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Financial Liability for Services Subject to Home Health Consolidated Billing

Provider Types Affected

Home Health Agencies (HHAs) and providers and suppliers of services to Medicare patients in a home health episode of care

Provider Action Needed

This instruction is intended mostly as an informational refresher. However, the article and CR3948 clarify guidance regarding Home Health Services (HHS) consolidated billing, particularly the guidance that addresses potential provider and beneficiary liability for payment. **Providers/suppliers treating Medicare patients in an episode of home health care are encouraged to review the entire CR3948.** Instructions for accessing CR3948 are provided at the end of this article.

The Centers for Medicare & Medicaid Services (CMS) is providing this information because questions about payment liability have persisted since the Home Health Prospective Payment System (HH PPS) was implemented in October 2000. CMS believes that providing clear answers in the *Medicare Claims Processing Manual* will help you better understand HH PPS.

Background

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing for all home health services that are included under a physician-authorized home health care plan. Earlier guidance and information about HH PPS consolidated billing was primarily published in articles attached to Program Memoranda.

CR3948 (from which this article is taken) improves the organization of and clarifies instructions about HH PPS. In particular, it identifies circumstances in which providers or beneficiaries may be liable for payment for services subject to HH PPS consolidated billing.

A Short Summary of the Guidance

Under HHS consolidated billing, only the primary HHA can bill for services included in a beneficiary's home health benefit during the beneficiary's HHA episode of care. With the exception of Durable Medical Equipment (DME) and physician-provided therapy services (discussed below), Medicare will not separately pay other providers or suppliers for any home health services that they render. Therefore, providers and

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suppliers of home health services should be aware that, under certain circumstances, they, or the beneficiary, could potentially bear the cost of these services.

The Guidance in More Detail

HH PPS consolidated billing provides that the Medicare payment for all of a beneficiary's home health items and services is to be made to a single (known as "primary") HHA that oversees that beneficiary's physician-authorized home health plan. This primary HHA is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. Further, the payment Medicare makes is to the primary HHA, regardless of who actually furnishes the service (including services furnished by others under arrangement to the primary HHA, by any other contracting or consulting arrangements existing with the primary HHA, or by any other mechanism).

However, while the primary HHA is responsible for providing all of a patient's home health services, they would not be responsible for payment to another provider if they were unaware of the physician's orders for that service. Therefore, if an independent provider/supplier were to provide the beneficiary a home health service that was already consolidated into the HHA's payment, their claim would be denied by Medicare and they would not receive payment.

Types of Services Subject to Home Health Billing

The following types of services are subject to this home health consolidated billing provision, and are included in the primary HHA's payment:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine 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.

Two types of services, however, are an exception to this guidance, and are therefore not subject to the home health consolidated billing methodology. These services are:

- Physician-performed therapy services (which means that although the procedure code would be subject to HH consolidated billing, the specialty code which indicates that it was provided by a physician removes it); and
- Durable Medical Equipment (DME).

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Billing of Durable Medical Equipment

DME warrants some further discussion. DME may be billed by a supplier to a Durable Medical Equipment Regional Carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to a Regional Home Health Intermediary (RHHI). To prevent duplicate RHHI and DMERC billing (the same dates of service for the same beneficiary), Medicare system edits ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though, by law, HH consolidated billing does not apply to DME. If the RHHI and the DMERC receive duplicate bills (for either purchase or rental), the first claim received will be processed and paid, and the subsequent duplicate claims will be denied.

How Do You Protect Yourself and the Beneficiaries?

In general, all providers and suppliers serving a home health patient should attempt to protect the beneficiary from unexpected liability by notifying them of the possibility that they can be responsible for payment.

Primary HHAs

Let's first discuss your responsibilities if you are the primary HHA. When a homebound beneficiary seeks care from you, you need to determine if they are already being served by a primary HHA. You can ask the beneficiary or his/her representative, if they are already being served by an HHA. Or, you can send an inquiry to your RHHI.

If the response indicates that the beneficiary is not already under the care of another HHA, you may admit them and you will become primary. The HHA that submits a successfully processed request for anticipated payment (RAP) or No-RAP Low Utilization Payment Adjustment (LUPA) will be recorded as the primary HHA for a given episode in the Common Working File (CWF).

You may also admit them, even if an episode is already open at another HHA, if the patient has chosen to transfer. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for that patient's consolidating billing.

At the time of their initial home health care admission, you, as the primary HHA, must advise the patient that you will be providing all of their home health services, including therapies and supplies. You must also explain the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will be furnishing their care, and the proposed visit frequency.

In addition, you must advise the patient, in advance (both orally and in writing), about possible payment sources, including what Medicare is expected to cover, as well as other payment sources, including payment from the patient. This discussion should help alert the beneficiary to the possibility of payment liability if they were to obtain services from anyone other than their primary HHA.

Independent Providers/Suppliers

Since Medicare payment for services that fall under home health consolidated billing is made to the primary HHA, independent providers or suppliers of these services need to understand that Medicare will not pay you separately. Therefore, before you provide a homebound beneficiary any services, you need to first determine if they are being served by a primary HHA.

To get this information you can, first, ask the beneficiary (or their authorized representative) if they are currently receiving home health services under a home health plan of care. In fact, beneficiaries and their

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representatives should have the most complete information as to whether or not they are receiving home health care. But, beneficiary-derived HH information, in and of itself, does not shift liability to either the beneficiary or to Medicare. Additionally, you can ask your intermediary or carrier.



Institutional providers who bill Fiscal Intermediaries (FIs) can access this information electronically through the home health Common Working File (CWF) inquiry process (See Chapter 10, Section 30.1, Health Insurance Eligibility Query to Determine Episode Status attached to CR3948.) Independent therapists who bill carriers or suppliers who bill DMERCs can call the provider toll free line to request home health eligibility information available on the CWF. (Those toll free numbers are available at <http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS web site.) But remember that the carrier's or DMERC's information is based only on claims Medicare has received from HHAs by the day of the contact.

If you are concerned about the reliability of any of this information, you should advise the HH beneficiary that if they decide to accept your services rather than those provided by the primary HHA, they can be liable for the payment.

Finally, if you learn of a home health episode and contact the primary HHA, you might inquire about the possibility of making a payment arrangement with them for the service. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to the providers involved and to Medicare beneficiaries.

Hospitals

Hospitals are responsible for making Medicare beneficiaries and caregivers aware of Medicare home health coverage policies in order to:

- Help ensure that those services are provided appropriately; and
- Alert the beneficiary to their potential liability under home health consolidated billing.

Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, §482.43 (b) (3) and (6)), your discharge planning process must include an evaluation of the likelihood that a patient will require post-hospital services and an evaluation of their availability. Hospitals need to counsel those beneficiaries who are to receive HH services after discharge that their primary HHA will provide all of their home health services. You should also provide them with a list of HHAs from which to choose, and notify the agency that you are referring the patient to and provide the agency with any counseling notes. This should serve as a reminder to the HHA to notify the beneficiary that they will be providing all of their HH services.

Other Important Information

Institutionalizing an HH patient

Under HH PPS, claims for inpatient hospital and Skilled Nursing Facility (SNF) services have priority over claims for home health services. Because institutionalized beneficiaries cannot receive home care, if Medicare detects dates of service on an HH PPS claim that fall within the dates of an inpatient or SNF

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claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This will be the outcome even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later.

Edits and Denials

Claims subject to consolidated billing may be identified either pre-payment or post payment. HH consolidated billing editing is applied when Medicare has received and processed the episode claim. Any line item services within the episode start, and end, or last billable service dates, will be edited.

Medicare sends information to the FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing. This rejection or denial may take place either prior to, or after, payment. If it occurs after payment, Medicare notifies the FI or carrier to make a post-payment rejection or denial. FI post-payment recoveries will be made automatically in the claims process, and carriers follow their routine overpayment identification and recovery procedures.

Important editing issues include the following:

- If Medicare receives only a Request for Anticipated Payment (RAP) from an HHA for an episode and an incoming claim from another provider contains dates of service within the 60-day home health episode period, Medicare alerts the FI or carrier that the incoming claim may be subject to consolidated billing.

The FI or carrier will process the claim for payment, but also alerts the provider on the remittance advice with remark code N88: *"This payment is being made conditionally. An HHA episode of care notice has been filed for this patient... This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*

- If an independent provider/supplier submits a claim for services (subject to home health consolidated billing) for a beneficiary under a home health care plan (place of service on the claim is "12 home"), but Medicare does not yet have a record of either a RAP or a home health claim for the episode of care, your carrier will alert you on the remittance advice with remark code N116: *"This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care... This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*
- In HH PPS consolidated billing, non-routine medical supplies are identified as a list of discrete items by HCPCS code. Medicare periodically publishes Routine Update Notifications that contain updated lists of non-routine supply codes and therapy codes that must be included in home health consolidated billing. The lists are updated annually, effective January 1, as a result of the annual changes in HCPCS codes, and also as frequently as quarterly if required by the creation of new, mid-year HCPCS codes. (Medlearn Matters articles are prepared to inform providers of these periodic updates.)
 - Any claim submitted to a DMERC, with dates of service that overlap the dates of an open HH PPS episode and containing a non-routine supply HCPCS code, will be denied.
 - Non-routine supply HCPCS codes, which may be claimed as part of providing certain emergency, surgical, diagnostic, and End Stage Renal Disease (ESRD) services, are either bundled into the rate paid for the primary service, or are otherwise incident to the primary service(s) being rendered.

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They do not fall within the bundling provisions of HH PPS, and are not subject to CWF consolidated billing edits.

- Medicare enforces consolidated billing for outpatient therapies on claims submitted to FIs, recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes have been cross-referenced to a list of HCPCS codes that represent the same services for use in editing against carrier claims. This list will also be updated periodically by Routine Update Notification.
- Remember, however, as mentioned earlier, physician-performed therapy services are not subject to home health consolidated billing.
- **Osteoporosis drugs** are subject to home health consolidated billing, even though they continue to be paid on a cost basis. Only a primary HHA can bill for their use by Medicare patients in an episode of care. For more detailed information, refer to Section 90.1 of Chapter 10 of the *Medicare Claims Processing Manual*, which is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site.

Additional Information

This article summarizes the information made available in CR3948. Providers treating Medicare patients in a home health episode of care are encouraged to be familiar with all the details of CR3948. You can find CR3948 at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that web page, look for CR3948 in the CR NUM column on the right, and click on the file for that CR. CR3948 includes revised portions of the *Medicare Claims Processing Manual* related to the HH PPS.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS web site.

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