CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12577	**Date: April 11, 2024**
	Change Request 13543

SUBJECT: Additional Enforcement of Required County Codes on Home Health Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create an edit in Original Medicare systems to ensure required county codes are reported on all home health claims.

EFFECTIVE DATE: October 1, 2024 - Claims processed on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.1.10.3/Submission of the Notice of Admission (NOA)
R	10/40.2/HH PPS Claims

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12577	Date: April 11, 2024	Change Request: 13543

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to create an edit in Original Medicare systems to ensure required county codes are reported on all home health claims.

Section 50208 Bipartisan Budget Act (BBA) of 2018 required that "in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished." The National Uniform Billing Committee created value code 85 defined "County Where Service is Rendered" effective January 1, 2019, to enable home health agencies and Medicare to meet this requirement. Original Medicare billing instructions have required reporting value code 85 on all Home Health Prospective Payment System (HH PPS) claims (Type of Bill (TOB) 032x) since January 1, 2019. However, enforcement edits in Medicare systems returned claims to the provider when value code 85 was absent only when a rural add-on payment adjustment applied to the claim.

A recent report (A-05-20-00031) from the Office of Inspector General (OIG) noted that county code reporting on HH PPS claims was incomplete and recommended Medicare edit claims to ensure the county code is present on all claims. OIG noted that the Social Security Act at 1895(c)(3) retains a permanent requirement to report the county code on all home health claims regardless of whether a rural add-on payment adjustment is in effect.

This CR creates an edit in the Fiscal Intermediary Shared System (FISS) to require the presence of value code 85 and a Federal Information Processing System (FIPS) county code on all claims with Type of Bill 032x. Such an edit is consistent with how Medicare has implemented the other statutory payment information requirements for HH PPS claims, such as 1985(c)(2) for 15-minute increment reporting of home health visits.

This CR also makes clarifications to home health billing instructions regarding Notice of Admission timeliness exceptions, charge reporting for telehealth visits and diagnosis code reporting.

B. Policy: This CR contains no new policy. It improves enforcement of an existing statutory requirement.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13543.1	The contractor shall return to the provider home health claims (TOB 032x other than 032A or 032D) if value code 85 and a corresponding FIPS state and county code value are not present.			X		X				
13543.1.1	The contractor shall ensure editing for the presence of value code 85 on all home health claims is performed before the claim is sent to the HH Pricer.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13543.2	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.			X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
13543.1	The current list of FIPS state and county codes is available at www.census.gov/geographies/reference-files/2022/demo/popest/2022-fips.html.
13543.1.1	Existing editing (return code 31) for valid FIPS code values when a rural CBSA code is present will continue to be performed by the HH Pricer.

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

V. CONTACTS

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

10.1.10.3 - Submission of the Notice of Admission (NOA)

(Rev. 12577; Issued: 04-11-24, Effective:10-01-24; Implementation: 10-07-24)

For each admission to home health, the HHA notifies Medicare systems via submission of a Notice of Admission (NOA).

HHAs shall send the NOA to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE). EDI submissions require additional data not required by the NOA itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website. HHAs may voluntarily agree to adopt the companion guide and use it to submit EDI NOAs at any time.

The HHA can submit an NOA to Medicare when:

- The HHA has obtained a verbal or written order from the physician that contains the services required for the initial visit, and
- The HHA has conducted an initial visit at the start of care.

Only one NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims.

NOAs must be submitted timely. A timely-filed NOA is submitted to and accepted by the A/B MAC (HHH) within five calendar days after admission date.

In instances where an NOA is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payment, by the number of days from the home health admission date to the date the NOA is submitted to, and accepted by, the A/B MAC (HHH), divided by 30. No LUPA per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

If an HHA fails to file a timely-filed NOA, it may request an exception, which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;

2. an event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the HHA;

3. a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or,

4. other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA.

When an NOA is submitted within the five day timely filing period, but the NOA contains inadvertent errors (such as a beneficiary identifier that has recently changed), the error may not trigger the NOA to be immediately returned to the HHA for correction. In these instances, the HHA must wait until the incorrect information is fully processed by Medicare systems before the NOA is returned for correction. Such delays in Medicare systems could cause the NOA to be late. Delays due to Medicare system constraints are outside the control of the HHA and may qualify for an exception to the timely filing requirement.
Medicare contractors shall grant an exception for the late NOA if the HHA is able to provide documentation showing:

(1) When the original NOA was submitted;
(2) When the NOA was returned for correction or was accepted and available for correction and;
(3) Evidence the HHA resubmitted the returned NOA within two business days of when it was available for correction or cancelled an accepted NOA within two business days and submitted the new NOA within two business days after the date that the cancellation NOA finalized.
The HHA shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the case. If the remarks are not sufficient, Medicare contractors shall request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above.
HHAs can reduce the number of errors and exception requests related changes to the beneficiary identifier by performing an eligibility check immediately before admission. This can confirm that the Medicare Beneficiary Identifier (MBI) is active and accurate since the eligibility inquiry system contains an MBI End Date field. If there is a date in that field, the MBI is not valid after that date. The HHA can contact the beneficiary or use the MBI Lookup tool to determine the current MBI to use on the NOA.

Since correct beneficiary identifier information is available to the HHA, only changes that occur shortly before the admission are beyond the HHA's control. A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the HHA more than two weeks prior to the admission date.

An admission period will be opened on CWF with the receipt and processing of the NOA. NOAs are submitted using TOB 032A. After this admission period is recorded, the HHA can submit claims for HH periods of care in the admission.

See section 40.1 for detailed submission instructions and required information for the NOA.

40.2 - HH PPS Claims

(Rev. 12577; Issued: 04-11-24, Effective:10-01-24; Implementation: 10-07-24)

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 30-day period of care. HHAs submit an NOA at the beginning of an admission and then submit one claim for each 30-day period of care. Claims submitted before an NOA has been received for the beneficiary will be returned to the provider.

Billing Provider Name, Address, and Telephone Number

Required – The HHA's minimum entry is the agency's name, city, state, and ZIP Code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. A/B MACs (HHH) use this information in connection with the provider identifier to verify provider identity.

Patient Control Number and Medical/Health Record Number

Required - The patient's control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

The HHA may enter the number assigned to the patient's medical/health record. If this number is entered, the A/B MAC (HHH) must carry it through their system and return it on the remittance record.

Type of Bill

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

032x - Home Health Services under a Plan of Treatment

4th Digit - Definition

> 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.
>
> 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement claim must be submitted for the period of care to be paid.
>
> 9 - Final Claim for an HH PPS Period – This code indicates an HH original bill to be processed following the submission of an HH PPS Notice of Admission (TOB 032A)

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

Statement Covers Period

Required - The beginning and ending dates of the period covered by this claim. For continuous care periods, the "through" date must be 29 days after the "From" date for a 30-day period of care

In cases where the beneficiary has been discharged or transferred within the period, HHAs will report the date of discharge in accordance with internal discharge procedures as the "through" date. If the beneficiary has died, the HHA reports the date of death in the "through date."

The HHA may submit claims for payment immediately after the claim "through" date. It is not required to hold claims until the end of the period of care 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 a date of admission matching the From date on the first period of care in an admission. On subsequent periods of care, the HHA continues to submit the admission date reported on the first period of care.

Point of Origin for Admission or Visit

Required - The HHA enters the appropriate NUBC point of origin code.

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 period of care will be paid a partial period payment adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 30-day period, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the period. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the partial period payment adjustment, changing the patient status code on the paid claims record to 06.

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, all periods of care with “from” dates before the termination date of the CCN that would extend beyond the termination date must be resolved by the provider submitting claims with “through” dates on or before the termination date. The provider must code the claim with 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 is 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 provider must code the claim 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.

In cases where an HHA provides care in a 30-day period of care and then discharges the beneficiary in the next 30-day period of care, but does not provide any billable visits in the next 30-day period, special handling of the patient status code may be needed. Normally, the patient status code for 30-day period before the discharge would be 30, since the beneficiary has not yet been discharged. However, since there will not be a claim for the period in which the discharge occurred, this would result in the HH admission period remaining open in Medicare systems and prevent billing for any later HH services.

In order to close the HH admission period in these cases, the HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. This will trigger Medicare systems to close the HH admission period. If the claim has been submitted with patient status 30 before the discharge occurred, the HHA should adjust the claim to change the patient status to 01.

If the cause of the discharge in the next 30-day period is a transfer to another HHA before any visits were provided, the HHA should take care not to report patient status 06 on the claim. This would result in an

incorrect partial period payment adjustment. If the cause of the discharge in the next 30-day period is the beneficiary's death, the HHA should take care not to report patient status 20 on the claim. This would result in an incorrect date of death being recorded in Medicare systems and potentially affect claims from other providers.

Condition Codes

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

If the claim is for a patient transferred from another HHA, the HHA enters condition code 47.

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

As a result of disaster conditions (such as hurricane or wildfire) that render submission of OASIS assessments impossible, Medicare may issue a waiver indicating OASIS submission is waived. In this case, HHAs should report condition code DR on their claim to indicate billing under the waiver. Since the OASIS assessment cannot be submitted, the HHA cannot report occurrence code 50 to show the assessment completion date. Claims without occurrence code 50 will be accepted if condition code DR is present.

When a provider is unable to submit a start of care OASIS for an admission period of care, they should submit the HIPPS code weighted closest to 1. For a period of continuing care, when a provider is unable to submit a follow-up OASIS, they should carry forward the last HIPPS code generated from the previous OASIS.

If as a result of disaster conditions, OASIS submission timeframes are relaxed, HHAs should submit claims without condition code DR as soon as the OASIS was submitted. In this case, matching OASIS assessment information and the occurrence code 50 date are required to ensure Medicare pays the claim accurately.

HHAs that are adjusting previously paid claims enter one of the condition codes representing Claim Change Reasons (code values D0 through E0). If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" indicating the reason for the HIPPS code change. HHAs use D9 if multiple changes are necessary.

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

When submitting an HH PPS claim for a denial notice, HHAs use condition code 21. See §60 for more detailed instructions regarding no-payment billing.

Required - If canceling the claim (TOB 0328), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

Required – The HHA enters occurrence code 50 and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090). If occurrence code 50 is not reported on a claim or adjustment, the claim will be returned to the provider for correction, unless condition code DR is present to indicate a waiver of OASIS reporting is in effect.

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

Code	Short Descriptor	Long Descriptor

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

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

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

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

Conditional - The HHA enters any other NUBC approved code to describe occurrences that apply to the claim.

Occurrence Span Code and Dates

Conditional - The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission.

Value Codes and Amounts

Required - Home health payments must be based upon the site at which the beneficiary is served, *as described by a CBSA code.* For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. *Value codes reporting both the CBSA and the State and County code where the beneficiary received home health services are required on all claims.*

For periods of care in which the beneficiary's site of service changes from one CBSA or county to another within the period, HHAs should submit the CBSA code or State and County code corresponding to the site of service at the end of the period.

Provider-submitted codes:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS)

Code	Title	Definition
		State and County Code of the place of residence where the home health service is delivered.

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

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. A/B MACs (HHH) always place condition code 61 on the claim along with this value code.
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
QF	Late-filed NOA penalty amount	The dollar amount that the claim payment was reduced due to the NOA being filed more than 5 days after the HH From date.
QV	Value-based purchasing adjustment amount	The dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. May be a positive or a negative amount.

If information returned from the CWF indicates all visits on the claim are Part A, the shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate

the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

HH PPS claims must report a 0023 revenue code line which contains a HIPPS code. HHAs enter only one 0023 revenue code per claim in all cases.

Claims must also report all services provided to the beneficiary within the period of care. All services must be billed on one claim for the entire period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.

Each service must be reported in line item detail. Each service visit (revenue codes 042x, 043x, 044x, 055x, 056x and 057x) must be reported as a separate line. Any of the following revenue codes may be used:

027x	Medical/Surgical Supplies (Also see 062x, an extension of 027x) Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS claims.
042x	Physical Therapy Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043x	Occupational Therapy Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
044x	Speech-Language Pathology Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

055x	Skilled Nursing Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
056x	Medical Social Services Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
057x	Home Health Aide (Home Health) Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: A/B MACs (HHH) will return claims to the provider if revenue codes 058x or 059x are submitted with covered charges on Medicare home health claims. They also return to the provider if revenue code 0624, investigational devices is reported on HH claims

Revenue Codes for Optional Billing of DME

Billing of DME provided in the period of care is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their A/B MAC (HHH) processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20 of this manual.

0274	Prosthetic/Orthotic Devices Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.
029x	Durable Medical Equipment (DME) (Other Than Renal) Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.
060x	Oxygen (Home Health) Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

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

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation "surg dressings," HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, defines routine vs. nonroutine supplies. HHAs use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

HHAs can assist Medicare's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027x for nonroutine supplies are also complete and accurate.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code in order to meet this requirement.

HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.

Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changes based on medical review or other processes, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code. The G- and Q- HCPCS codes listed below are for use by HHAs on Type of Bill 032x only. Claims with these HCPCS codes will be returned to the provider if submitted with Type of Bill 034x.

To report HH visits, the HHA reports one of the following HCPCS codes to represent a visit by each HH care discipline:

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

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.

G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.

G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

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

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

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.

G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

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

Speech-Language Pathology (revenue code 044x)

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

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

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

Skilled Nursing (revenue code 055x)

General skilled nursing:

G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting

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

Care plan oversight:

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).

G0493 Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

G0494 Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

Training:

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

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

Medical Social Services (revenue code 056x)

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

Home Health Aide (revenue code 057x)

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

Regarding all skilled nursing and skilled therapy visits

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

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, Medicare would expect the HHA to report the G-code which reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code that reflects the service for which most of the time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

Telehealth Service Reporting

Beginning on or after January 1, 2023, HHAs may voluntarily report the use of telecommunications technology in the provision of home health services on claims. This information is required on home health claims beginning on July 1, 2023. HHAs shall submit the use of telecommunications technology when furnishing home health services, on the home health claim via three G-codes.

G0320: home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system

G0321: home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system

G0322: the collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring).

HHAs shall submit services furnished via telecommunications technology in line item detail *and with covered charges*. Each service must be reported as a separately dated line under the appropriate revenue code for each discipline furnishing the service. Two occurrences of G0320 or G0321 on the same day for the same revenue code shall be reported as separate line items *with the same date of service and with service units reporting 1. Services furnished via telecommunications technology are not considered by Medicare systems when enforcing requirements for matching visit dates on home health claims.*

The use of remote patient monitoring that spans a number of days shall be reported as a single G0322 line item reporting the beginning date of monitoring and the number of days of monitoring in the service units field. If more than one discipline is using the remote monitoring information during the billing period, the HHA may choose which revenue code to report on the remote monitoring line item.

Claims with no billable visits are not submitted to Mediare, including claims for billing periods where only telehealth services are provided.

Site of Service Reporting

HHAs must report where home health services were provided. The following codes are used for this reporting:

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

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

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

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

Disposable Negative Pressure Wound Therapy Services

Effective for claims with statement covers Through dates on or after January 1, 2024, Medicare makes a separate payment amount for a disposable negative pressure wound therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the supply price used to determine the relative value for the service under the Medicare Physician Fee Schedule (as of January 1, 2022) for the applicable disposable device and updated by the consumer price index for all urban consumers minus the productivity adjustment for each future year.

Disposable NPWT services are billed using the following HCPCS code:

- A9272 - wound suction, disposable, includes dressing, all accessories and components, any type, each.

The HHA reports the HCPCS code with revenue code 027x (other than 0274), units representing the number of disposable devices provided during the billing period and a charge amount. Since Medicare payment no longer includes the services of the practitioner applying the device, revenue codes 042x, 043x or 0559 are not used for dNPWT HCPCS codes on Type of Bill 032x.

Modifiers

If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 10.1.10.3), append modifier KX to the HIPPS code reported on the revenue code 0023 line.

Service Date

Required - For initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the period. Claims and provider-submitted adjustments where the Admission Date and From Date match but the 0023 revenue code line date does not also match are returned to the provider. Contractor-submitted adjustments are excluded from this edit.

For subsequent periods, the HHA reports on the 0023 revenue code the date of the first visit provided during the period, regardless of whether the visit was covered or non-covered.

For other line items detailing all services within the period, the HHA reports service dates as appropriate to that revenue code. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

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

Service Units

Required - Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the claim. For line items detailing all services within the period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes.

For the revenue codes that represent home health visits (042x, 043x, 044x, 055x, 056x, and 057x), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported.

Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. If any visits report over 96 units (over 24 hours) on a single line item, Medicare systems return the claim returned to the provider.

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

Telehealth services with HCPCS codes G0320 or G0321 are reported with units of 1.

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 period of care, 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

Conditional - Treatment authorization codes are not required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 0327) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Employer Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Principal Diagnosis Code

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

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

Other Diagnosis Codes

Required - The HHA enters the full diagnosis codes for additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may not duplicate the principal diagnosis as an additional or secondary diagnosis.

In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

The following instructions apply to both Principal and Other Diagnosis Code reporting.

Diagnosis coding and claim dates:

Diagnosis codes that reflect the patient's condition as of the start of a period of care *(the claim From date)* are reflected on the claim for the current period of care. Diagnosis codes that reflect a change in the patient's condition during a period of care should be reflected on the claim for the next period.

ICD diagnosis codes are updated each year on October 1 and April 1. While the claim describes the patient's condition as of the From date, if the claim Through date spans across an ICD update, the codes that are valid after the update are reported on the claim.

For example, the HHA submits a claim spanning September 15, 2023 to October 14, 2023, for a patient that has Parkinson's Disease as a secondary diagnosis, The code in effect on September 15, 2023 is G20 (Parkinson's Disease) but effective October 1, the code that applies to the patient's condition changed to G20.C (Parkinsonism, unspecified). The G20.C code is reported on the claim.

The version of the HH Grouper logic applied to each claim is determined is based on the claim From date. In the case of a claim with a From date of September 15, 2023 and Through date of October 14, 2023, the Grouper applies the logic and codes in effect for dates of service before September 30, 2023 and not the logic and codes effective October 1. When a diagnosis code changes as describe above, the HH Grouper maps the new code back to its predecessor code to correctly determine the case-mix scoring and the HIPPS code for the claim (e.g. maps G20.C back to G20 and uses the G20 code to assign the HIPPS code).

Claim and assessment diagnosis codes:

The diagnosis codes used for payment grouping are determined from claim coding rather than the OASIS assessment. As a result, the claim and OASIS diagnosis codes are not expected to match in all cases.

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

Attending Provider Name and Identifiers

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

Other Provider (Individual) Names and Identifiers

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

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

Remarks

Conditional – If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 10.1.10.3), enter information supporting the exception category that applied to the NOA.

The HHA shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the case. If the remarks are not sufficient, Medicare contractors shall request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above.

Medicare contractors shall not grant exceptions if:
• the HHA can correct the NOA without waiting for Medicare systems actions
• the HHA submits a partial NOA to fulfill the timely-filing requirement, or
• HHA with multiple provider identifiers submit the identifier of a location that did not actually provide the service

In the great majority of cases, the five day timely filing period allows enough time to submit NOAs on a day when Medicare systems are available (i.e. the period allows for ("dark days"). Additionally, the receipt date is typically applied to the NOA immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, if the HHA can provide documentation showing an NOA is submitted on the day before a dark day period and the NOA does not receive a receipt date until the day following the dark days, the contractor shall grant an exception to the timely filing requirement. CMS expects these cases to be very rare.

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