CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 481

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: FEBRUARY 25, 2005

Change Request 3691

SUBJECT: Updated Manual Instructions for the Medicare Claims Processing Manual, Chapter 10

I. SUMMARY OF CHANGES: This Change Request updates instructions located in Chapter 10 of the Medicare Claims Processing Manual. Chapter 10 has been updated to conform to the changes in the National Uniform Billing Committee code-set, revises dated information that had been superseded by other instructions, updates Medicare + Choice to Medicare Advantage Organization, and inserts instructions that were omitted during the conversion from the paper manual to the Internet Only Manual.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : March 28, 2005

IMPLEMENTATION DATE : March 28, 2005

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

II. CHANGES IN MANUAL INSTRUCTIONS: ***(N/A if manual is not updated)***

R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / SubSection / Title
R	10/Table of Contents
R	10/10/General Guidelines for Processing Home Health Agency (HHA) Claims
R	10/10.1.5.2/ Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes on HH PPS Episodes
R	10/10.1.23/Exhibit: General Guidance on Line Item Billing Under HH PPS
R	10/40.1/ Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims

R	10/80/Special Billing Situations Involving OASIS Assessments
R	10/90/Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 481	Date: February 25, 2005	Change Request 3691

SUBJECT: Updated Manual Instructions for the Medicare Claims Processing Manual, Chapter 10

I. GENERAL INFORMATION

A. Background: This Change Request updates instructions located in Chapter 10 of the Medicare Claims Processing Manual. Chapter 10 has been updated to conform to the changes in the National Uniform Billing Committee code-set, revises dated information that had been superseded by other instructions, updates Medicare + Choice to Medicare Advantage Organization, and inserts instructions that were omitted during the conversion from the paper manual to the Internet Only Manual.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3691.1	RHHIs shall update operational procedures, as necessary, to accommodate the following revisions to Chapter 10 of the Medicare Claims Processing Manual: - changes in the National Uniform Billing Committee code-set; - revised dated information that had been superseded by other instructions (CR 2483 which was issued in January of 2003); - updates Medicare + Choice to Medicare Advantage Organization; and - inserts instructions that were omitted during the conversion from the paper manual to the Internet Only Manual.		X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B.Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: March 28, 2005 **Implementation Date:** March 28, 2005 **Pre-Implementation Contact(s):** Yvonne Young, 410-786-1886, (Yyoung@cms.hhs.gov), Wil Gehne, 410-786-6148, wgehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

Table of Contents

(Rev.481, 02-25-05)

10 - General Guidelines for Processing Home Health Agency (HHA) Claims

(Rev. 481 , Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

This chapter, in general, describes bill processing requirements that are applicable only to home health agencies. For general bill processing requirements refer to the appropriate other chapters in the Medicare Claims Processing Manual. For a description of coverage policies see Chapter 10 in the Medicare Benefit Policy Manual and/or the Medicare National Coverage Determinations Manual.

A - Where and How to Bill

Form CMS-1450, the UB-92, is used by institutional providers, including home health agencies, to bill Medicare. Such claim forms are submitted to the regional home health intermediaries (RHHIs). Home health agencies (HHAs) bill all their home health services on this form. Some home health agencies may also become approved as DME suppliers, in which case they would submit bills for DMEPOS services to the carrier on Form CMS-1500 or the electronic equivalent.

Reference to the claim form in this chapter reference the paper or hard-copy version of the Form CMS-1450 (UB-92) unless otherwise noted. However, the instructions regarding specific data requirements apply also to electronic equivalents of the form.

B - Services to Include on the Claim for Home Health Benefits

Effective for all services provided on or after October 1, 2000, all services under the home health plan of care, except the following are included in the home health PPS payment amount. Services that may *be* included in the plan of care but excluded from the HH prospective payment system (HH PPS) are:

- Osteoporosis drugs (although the cost of administration is within the PPS rate); and
- Durable medical equipment, including prosthetics, orthotics, and oxygen

DMEPOS services may be included on the bill type 32X for the home health benefits, and are paid in addition to the PPS payment. Osteoporosis drugs must be billed on bill type 34X.

Other services not under an HH plan of care provided by an HHA are billed using type of bill 34X. Such services not under a plan of care, and services not part of the home health benefit, are often referred to as "Part B and other health services." See §90 for guidance as to the payment methodologies used by Medicare to reimburse these services, and see §40.4 in this chapter for information on deductible and coinsurance. Physical therapy, occupational therapy and speech language pathology services not delivered under an HH plan of care (optional Form CMS-485), are paid under the Medicare Physician Fee Schedule (See Chapter 5.) Such services must be delivered under other plans of care (Forms 700 and 701).

10.1.5.2 - Effect of Election of *Medicare Advantage (MA) Organization* and Eligibility Changes on HH PPS Episodes

(Rev. 481, Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

If a Medicare beneficiary is covered under an *MA organization* during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the Medicare payment source changes. With that assessment, a*n* RAP may be sent to Medicare to open an HH PPS episode.

If a beneficiary under fee-for-service receiving home care elects *MA organization* during an HH PPS episode, the episode will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The *MA organization* becomes the primary payer upon the *MA organization* enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner.

10.1.23 - Exhibit: General Guidance on Line Item Billing Under HH PPS

(Rev. 481, Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

An Acronym List is offered in §10.1.24, to help with interpretation of this section, which, due to format constraints, could not spell out all terms.

The following tables are added for quick reference on billing most line-items on HH PPS Requests for Anticipated Payment (RAPs) and claims, the first table groups services, and the second table groups items and supplies:

Quick Billing Reference for Services			
TYPE OF LINE ITEM	**Episode**	**Services/Visits**	**Outlier**
CLAIM CODING	New 0023 revenue code with new HIPPS code (HHRG) on HCPCS field of same line	Current revenue codes 042X, 043X, 044X, 055X, 056X, 057X w/Gxxxx HCPCS for increment reporting, (**NOTE** revenue codes 058x and 059x not permitted for HH PPS)	Determined by Pricer - NOT billed by HHAs
TYPE OF BILL (TOB)	Billed on 32X only (have *HH POC*, patient homebound)	Billed on 32X only if POC; 34X*if no *HH POC*	Appears on remittance only for HH PPS claims (via Pricer)
PAYMENT BASIS	PPS episode rate: (1) full episode w/ or w/out SCIC adjustment; (2) less than full episode w/ PEP adjustment, (3) LUPA paid on visit basis (4) therapy threshold adjustment	When LUPA on 32X, visits paid on adjusted national standardized per visit rates; paid as part of Outpatient PPS for 34X*	Addition to PPS episode rate payment only, NOT LUPA, paid on claim basis, not line item

Quick Billing Reference for Services			
TYPE OF LINE ITEM	**Episode**	**Services/Visits**	**Outlier**
PPS CLAIM?	Yes, RAPs and Claims	Yes, Claims only [34X*no *HH POC* /non-PPS]	Yes, Claims only

NOTE: For HH PPS, HHA submitted RAP TOB must be 322 - may be cancelled by 328; Claim TOB must be 329 - may be adjusted by 327, or 328; 33X equivalents will also be processed.

*34X claims for HH visit/services on this chart will not be paid separately if an HH episode for same beneficiary is open on CWF (exceptions noted on chart below).

Quick Billing Reference for Supplies						
TYPE OF LINE ITEM	**DME**** **(nonimplantable, other than Oxygen & P/O)**	**Oxygen & P/O** **(nonimplantable P/O)**	**Nonroutine***** **Medical Supplies**	**Osteoporosis Drugs**	**Vaccines**	**Other Outpatient Items (antigens, splints & casts)**
CLAIM CODING	Current revenue codes 029X, 0294 for drugs/supplies for effective DME use w/HCPCS	Current revenue codes 060X (Oxygen) and 0274 (P/O) w/HCPCS	Current revenue code 027x and voluntary use of 0623 for wound care supplies	Current revenue code 0636 & HCPCS	Current revenue codes 0636 (drug) and HCPCS, 771 (administration HCPCS)	Current revenue code 0271 & HCPCS
TOB	Billed to RHHI on 32X if *HH POC*, 34X* if no *HH POC*	Billed to RHHI on 32X if *HH POC*, 34X* if no *HH POC*	Billed on 32X if *HH POC*, or 34* if no *HH POC*	Billed on 34X* only	Billed on 34X* only	Billed on 34X* only
PAYMENT BASIS	Fee Schedule	Fee Schedule	Bundled into PPS payment if 32X (even LUPA); paid in cost report settlement for 34X*	Cost, paid separately with open HH PPS episode, but subject to HH consolidated billing	*Paid separately based on reasonable cost* with or without open HH PPS episode	Paid as part of Outpatient PPS, and paid separately with or without open HH PPS episode
PPS CLAIM?	Yes, Claim only [34X* no *HH POC*/non-PPS]	Yes, Claim only [34X* no *HH POC*/non-PPS]	Yes, Claim only [34X* no *HH POC*/non-PPS]	No (34X* claims only)	No (34X* claims only)	No (34X* claims only)

NOTE: *For HH PPS, HHA submitted Claim TOB must be 329 (adjusted by 327 or 328).*

* 34X claims for HH services, **except as noted for specific items above**, will not be paid separately if a HH episode for same beneficiary is open on CWF.

** Other than DME treated as routine supplies according to Chapter 4.

*** Routine supplies are not separately billable or payable under Medicare home health care. When billing on TOB 32X, catheters and ostomy supplies are considered nonroutine supplies and are billed with revenue code 027X.

40.1 - Request for Anticipated Payment (RAP)

(Rev. 481, Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, 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 request for anticipated payment (RAP) with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, a*n* RAP and a claim will be submitted for each episode period. Each claim, usually following a*n* RAP and at the end of an episode, 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 next remittance advice.

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 next remittance advice (RA) will be used to recoup the overpaid amount.

While a*n* RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims. The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

Form Locator (FL) 1. (Untitled) 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 (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH RAP billing.

FL 3. 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.

FL 4. TOB Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type

of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

NOTE: While the bill classification of "3," defined as "Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)" may also be appropriate to a HH PPS claim depending upon a beneficiary's eligibility, Medicare encourages HHAs to submit all RAPs with bill classification "2." Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	**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 code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If a*n* 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.

RHHIs will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

FL 5. Not required for Medicare HH RAP billing.

FL 6. 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.). All dates are in the format MM-DD-YY.

FL 7. Not required for Medicare HH RAP billing.

FL 8. Not required for Medicare HH RAP billing.

FL 9. Not required for Medicare HH RAP billing.

FL 10. Not required for Medicare HH RAP billing.

FL 11. Not required for Medicare HH RAP billing.

FL l2. Patient's Name

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

FL l3 Patient's Address

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

FL 14. Patient's Birthdate

Required - Month, day, and year of birth (MM-DD-YY) of patient.

Left blank if the full correct date is not known.

FL l5. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH RAP billing.

FL l7. Admission Date

Required - Date the patient was admitted to home health care (MM-DD-YY). On the first RAP in an admission, this date should match the statement covers "from" date in FL 6. 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.

FL 18. Not required for Medicare HH RAP billing.

FL 19. Not required for Medicare HH RAP billing.

FL 20. Source of Admission

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

Code	Definition
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital (CAH)
B	Transfer from Another HHA
C	Readmission to Same HHA

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

FL 21. Not required for Medicare HH RAP billing.

FL 22. Patient Status

Required - Indicates the patient's status as of the "through" date of the billing period (FL 6). 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 structure

Code	Definition
30	Still patient *or expected to return for outpatient services*

FL 23. Medical Record Number

Optional - This is the number assigned to the patient's medical/health record. The RHHI must carry information entered in this field through their system and return it to the biller.

FLs 24 - 30. Condition Codes

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

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" in FL 84, indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

FL 31. Not required for Medicare HH RAP billing.

FL 32, 33, 34, and 35. Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YY).

Fields 32A-35A must be completed before fields 32B-35B are used.

FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "through" date is in the date field.

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

For a complete list of Occurrence Codes, see Chapter 25.

FL 36. Occurrence Span Code and Dates

Not Required - Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If canceling a*n* RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, HHAs show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

FL 38. Not required for Medicare HH RAP billing.

FLs 39-41. 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 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.

A description of the MSA system and codes can be found at the following Web site:

http://www.census.gov/population/estimates/metro-city/a99mfips.txt

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or nondollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the biller must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." FLs 39a through 41a must be used before FLs 39b through 41b (i.e., the first line is used before the second line).

For a complete list of value codes, see Chapter 25.

FL 42 and 43 Revenue Code and Revenue Description

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

Revenue Code.	Description
0023	Home Health Services

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. 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.

HHAs may report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of the charges billed. However, Medicare claims processing systems will overlay this amount with the total payment for the RAP.

FL 44. HCPCS/Rates

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.

FL 45. 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.

FL 46. Units of Service

Optional - Units of service are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line. Medicare claims processing systems will place the payment amount for the RAP in this field on the electronic claim record.

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.

FL 48. Noncovered Charges

Not Required - The HHA does not report noncovered charges for Medicare on RAPs.

FL 49. Not required for Medicare HH RAP billing.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

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

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare. It must be entered on the same line (A, B, or C) as "Medicare" in FL 50.

If a Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number, indicating patient status 06. This claim will be paid a PEP adjustment. Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases report the new provider number in this field.

FLs 52A, B, and C. 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.

FL 53. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 56. Not required for Medicare HH RAP billing.

FL 57. Not required for Medicare HH RAP billing.

FLs 58A, B, and C. 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 in FLs 50-54, record the patient's name as shown on the patient's HI card or other Medicare notice.

FLs 59A, B,and C. Patient's Relationship to insured, Not required for Medicare HH RAP billing

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required.

See Chapter 25.

FL 61. Not required for Medicare HH RAP billing.

FL 62. Not required for Medicare HH RAP billing.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

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.

FL 64. Not required for Medicare HH RAP billing.

FL 65. Not required for Medicare HH RAP billing.

FL 66. Not required for Medicare HH RAP billing.

FL 67. 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 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

FLs 68-75. Other Diagnoses 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. None of these other diagnoses may duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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 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 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH RAP billing.

FL 77. Not required for Medicare HH RAP billing.

FL 78. Not required for Medicare HH RAP billing.

FL 79. Not required for Medicare HH RAP billing.

FL 80. Not required for Medicare HH RAP billing.

FL 81. Not required for Medicare HH RAP billing.

FL 82. Attending/Requesting Physician I.D.

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

FL 83. Not required for Medicare HH RAP billing.

FL 84. Remarks

Required - Remarks are necessary when canceling a*n* RAP, to indicate the reason for the cancellation.

FL 85. Not required for Medicare HH RAP billing.

FL 86. Not required for Medicare HH RAP billing.

40.2 - HH PPS Claims

(Rev. 481, Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

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. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After a*n* 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 remittance advice information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

FL 1. (Untitled) 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. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH PPS claim billing

FL 3. Patient Control 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.

FL 4. TOB

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

NOTE: While the bill classification of 3, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims system determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - 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 a 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 frequency codes 7, or 8.

HH PPS claims will be submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." FIs do not accept late charge bills, submitted with frequency "5" on HH PPS claims. To add services within the period of a paid HH claim, an adjustment must be submitted by the HHA.

FL 5. Not required for Medicare HH PPS claim billing.

FL 6. Statement Covers Period (From-Through)

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 in FL 22 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 a discharge claim is submitted due to change of FI, see FL 22 below. If the beneficiary has died, the HHA reports the date of death in the through date. In such cases, the "through" date field should represent the date of discharge or last billable service 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.

All dates are submitted in the format MM-DD-YY.

FL 7. Not required for Medicare HH PPS claim billing.

FL 8. Not required for Medicare HH PPS claim billing.

FL 9. Not required for Medicare HH PPS claim billing.

FL 10. Not required for Medicare HH PPS claim billing.

FL 11. Not required for Medicare HH PPS claim billing.

FL 12. Patient's Name

Required - Enter the patient's last name, first name, and middle initial.

FL 13. Patient's Address

Required - Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate

Required - Enter the month, day, and year of birth (MM-DD-YY) of patient. If the **full** correct date is not known, leave blank.

FL 15. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH PPS claim billing.

FL l7. Admission Date

Required - The HHA enters the same date of admission that was submitted on the RAP for the episode (MM-DD-YY).

FL 18. Not required for Medicare HH PPS claim billing.

FL 19. Not required for Medicare HH PPS claim billing.

FL 20. Source of Admission

Required - Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Not required for Medicare HH PPS claim billing.

FL 22. Patient Status

Required - Enter 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.

Code	Definition
0l	Discharged to home or self-care (routine charge)
02	Discharged/transferred to other short-term general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to *a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care*
06	Discharged/transferred to home care of organized home health service organization, **OR** Discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice
20	Expired
30	Still patient or expected to return for outpatient services
43	*Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)*
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharge*d*/transferred to a hospital-based Medicare approved swing bed

Code	Definition
62	*Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital*
63	*Discharged/transferred to a long-term care hospital (LTCH)*
64	*Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare*
65	*Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)*
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care *(deleted October 1, 2003)*
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care *(deleted October 1, 2003)*

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 intermediary to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the intermediary 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 partial episode payment (PEP) adjustments by using patient status code 06. Billing for the beneficiary is being "transferred" to the new intermediary.

In cases where the ownership of an HHA is changing which causes the six digit Medicare provider number to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number 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 partial episode payment (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 six digit Medicare provider number, 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, refer them to the appropriate state OASIS education coordinator.

FL 23. Medical Record Number

Required - Enter the number assigned to the patient's medical/health record. The RHHI must carry it through their system and return it on the remittance record.

FLs 24 - 30. Condition Codes

Optional - Enter any NUBC approved code to describe conditions that apply to the claim.

Claim Change Reasons

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Codes
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" in FL 84 indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3x8), HHAs report the condition codes D5 or D6 and enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

For a complete list of Condition Codes see Chapter 25.

FL. 31. Not required for Medicare HH PPS claims billing

FL 32, 33, 34, and 35. Occurrence Codes and Dates

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

See Chapter 25.

FL 36. Occurrence Span Code and Dates

Optional - 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.

For a complete list of Occurrence Span codes see Chapter 25.

FL 37. Internal Control Number (ICN)/ 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. The HHA inserts the ICN/DCN of the claim to be adjusted here. The HHA shows payer A's ICN/DCN on line "A" in FL 37, and shows the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

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 an ICN/DCN on all HH PPS claims, only on adjustments to paid claims.

FL 38. Not required for Medicare HH PPS claim billing.

FLs 39-41. Value Codes and Amounts

Required - See §40.1, FL 39 - 41.

For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: FI value codes. Providers report code 61. The FI places codes 17 and 61 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Always place condition

Code	Title	Definition
		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 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 §1812a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI 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, change the TOB on the claim record to 33X, 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, change the TOB on the claim record to 32X, 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 not change the TOB and will return the claim to CWF with RIC code U.

FL 42 and 43 Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by "X" in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim. If there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more then once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change. Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero charges in FL 46. See §40.1, FL 44, for more detailed information on the HIPPS code.

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 *(**NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)*	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 a*n* HCPCS code, the date of service units and a charge amount.

042X Physical Therapy

Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), 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: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), 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: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), 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: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), 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: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), 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: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: FIs 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

RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

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.

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

062X 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.

Chapter 7 of the Medicare Benefit Policy Manual defines routine vs. nonroutine supplies. HHAs will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. 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.

HHAs may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum charges billed. Medicare claims processing systems will assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates

Required - On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a SCIC, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

FL 45. Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. 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 FL 43. For service visits that begin in one calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

FL 46. Units of Service Required

The HHA should not report units of service on 0023 revenue code lines. 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 FL 43. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as units of service 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.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line (the field may be zero or blank). Medicare claims processing systems will place the episode payment amount for the claim in this field on the electronic claim record. For LUPA claims, the per visit payment will be reported on individual line items.

For line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. 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.

FL 48. Noncovered Charges

Required - The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. The HHA reports all noncovered charges, including no-payment claims.

Claims with Both Covered and Noncovered Charges

The HHA reports (along with covered charges) all noncovered charges, related revenue codes, and HCPCS codes, where applicable.

HHA Bills with All Noncovered Charges

The HHA submits claims when all of the charges on the claim are noncovered (no-payment claim). The HHA completes all items on a no-payment claim in accordance with instructions for completing claims for payment, with exceptions including all charges reported as noncovered. See chapter 1, section 60 for further instructions on no-payment bills.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

The HHA reflects a change in Medicare provider number within a 60-day episode by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. In this case, it reports the original provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - See Chapter 25.

FL 53. Not required for Medicare HH PPS claim billing.

FL 54. Not required for Medicare HH PPS claim billing.

FL 55. Not required for Medicare HH PPS claim billing.

FL 56. Not required for Medicare HH PPS claim billing.

FL 57. Not required for Medicare HH PPS claim billing.

FLs 58A, B, and C. Insured's Name

Required only if MSP involved. See the Medicare Secondary Payer Manual. Enter the beneficiary's name as shown on the Health Insurance Claim card. The name should be recorded on line A if Medicare is prime, line B if Medicare is secondary, and line C if Medicare is the tertiary payer. This placement, A, B, or C, should correspond with the line Medicare was recorded on in FL50.

FLs 59A, B, and C. Patient's Relationship To Insured

Required only if MSP involved. See the Medicare Secondary Payer Manual.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

Required only if MSP involved. See the Medicare Secondary Payer Manual. Enter the Medicare health insurance claim number as shown on the Medicare card. Place this information on Line A, B, or C as consistent with FL 58.

FLs 61A, B, and C. Group Name

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FLs 62A, B, and C. Insurance Group Number

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FL 64. Employment Status Code

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 65. Employer Name

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

Where the HHA is claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, it enters the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location

Required only if MSP involved. See the Medicare Secondary Payer (MSP) Manual.

FL 67. 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 code and principle diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FLs 68-75. Other Diagnoses 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 listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (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 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 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH PPS claim billing.

FL 77. Not required for Medicare HH PPS claim billing.

FL 78. Not required for Medicare HH PPS claim billing.

FL 79. Not required for Medicare HH PPS claim billing.

FL 80. Not required for Medicare HH PPS claim billing.

FL 81. Not required for Medicare HH PPS claim billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has signed the plan of care.

FL 83. Not required for Medicare HH PPS claim billing.

FL 84. Remarks

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

FL 85. Not required for Medicare HH PPS claim billing.

FL 86. Not required for Medicare HH PPS claim billing.

80 - Special Billing Situations Involving OASIS Assessments

(Rev. 481, Issued 02-25-05, Effective: 03-28-05, Implementation: 03-28-05)

Maintaining the link between payment episode periods and OASIS assessment periods is central to HH PPS. However, in some circumstances these periods may be difficult to synchronize. The following instructions provide guidance for some of the more common of these situations.

A - Changes in a Beneficiary's *Medicare Advantage (MA)* Organization Enrollment Status

1 - Payment Source Changes From *MA Organization* to Medicare Fee-For-Service (FFS)

If a Medicare beneficiary is covered under an *MA Organization* during a period of home care, and subsequently decides to change to Medicare FFS coverage, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Medicare FFS. With that assessment, a*n* RAP may be sent to Medicare to open an HH PPS episode. HHAs are advised to verify the patient's payer source on a weekly basis when providing services to a patient with *an MA Organization* payer source to avoid the circumstance of not having an OASIS to generate a billing code for the RAP, or having the patient discharged without an OASIS assessment.

If a follow-up assessment is used to generate a new start of care assessment, CMS highly recommends, but does not require, a discharge OASIS assessment be done.

While this is not a requirement, conducting a "paper" discharge at the point where the patient's change in insurance coverage occurred will provide a clear endpoint to the patient's episode of care for purposes of the individual HHA's outcome-based quality monitoring (OBQM) reports. Otherwise, that patient will not be included in the HHA's OBQM statistics. It will also keep that patient from appearing on the HHA's roster report (a report the HHS can access from your state's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection.

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, that too should be marked.) CMS realizes that the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide services though the Medicare payment source *h*as changed from *an MA Organization* to FFS.

In cases where the patient changes from *MA* coverage to FFS coverage, the patient's overall Medicare coverage is uninterrupted. This means an HH PPS episode may be billed beginning on the date of the patient's FFS coverage. Upon learning of the change in *MA* election, the HHA should submit a RAP using the date of the first visit provided

after the FFS effective date as the episode "from" date, and using the OASIS assessment performed most recently after the change in election to produce a HIPPS code for that RAP.

The claims-OASIS matching key information in FL 63 should reflect this assessment. If a new start of care (SOC) OASIS assessment was not conducted at the time of the change in pay source, a correction to an existing OASIS assessment may be necessary to change the reported payer source and to complete the therapy item (M0825). The HHA should correct the existing OASIS assessment conducted most closely after the new FFS start date. If more than one episode has elapsed before the HHA learns of the change in payer source, this procedure can be applied to the additional episode(s). If the patient is still receiving services, the HHA must complete the routine follow-up OASIS assessments (RFA4) consistent with the new start of care date. In some cases, HHAs may need to inactivate previously transmitted assessments to reconcile the data collections with the new episode dates.

EXAMPLE: A patient has a*n* SOC date of November 22, 2000 as a managed care patient. On December 15 the patient disenrolls from managed care and becomes a Medicare FFS patient, but the HHA was not notified. The HHA finds out about the disenrollment on February 1, 2001, when it bills the *MA Organization*. The HHA had conducted a follow-up OASIS assessment on January 19, 2001, in keeping with the recertification assessment timing requirements. It did not, however, do an OASIS within 5 days of December 15. How does the HHA get paid under PPS for the services that were provided to this patient between December 15 and February 1?

The HHA should go to the January 19, 2001 OASIS assessment, use the information recorded there, and generate a new start of care assessment using the data from that assessment. This new start of care assessment should reflect December 15 as the start of care date at item M0030 and should accurately reflect the therapy need at M0825 for the episode beginning December 15 in order to generate the HIPPS code for billing purposes. The date the assessment was completed (M0090) should reflect the original date, i.e., January 19, 2001. Timing warnings from the OASIS state system will be generated based on the difference between the start of care date and the date the assessment was completed (> 5 days), but these warnings are unavoidable in these situations and can be disregarded.

Since the January 19 assessment is no longer relevant to this episode, it can be inactivated according to the current policies for correcting OASIS records. The HHA would conduct a routine follow-up assessment (RFA4) based on the December 15 start of care date, that is between February 8 and February 12, 2001, and every 60 days from that point on if the patient continues care.

In the rare situation in which the HHA has not performed OASIS assessments on the patient while the patient was under *MA* coverage (as is required for all skilled need patients under OASIS regulations) and the patient has been discharged, the HHA may use their medical records to reconstruct the OASIS items needed to determine a HIPPS code applicable to the period of Medicare fee-for-service eligibility and coverage.

2. Payment Source Changes From FFS to *MA Organization*

In cases where the patient elects *MA* coverage during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment - PEP - adjustment). The *MA Organization* becomes the primary payer upon the *MA* enrollment date. The HHA may learn of the change after the fact, for instance, upon rejection of their claim by Medicare claims processing systems. The HHA must resubmit this claim indicating a transfer of payer source using patient status code "06," and reporting only the visits provided under the fee-for-service eligibility period. The claim through date and the last billable service must occur before the *MA* enrollment date. If the patient has elected to move from Medicare FFS to an *MA Organization* and is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

B. Inpatient Hospital Stays On or Near Day 60/61 of Continuous Care Episodes

1. Beneficiary is in Hospital on Both Days 60 and 61

A beneficiary may be in the hospital for the entirety of both day 60 (the last day of one episode) and day 61 (the first day of the next episode of continuous care). In this case, HHAs must discharge the beneficiary from home care for Medicare billing purposes, because home care could not be provided until what would be, at the earliest, Day 62. There has been a gap in the delivery of home care between the two episodes and so the episodes cannot be billed as continuous care. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 of the UB-92 claim form (or electronic equivalent) that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be submitted to the State Agency as a Start of Care assessment.

2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61

A hospital discharge may occur on day 60 or day 61and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last *5* days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary's admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this

case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency.

3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care.

The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode.

C. Patients for Whom OASIS Transmission to the State Agency is Not Allowed

Rare cases may arise in which an HHA provides Medicare-covered home health services to a beneficiary for whom an OASIS assessment is normally not required. Examples of this would be pediatric or maternity patients that are entitled to Medicare by their disability status. In these cases, an OASIS assessment must be performed on the patient exclusively in order to arrive at a HIPPS code to place on the RAP and the claim for the episode. This HIPPS code is necessary to serve as the basis of payment for the episode. However, do not transmit this OASIS assessment to the State Agency because it is not allowed by law.

Since the OASIS assessment on which payment is based is not transmitted to the State, the claim for the episode must not report a 'claims-OASIS matching key' in the treatment authorization field of the claim form. Instead, this field on the claim form for the RAP or claim should be filled with a string of ones (e.g., "1111111111111111") in order to pass a Medicare claims system edit which requires this field to contain a numeric value. This is one of the two circumstances in which the 'claims-OASIS matching key' on a RAP or claim for payment may be filled with ones. (See Chapter 1 for the other use of this practice on no-payment claims.) In all other respects, the RAP and claim for the episode should be identical to other HH PPS RAPs and claims.

Inpatient Hospital Stays and the End of Episodes - Five Scenarios

The chart below presents the information in this section in tabular form. Each example assumes an episode beginning 10-2-2002 which would otherwise end 11-30-2002 ("Day 60"). The subsequent episode could begin 12-1-2002 ("Day 61") and end 1-29-2003.

Scenario Example	OASIS Impact	Claim Impact
1) Hospitalized on Days 60 AND 61 • Beneficiary is assessed for recertification on 11-26-2002 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-2-2002 • Returns to same HHA, receives next visit 12-3-2002	Start of Care (SOC) assessment upon return from hospital	Episodes are NOT considered continuous care: • RAP submitted with "From" and admission date of 12-3-2002, • New episode now extends to 1-31-2003 • Matching key reflects SOC assessment
2) Discharge on Day 60 or 61, HIPPS code changes • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HBGK1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 11-30-2002 (Day 60) • Returns to same HHA, receives next visit and resumption assessment 12-2-2002, HIPPS code: HCHL1.	Resumption of Care (ROC) assessment upon return from hospital, submitted as SOC	Episodes are NOT considered continuous care: • RAP submitted with "From" and admission date of 12-2-2002, • New episode now extends to 1-30-2003 • Matching key reflects SOC assessment
3) Discharge on Day 60 or 61, HIPPS code unchanged • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-1-2002 (Day 61) • Returns to same HHA, receives next visit and resumption assessment on or after 12-2-2002, HIPPS code: HDIM1.	ROC assessment upon return from hospital	Episodes ARE considered continuous care: • RAP submitted with "From" date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment

Scenario Example	OASIS Impact	Claim Impact
4) Hospitalized on Day 61, HIPPS code changes • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HAEK1 • Admitted to hospital on 12-1-2002 (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives first visit in episode and resumption assessment 12-5-2002, HIPPS code: HBFL1.	ROC assessment upon return from hospital, submitted as SOC	Episodes are NOT considered continuous care • RAP submitted with "From" and admission date of 12-5-2002, • New episode now extends to 2-2-2003 • Matching key reflects SOC assessment
5) Hospitalized on Day 61, HIPPS code unchanged • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 12-1-2002, after HH visit same day (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives next visit and resumption assessment 12-5-2002, HIPPS code: HDIM1.	ROC assessment upon return from hospital	Episodes ARE considered continuous care • RAP submitted with "From" date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment

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

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Form CMS-1450 is submitted for certain Part B medical and other health services for which the HHA may receive payment outside of the prospective payment system. (See the Medicare Benefit Policy Manual, Chapter 7). Refer to instructions in Chapter 20 of this manual and **§90.1** in this chapter for submitting claims under arrangement with suppliers.

A - Patient Not Under A Home Health Plan Of Care

The HHA uses a Form CMS-1450 (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 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*.)

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 Form CMS-1450 (Bill Type 34X). All other services are home health services and should be billed as a 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 or as a medical and other health service on bill types 32X, 33X, and 34X as appropriate.

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 FI to apply the appropriate deductible for both years. HH PPS claims (TOB 32X or 33X) may span the calendar year since they represent 60-day episodes, and episodes should be attributed to the Federal fiscal year or 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, on the PPS claim to the RHHI. These services are billed to Medicare carriers using the HHAs carrier number on the Form CMS-1500 claim. To submit such claims to the carrier, the HHA must have a CLIA number and a billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate carrier 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.