CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1431	**Date: February 1, 2008**
	Change Request 5868

Subject: Update to the Implementation Date for Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services issued Change Request (CR) 5551, Transmittal 1246 on May 22, 2007. This CR is updating that instruction to implement the instructions in July of 2008, and not in April of 2008 as previously indicated.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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	10/10/General Guidelines for Processing Home Health Agency (HHA) Claims
R	10/20/Home Health Prospective Payment System (HH PPS) Consolidated Billing

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1431	Date: February 1, 2008	Change Request: 5868

SUBJECT: Update to the Implementation Date for Home Health Agencies (HHAs) Providing Durable Medical Equipment (DME) in Competitive Bidding Areas

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: Pursuant to section 1847 of the Social Security Act, competitive bidding will be conducted for certain DME.

Beginning in 2008, in a competitive bidding area, a supplier must be awarded a contract by Medicare in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program, must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items will be identified by HCPCS codes and the competitive bidding areas will be identified based on ZIP Codes where beneficiaries receiving these items maintain their permanent residence. The DME MACs will have edits in place indicating which entities are eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

The Centers for Medicare & Medicaid Services issued CR 5551, Transmittal 1246 on May 22, 2007. This change request is updating that instruction to implement the following instructions in July of 2008, and not in April of 2008 as previously indicated.

B. Policy: All suppliers of competitively bid DME must bill the DME MAC for these items and will no longer be allowed to bill the RHHIs for competitive bid items. Claims submitted to the RHHI for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs, who will have jurisdiction over all claims for competitively bid items. Claims for DME furnished by HHAs that are not subject to competitive bidding would still be submitted to the RHHIs.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5868.1	Medicare systems shall return HH claims to the provider when HCPCS codes that are identified as being in a competitive bidding area are present. **NOTE:** The CMS download file shall be used to identify						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the applicable HCPCS codes, ZIP Codes, and CBSAs.										
5868.2	RHHIs shall download the HCPCS and zip code files quarterly upon receipt of the data set names contained in the DMEPOS Competitive Bidding Quarterly File Update change requests, beginning in July 2008. **NOTE:** For your reference, the applicable HCPCS codes, ZIP Codes and Core Based Statistical Areas (CBSAs) for the competitive bidding areas can be found on the following Competitive Bid Implementation Contractor (CBIC) Web site: http://www.dmecompetitivebid.com/cbic/cbic.nsf/(Pages)/Competitive+Bid+Areas"					X					
5868.3	RHHIs shall instruct providers to remove the affected DME lines and submit those charges to the DME MAC for processing when a claim has been returned for the presence of HCPCS codes that fall within a competitive bidding area.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5868.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5868.1	Implementation of the service areas is being done by CBSA, therefore, editing value code 61 for the beneficiary's location.
5868.3	Medicare systems shall change the effective and implementation dates from April 1, 2008 to July 1, 2008.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Yvonne Young, 410-786-1886, Yvonne.young@cms.hhs.gov, Wil Gehne, 410-786-6148, Wilfried.Gehne@cms.hhs.gov (Claims Processing) or Karen Jacobs, 410-786-2173, Karen.Jacobs@cms.hhs.gov (Policy)

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:

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

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

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

(Rev.1431, Issued: 02-01-08, Effective: 07-01-08, Implementation: 07-07-08)

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-*04*, 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-*04*) 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. *See §20 for additional instructions regarding competitively bid DME.* 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).

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

(Rev.1431, Issued: 02-01-08, Effective: 07-01-08, Implementation: 07-07-08)

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

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

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

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

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

Medicare periodically publishes Routine Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes, which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

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

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

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

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis, in addition to episodes payments, and are billed on a claim with a bill-type that is not specific to HH PPS (TOB 34X). When an HH episode is open for a specific beneficiary, only the primary HHA serving the beneficiary will be permitted to bill osteoporosis drugs for them. For more detailed information, refer to §90.1.