CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2694	**Date: May 3, 2013**
	Change Request 8244

SUBJECT: Discontinuation of Home Health Type of Bill 33X

I. SUMMARY OF CHANGES: This CR makes manual section and system changes to conform with the National Uniform Billing Committee's decision to discontinue the use of type of bill 33X.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

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	1/60.4/Noncovered Charges on Outpatient Bills
R	10/10.1.10.4/Claim Submission and Processing
R	10/30.11/Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File
R	10/40.1/Request for Anticipated Payment (RAP)/
R	10/40.2/HH PPS Claims
R	10/40.4/Collection of Deductible and Coinsurance from Patient
R	10/70.1/General
R	10/90/Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)
R	10/90.1/Osteoporosis Injections as HHA Benefit

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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: 2694	Date: May 3, 2013	Change Request: 8244

SUBJECT: Discontinuation of Home Health Type of Bill 33X

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

A. Background: The National Uniform Billing Committee (NUBC) maintains the Type of Bill code set, among others, for use on insitutional claims by the healthcare industry. In 2012, the NUBC voted to revise the Type of Bill codes used for home health claims. The revisions simplify the code set by using one Type of Bill code for all home health services provided under a home health plan of care.

The 033X Type of Bill will no longer be used. The 032X Type of Bill has been redefined to mean "Home Health Services under a Plan of Treatment." This Change Request defines the changes needed for Medicare systems to implement these revisions and updates the home health chapter of Pub. 100-04, Medicare Claims Processing Manual to reflect the new definitions.

B. Policy: Effective for home health episodes beginning on or after October 1, 2013, Original Medicare will no longer accept institutional claims submtted with Type of Bill 033X.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8244.1	Medicare contractors shall return to the provider all RAPs and claims with Type of Bill (TOB) 033X and a statement covers "From" date on or after October 1, 2013.	X					X	X				CEM-A, PS&R
8244.2	Medicare contractors shall implement the home health Part A-Part B Trust Fund payment shift using the visit counts reported in value codes 62 and 63.							X			X	
8244.3	Medicare contractors shall update home health prospective payment system (HH PPS) claims (TOB 032X) as follows to indicate services are to be paid from the Part B Trust Fund during processing that occurs before checking the beneficiary's eligibility : 1. Reflect the total visit count for the claim in a value code 63 amount							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	2. Reflect the total payment amount for the claim in a value code 65 amount 3. Assign the Record Identification Code (RIC) value of 'W.'											
8244.4	Medicare contractors shall ensure that the value codes 62 - 65 and RIC codes on HH PPS claims are consistent with the beneficiary's entitlement to payment from the Part A Trust Fund, the Part B Trust Fund or both.							X			X	
8244.4.1	Medicare contractors shall identify HH PPS claims which indicate Part B payment when the payment should only be made from the Part A Trust Fund.										X	
8244.4.2	Medicare contractors shall update HH PPS claims as follows when the beneficiary's eligibility indicates that services should be paid from the Part A Trust Fund : 1. Remove the value code 63 and value code 65 amounts 2. Reflect the total visit count for the claim in a value code 62 amount 3. Reflect the total payment for the claim in a value code 64 amount 4. Change the Record Identification Code (RIC) value to 'V.'							X				
8244.4.3	Medicare contractors shall identify HH PPS claims which indicate Part B payment when the payment should be made from both the Part A and Part B Trust Funds.										X	
8244.4.4	Medicare contractors shall update HH PPS claims as follows when the beneficiary's eligibility indicates that services should be paid from both the Part A and Part B Trust Funds: 1. Revise the visit count in the value code 63							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	amount to reflect the Part B visits 2. Revise the payment amount in the value code 65 amount to reflect the Part B payment 3. Reflect the visit count for the Part A visits in a value code 62 amount 4. Reflect the payment for the Part A visits in a value code 64 amount 5. Change the Record Identification Code (RIC) value to 'U.'											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8244.5	MLN Article: 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 sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's 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.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8244.1	The new 277 C CEM-A edit shall consist of the following: Edit reference: X223.150.2300.DTP03.030; Disposition/error code: CSCC A7: "Acknowledgement /Rejected for Invalid Information…" CSC 228: "Type of bill for UB claim"; and Proposed 5010 Edit: If the 2300.DTP03 (DTP01 = “434”) “FROM” date is on or after October 1, 2013, 2300.CLM05-1 must not = “33”. Note that the new CEM-A edit for this CR will appear on the January 2014 edits spreadsheet.

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

60.4 - Noncovered Charges on Outpatient Bills

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The term "outpatient" is often used very generally. *In this section, the term "outpatient" uses the designation of types of bill as inpatient or outpatient as defined in the National Uniform Billing Committee*.

TABLE: ***Original Medicare Types of Bill – Inpatient or Outpatient.***

Designation	***Types of Bill Paid by Original Medicare***	***Medicare Trust Fund Payment***
Inpatient	*11x – Hospital* *18x – Swing Bed* *21x – Skilled Nursing Facility (SNF)* *41x – RNHCI – Religious Non-Medical Health Care Institution*	*Part A*
Outpatient	*81x, 82x – Hospice*	*Part A*
	32x, – Home Health (HH) Services under a Plan of Treatment	*Part A and Part B*
	12x, 13x, 14x – Hospital *22x, 23x – SNF* *34x – HH Services not under a Plan of Treatment* *71x – RHC – Rural Health Clinic* *72x – RDF – Renal Dialysis Facility* *74x – OPT – Outpatient Physical Therapy (Rehabilitation Agency)* *75x – CORF – Comprehensive Outpatient Rehabilitation Facility* *76x – CMHC – Community Mental Health Center* *77x – FQHC – Federally Qualified Health Center* *85x – Critical Access Hospital (CAH)*	*Part B*

Note that under these designations, types of bill 12X and 22X which are referred to as "inpatient Part B," are designated as outpatient. Also, hospice claims are designated as outpatient while they can report both inpatient and outpatient levels of care.

10.1.10.4 - Claim Submission and Processing

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The remaining split percentage payment due to an HHA for an episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services are provided for the episode and the physician has signed the plan of care and any subsequent verbal order. Signed orders are required every time a claim is submitted, no matter what payment adjustment may apply.

HH claims must be submitted with type of bill (TOB) 329. The HH PPS claim will include elements submitted on the RAP, and all other line item detail for the episode. At a provider's option, any durable medical equipment, oxygen or prosthetics, and orthotics provided may also be billed on the HH PPS claim, and this equipment will be paid in addition to the episode payment.

However, osteoporosis drugs must be billed separately on 34X claims, even when an episode is open. Payment for bill type 34X is dependent upon the Part B methodology used for the service, as defined by the HCPCS code.

An HH PPS claim with TOB 329 is processed in Medicare claims processing systems as a debit/credit adjustment against the record created by the RAP. The related remittance advice will show the RAP payment was recouped in full and a 100 percent payment for the episode was made on the claim, resulting in a net remittance of the balance due for the episode.

Claims for episodes may span calendar and fiscal years. The RAP payment in one calendar or fiscal year is recouped and the 100 percent payment is made in the next calendar or fiscal year, at that year's rates, since claim payment rates are determined using the Statement Covers Period "Through" date on the claim, for all services in the episode.

Once the final payment for an episode is calculated, Medicare claims processing systems will determine whether the claim should be paid from the Medicare Part A or Part B trust fund. This A-B shift determination will be made only on claims, not on RAPs. HHA payment amounts are not affected by this process. Value codes for A and B visits (value codes 62 and 63) and dollar amounts (64 and 65) may be visible to HHAs on electronic claim remittance records, but providers do not submit these value codes or determine to distinguish Part A or Part B visits.

30.11 - Exhibit: Chart Summarizing the Effects of RAP/Claim Actions on the HH PPS Episode File

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The following chart summarizes basic effects of HH PPS claims processing on the episode record:

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Initial RAP	• Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Subsequent Episode RAP	• Opens another subsequent episode using RAP's "from"	• Other RAPs submitted during this open episode will be rejected unless an

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
	date to set Period Start Date • Period End Date is automatically calculated to extend through next 60 days • DOEBA and DOLBA are left blank	indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Initial RAP with condition code 47	• Opens an episode record using RAP's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA and DOLBA are left blank • The Period End Date *is automatically changed to reflect* the RAP's "from" date.	• The Period End Date on the RAP of the HHA the beneficiary is transferring from is automatically changed to reflect the "from" date on the RAP submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer situation occurs
RAP Cancellation by Provider or Contractor	• The episode record is deleted from CWF	• No episode record is present to prevent RAP submission or No-RAP LUPA claim submission by another provider, making that provider the primary HHA for the dates of the episode
RAP Cancellation by System	• The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • In order to receive payment for this episode, the original RAP must be resubmitted before the final claim is submitted • To correct information on this RAP, the original RAP must be cancelled by the HHA and then re-submitted once more with the correct information
Claim (full episode)	• 60-day episode record is completed; • Period End Date remains at the 60th day • DOEBA is updated to reflect first visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
	• DOLBA is updated to reflect last visit date in episode	
Claim (discharge with goals met prior to Day 60)	• Episode record completed • Period End Date remains at the 60th day; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present
Claim (transfer)	• Episode record completed • Period End Date reflects claim "Through" date; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• A RAP or No-RAP LUPA claim will be accepted if the "from" date is on or after episode "through" date
No-RAP LUPA Claim	• Opens an episode record using claim's "from" date to set Period Start Date • Period End Date is automatically calculated to extend through 60th day • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present • Other No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present • Because a RAP is not submitted in this situation until the No-RAP LUPA claim is submitted, another provider can open an episode by submitting a RAP or by submitting a No-RAP LUPA Claim
Claim Adjustment	• No impact on the episode unless adjustment changes patient status to transfer or service lines are added or removed to change the DOEBA or DOLBA date.	• No impact
Claim Cancellation by Provider or Contractor	• The episode is deleted from CWF	• No episode exists to prevent RAP submission or No-RAP LUPA claim submission by another provider, making that provider the primary HHA for the dates of the episode
Claim Cancellation by System	• The episode record remains open on CWF	• Other RAPs submitted during this open episode will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
		• No-RAP LUPA claims will be rejected unless an indicator of a transfer or discharge/readmission is present

40.1 - Request for Anticipated Payment (RAP)

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

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

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

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

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

Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity.

Patient Control Number

Optional - The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

Type of Bill

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

032x - Home Health Services under a Plan of Treatment

4th Digit	**Definition**
2-Interim-First Claim	For HHAs, used for the submission of original or replacement RAPs.
8-Void/Cancel of a Prior Claim	Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP must be submitted for the episode to be paid. If a

	RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted.

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

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

Statement Covers Period (From-Through)

Required - Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.).

Patient Name/Identifier

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

Patient Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

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

Left blank if the full correct date is not known.

Patient Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

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

Point of Origin for Admission or Visit

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

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

Patient Discharge Status

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

Condition Codes

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

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

If canceling the RAP (TOB 3X8), the agency reports one of the following:

Claim Change Reasons

Code	Title	Definition
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

Enter "Remarks" indicating the reason for cancellation.

Occurrence Codes and Dates

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

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

Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.

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

Revenue Code and Revenue Description

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

Revenue Code	Description
0023	HIPPS - Home Health PPS

The 0023 code is not submitted with a charge amount.

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

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

HCPCS/Accommodation Rates/HIPPS Rate Codes

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

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

Service Date

Required - On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

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

Service Units

Required – Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the RAP. If additional revenue codes are submitted on the RAP, the HHA reports service units as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Total Charges

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

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

Payer Name

Required - See Chapter 25.

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

Release of Information Certification Indicator

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

National Provider Identifier – Billing Providers

Required - The HHA enters their provider identifier.

Insured's Name

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

Insured's Unique Identifier

Required - See Chapter 25.

Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX
9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA

9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

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

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format.

Document Control Number (DCN)

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

Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-CM code and principle diagnosis reported on the claim must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis.

For other diagnoses, the diagnoses and ICD-9-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). 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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

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

Remarks

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

40.2 - HH PPS Claims

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

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. Payment for this episode will usually be made in two parts. After a RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

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 remittance advice (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. Medicare contractors 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 Medicare contractor 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 requests for anticipated payment 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." Medicare contractors 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

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. The patient status code must be 30 in these cases.

In cases where the beneficiary has been discharged or transferred within the 60-day episode 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."

Any NUBC approved patient status code may be used in these cases. 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 60-day episode 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 partial episode payment (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 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 60-day episode. 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 Medicare contractor to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each contractor. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the contractor 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 contractor.

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.

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 3X8), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

Conditional - The HHA enters any 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 episodes in which the beneficiary's site of service changes from one CBSA to another within the episode period, HHAs should submit the CBSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: Contractor-entered value codes. The Medicare contractor enters codes 17 and 62 - 65 on the claim in processing. They may be visible in the Medicare contractor's online claim history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Contractors 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 -	The dollar amounts determined to be associated

Code	Title	Definition
	Part B	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 Common Working File (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. The fifth position of the code represents the non-routine supply (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. 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: Contractors 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 Durable Medical Equipment (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 Medicare contractor 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 CMS' 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

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 5th position of the HIPPS code. The 5th 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 5^{th} position containing the letters S through X, the claim must also report a non-routine supply revenue 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 5th 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 Medicare contractor 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. 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 revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code.

To report HH visits on episodes beginning before January 1, 2011, the HHA reports a single HCPCS code to represent a visit by each HH care discipline. These codes are:

G0151 Services of physical therapist in home health or hospice setting, each 15 minutes.

G0152 Services of an occupational therapist in home health or hospice setting, each 15 minutes.

G0153 Services of a speech language pathologist in home health or hospice setting, each 15 minutes.

G0154 Services of skilled nurse in the home health or hospice settings, each 15 minutes.

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

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

To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports one of the following HCPCS code 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.

<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.

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.

G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Skilled Nursing (revenue code 055x)

G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

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).

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.

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 (NO)

The location where services were provided must always be reported along with the first billable visit in an HH PPS episode. 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 - On the 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. 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.

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. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

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 - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element enables historical claims data to be linked to individual OASIS assessments supporting the payment of individual claims for research purposes. It is also used in recalculating payment group codes in the HH Pricer (see section 70).

The format of the treatment authorization code is shown here:

Position	Definition	Format
1-2	M0030 (Start-of-care date) – 2 digit year	99
3-4	M0030 (Start-of-care date) – alpha code for date	XX
5-6	M0090 (Date assessment completed) – 2 digit year	99
7-8	M0090 (Date assessment completed) – alpha code for date	XX

9	M0100 (Reason for assessment)	9
10	M0110 (Episode Timing) – Early = 1, Late = 2	9
11	Alpha code for Clinical severity points – under Equation 1	X
12	Alpha code for Functional severity points – under Equation 1	X
13	Alpha code for Clinical severity points – under Equation 2	X
14	Alpha code for Functional severity points – under Equation 2	X
15	Alpha code for Clinical severity points – under Equation 3	X
16	Alpha code for Functional severity points – under Equation 3	X
17	Alpha code for Clinical severity points – under Equation 4	X
18	Alpha code for Functional severity points – under Equation 4	X

NOTE: The dates in positions 3-4 and 7-8 are converted to 2 position alphabetic values using a hexavigesimal coding system. The 2 position numeric point scores in positions 11 – 18 are converted to a single alphabetic code using the same system. Tables defining these conversions are included in the documentation for the Grouper software that is available on the CMS Web site.

Position	Definition	Actual Value	Resulting Code
1-2	M0030 (Start-of-care date) – 2 digit year	2007	07
3-4	M0030 (Start-of-care date) – code for date	09/01	JK
5-6	M0090 (Date assessment completed) – 2 digit year	2008	08
7-8	M0090 (Date assessment completed) – code for date	01/01	AA
9	M0100 (Reason for assessment)	04	4
10	M0110 (Episode Timing)	01	1
11	Clinical severity points – under Equation 1	7	G
12	Functional severity points – under Equation 1	2	B
13	Clinical severity points – under Equation 2	13	M
14	Functional severity points – under Equation 2	4	D
15	Clinical severity points – under Equation 3	3	C
16	Functional severity points – under Equation 3	4	D
17	Clinical severity points – under Equation 4	12	L
18	Functional severity points – under Equation 4	7	G

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

The treatment authorization code that would appear on the claim would be, in this example: 07JK08AA41GBMDCDLG.

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.

The claims-OASIS matching key on the claim will match that submitted on the RAP.

Medicare systems validate the length of the treatment authorization code and ensure that each position is in the correct format.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) 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-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9-CM code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).

The principal diagnosis code on the claim will match that submitted on the RAP.

Other Diagnosis Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight 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.

For other diagnoses, the diagnoses and ICD-9-CM codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses). 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-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9-CM guidelines.

Diagnosis codes in OASIS form item M1024, which reports Payment Diagnoses, are not directly reported in any field of the claim form. If under ICD-9-CM coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M1022 and will be reported on the claim. In other circumstances, the codes reported in payment diagnosis fields in OASIS may not appear on the claim form at all.

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician who has signed the plan of care.

Remarks

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

40.4 - Collection of Deductible and Coinsurance from Patient

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The following table is a summary of deductible and coinsurance by bill type:

Bill Type	Rule
Patient Under Home Health Plan of Care (Bill Type 32X)	No deductible applicable; and No coinsurance applicable Exception: Coinsurance applies on DME and orthotic/prosthetic claims.
Patient Not Under HH Plan of Care, Part B Medical and Other Health Services and Osteoporosis Injections (Bill Type 34X)	Deductible applies; and Coinsurance applies Exception: Deductible and coinsurance may be waived for certain preventive services (see chapter 18)

There is usually no requirement for Part B deductible or coinsurance under a home health plan of care. An exception to this rule applies to osteoporosis injections where a Part B deductible and coinsurance must be collected, even if the drug is provided under a plan of care.

Where deductible and coinsurance apply for Part B medical and other health services **not** covered under a plan of care, the HHA collects the amount of any unmet deductible from the patient. To determine this amount the HHA interviews the patient. If the patient is unable to conduct their own affairs, the HHA interviews a member of the patient's family or other acceptable representative.

Another exception is the services paid under the DMEPOS fee schedule.

The following rules apply to payment and patient liability for DME and prosthetics and orthotics when furnished by an HHA not under PPS.

According to Federal regulations found in 42 CFR 410.2, a nominal charge provider means a provider that furnishes services free of charge or at a nominal charge, and is either a public provider or another provider that (1) demonstrates to CMS' satisfaction that a significant portion of its patients are low-income; and (2) requests that payment for its services be determined accordingly.

70.1 - General

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

Home health services billed on TOB 32X are reimbursed based on calculations made by the HH Pricer. The HH Pricer is a module within CMS' claims processing systems. The HH Pricer makes all payment calculations applicable under HH PPS, including percentage payments on requests for anticipated payment (RAPs), claim payments for full episodes of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial episode payment (PEP) adjustments, therapy threshold adjustments, and outlier payments.

Medicare claims processing systems must send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the shared systems. The following sections describe the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make payment determinations. No part of the Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare. The following is presented for Medicare contractors and as information for the HHAs, in order to help HHAs understand their HH PPS payments and how they are determined.

90 - Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

HHAs may submit claims for certain Part B medical and other health services for which the HHA may receive payment outside of the prospective payment system (See *Pub. 100-02*, Medicare Benefit Policy Manual, chapter 7).

A Patient Not Under A Home Health Plan Of Care

The HHA submits claims with type of bill (TOB) 34X to bill for certain Part B "medical and other health services" when there is no home health plan of care. Specifically the HHA may bill using TOB 34X for the following services. (There must be a physician's certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Rental or purchase of DME. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Prosthetic devices. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.
- Outpatient physical therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient speech-language pathology services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Diabetes Outpatient Self-Management Training (DSMT). (See the Medicare Benefit Policy Manual, chapter 15, section 300.5.1)
- Bone Mass Measurements. (See the Medicare Claims Processing Manual, chapter 13, section 140.)
- Smoking and Tobacco-Use Cessation Counseling Services. (See the Medicare Claims Processing Manual, chapter 32, section 12.)

Bills for services not under a home health plan of care should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g., monthly, without regard to an episode of care. These items are not reimbursed under HH PPS.

B The Patient is Under a Home Health Plan of Care

If a patient is receiving home health services under a plan of care, the agency may bill for the following services on TOB 34X. All other services are home health services and should be billed as an HH PPS episode with Bill Type 32X.

- A covered osteoporosis drug, and
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines.

DME, orthotic, and prosthetics can be billed as a home health service *using type of bill 32X* or as a medical and other health service *using type of bill 34X* as appropriate. Alternately, these services may be provided to HH beneficiaries by a supplier. Refer to instructions in chapter 20 of this manual for submitting claims under arrangement with suppliers.

C Billing Spanning Two Calendar Years

The agency should not submit a Part B medical and other health services bill (bill type 34X only) for an inclusive period beginning in 1 calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits the contractor to apply the appropriate deductible for both years. HH PPS claims (TOB 32X) may span the calendar year since they represent 60-day episodes, and episodes should be paid based on the payment rates in effect in the calendar year in which they end.

D Billing For Laboratory Services

HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not report laboratory services, even when on the HH plan of care, to a Medicare contractor using an institutional claim format. These services are always billed to Medicare contractors using a professional claim format. To submit such claims, the HHA must have a CLIA number and a professional billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate contractor to obtain a billing number. The survey process is used to validate that laboratory services in an HHA facility are being provided in accordance with the CLIA certificate.

90.1 - Osteoporosis Injections as HHA Benefit

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

A - Billing Requirements

The administration of the drug is included in the charge for the skilled nursing visit billed *using type of bill* 32X. The cost of the drug is billed *using type of bill* 34X, using revenue code 0636. Drugs that have the ingredient calcitonin are billed using HCPCS code J0630. Drugs that have the ingredient teriparatide may be billed using HCPCS code J3110, if all existing guidelines for coverage under the home health benefit are met. All other osteoporosis drugs that are FDA approved and are awaiting an HCPCS code must use the miscellaneous code of J3490 until a specific HCPCS code is approved for use.

HCPCS code J0630 is defined as up to 400 units. Therefore, the provider must calculate units for the bill as follows:

Units Furnished During Billing Period	Units of Service Entry on Bill
100-400	1
401-800	2
801-1200	3
1201-1600	4
1601-2000	5
2001-2400	6

HCPCS code J3110 is defined as 10 mcg. Providers should report 1 unit for each 10 mcg dose provided during the billing period.

These codes are paid on a reasonable cost basis, using the provider's submitted charges to make initial payments, which are subject to annual cost settlement.

Coverage requirements for osteoporosis drugs are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 50.4.3. Coverage requirements for the home health benefit in general are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.

B - Denial Messages

If the claim for an osteoporosis drug is denied because it was not an injectable drug approved by the FDA, the Medicare contractor shall use the appropriate message below on the MSN:

- MSN Message 6.2: "Drugs not specifically classified as effective by the Food and Drug Administration are not covered."

If the claim for an osteoporosis injection is denied because the patient did not meet the requirements for coverage, the Medicare contractor shall use:

- MSN message 6.5, which reads, "Medicare cannot pay for this injection because one or more requirements for coverage were not met."

C - Edits

Medicare system edits require that the date of service on a 34X claim for covered osteoporosis drugs falls within the start and end dates of an existing home health PPS episode. Once the system ensures the service dates on the 34X claim fall within an HH PPS episode that is open for the beneficiary on CWF, CWF edits to assure that the provider number on the 34X claim matches the provider number on the episode file. This is to reflect that although the osteoporosis drug is paid separately from the HH PPS episode rate it is included in consolidated billing requirements (see §10.1.25 regarding consolidated billing).

Claims are also edited to assure that the claim is an HH claim (type of bill 34X), the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present.