CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 226 **Date: JULY 9, 2004**

CHANGE REQUEST 3350

I. SUMMARY OF CHANGES: This instruction provides the quarterly update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.25/HH PPS Consolidated Billing and Primary HHAs

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

***Medicare contractors only**

Attachment – Recurring Update Notification

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SUBJECT: Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

I. GENERAL INFORMATION

A. Background: The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list which are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing. Medicare contractors include fiscal intermediaries (FIs), carriers, and durable medical equipment regional carriers (DMERCs).

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

This recurring update notification provides the quarterly HH consolidated billing update effective October 1, 2004. Quarterly updates were not needed for April or July 2004. This is the only quarterly update for calendar year 2004. The next changes to the HH consolidated billing code list will come with the annual update for calendar year 2005. The specific change is described below.

B. Policy: Effective October 1, 2004, the following code is added to enforcement of HH consolidated billing to reflect a mid-year update to HCPCS:

G0329 Electromagntic tx for ulcers

Long descriptor for code G0329: Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is found in Medicare regulations at 42 CFR 409.100.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. All bulletins and notifications shall inform providers and suppliers that the HH consolidated billing master code list is available at the following Internet address: cms.hhs.gov/providers/hhapps/#billing.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3350.1	Medicare claims processing systems shall add HCPCS code G0329 to the list of codes used to enforce existing HH consolidated billing edits for claims with dates of service on or after October 1, 2004.	CWF

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3350.1	The current CWF home health consolidated billing edits for therapies are alert 7703, edit 5390, and the associated unsolicited response process.

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Wil Gehne, (410) 786-6148, wgehne@cms.hhs.gov (Intermediaries) Claudette Sikora, (410) 786-5618, csikora@cms.hhs.gov (Carriers) **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

10.1.25 – HH PPS Consolidated Billing and Primary HHAs

(Rev. 226, Issued 07-09-04) (Effective: October 1, 2004/Implemetation: October 4, 2004)

HH-467.35, A3-3639.35, PM-AB-00-112

The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services is to be made to a single home health agency (HHA) overseeing that plan, and this HHA is known as the primary agency or 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 a 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**.**

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 the first 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 CWF based HIQH inquiry system for HH PPS. 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 provider types including and beyond HHAs (i.e., outpatient hospital facilities, suppliers). Contractors will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under a HH plan of care when the primary HHA has already billed other services under a HH plan of care for the beneficiary. Providers and suppliers may access information on existing episodes through the ANSI X12N 270/71 inquiry process system. See §30.1.

DME is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a DMERC or billed by an HHA (including HHAs other than the primary HHA) to a RHHI. Refer to §90.1. 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.*

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 episodes are open for specific beneficiaries, only the primary HHAs serving these beneficiaries will be permitted to bill osteoporosis drugs for them. For more detailed information, refer to §90.1.