the end of the billing period.

PEP - Partial Episode Payment (adjustment). A reduced episode payment that may be made based on the number of service days in an episode (always less than 60 days, employed in cases of transfers or discharges with readmissions).

Period - The unit of payment for the HH PDGM, a period of care covering up to 30 days of HH services.

PDGM – Patient-Driven Groupings Model. The case-mix system applied to HH PPS claims with From dates on or after January 1, 2020.

PPS - Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

Pricer - Software modules in Medicare claims processing systems used to calculate payments under prospective payment systems.

RA - Remittance Advice

RAP - Request for Anticipated Payment. First of two transactions submitted for a HH PPS episode to receive the first split percentage payment for the episode.

Revenue Code - Four position payment codes for services or items placed in the Revenue Codes field on institutional claim formats. An “x” in the last digit of revenue codes means that value can vary from 0-9.

TOB - Type of Bill (e.g., 032x, 034x). Coding representing the nature of each institutional claim (i.e., type of provider, such as home health; frequency of bill) - an “x” in the last digit of the TOB means that value can vary from 0-9.

40.2 - HH PPS Claims

(Rev.10086, Issued: 05-01-2020, Effective: 01-01-2020, Implementation: 10-05-2020)

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.

To determine the 14 day period, include the "From" date, then count back using the day before the "From" date as day 1. For example, if the "From" date is January 20th, then January 19th is day 1. Counting back from January 19th, the 14 day period is January 6 through January 19. If an inpatient discharge date falls on any date in that period or on the admission day itself (January 20), it is eligible to be reported on the claim.

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent *applicable* 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 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:

<u>Physical Therapy (revenue code 042x)</u>

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.
G2168 Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

<u>Occupational Therapy (revenue code 043x)</u>

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.
G2169 Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

<u>Speech-Language Pathology (revenue code 044x)</u>

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.

Medical Social Services (revenue code 056x)

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

Home Health Aide (revenue code 057x)

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

Regarding all skilled nursing and skilled therapy visits

In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, 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.

Corrections to diagnosis codes reported on a RAP that reflect the patient's condition as of the start of a period of care may be reflected on the claim for the current period of care. Changes to diagnosis codes that

reflect a change in the patient's condition during a period of care should be reflected on the RAP and claim for the next period.

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.