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Related Change Request (CR) #: CR 7338

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Related CR Transmittal #: R2230CP

Implementation Date: August 28, 2011

Revisions to the "Medicare Claims Processing Manual" - Chapter 10 (Home Health Agency Billing)

Note: This article was updated on August 20, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

Home Health (HH) providers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for HH services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7338 which provides updates to the "Medicare Claims Processing Manual" (Pub. 100-04) Chapter 10 (Home Health Agency Billing).

CAUTION – What You Need to Know

CR7338 updates and removes outdated references to Centers for Medicare & Medicaid Services (CMS) policies no longer in effect. It also adds various detail clarifications to existing manual sections and makes conforming changes to reflect the new G-codes for HH services created by CR7182.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

CR7338 updates the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 10 (Home Health Agency Billing)) which is included as an attachment. A principal reason for these updates is to remove outdated references and to make various detail clarifications to existing sections of Chapter 10 (Home Health Agency Billing). Clarifying revisions to Chapter 10 include:

- The Transfer Situation – Payment Effects Section (10.1.13): "In rare cases, a beneficiary may elect to transfer between HHAs and their admission date at the "transfer to" HHA may fall on the day immediately following the end of an episode at the "transferred from" agency. The "transferred from" agency may not have submitted a RAP for the new episode of continuous care, so the "transfer to" HHA may not see a record of an open episode when they access the Medicare inquiry system. They will likely see the record of the immediately adjacent episode and should provide the same notifications to the beneficiary as in any other transfer situation. Documentation of these notifications may be needed if the transfer is disputed and verification is required as described in the "Medicare Benefit Policy Manual", chapter 7, section 10.8.E."
- Discharge and Readmission Situation Under HH PPS - Payment Effects Section (10.1.14): "Note that beneficiaries do not have to be discharged within the episode period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, the discharge is not recognized for Medicare payment

purposes. All the HH services provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim. "

Effective January 1, 2008, the HH Prospective Payment System (HH PPS) was revised to refine the case-mix system. In the course of this revision to the HH PPS, a number of policies and processes in the original HH PPS were terminated (e.g. significant changes in condition or payment adjustments related to OASIS item M0175). CR7338 removes these references, and Chapter 10 now reflects only policies in effect since January 1, 2008.

On December 17, 2010, the Centers for Medicare & Medicaid Services (CMS) issued CR7182 (see https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R824OTN.pdf), which created new G-codes for reporting skilled nursing and skilled therapy services in the HH setting. CR7338 updates the claims submission instructions of Chapter 10 to include these new G-codes in the HH PPS Claims Section (40.2) and the G-Code part of that section is included below:

Healthcare Common Procedure Coding System (HCPCS)/Accommodation Rates/Health Insurance PPS (HIPPS) Rate Codes

Required - On the 0023 revenue code line, the HH Agency (HHA) must report the HIPPS code that was reported on the Request for Anticipated Payment (RAP). The first four positions of the code must be identical to the value reported on the RAP. The fifth position may vary from the letter value reported on the RAP to the corresponding number which represents the same non-routine supply severity level but which reports that non-routine supplies were not provided.

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

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code.

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

G-Code	Descriptor
G0151	Services of physical therapist in home health or hospice setting, each 15 minutes.
G0152	Services of an occupational therapist in home health or hospice setting, each 15 minutes.
G0153	Services of a speech language pathologist in home health or hospice setting, each 15 minutes.
G0154	Services of skilled nurse in the home health or hospice settings, each 15 minutes.
G0155	Services of a clinical social worker under a home health plan of care, each 15 minutes.

G-Code	Descriptor
G0156	Services of a home health aide under a home health plan of care, each 15 minutes.

To report HH visits on episodes beginning on or after January 1, 2011, the HHA reports one of the following HCPCS code to represent each HH care discipline:

Physical Therapy (revenue code 042x)

G-Code	Descriptor
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

Occupational Therapy (revenue code 043x)

G-Code	Descriptor
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

Speech-Language Pathology (revenue code 044x)

G-Code	Descriptor
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Skilled Nursing (revenue code 055x)

G-Code	Descriptor
G0154	Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.
G0162	Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).
G0163	Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).
G0164	Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Medical Social Services (revenue code 056x)

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

Home Health Aide (revenue code 057x)

G-Code	Descriptor
G0156	Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding All Skilled Nursing and Skilled Therapy Visits

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

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

time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

Additional Information

The official instruction, CR7338, issued to your RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2230CP.pdf on the CMS website.

If you have any questions, please contact your RHHIs at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.