DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

Revised products from the Medicare Learning Network® (MLN)

- "Telehealth Services", Fact Sheet, ICN 901705, downloadable

MLN Matters® Number: MM8136 Revised	Related Change Request (CR) #: CR 8136
Related CR Release Date: April 2, 2013	Effective Date: Home Health Episodes beginning on or after July 1, 2013
Related CR Transmittal #: R2680CP	Implementation Date: July 1, 2013

Data Reporting on Home Health Prospective Payment System (HH PPS) Claims

Note: This article was revised on April 19, 2013, to delete "and indicating whether services were added to the HH plan of care by a physician who did not certify the plan of care" from the "Provider Action Needed" section. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) that bill Regional Home Health Intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8136 which adds new data reporting requirements for Home Health Prospective Payment System (HH PPS) claims. Home Health Agencies (HHAs) must report new codes indicating the location of where services were provided. Make sure that your billing staffs are aware of these changes.

Background

Generally, Original Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate pays for the delivery of home health services, which includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Claims must report all home health services provided to the beneficiary within the episode.

Healthcare Common Procedure Coding System (HCPCS) codes Q5001 through Q5009 currently describe where hospice services were provided (in the patient's home, assisted living facility, etc). These codes have been reported on hospice claims since 2007.

Medicare is planning to capture data to show where home health services were provided by requiring Home Health Agencies (HHAs) to report the location on the claim.

Effective for HH episodes beginning on or after July 1, 2013, HHAs are to use the HCPCS codes Q5001, Q5002, and Q5009 on home health claims to report where home health services were provided. The following table lists the definitions of the Q codes Q5001, Q5002, and Q5009, which were revised effective April 1, 2013:

HCPCS Code	Definition
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5009	Hospice or home health care provided in place not otherwise specified (NO)

The patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. Q code Q5002 should be used to indicate that home health services were provided at an assisted living facility (as defined by the State in which the beneficiary is located). Conversely, Q code Q5001 should be used to indicate that home health services provided at a patient's residence except in the cases where the services are provided at an assisted living facility. Finally, Q code Q5009 may be reported in the rare instance an HHA believes the definitions of Q5001 and Q5002 do not accurately describe the location where services are provided.

The location where services were provided should be reported along with the first billable visit in a HH PPS episode. In addition to reporting a service line according to current instructions, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit, and a nominal charge (e.g., a penny).

If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Note: Revisions to the definitions of the Q codes above (Q5001, Q5002, and Q5009) will be published in the HCPCS update on March 31, 2013.

Billing Information

Note the following billing requirements:

- HCPCS codes Q5001, Q5002, or Q5009 must be reported on HH PPS claims containing revenue code 042X, 043X, 044X, 055X, 056X, or 057X or the claim will be returned to the provider.
- The line item date of service of the line reporting Q5001, Q5002, or Q5009 must match the earliest dated HH visit line (revenue codes 042X, 043X, 044X, 055X, 056X, or 057X) on the claim or the claim will be returned to the provider.
- When more than one line on an HH PPS claim reports Q5001, Q5002, or Q5009, then the same HCPCS code must not be reported on consecutive dates or the claim will be returned to the provider.
- Claim lines reporting Q5001, Q5002, or Q5009 are not included in the visit counts passed to the HH Pricer, nor are they counted in medical policy parameters that count number of visits.

Additional Information

The official instruction, CR8136 issued to your A/B MACs and RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2680CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your A/B MACs and 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.