

HOME HEALTH CARE

EFFECTIVE JANUARY 1, 2020

Overview

This guide provides an overview of Medicare reimbursement methodologies and potential coding options for home health care services and CY 2020 Medicare payment rates. Reimbursement may vary under individual state Medicaid programs and commercial payer policies. Providers should consult with their appropriate payer contacts to ensure alignment on coverage, coding and payment expectations for the utilization of these technologies and/or the associated services.

Home Health Care (HHC)

Home healthcare (HHC) is a skilled service provided to patients recovering from illness or injury in their own home. It may include wound care, pain management, nutrition therapy, or physical or occupational therapy. Services are scheduled and provided through a primary certified home health agency (HHA). The HHA is required to meet the Medicare Conditions of Participation (CoP) prior to certification. They must also be in compliance with the Outcome and Assessment Information Set (OASIS) data collection and transmission requirements. The OASIS was designed to measure HHC outcomes and patient risk factors including sociodemographics, the patient's support system, health status, functional status, and health service utilization characteristics of the patient.

Patient Benefits

For a patient to be eligible under either Medicare Part A or Part B for home health services, a physician must develop a care plan and certify that the patient is eligible for HHC according to the following five requirements:

- The patient needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services;
- The patient is confined to the home (homebound);
- A plan of care (POC) has been established and will be periodically reviewed by a physician;
- Services will be furnished while the individual was or is under the care of a physician;
- A face-to-face encounter not by a physician or nurse practitioner who has a financial relationship with the HHA no more than 90 days prior to the home health start of care date, or within 30 days of the start of the home health care.

There are many circumstances that determine whether Part A or Part B is responsible for a payment of a patient's benefits. Please consult Chapter 7, Section 60 of the Medicare Benefit Policy Manual for specific instructions.
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

When patients are confined to their home, they are considered "homebound." By definition, Medicare states that "an individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive healthcare treatment."¹

Eligible services are paid to the HHA in 30-day periods of care. Payment for care is tied to a Patient Driven Grouping Model (PDGM), a revised case mixed adjustment methodology. Certification and recertification must be performed every 60 days in order to continue the Home Health benefit. If HHC is discontinued but then a new episode is required a physician must complete a new certification. For patients to continue to receive therapy services under the HHC benefit, functional reassessments must occur at least every 30 days by a qualified therapist.

Coverage

Medical Necessity

Skilled services and products provided to patients must be reasonable and necessary in order to be covered by Medicare. The HHC coverage decision is based on information in the care plan, the OASIS assessment, or from the patient's medical record.

Certification and recertification are required to be performed by a physician every 60 days. Failure to do so or insufficient documentation will result in non-payment of the HHA claim. In this case, any claim submitted for performing the certification/recertification would also be non-covered (see G0180 and G0179 below)

Some of the skilled nursing services considered reasonable and necessary include²:

- Observation and assessment of the patient's condition
- Teaching and training of family members or caregivers in the treatment regimen
- Administration of medications
- Tube feedings
- Nasopharyngeal and tracheostomy aspiration
- Catheter care
- Wound care
- Ostomy care
- Heat care
- Administration of medical gases
- Rehabilitation
- Venipuncture (except for the sole purpose of HHC services)

Coding

Coding for HHA services are reported under the ICD-10-CM, HCPCS Health Insurance Prospective Payment System (HIPPS) and revenue code systems. Payment is made on a 30-day period basis. Non routine supplies are included in the base payment under the PDGM and are not separately billable.

Coding of Certification/Recertification

The following HCPCS codes are used on physician claims when certifying/recertifying patient eligibility for HHC services:

- G0180 – Physician certification home health patient for Medicare-covered home health services under a home health plan of care
- G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care

Coding the Request for Anticipated Payment (RAP)

When submitting the initial RAP, a single revenue code line is reported using revenue code 0023 (HIPPS – Home Health PPS) with a zero charge, and a single HIPPS code that will be the basis for the anticipated payment. See below for further instructions on Split Billing.

Coding the Final Episode Claim

Final episode claims must also report the services provided to the patient during the 30-day episode of care. These are reported using the revenue and HCPCS codes listed in Table 1.

Table 1: Revenue Codes and Associated HCPCS Codes by Service Type

HCPCS CODE	REVENUE CODE	PROCEDURE DESCRIPTION
G0151, G0157, G0159	042x	Physical Therapist
G0152, G0158, G0160	043x	Occupational Therapist
G0153, G0161	044x	Speech-Language Pathologist
G0493, G0299	055x	Skilled nursing by RN
G0494, G0300	055x	Skilled nursing by LPN
G0495	055x	Skilled nursing by RN for training and education
G0496	055x	Skilled nursing by LPN for training and education
G0155	056x	Clinical Social Worker
G0156	057X	Home Health Aide

Coding for Optional Billing of DME

DME is reported either by the supplier or the HHA. If the HHA opts to report the DME on their HH PPS claims, they must use the revenue codes listed below in Table 2. DME is paid separately in addition to the HH PPS claims under a DME fee schedule. See the Medtronic DME Reimbursement Reference Guide for detailed billing of DME.

Table 2: Revenue Codes for HHA Optional Billing of DME

REVENUE CODE	PROCEDURE DESCRIPTION	REQUIRED DETAIL
027	Prosthetic/Orthotic Devices	HCPCS code, service units, date of service, charge
029x	Durable Medical Equipment (DME)	HCPCS code, service units, date of purchase, charge. Monthly rental items should be reported with a separate line for each month's rental.
060x	Oxygen (Home Health)	HCPCS code, service units, date of service, charge
0623	Medical/Surgical Supplies – Extension of 027x	Service units, charge

Payment

Payment for HHC is made under the Medicare program based on a 30-day period of care using the Home Health Prospective Payment System (HH PPS). The 30-day period payment rate includes costs for six home health provider types (disciplines) including: skilled nursing services, home health aid services, physical therapy, speech-language pathology services, occupational therapy services and medical services. New in CY 2020 there is a provision that therapist assistants can provide maintenance care.

All medical supplies (routine or non-routine) are paid under one of the assigned 432 PDGMs. Consolidated billing governs the HHPPS, which means HHA cannot “unbundle” the services and supplies included in their payment. The CY 2020 Medicare National standardized 30 - day period payment amount is \$1,864.03

Separately Billable Services Excluded from HH PPS Consolidated Billing

There are a number of services that are excluded from Consolidated Billing (CB) that may be separately billable to Part B for patients being treated as part of a 60-day HHC episode. Claims are filed by the individual provider. This includes services provided by physicians and nurse practitioners who are paid under the physician fee schedule. Supplies directly related to the service billed under this scenario are included in the physician's payment and not subject to the HH PPS consolidated billing.

Parenteral and enteral nutrition, prosthetics, orthotics, DME and DME supplies are not considered medical supplies and as such are excluded from the 60-day episode rate and should be separately billed. However, catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by a HHA are considered included in consolidated billing and should not be billed separately for patients under a home health plan of care.³ See the Medtronic DME Reimbursement Reference Guide for detailed billing of DME.

It is recommended that HHA providers consult the Home Health Consolidated Billing Mater Code List to all codes subject to CB: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html

Main Components of the Home Health Prospective Payment System (HH PPS)

Split Billing

In order to assist newly enrolled HHAs with cash flow, Medicare has continued a split billing approach based on the submittal of a Request for Anticipated Payment (RAP) by the HHA that outlines the total costs of care for a patient. Based on the overall cost Medicare will make an initial payment of 20%. Subsequent payments will be made based on 30-day periods of care. A late submission penalty will be applied for failure to submit the RAP within five calendar days of the start of the 30-day period of care and within five calendar days of day 31 for the second subsequent 30-day period of care.

Outlier Payments

When there are exceptionally large costs due to a patient's resource needs, outlier payments are available in addition to the 30-day period of care payment. The amount of the outlier payment received by the HHA may not exceed 2.5% of the total annual anticipated claims submitted to CMS.

Low Utilization Payment Adjustment (LUPA)

A Low-Utilization Payment Adjustment (LUPA) is made for patients who require four or fewer visits during the 60-day treatment plan. These visits are paid at the service specific per visit amount multiplied by the number of actual visits furnished.

A new episode begins when a patient elects to transfer to another HHA, or is discharged and readmitted to the same HHA during the 60-day treatment plan. When the new 60-day clock is started, a new plan of care reference is established, and a comprehensive assessment must be conducted. The original 30-day plan of care payment is adjusted to reflect the number of days the patient received HHC prior to the change event.

CY 2020 Transition to 30-day plan of care

The 30-day payment amount for 30-day periods of care beginning on and after January 1, 2020. Because CY 2020 is the first year of the PDGM and the change to a 30-day unit of payment, there will be a transition period to account for those home health episodes of care that span the implementation date. Therefore, for 60-day episodes (that is, not LUPA episodes) that begin on or before December 31, 2019 and end on or after January 1, 2020 (episodes that would span the January 1, 2020 implementation date), payment made under the Medicare HH PPS will be the CY 2020 national, standardized 60-day episode payment amount.

Table 3: CY 2020 Medicare National Per Visit Payment Rates⁴

HH DISCIPLINE	CY 2020 PER-VIST PAYMENT*
Home Health Aide	\$67.78
Medical Social Services	\$239.92
Occupational Therapy	\$164.74
Physical Therapy	\$163.61
Skilled Nursing	\$149.68
Speech-Language Pathology	\$177.84

*For providers who have submitted the required quality data.

Quality Reporting

As part of the CY2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act requirement to implement a quality measure addressing the transfer of health information, CMS is finalizing the adoption of two new quality measures that assess the transfer of health information. The two measures are: (1) Transfer of Health Information to Provider-Post-Acute Care; and (2) Transfer of Health Information to Patient-Post-Acute Care. These finalized measures are designed to improve patient safety by ensuring that the patient's medication list is provided to a provider and the patient as part of the discharge process. These two finalized measures also fulfill CMS's strategic initiatives to promote effective communication and coordination of care, specifically in the Meaningful Measure Initiative area of transfer of health information and interoperability.

The IMPACT Act also requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADEs). CMS is finalizing the adoption of several SPADEs to fulfill IMPACT Act requirements. These SPADEs are designed to assess cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, and social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation). The addition of these SPADEs to the Outcome and Assessment Information Set (OASIS) will improve coordination of care and facilitate communication between HHAs and other members of the healthcare community, which is in alignment with CMS's strategic initiative to improve interoperability.

Home Health Value-Based Purchasing (HHVBP) Model

One of the goals of the HHVBP Model is to enhance the current public reporting process for home health. CMS believes that publicly reporting HHVBP Model performance data would contribute to more meaningful and objective comparisons among HHAs on their level of quality relative to their peers, incentivize HHAs to improve their quality performance and could enable beneficiaries to make better informed decisions about where to receive care.

In CY 2020, CMS will publicly report the Total Performance Scores (TPS) and TPS Percentile Ranking from the Performance Year 5 (CY 2020) Annual TPS and Payment Adjustment Report (Annual Report) for each Home Health Agency (HHA) in the nine Model states that qualified for a payment adjustment for CY 2020.

Therapy Specific Coding and Reimbursement Information

Payment to Home Health Agencies is made on a 30-day episode basis under consolidated billing, and is intended to cover all costs for routine and non-routine medical supplies. However, there are a number of services that are excluded from consolidated billing that may be separately payable under Part B.

Parenteral and enteral nutrition, prosthetics, orthotics, DME and DME supplies are not considered medical supplies and as such are excluded from the 30-day episode rate and should be separately billed. However, catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by a HHA are considered included in consolidated billing and should not be billed separately for patients under a home health plan of care. See the Medtronic DME Reimbursement Reference Guide for detailed billing of DME.

It is recommended that HHA providers consult the Home Health Consolidated Billing Mater Code List to all codes subject to CB:

REFERENCES:

¹Medicare Benefit Policy Manual; Chapter 7, Section 30.1.1

²Medicare Benefit Policy Manual; Chapter 7, Section 40.1.2.

³Medicare Benefit Policy Manual; Chapter 7, Section 50.4.1.1.

⁴CY 2020 CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements Final Rule, Federal Register (84 Fed. Reg. No.217) November 8, 2019, 42 CFR Part 409, 414, 484, 486, and 488 page 60540.

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