DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Implementation Date: July 5, 2016

New Condition Code for Reporting Home Health Episodes with No Skilled Visits

Note This article was revised on June 29, 2016, due to an updated Change Request (CR). The update deleted business requirement 9474.10 and the corresponding manual language in Section 20.2.5 in the CR. The transmittal number and CR release date and link to the transmittal was also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 9474 informs you of revisions of the Medicare billing instructions for home health claims to allow the use of a new condition code - 54. The code indicates that the HHA provided no skilled services during the billing period, but the HHA has documentation on file of an allowable circumstance. Make sure that your billing staffs are aware of these changes.

Background

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act require that, in order to be eligible to receive Medicare home health services, the beneficiary must have a skilled need (that is, require intermittent Skilled Nursing (SN) services, Physical Therapy (PT), and/or Speech Language Pathology (SLP) services or have a continuing need for Occupational Therapy (OT) services). In order to better enforce this requirement, CR9027 (see related article **MM9027**) revised Original Medicare systems to return to the provider any claims for episodes that are the first episode in a sequence of episodes or are the only

episode of care received by a beneficiary for which patient eligibility for the Medicare home health benefit has not been established (that is, no SN, PT, or SLP visits reported on the claim).

Enforcing this requirement on claims for subsequent episodes of HH care could not be automated using previously existing codes. There may be circumstances which prevent the HHA from delivering the skilled services planned for an episode, such as an unexpected inpatient admission. Determining whether payment is allowable requires development of the claim. **Chapter 7**, Section 40.1.3, of the "Medicare Benefits Policy Manual" states:

> "Since the need for 'intermittent' skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services."

Medicare requested the National Uniform Billing Committee to create a new code that would allow the HHA to indicate upon submission that such documentation exists. A new condition code 54 is effective on July 1, 2016 and is defined as "No skilled HH visits in billing period. Policy exception documented at the HHA." Submission of this code will streamline claims processing for both the payer and provider. Claims without skilled visits that are submitted without the new condition code will be returned to the provider. This will allow the HHA to:

- Add any accidentally omitted skilled services to the claim;
- Submit the claim as noncovered, if appropriate; or
- Append the new condition code.

These actions will prevent unnecessary reviews and denials for the HHA and allow Medicare to better target medical review resources.

Also, CR9474 addresses unintended consequences of the implementation of new Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing visits. CR9369 (see related article **MM9369**) terminated HCPCS code G0154, replacing it with two new codes, G0299 and G0300. During the implementation of CR9369, CMS discovered several other processes are affected by this coding change:

- G0299 and G0300 were previously used to describe defibrillator services. An edit in Medicare systems requires certain diagnosis codes appropriate to support the need for dates of service on or after January 1, 2016.

- Another edit in Medicare systems currently requires that revenue code 055x is always reported with HCPCS G0154 on hospice claims. This edit would set inappropriately on all hospice claims with dates of service on or after January 1, 2016.

The Centers for Medicare & Medicaid Services (CMS) directed the MACs to temporarily deactivate these two edits to prevent Medicare from returning claims in error. CR9474 revises these edits so MACs can reactivate them without any adverse impact.

Medicare systems also use HCPCS code G0154 in the criteria for identifying the earliest date when calculating Low Utilization Payment Adjustment (LUPA) add on amounts. When home health agencies can no longer report G0154, the earliest visit date for skilled nursing visits reported with G0299 or G0300 will not be used in the calculation. This will result in some claims not receiving LUPA add on amounts or receiving a payment based on the wrong service discipline. CR9474 corrects this error and instruct MACs to adjust home health claims to correct payments within 60 days of the implementation date of CR9474.

Finally, CR9474 contains a number of routine maintenance revisions to home health billing contained in the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 10, Home Health Agency Billing. The revisions include reformatting the presentation of remittance advice codes and ensuring code pairs are compliant with CAQH/CORE requirements. They include an update to the Pricer logic section to reflect case-mix scoring changes for calendar year 2016 and to correctly reflect LUPA add-on calculations which were effective January 1, 2014.

Additional Information

The official instruction, CR9474, issued to your MAC regarding this change, is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3553CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

Document History

Date of Change	Description
June 29, 2016	The article was revised to delete business requirement 9474.10 in the CR and the corresponding manual language in Section 20.2.5. The transmittal number and CR release date and link to the transmittal was also changed
February 5, 2016	Initial post