CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1988	**Date: June 14, 2010**
	Change Request 6911

NOTE: Transmittal 1952, dated April 28, 2010, is rescinded and replaced by Transmittal 1988, dated June 14, 2010. This Change Request is being re-issued to indicate FISS as a responsible party for requirement 6911.6; and MBD, NGD and HETS as responsible parties for requirement 6911.7. All other information remains the same.

SUBJECT: Enhancements to Home Health (HH) Consolidated Billing

I. SUMMARY OF CHANGES: This Change Request refines edits enforcing HH consolidated billing of supplies. It also creates a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/20/Home Health Prospective Payment System (HH PPS) Consolidated Billing
R	10/20.1.2/Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
R	10/20.2/Home Health Consolidated Billing Edits in Medicare Systems
R	10/20.2.1/Nonroutine Supply Editing
R	10/20.2.2/Therapy Editing

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1988	Date: June 14, 2010	Change Request: 6911

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SUBJECT: Enhancements to Home Health (HH) Consolidated Billing

Effective Date: October 1, 2010
Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: This transmittal provides requirements for two enhancements to the implementation of the consolidated billing policy under the home health prospective payment system (HH PPS). It refines the HH consolidated billing edits Medicare systems apply to supplier claims. It also creates a new source of information about HH services for providers and suppliers whose services are subject to HH consolidated billing.

Refinement of Nonroutine Supply Editing

Nonroutine supplies provided during an HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 20.2.1. If the date of service for a nonroutine supply HCPCS code that is subject to HH consolidated billing falls within the dates of an HH episode, the line item is rejected by Medicare systems. Nonroutine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that nonroutine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap an HH episode, the service is rejected contrary to the original intent of this edit.

The requirements below modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and so are appropriate for payment if all other payment conditions are met. This edit will be changed to only reject services if the 'from' date on the supply line item falls within an HH episode.

New Auxiliary File Regarding HH Plan of Care Certifications

Chapter 10, section 20.1 describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is

currently in an HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. The requirements below call for the creation of a new file in Medicare's Common Working File (CWF) system, which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiaries care. Medicare pays physicians for this service using the following two codes:

G0179 Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care
G0180 Physician Certification For Medicare-covered Home Health Services Under A Plan of Care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for an HH episode promptly in order to receive their initial 60% or 50% payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that an HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid.

Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information maintained on CWF, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

This transmittal also makes various revisions to chapter 10, section 30, to make the description of HH consolidated billing more clear and complete.

B. Policy: This transmittal contains no new policy. This transmittal improves and refines the implementation of existing policy.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Refinement of Nonroutine Supply Editing										
6911.1	Medicare systems shall reject nonroutine supply line items on professional claims submitted to DME MACs which are subject to HH consolidated billing when the line item 'from' date falls after the start date of an HH episode.									X	
6911.2	Medicare systems shall return alerts on professional claims containing nonroutine supply line items which are subject to HH consolidated billing when the line item									X	

Number	Requirement	Responsibility (									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	'from' date falls after the start date of an HH episode when no final HH claim for the episode has been received.										
	New Auxiliary File Regarding HH Plan of Care Certifications										
6911.3	Medicare systems shall create a new auxiliary file to display HH plan of care certifications for each beneficiary.									X	
6911.4	Medicare systems shall display the certification code paid and the line item date of service for the code on the HH certification auxiliary file each time a professional claim is paid for HCPCS codes G0179 or G0180. Note: If other services are paid on the same professional claim, information relating to the other services shall not be displayed. Only information regarding G0179 or G0180 shall update the file.									X	
6911.5	Medicare systems shall display the HH certification auxiliary file information on an HIMR screen.									X	
6911.6	Medicare systems shall display the HH certification auxiliary file information on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	
6911.6.1	Medicare systems shall allow the provider to enter an inquiry date when accessing the HH certification auxiliary file via CWF provider query screens.									X	
6911.6.2	When the provider enters an inquiry date via CWF provider query screens, Medicare systems shall display all certification code dates within 9 months before the date entered.									X	
6911.6.3	When the provider does not enter an inquiry date via CWF provider query screens, Medicare systems shall display all certification code dates within 9 months before the current date as the default response.									X	
6911.7	Medicare systems shall include the HH certification auxiliary file information in the data file sent to HETS.									X	MBD, NGD, HETS
6911.8	The Multi-Carrier System Desktop Tool (MCSDT) shall display the HH certification auxiliary file information in a format equivalent to the CWF HIMR screen.							X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6911.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
6911.1	This requirement affects CWF edit 5389 and the associated informational unsolicited response process.
6911.2	This requirement affects CWF alert 7702.

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148 or Yvonne Young, yvonne.young@cms.hhs.gov, 410-786-1886

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

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

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

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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.

20 - Home Health Prospective Payment System (HH PPS) Consolidated Billing

(Rev.1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare payment for all such items and services is to be made to a single home health agency (HHA) overseeing that plan. This HHA is known as the primary HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise." Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Exception: Therapy services are not subject to the home health consolidated billing methodology when performed by a physician.

Medicare periodically publishes Routine Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes, which Medicare also publishes annually. The lists

may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

The HHA that submits a Request for Anticipated Payment (RAP) or No-RAP LUPA claim successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given episode in the Common Working File (CWF). If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Contractors will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within an episode (*see §20.2 for details*). Contractors will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under an HH plan of care (using type of bill 34X) when the primary HHA has already billed other services under an HH plan of care (type of bill 32X) for the beneficiary. Institutional providers may access information on existing episodes through the home health CWF inquiry process. See §30.1.

Durable Medical Equipment (DME) is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier or an HHA (including HHAs other than the primary HHA). Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted *by multiple providers* for the same dates of service for the same beneficiary. In the event of duplicate billing, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent payment for the purchase and the rental of the same item for the same dates of service. In this event, the first claim received, regardless of whether for purchase or rental, will be processed and paid.

The exception to the above, however, is competitive bidding for certain DME. HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program, must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP Codes where beneficiaries receiving these items maintain their permanent residence. *Home health agency claims* submitted for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs, who will have jurisdiction over all claims for competitively bid items.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis in addition to episodes payments. For more detailed information, *refer to §20.2.3 and §90.1*.

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing

(Rev.1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. *Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.*

Additionally, information about current home health episodes may be available from Medicare contractors. Institutional providers (providers who bill *using the institutional claim format*) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists or suppliers who bill *using the professional claim format* also have access to a similar electronic inquiry via the HIPAA standard eligibility transaction – the 270/271 transaction. *They may also*, as a last resort, call their contractor's provider toll free line to request home health eligibility information available on the Common Working File. The *contractor's* information is based only on claims Medicare has received from home health agencies at the day of the contact.

Beginning October 2010, another source of information is available via the CWF. Medicare systems will maintain a data file that captures and displays the dates when Medicare paid physicians for the certification or recertification of the beneficiary's HH plan of care. Physicians submit claims for these services to contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for an HH episode promptly in order to receive their initial 60% or 50% payment for that episode.

But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that an HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems display, for each Medicare beneficiary, the code for certification (G0180) or recertification (G0179) and the date of service for either of the two codes.

Suppliers and providers should note that this information is supplementary to the previously existing sources of information about HH episodes. Like HH episode information maintained on CWF, certification information is only as complete and timely as billing by providers allows it to be. For many episodes, a physician certification claim may never be billed. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

If a therapy provider or a supplier learns of a home health episode from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH episode, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health episode and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

20.2 - Home Health Consolidated Billing Edits in Medicare Systems

(Rev.1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

In short, consolidated billing requires that only the primary HHA bill services under the home health benefit, with the exception of DME and therapy services provided by physicians, for the period of that episode. The types of service most affected are nonroutine supplies and outpatient therapies, since these services are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

Home health consolidated billing editing is applied when the episode claim has been received and processed in CWF. Edits are applied if the claim subject to consolidated billing contains dates of service between and including the episode start date and the last billable service date for the episode if the patient is discharged or transferred. If the patient is not discharged or transferred, the episode end date is used for editing purposes. Any line item services within the episode start date and last billable service date or episode end date, whichever is appropriate for the patient status, will be edited. CWF sends information to *contractors* that enable them to reject or deny line items on claims subject to consolidated billing.

Claims subject to consolidated billing may be identified in one of two ways. Claims may be edited when the HH PPS claim had been received before the claim for services subject to consolidated billing. In these cases, the line items subject to consolidated billing are rejected or denied prior to payment. Claims may also be identified when the HH PPS claim is received after the other claims subject to consolidated billing. In these cases, the claim for services subject to consolidated billing has already been paid. CWF then notifies the *contractor* to make a post-payment rejection or denial.

For post-payment rejections of claims billed *on institutional claims*, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed *on professional claims*, those contractors will follow their routine overpayment identification and recovery procedures. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

Whether a claim for services subject to consolidated billing is identified pre- or post-payment, messages explaining line-item actions for home health consolidated billing appear on remittance advice for providers and Medicare Summary Notices (MSNs) for beneficiaries.

Claims subject to home health consolidated billing receive the following remittance advice codes:

- Reason Code B15: "Payment adjusted because this procedure/service is not paid separately"

- Remark Code N70: "Home health consolidated billing and payment applies"

Since home health consolidated billing is not an ABN situation, coding on incoming claims cannot allow Medicare systems to fully identify the payment liability for any denial. As described in §20.1, whether the denial is the liability of the primary HHA or the beneficiary is determined by whether the services are provided under arrangement and whether the beneficiary received notice of their potential liability. These denials are shown as provider liability on remittance advices (group code CO) to ensure therapy providers or suppliers explore whether a payment arrangement exists or can be made for the services. Despite this coding limitation, Medicare recognizes that ultimately beneficiaries may be liable for these services.

20.2.1 - Nonroutine Supply Editing

(Rev.1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code. This list *is* updated periodically by Recurring Update Notification. When an HH PPS episode *that has been updated by the receipt of a final claim for the episode* exists at CWF, any claim with a nonroutine supply HCPCS code that is submitted to a DME MAC with *a date* of service that overlap*s* the episode dates will be denied. *Supplies are billed to DME MACs using the professional claim format, in which line items have both a 'from' and 'to' date. The line item 'from' date is used to enforce consolidated billing of nonroutine medical supplies.*

Claims submitted *by providers using the institutional claim format* may include a nonroutine supply HCPCS code in addition to the other services provided. *These supplies (e.g., supplies* for certain emergency, surgical, diagnostic, and end stage renal disease services*)* are either bundled into the rate paid for the primary service or are

otherwise incident to the primary service(s) being rendered, *therefore* these supplies do not fall within the bundling provisions of HH PPS. *As a result, supplies reported on institutional claims* are not subject to consolidated billing edits by CWF.

20.2.2 - Therapy Editing

(Rev.1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

On claims submitted *by providers using the institutional claim format*, CWF enforces consolidated billing for outpatient therapies *by* recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes *are subject to consolidated billing when submitted on types of bill 13x, 23x, 34x, 74x, 75x or 85x*.

On claims submitted by practitioners using the professional claim format, CWF enforces consolidated billing for outpatient therapies using a list of HCPCS codes which represent *therapy* services. This list *is* also updated periodically by Recurring Update Notification.

Therapy services *on professional claims* are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.