CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12888	**Date: October 10, 2024**
	Change Request 13812

SUBJECT: Allowing Home Health (HH) Telehealth Services During an Inpatient Stay

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise Original Medicare claims editing to allow non-paid telehealth visits to be reported while a beneficiary is hospitalized.

EFFECTIVE DATE: April 1, 2025 - For claims processed on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

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	10/30.9/Coordination of HH PPS Claims Episodes With Inpatient Claim Types

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

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise Original Medicare claims editing to allow non-paid telehealth visits to be reported while a beneficiary is hospitalized.

II. GENERAL INFORMATION

A. Background: Medicare beneficiaries cannot be inpatients in a hospital or skilled nursing facility and receive home health care simultaneously. If an HH Prospective Payment System (PPS) claim is received, and Medicare systems find dates of service on the HH claim that falls within the dates of an inpatient, skilled nursing facility or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence), the Common Working File (CWF) will reject the HH claim with edit 7080. The Home Health Agency (HHA) may submit a new claim removing any dates of service within the inpatient stay that were billed in error.

This date overlap editing should not apply to HH telehealth reporting, Healthcare Common Procedure Coding System (HCPCS) codes G0320, G0321 or G0322. These services are non-payable reporting items so they do not create any duplicate payment. The codes may represent the HHA remaining in contact with caregivers while the beneficiary is an inpatient. CMS has learned that these codes are currently rejecting with CWF edit 7080 in error, requiring HHAs to remove the reporting lines in order to process the claim. The requirement below corrects this error and allows HCPCS G0320, G0321 or G0322 dates on an HH PPS claim to overlap inpatient stays.

B. Policy: This CR does not contain any new policy. It corrects the implementation of existing HH telehealth reporting policy.

III. 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	
13812.1	The contractor shall allow an HH claim (Type of Bill 032x other than 032A or D) with line item dates of service falling within an inpatient stay if HCPCS G0320, G0321 or G0322 are present on the line.								X	

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don’t need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part HHH

V. 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:
.1	This requirement creates a bypass condition for CWF edit 7080. All other conditions for handling dates in the edit are unchanged.

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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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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

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 12888; Issued:10-10-24; Effective:04-01-25; Implementation: 04-07-25)

Beneficiaries cannot be institutionalized and receive home health care simultaneously. Therefore claims for institutional inpatient services (inpatient hospital, skilled nursing facility (SNF) and swing bed claims), have priority in Medicare claims editing over claims for home health services.

If an HH PPS claim is received, and *Medicare systems find* dates of service on the HH claim that falls within the dates of an inpatient, SNF or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence), Medicare systems will reject the HH claim. The HHA may submit a new claim removing any dates of service within the inpatient stay that were billed in error.

Medicare systems allow an exception for HH telehealth reporting, HCPCS codes G0320, G0321 or G0322. An HH PPS claim may be processed if dates of service with these codes fall within an inpatient stay. This is because the services are non-payable reporting items, so they do not create any duplicate payment. The codes may represent the HHA remaining in contact with caregivers while the beneficiary is an inpatient.

If the HH PPS claim is received first and the inpatient hospital, SNF or swing bed claim comes in later, but contains dates of service duplicating dates of service on the HH PPS claim, Medicare systems will adjust the previously paid HH PPS claim to non-cover the duplicated dates of service, *excluding telehealth services*.