Program Memorandum Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-03-021 **DATE: MARCH 13, 2003**

CHANGE REQUEST 2619

SUBJECT: Provider Education Regarding Home Health Consolidated Billing (HH CB) and Provider Liability

The attached article (Attachment 1) is for publication in your next regularly scheduled bulletin, and for posting on your provider education Web site, within 2 weeks of receiving this Program Memorandum (PM). In addition, if you have a list-serv that targets the affected provider community (e.g., independent therapists and DME suppliers) you should use your list-serv to notify subscribers that important information about HH CB and provider liability is available on your Web site.

HH CB has been in effect since October 1, 2000. Since that time, therapy or supply claims subject to HH CB which were received after a home health agency (HHA) claim had been paid were denied since payment for the service had already been made to the HHA. Therapies (physical, occupational and speech-language pathology services) and medical supplies covered under the home health benefit are bundled while a patient is under a Medicare home health plan of care and subject to consolidated billing. Physician services that are paid under the physician fee schedule and billed to the carrier are not recognized as a covered home health service nor subject to consolidated billing.

During 2002, Medicare developed processes to also enforce HH CB in cases in which a consolidated therapy or supply claim was received and paid prior to the payment of the HHA claim. Under these processes, if a claim is paid and is later identified as subject to HH CB, the payment for the services will be recovered by Medicare.

Independent therapists and DME suppliers are responsible for determining whether the beneficiary they are serving is under a home health plan of care. To facilitate this determination, CMS will, in the future, have available to providers a home health inquiry information system through the Eligibility Benefit Inquiry/Response (270/271) Transaction System.

The article informs independent therapists and suppliers of their responsibility, prior to the full implementation of the inquiry transaction, to seek home health status from the beneficiary they wish to serve (or from the beneficiary's authorized representative) and/or, as a last resort, to call their contractor's provider toll free line to request home health eligibility information available on the Common Working File. Beneficiaries and their representatives should have the most complete information as to whether or not they are in a home health episode of care. The carrier's information is only based on what CMS has received from the home health agencies at the time of the contact. As a result of the latter, you should be aware of the possibility of a potential increase in calls. Unless your IVR can be used to answer these home health eligibility inquiries, direct such calls to the Customer Service Representative (CSR) as of April 1, 2003. Calls directed to the CSR for eligibility not pertaining to home health should be referred back to the IVR line.

Because your CSRs may require training in order to be able to interpret the home health information for eligibility, also attached (Attachment 2) is information on how CSRs should enter and interpret the transaction identifiers in order to respond to inquiries from providers requesting to know whether a beneficiary is currently in a home health episode of care. Training should be completed by April 1, 2003.

The *effective date* for this PM is March 13, 2003.

The *implementation date* for this PM is March 13, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after March 31, 2004.

If you have any questions concerning provider education activities addressed in this PM, contact Mary Loane at (410) 786-1405.

Attachments

Attachment 1

Independent Therapists and DME Suppliers – Billing For Therapy Services Or Supplies That May Be Part Of A Home Health Stay

Before you provide therapy services to a Medicare beneficiary, you need to be certain whether or not a home health episode of care exists for that beneficiary, and whether or not an actual home health discharge date exists. This article provides information that will help you determine whether Medicare will pay separately for your service or whether payment for the services are consolidated into Medicare's payment to a home health agency (HHA). Claims consolidated in the HHA's payment will continue to be denied and you will not receive payment! Medicare adjusts claims for services already consolidated into the HHA's payment and will recover your payment for these services. You will receive a remittance advice on any denied claim which will read as follows: **reason code B15:** ***"Payment adjusted because this procedure/service is not paid separately",*** and **remark code N70:** ***"Home health consolidated billing and payment applies."***

To help you determine whether the beneficiary is in a home health episode of care, CMS will, in the future, make home health inquiry information available to you electronically, through the Eligibility Benefit Inquiry/Response (270/271) Transaction System. Until and unless you have access to this system, it is your responsibility to simply ask the beneficiary (or his/her authorized representative) if he/she is presently under a home health plan of care. Payment for the services denied by Medicare may be sought from the beneficiary, but you should advise them of their obligation for payment prior to delivering the service.

Remember, you are responsible for determining if the beneficiary you wish to serve is eligible to receive additional Medicare payment for your services. Services provided to a beneficiary who is not eligible to receive those services because they are already in a home health plan of care, are not payable.

Attachment 2

Guidance to Carrier Customer Service Representatives in Accessing and Understanding HH Episode Information Available on the Common Working File

Customer Service Representatives at Medicare Carriers (including Durable Medical Equipment Regional Carriers) may be contacted by physical therapists or medical equipment supplies regarding a Medicare beneficiary's status in an episode of home health care. These providers need this information in order to determine whether Medicare will pay separately for their services or whether the services are subject to the consolidated billing provisions of the home health prospective payment system (HH PPS).

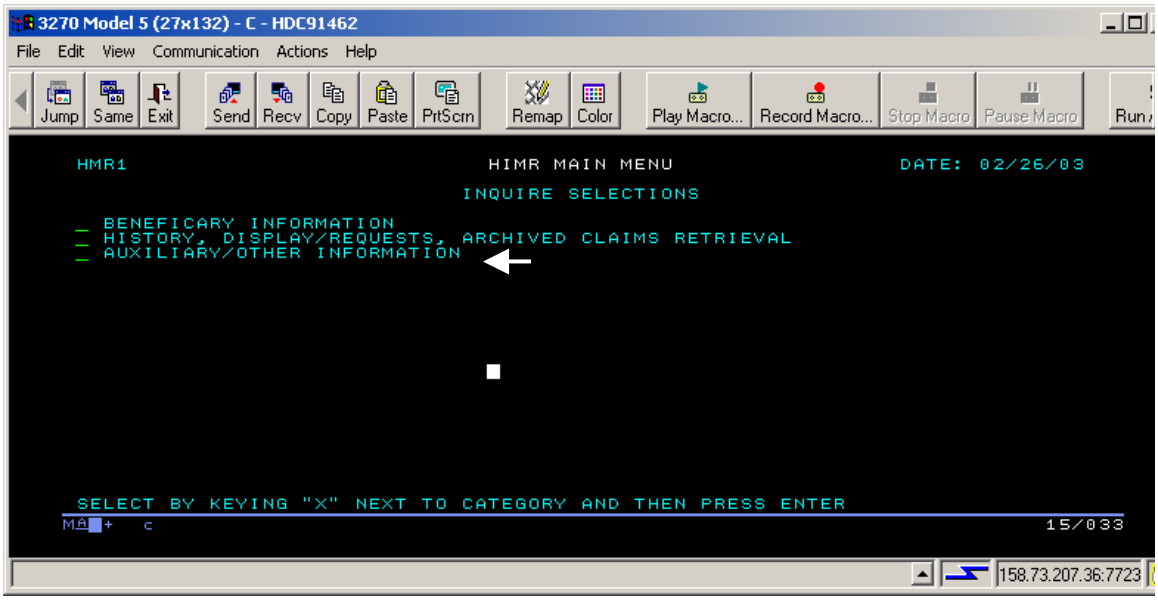
The CSR may release eligibility information to providers via the telephone after validating the provider's name and number and after obtaining the following information:

- Beneficiary last name and first initial;
- Beneficiary date of birth;
- Beneficiary Health Insurance Claim (HIC) number; and,
- Beneficiary gender.

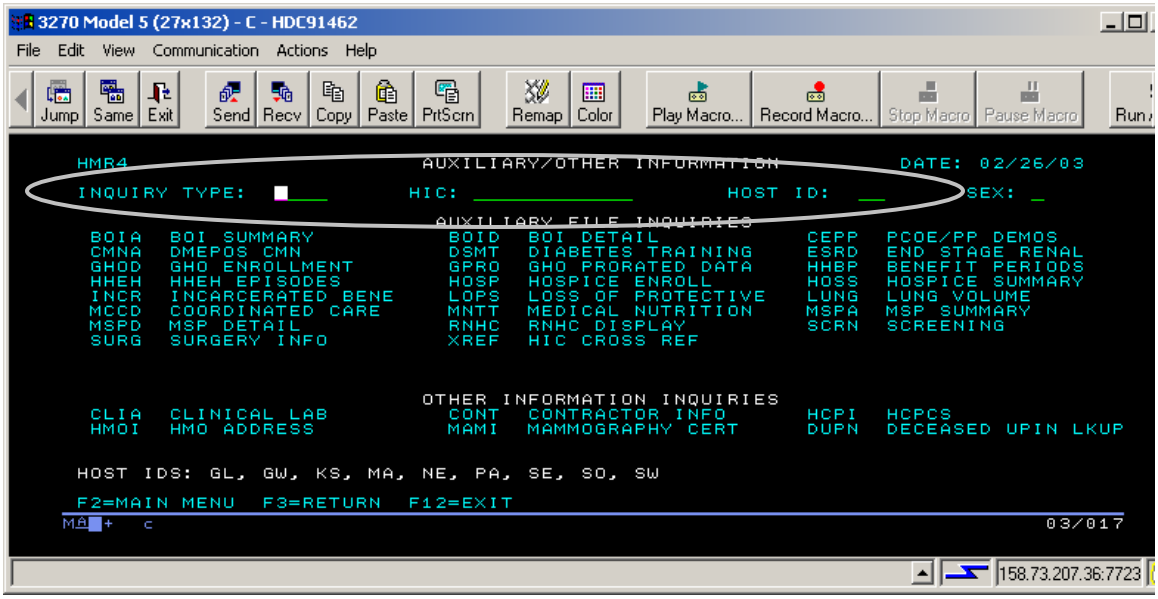
Please note that these items must match exactly.

Information indicating a beneficiary's home health status is available via the Common Working File (CWF). To access this information, take the following steps:

1) Access the CWF Health Insurance Master Record (HIMR) main menu (shown below). Select the "Auxiliary/Other Information" option by entering an S in that field.

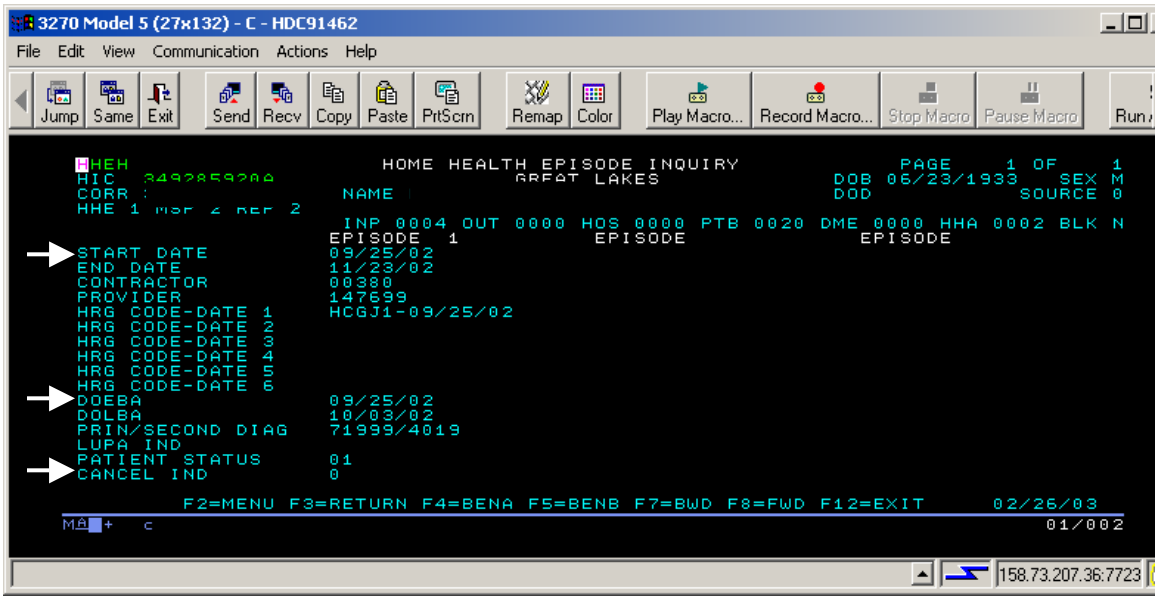


2) A screen (shown below) of "Auxiliary/Other Information" options will be displayed. In the "Inquiry Type" field, enter HHEH to access the screen to request to view a beneficiary's home health episode information. (**NOTE:** HHEH is the CWF transaction identifier for the national HH PPS episode history file described in the Medicare Intermediary Manual in §3640.5.)



In the "HIC:" field, enter the Health Insurance Claim (HIC) number that the therapist or supplier gives for the beneficiary in question. In the "Host ID" field, enter your local CWF host site. If records for the beneficiary in question are not found, enter identifiers for other CWF hosts until the records for the beneficiary are found.

3) The "Home Health Episode Inquiry" screen (shown below) will be displayed.



This screen provides all the information needed to advise the therapist or supplier regarding the beneficiary's home health episode status. The key fields to investigate are the episode "Start Date," "End Date," "DOEBA," "DOLBA" and "Patient Status." Other fields on the screen are used by Fiscal Intermediaries in adjudicating home health agency claims and can be disregarded for purposes of determining whether home health consolidated billing applies.

NOTE: DOEBA and DOLBA are the dates of the earliest and latest billing activity. They represent the earliest and latest date the beneficiary received a service visit from a home health agency.

4) Read the key fields, and advise the provider according to one of the three possible scenarios.

Scenario A: The episode "Start Date" and "End Date" are populated, the DOEBA and DOLBA fields are blank and the "Patient Status" code is 30.

What this means: A home health episode of care has been opened on CWF by the submission of a home health Request for Anticipated Payment (RAP) by the home health agency. While a record of a full 60 day episode is present, CWF does not indicate whether the beneficiary has been discharged from the home health agency during that period.

Advise the therapist or supplier: Inform the therapist or supplier of the start and end dates of the home health episode. But inform them that since record of the beneficiary's discharge status is not known, CWF information cannot conclusively determine whether home health consolidated billing will apply. Advise the provider to ask the beneficiary or the beneficiary's representative whether the beneficiary is still under the care of the home health agency.

Effect on a claim: If a therapy or supply claim is submitted before more information becomes available to CWF (through the processing a final claim for the home health episode), the therapy or supply claim would be paid. A remark code (N88) will be applied to the remittance advice for the payment, indicating that the payment is conditional and may be subject to recovery if home health consolidated billing is later found to apply.

Scenario B: The episode "Start Date" and "End Date" are populated, the DOEBA and DOLBA fields are also populated and the "Patient Status" code is 30.

What this means: A home health episode of care has been completed by the home health agency and a final claim for the episode has been processed. The patient status code of 30 (defined as "Still Patient") indicates that at the end of the episode the beneficiary had not been discharged by the home health agency. The patient will receive another episode care beginning the day after the episode end date shown.

Advise the therapist or supplier: Inform the therapist or supplier of the start and end dates of the home health episode. Inform them that since the beneficiary was under the care of the home health agency for the entire 60 day episode, home health consolidated billing applies to the entire episode period. Advise the provider that Medicare will not pay separately for therapy or non-routine supply services in this period. If the beneficiary chooses to receive the services, a payment arrangement must be made with the home health agency or the beneficiary will be liable for any charges.

Effect on a claim: If a therapy or supply claim is submitted in this instance, all services subject to home health consolidated billing will receive line item denials.

Scenario C: The episode "Start Date" and "End Date" are populated, the DOEBA and DOLBA fields are also populated and the "Patient Status" code is any value other than 30.

What this means: A home health episode of care has been completed by the home health agency and a final claim for the episode has been processed. All patient status code other than 30 indicates that the beneficiary had been discharged by the home health agency on or before the close of the 60 day episode. The patient's discharge is effective as of the "DOLBA" date.

Advise the therapist or supplier: Inform the therapist or supplier of the episode start date and the "DOLBA" date.

- If their dates of service fall between these dates (including the start date but excluding the "DOLBA" date), advise them that home health consolidated billing applies to the services and Medicare will not pay separately for therapy or non-routine supply services.

- If their dates of service fall outside these dates (i.e., they fall on or after the "DOLBA" date), advise them that home health consolidated billing does not applies to the services and Medicare will pay separately for therapy or non-routine supply services.

  Effect on a claim: If a therapy or supply claim is submitted in this instance:

- If the dates of service on the claim fall between these dates (including the start date but excluding the "DOLBA" date), all services subject to home health consolidated billing will receive line item denials.

- If the dates of service on the claim fall outside these dates (i.e., they fall on or after the "DOLBA" date), services otherwise subject to home health consolidated billing will be paid without any additional notice on the remittance advice.