Overview
This guide includes an overview of Medicare reimbursement methodologies and potential coding options for the use of select Medtronic technologies and services related to CY 2017 Medicare payment rates. Similarly, reimbursement opportunities may exist 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 services 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 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


When patient 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.”

Eligible services are paid to the HHA in 60-day episodes of care. At the end of the 60-day episode, patients may be eligible for subsequent 60-day episodes, but recertification is required in order to continue to receive the home health benefit. If HHC is discontinued but then a new episode is required, the physician must begin again and 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 for every 60-day episode. If this is not complete or there was insufficient documentation to support the patient’s eligibility, the HHA claim will not be covered. 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 include:

- 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
- 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 and Health Insurance Prospective Payment System (HIPPS) and revenue code systems. Payment is made on a 60-day episode basis (see below) under consolidated billing, and is intended to cover all costs for routine and non-routine medical supplies. DME is excluded from consolidated billing for HHA unless it falls under competitive bidding.

Effective October 1, 2015, all providers must submit ICD-10-CM diagnosis codes to Medicare and other payers. These codes will replace those currently submitted using ICD-9-CM diagnosis codes. As a result, Medicare provided special guidance for HHA’s who submit 60-payment episodes for episodes spanning October 1. All diagnosis codes, including the principal diagnosis, must match those reported on the OASIS form. For details on submitting these claims, refer to the MLN Matters article Number SE1410: [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf)

**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 (patient not present)
- G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

**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 60-day episode of care. These are reported using the revenue and HCPCS codes listed in Table 1 below.

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

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>REVENUE CODE</th>
<th>PROCEDURE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151, G0157, G0159</td>
<td>042x</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>G0152, G0158, G0160</td>
<td>043x</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>G0153, G0161</td>
<td>044x</td>
<td>Speech-Language Pathologist</td>
</tr>
<tr>
<td>G0154, G0163, G0164</td>
<td>055x</td>
<td>Skilled Nursing (LPN or RN)</td>
</tr>
<tr>
<td>G0155</td>
<td>056x</td>
<td>Clinical Social Worker</td>
</tr>
<tr>
<td>G0156</td>
<td>057x</td>
<td>Home Health Aide</td>
</tr>
</tbody>
</table>

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**

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

Note: HHAs may voluntarily report a separate revenue code line for charges for non-routine wound care supplies, using revenue code 0623. HHAs use this code to report charges for ALL non-routine wound care supplies, including but not limited to surgical dressings.

Providers may also request coding assistance through the Medtronic Reimbursement Support Line at 877-278-7482.

**Payment**

Payment for HHC is made under the Medicare program based on a 60-day episode of care using the Home Health Prospective Payment System (HH PPS). The 60-day episode payment rate includes costs for six home health provider types (disciplines) including: skilled nursing services, home health aide services, physical therapy, speech-language pathology services, occupational therapy services and medical social services. Included under HH PPS consolidated billing are all routine and non-routine medical supplies. Consolidated billing governs the HH PPS, which means the HHA cannot “unbundle” the services and supplies included in their payment. The CY 2017 Medicare National standardized 60-day episode payment amount is $3,019.58.

Under the Medicare HH PPS, payment can be varied based on a case-mix adjustment determined by the patient’s health condition and service needs. Adjustments to payment are also made for shortened episodes, and discharges with readmissions within the 60-day episode of care. For patients who have expensive care needs, HHAs may receive outlier payments to help off-set these costs.
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. 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 HHAs with cash flow, Medicare has established a split billing approach to the 60-day episode of care. Under this arrangement there are two separate payments; initial and final. The HHA makes an initial Request for Anticipated Payment (RAP), and a separate claim is filed at the end of the episode. The initial 60-day episode will be paid at 60% of the estimated case-mix adjusted episode payment, and 40% will be paid for the final episode claim. Subsequent 60-day episodes will be paid at a 50/50 percentage payment split.

Case Rate Adjustment

A case rate adjustment is made to the HH PPS payment based on the patient’s condition and expected therapy needs. The adjustment methodology is based on data elements from the OASIS instrument collected from the comprehensive assessment performed for each eligible 60-day episode of care. These items are used to determine the case-mix adjustment to the standard payment rate. Patients are assigned to one of 153 possible case-mix groups called Home Health Resource Groups (HHRGs) measured by the OASIS.

There are 1836 HIPPS codes for reporting the case-mix under the HH PPS. The codes, along with their CY 2017 associate case-mix weight can be found at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html

Outlier Payments

When there are exceptionally large costs due to a patient’s resource needs, outlier payments are available in addition to the 60-day case-mix adjusted episode payment. Outlier payments are made when costs exceed a threshold amount for the case-mix group. The amount of the outlier payment is determined by the amount of costs beyond the threshold, and based on a comparison of the standard per-visit amount compared to the actual number of visits by discipline reported on the claims.

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 episode. These visits are paid at the service-specific per-visit amount multiplied by the number of actual visits furnished. Refer to Table 3 for the CY 2017 per visit rates.
### Table 3: CY 2017 Medicare National Per Visit Payment Rates

<table>
<thead>
<tr>
<th>DISCIPLINE</th>
<th>CY 2017 PER-VIST PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
</tr>
</tbody>
</table>

**Partial Episode Payment (PEP) Adjustment**

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 episode. When the new 60-day episode clock is started, a new plan of care reference is established and a comprehensive assessment must be conducted. The original episode payment is adjusted to reflect the number of days the patient received HHC prior to the change event.

**Quality Reporting**

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) imposed new data reporting requirements for certain post-acute care providers, including HHAs. This includes submission of standardized data using assessments for use in the quality measures for which the IMPACT Act specifies five domains. HHAs must submit the required data or risk a 2% point reduction in their annual payment update. Details about the quality reporting measures, data submission deadlines and reconsiderations, exceptions and extensions may be found at: [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html)

“The Home Health Conditions of Participations (CoPs) require HHAs to submit OASIS assessments as a condition of payment and also for quality measurement purposes. HHAs that do not submit quality measure data to CMS will see a two percent reduction in their annual payment update (APU). In the CY 2015 rule, CMS established a minimum submission threshold for the number of OASIS assessments that each HHA must submit at 70 percent. This means that HHAs will be required to submit both admission and discharge OASIS assessments for a minimum of 70 percent of all patients with episodes of care occurring during the reporting period. CMS will increase the compliance threshold over the next two years to reach a maximum threshold of 90 percent.” [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits)

**Therapy Specific Coding and Reimbursement Information**

Payment to Home Health Agencies is made on a 60-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 for patients being treated as part of a 60-day HHC episode. Claims are filed by the individual provider.

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. 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](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html)
REFERENCES:

1 Medicare Benefit Policy Manual; Chapter 7, Section 30.1.1
2 Medicare Benefit Policy Manual; Chapter 7, Section 40.1.2.
3 Medicare Benefit Policy Manual; Chapter 7, Section 50.4.1.1.
4 CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies; Final Rule, Federal Register (79 Fed Reg, No. 215) November 6, 2014. 42 CFR Parts 409, 424, et al.
5 Medicare Benefit Policy Manual; Chapter 7, Section 50.4.1.1.

DISCLAIMER:

The information contained in this guide is for educational purposes only and is not intended to serve as reimbursement advice. The information herein is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information is subject to change, cannot guarantee coverage or reimbursement. Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient’s condition and procedures performed for a patient and to consult with each patient’s health plan for appropriate reporting of each procedure. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, ICD-10, Revenue Code publications, or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.