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	Related Change Request (CR) #: CR 8136
Related CR Release Date: February 1, 2013	Effective Date: Home Health Episodes beginning on or after July 1, 2013
Related CR Transmittal #: R2650CP	Implementation Date: July 1, 2013

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

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 and indicating whether services were added to the HH plan of care by a physician who did not certify the plan of care. 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:

1. Where home health services were provided by requiring Home Health Agencies (HHAs) to report the location on the claim; and
2. When a physician (other than the certifying physician) changes/adds to the plan of care. This will enable the program to see how often additional orders are added to the plan of care.

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 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.

HHAs must report when there are changes/additions to the plan of care by a physician other than the certifying physician using a modifier to indicate changes/additions to the plan of care by a physician other than the certifying physician. Modifier XX must be appended to the HCPCS G code describing any visits added to the plan of care by that physician.

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. Modifier XX is a placeholder value. The actual modifier and its final definition will also be published in the HCPCS update. CR8136 and this article will be reissued with the final modifier information following the March 31, 2013 HCPCS update.

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/R2650CP.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.