

Home Health Agencies & Home and Community-Based Services

Introduction

Purpose

The purpose of this module is to provide billing information applicable to Home Health Agencies (HHA) and Home and Community-Based Services Programs (HCBS).

Objectives

- Define HHA and HCBS
- Highlight HHA and HCBS Level II national and revenue codes
- Provide HHA claim examples
- Detail documentation requirements for Physician Treatment Plans
- Identify who can provide HCBS services
- Highlight the eligibility and authorization requirements for HCBS
- Provide special billing instructions for HCBS claim submission

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Home Health Program Description

An HHA is a public agency that is primarily engaged in providing skilled services as outpatient services prescribed by a physician and provided at the recipient's home. Services are conducted in accordance with a written treatment plan and are reviewed by a physician every 60 days. The treatment plan must indicate a need for one or more of the following services:

- Part-time or intermittent skilled nursing service by licensed nursing personnel
- In-home medical care services as defined in the *Welfare and Institutions Code* (W&I Code) Section 14132(t)
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Medical supplies other than drugs and biologicals
- Other home health services
- The use of medical appliances, provided for under an approved treatment plan

NOTE

Durable Medical Equipment (DME), such as an infusion pump, is reimbursable only when billed by a valid DME provider. DME cannot be billed by an HHA provider.

NOTES

Policies

Coverage Requirements

HHAs are covered subject to the requirements specified in the *California Code of Regulations*, CCR, Title 22, Section 51003, 51125, 51129, 51146, 51217, 51337, 51455 and 51523 in the following general situations:

- During the convalescent phase of post hospital or institutional discharge or during the convalescent phase following an acute episode or exacerbation of an illness of a homebound recipient.
- When the homebound patient can be maintained at home in lieu of institutional placement with skilled nursing or other care. Medi-Cal does not require that the patient receive any particular therapeutic service as prerequisite for any other therapeutic service.

Refer to *Criteria for Home Health Agency Services* on the DHCS website (www.dhcs.ca.gov/services/medi-cal/Documents/ManCriteria_29_HmeHlthAgen.htm)

HCPCS Level II Local Code Conversion

HCPCS Level III local codes were discontinued and replaced with 10 new Health Insurance Portability and Accountability Act (HIPAA)-compliant HCPCS Level II codes for dates of service on or after June 1, 2016. HIPAA now requires the use of revenue codes when submitting claims for adjudication. Claims submitted without a revenue code will be denied.

| Current CPT/HCPCS Level II Code Description | Revenue Code Description | Frequency Limitations & Authorization Requirements |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes) | 0421 (physical therapy/visits) | As authorized, or as necessary to complete initial or six month case evaluation (HCPCS code G0162 and revenue code 0583) |
| G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes) | 0431 (occupational therapy/visit) | Same as previous |

A Home Health Agencies & Home and Community-Based Services

| Current CPT/HCPCS Level II Code Description | Revenue Code Description | Frequency Limitations & Authorization Requirements |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes) | 0441 (speech pathology/visit) | Same as previous |
| G0154 (direct skilled nursing services of a licensed nurse [LPN or RN] in the home health or hospice setting, each 15 minutes) | 0551 (skilled nursing/visit) | As authorized, or as necessary to complete initial or six month case evaluation (HCPCS code G0162 and revenue code 0583) |
| G0155 (services of clinical social worker in home health or hospice settings, each 15 minutes) | 0561 (medical social services/visit) | Same as previous |
| G0156 (services of home health/hospice aide in home health or hospice setting, each 15 minutes) | 0571 (aide/home health/visit) | As authorized/TAR required |
| G0162 (skilled services by a registered nurse [RN] delivery of management/evaluation of plan of care, each 15 minutes) | 0583 (visit/home health/assessment) | Four in six months (1 hour)/TAR not required |
| G0162 (same as previous) | 0589 (visit/home health/other) | Four in six months (1 hour)/TAR not required |
| 99501 (home visit for postnatal assessment and follow-up care) | 0580 (visit/home health) | Once in six months/TAR not required |
| 99502 (home visit for newborn care and assessment) | 0580 (visit/home health) | Once in six months/TAR not required |
| 99600 (unlisted home visit service or procedure) | 0589 (visit/home health/other) | As authorized/TAR required |

TAR Reminders

Effective for dates of service on or after June 1, 2016, *Treatment Authorization Requests* (TARs) containing HCPCS Level III were end-dated and no longer permitted.

All home health services billing HCPCS Level II national codes require an approved TAR for dates of service on or after June 1, 2016.

TARs submitted with dates of service on or after June 1, 2016, require the HCPCS Level II national home health codes.

NOTE

Refer to the HCPCS Level II Local Code Conversion table for code description, revenue code and TAR requirements. All home health services billing HCPCS Level II national codes require an approved TAR on or after June 1, 2016.

NOTES

Home Health Agencies Billing

Physician Treatment Plan

Authorization requests for services beyond the case evaluation require prior approval and must include a written treatment plan that will be approved and signed by a physician within 30 working days of the treatment plan.

Since the ordering physician has 30 working days to sign a written treatment plan, an authorization request may be submitted to the TAR Processing Center with an unsigned written treatment plan. The unsigned written treatment plan must have a physician's verbal order for services, taken and recorded by a health care professional at the time services are ordered. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

The treatment plan must include:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset of the illness
- Specific types of services to be rendered by each discipline
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
- The extent to which HHA care has been previously provided and benefits or improvements demonstrated by such care
- A description of the home situation, to include whether assistance is available from household members, homemakers, attendants or others

A re-authorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

NOTE

Upon request, the written treatment plan must be available to Department of Health Care Services (DHCS) staff by providing HHA documenting evidence of the ordering physician's signature within 30 working days of the treatment plan date.

Knowledge Review

1. HHA services are provided as outpatient services.
True False
2. Treatment plans must be reviewed every:
 - a. 15 days
 - b. 30 days
 - c. 60 days
 - d. As appropriate
3. HHA claims require the use of revenue codes when submitting claims for adjudication.
True False
4. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.
True False

NOTES

Answer Key: 1) True; 2) c. 60 days; 3) True; 4) True

Same Day Services

Skilled Care Services

When performing any of the skilled care services (HCPCS codes G0151 – G0155) listed below on the same date of service as the initial or six-month case evaluation (revenue code 0583 and HCPCS code G0162), both services must be billed on the same claim and are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

| Service | HCPCS Code | Revenue Code |
|-------------------------|------------|--------------|
| Physical therapy | G1051 | 0421 |
| Occupational therapy | G0152 | 0431 |
| Speech therapy | G0153 | 0441 |
| Skilled nursing | G0154 | 0551 |
| Medical social services | G0155 | 0561 |

NOTE

Only one skilled care service may be billed in conjunction with the initial evaluation.

Mother and Baby

Services performed for a mother and baby on the same day require a separate *UB-04* claim form and a separate TAR for each recipient.

- HHA providers who render services to a mother and her newborn(s) during the neonatal period (month of delivery and subsequent month) may be reimbursed without authorization for only one initial skilled nursing visit utilizing revenue code 0551 and HCPCS code G0154.
- A case evaluation and initial treatment plan is reimbursable for the mother without authorization using revenue code 0583 and HCPCS code G0162.
- A case evaluation and initial treatment plan for the newborn using the mother's Medi-Cal ID number may be reimbursed without authorization when it is performed on a different date than the mother's case evaluation and initial treatment plan using revenue code 0583 and HCPCS code G0162.
- If more than one visit is necessary or if services are rendered to mother and infant on the same date of service for the month of birth and the following month and the infant is using the mother's ID, authorization is required.

Home Health Psychiatric Nursing Services

HHA services are excluded from coverage by the Mental Health Program (MHP) as set forth in the *California Code of Regulations* (CCR). However, home health psychiatric nursing is a skilled nursing service that may be provided by an HHA to a Medi-Cal recipient with a psychiatric illness or condition.

NOTE

HHA psychiatric nursing service visits require the submission of a TAR for approval. The TAR must be accompanied by a written plan of care approved by a physician every 62 days.

Refer to the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual for authorization requirements.

The following are examples of psychiatric services that may be provided by a home health nurse:

- Make an initial evaluation using observation and assessment skills
- Evaluate, review and teach the use of medications, emphasizing compliance
- Administer IM or I.V. medication, if necessary
- Manage situational (or other) crises; perform suicidal assessments, as necessary
- Provide psychotherapeutic assessments as ordered by the physician, which may include supportive counseling, behavior modification (for obsessive-compulsive behaviors such as hand washing) and cognitive retraining (positive thinking process)
- Provide psychological education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

Home Health Aide Services

Home health aide services (revenue code 0571 and HCPCS code G0156) are both Medicare and Medi-Cal benefits. These services may include personal care and household services that must be billed as part of a physician-approved treatment plan and must be supervised by a registered nurse therapist.

Personal care services include:

- Ambulation
- Bathing
- Catheter site care
- Feeding assistance
- Grooming
- Medical assistance
- Prescribed exercise assistance
- Range of motion exercises
- Skin care
- Transfers out of bed

Certain household services may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the home health aide's service time.

A Home Health Agencies & Home and Community-Based Services

Each “per visit allowance” is measured in units of 15-minute increments. Four units equal one hour of service, which equates to one “per visit allowance.” A maximum of four units may be billed as a “per visit allowance.” Each “per visit allowance” billed represents a minimum of one hour of service to the recipient, with the exception of “Home Health Aide Services,” which represent a minimum of two hours of the service to the recipient. The total number of services billed should be indicated in the *Service Units* field (Box 46) of the *UB-04* claim in 15-minute increments. For example, two hours of service should be billed as eight units.

NOTE

For rates regarding HHA services, refer to the chart in the *Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* (home hlth cd) section of the Part 2 manual.

Diabetes Prevention Program (DPP) Benefit

Medi-Cal providers who meet the Centers for Disease Control and Prevention (CDC) standards to offer DPP services and wish to render diabetes prevention services in addition to their other Medi-Cal services must submit a Medi-Cal Supplemental Changes Form (DHCS 6209) to DHCS. Upon approval, providers will be designated as DPP providers. Only enrolled DPP providers may be reimbursed for DPP services rendered by peer coaches who have been trained to deliver the required curriculum and have the skills, knowledge and qualities specified in the National Diabetes Prevention Program guidelines.

For more information about provider requirements, refer to the *Diabetes Prevention Program* (diabetes) section of the Part 2 manual.

Diabetes prevention services can be offered through the following delivery methods:

- In person: Participants are physically present in a classroom or classroom-like setting and peer coaches provide training.
- Distant learning: Peer coaches deliver sessions via remote classroom where the coach is present in one location and participants are calling or video-conferencing from another location.

NOTE

Providers may refer to the Frequently Asked Questions (FAQs) for DPP services on the DHCS website for additional information.

Providers are required to meet all state and federal translation and interpretation standards. Providers include the following:

- Medi-Cal provider-designated agents
- Public and private agencies and/or individuals engaged in planning, providing or securing Medi-Cal services for recipients seeking diabetes prevention services

NOTE

Information about interpretation and translation services is located in the *Provider Regulations* section of the Part 1 manual.

DPP Billing Codes

| Core Sessions (months one through six): | | |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------|
| A core session is approximately one hour and adheres to the CDC curriculum for core sessions. | | |
| HCPCS Code | Description | Notes |
| G9873 | First Medi-Cal DPP core session was attended by a DPP recipient | Payment is without regard to weight loss |
| G9874 | Four total Medi-Cal DPP core sessions were attended by a DPP recipient | |
| G9875 | Nine total DPP core sessions were attended by a DPP recipient | |

NOTE

For the complete list of billable codes for core and ongoing maintenance sessions delivered in months 7-24, refer to the *Diabetes Prevention Program* (diabetes) section of the Part 2 manual.

Medical Supplies

Medical supplies sent to Medi-Cal recipients by HHA personnel may be covered as separately reimbursable items subject to authorization. Supplies are separately reimbursable if:

- They are not used as part of a treatment visit (that is, they are left with the recipient for later use)
- They are provided in accordance with the recipient's written treatment plan

Under Medi-Cal, the medical supply used in connection with the treatment visit (for example, bandages used to change dressings) is included in the reimbursement for the nursing visit. The reimbursement is intended to include the cost of incidental supplies. Medical supplies can be considered separately reimbursable only when they are left with the recipient.

Medical supplies are:

- Subject to authorization regardless of their cost
- Billed with revenue code 0270 and HCPCS code A9999
 - Billed "By Report"
 - An invoice, an itemized list and a TAR should be attached to the claim
- Treatment plan must state these supplies are consistent with the treatment proposed

A Home Health Agencies & Home and Community-Based Services

Homebound Recipient

A homebound recipient is essentially confined to his or her home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his or her home except for brief or infrequent periods of time. Homebound Medi-Cal eligible recipients must have full-scope eligibility for the month(s) that service is rendered.

Other HHA Services

Other services provided by HHA personnel that do not apply to any of the previous categories may be separately reimbursable and subject to authorization.

Example: Respiratory therapist services should be billed with CPT code 99600 and revenue code 0589.

- Must be billed "By Report"
- An invoice, an itemized list and a TAR should be attached to the claim

Home Health Agencies Billing Scenarios

The billing scenario examples in this module are provided to assist providers in billing HHA services on the *UB-04* claim form. Please adapt to your billing situation.

Refer to the *UB-04 Completion: Outpatient Services* (ub comp op) section in the Part 2 provider manual for instructions to complete claim fields not explained in the following example. Examples are samples only.

Skilled Nursing Services: “From-Through Billing”

Figure 1 and Figure 1a. A physician has prescribed in-home medical care for a recipient who requires intermittent injections. The recipient has a written plan of care that is reviewed by the physician every 60 days. The agency that renders the services submits claims monthly. The skilled nursing visits are billed in the “from-through” format and require authorization.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

Claim line 1:

- Enter the description of the service rendered (skilled nursing visits) in the *Description* field (Box 43).
- Enter the “from” date of service (June 1, 2018) in six-digit format as 060118 in the *Service Date* field (Box 45).

Claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the specific days the services were rendered (6/1, 5, 8, 13, 20, 26 and 30) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the “through” date of service (June 30, 2018) in six-digit format as 063018 in the *Service Date* field (Box 45).
- Enter a “28” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

A Home Health Agencies & Home and Community-Based Services

Claim line 3:

- Enter code “0589” to indicate that this is a home health visit in the *Revenue Code* field (Box 42).
- Enter the description of the service rendered (administered drugs) in the *Description* field (Box 43).
- Enter the procedure code (99600) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim line 4:

- Enter code “0270” in the *Revenue Code* field (Box 42) to indicate that this home health visit involved providing medical supplies.
- Enter the description of the service rendered (medical supplies) in the *Description* field (Box 43).
- Enter the procedure code (A9999) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim line 23:

- Enter code “001” to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges in the *Total Charges* field (Box 47).

NOTES

Remaining Claim Fields

| Box # | Field name | Instructions |
|-------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4 | Type of Bill | Enter the two-digit facility type code "33" (home health – outpatient) and one-character claim frequency code "1" as "331." |
| 50 | Payer Name | Enter "O/P MEDI-CAL" to indicate the type of claim and payer. |
| 56 | NPI | Enter the HHA's NPI. |
| 63 | Treatment Authorization Codes | Enter the 11-digit TAR number. |
| 66 | ICD Indicator (DX) | Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim. |
| 67 | Unlabeled (Primary Diagnosis Code) | Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point. |
| 77 | Operating | Enter the rendering provider's NPI. |
| 80 | Remarks | HCPCS code A9999 must be billed "By Report," which requires an invoice, itemized list of supplies and a TAR to be attached to the claim. Indicate that the claim has attachments. Refer to the <i>Home Health Agencies (HHA)</i> (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions. |

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A Home Health Agencies & Home and Community-Based Services

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| 1 UPTOWN MEDICAL CENTER | 2 | | 3a PAT ONTL # | | 4 TYPE OF BILL | | |
| 140 SECOND STREET | | | b. MED. REC. # | | 331 | | |
| ANYTOWN CA 958235555 | | | 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM THROUGH 7 | | |
| 8 PATIENT NAME a | | 9 PATIENT ADDRESS a | | | | | |
| b DOE, JOHN | | | | | | | |
| 10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | |
| 17 STAT | 18 | 19 | 20 | 21 | CONDITION CODES 22 | 23 | |
| 24 | 25 | 26 | 27 | 28 | 29 ACDT STATE | 30 | |
| 31 OCCURRENCE DATE | 32 OCCURRENCE DATE | 33 OCCURRENCE DATE | 34 OCCURRENCE DATE | 35 OCCURRENCE DATE | 36 OCCURRENCE SPAN FROM THROUGH | 37 | |
| a | b | c | d | e | f | g | |
| 38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT | 42 | 43 | 44 | |
| a | b | c | d | e | f | g | |
| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
| 1 | SKILLED NURSING VISITS | | 060118 | | | | 1 |
| 2 | 0551 6/1, 5, 8, 13, 20, 26, 30 | G0154 | 063018 | 28 | 770 00 | | 2 |
| 3 | 0589 ADMINISTERED DRUGS | 99600 | 060118 | 1 | 100 00 | | 3 |
| 4 | 0270 MEDICAL SUPPLIES | A9999 | 063018 | 1 | 25 00 | | 4 |
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| 23 | 001 | PAGE OF | CREATION DATE | TOTALS | 895 00 | | 23 |

Figure 1: Partial Skilled Nursing Services

NOTES

| | | | | | | | | | |
|--------------------------------------------------------|----------------------|-------------------|-------------------------------------------------|----------------------------|---------------|----------------------|-------------------------------------|-----------------------------|------------------------------------|
| 50 PAYER NAME O/P MEDI-CAL | | 51 HEALTH PLAN ID | | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE 895 00 | 56 NPI 0123456789 | 57 OTHER PRV ID |
| 58 INSURED'S NAME | | 59 PREL | 60 INSURED'S UNIQUE ID 90000000A95001 | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | |
| 63 TREATMENT AUTHORIZATION CODES 01234567890 | | | | 64 DOCUMENT CONTROL NUMBER | | | 65 EMPLOYER NAME | | |
| 66 DX 0 | D1D1D1D | A | B | C | D | E | F | G | H |
| 68 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 FPS CODE | 72 ECI | a | b | c |
| 74 PRINCIPAL PROCEDURE CODE | DATE | a | OTHER PROCEDURE CODE | DATE | b | OTHER PROCEDURE CODE | DATE | 75 | 76 ATTENDING NPI |
| | | | | | | | | LAST | |
| | | | | | | | | FIRST | |
| c | OTHER PROCEDURE CODE | DATE | d | OTHER PROCEDURE CODE | DATE | e | OTHER PROCEDURE CODE | DATE | 77 OPERATING NPI 1234567890 |
| | | | | | | | | LAST | |
| | | | | | | | | FIRST | |
| 80 REMARKS SEE ATTACHMENTS | | 81 CC | a | b | c | d | 78 OTHER NPI | QUAL | 79 OTHER NPI |
| | | | | | | | | LAST | |
| | | | | | | | | FIRST | |
| | | | | | | | | QUAL | |
| | | | | | | | | FIRST | |

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC™ NUBC is a service mark of NUBC Corporation LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 1a: Partial Skilled Nursing Services

NOTES

Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

Figure 2 and Figure 2a. A physician has prescribed in-home medical care for a patient who had a stroke. The patient has a written plan of care that is reviewed by the physician every 60 days. This claim is submitted for initial case evaluation plus treatment plan services. No TAR is required for a skilled nursing visit rendered on the same day as the initial evaluation (HCPCS Level II code G0162). These services are billed on the same claim form.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

Claim line 1:

- Enter code “0583” in the *Revenue Code* field (Box 42) to indicate that this is a visit/home health assessment.
- Enter the description of the service rendered (Initial case evaluation) in the *Description* field (Box 43).
- Enter the procedure code (G0162) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2018) in six-digit format as 060118 in the *Service Date* field (Box 45).
- Enter a “1.” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the description of the service rendered (skilled nursing visit) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2018) in six-digit format as 060118 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

Claim line 23:

- Enter code “001” in the *Revenue Code* field (Box 42) to designate that this is the total charge line.
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

| Box # | Field name | Instructions |
|--------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4 | Type of Bill | Enter the two-digit facility type code "33" (home health – outpatient) and one-character claim frequency code "1" as "331." |
| 50 | Payer Name | Enter "O/P MEDI-CAL" to indicate the type of claim and payer. |
| 56 | NPI | Enter the HHA's NPI. |
| 66 | ICD Indicator (DX) | Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim. |
| 67 | Unlabeled (Primary Diagnosis Code) | Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point. |
| 77 | Operating | Enter the rendering provider's NPI. |

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A Home Health Agencies & Home and Community-Based Services

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|--------------------------------|--------------------------------|------------------------------|----------------------------------------|
| 1 UPTOWN MEDICAL CENTER | 2 | 3a PAT ONTL # | 4 TYPE OF BILL |
| 140 SECOND STREET | | b. MED REC # | 331 |
| ANYTOWN CA 958235555 | | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH |
| 9 PATIENT NAME | a | 9 PATIENT ADDRESS | a |
| b DOE, JOHN | b | c | d |
| 10 BIRTHDATE | 11 SEX | 12 DATE | 13 HR |
| 08241980 | M | | |
| 14 TYPE | 15 SRC | 16 DHR | 17 STAT |
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| 26 | 27 | 28 | 29 ACCT STATE |
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| 30 | 31 OCCURRENCE DATE | 32 OCCURRENCE DATE | 33 OCCURRENCE DATE |
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| 34 | 35 | 36 | 37 |
| | | | |
| 38 | 39 CODE | 40 CODE | 41 CODE |
| | | | |
| a | b | c | d |
| | | | |
| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE |
| 1 0583 | INITIAL CASE EVALUATION | G0162 | 060118 |
| 2 0551 | SKILLED NURSING VISIT | G0154 | 060118 |
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Figure 2: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

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|--------------------------------------|--|--------------------------------|----------|-------------------------------------------------|------------|---------------------------------------|-------------------------------------|-------------------------------------|--------------------|
| 50 PAYER NAME O/P MEDI-CAL | | 51 HEALTH PLAN ID | | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE 102 00 | 56 NPI 0123456789 | 57 OTHER PRV ID |
| 58 INSURED'S NAME | | | 59 P.REL | 60 INSURED'S UNIQUE ID 90000000A95001 | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | |
| 63 TREATMENT AUTHORIZATION CODES | | | | 64 DOCUMENT CONTROL NUMBER | | | 65 EMPLOYER NAME | | |
| 66 DX D1D1D1D | | A | | B | | C | | D | |
| 69 ADMIT DX 0 | | 70 PATIENT REASON DX a | | b | | 71 FPS CODE c | | 72 ECI a | |
| 74 PRINCIPAL PROCEDURE CODE DATE | | 3 OTHER PROCEDURE CODE DATE | | b OTHER PROCEDURE CODE DATE | | 75 | | 76 ATTENDING NPI LAST FIRST QUAL | |
| c OTHER PROCEDURE CODE DATE | | d OTHER PROCEDURE CODE DATE | | e OTHER PROCEDURE CODE DATE | | 77 OPERATING NPI 1234567890 | | QUAL LAST FIRST | |
| 80 REMARKS | | | | 81CC a | | 78 OTHER NPI LAST FIRST QUAL | | 79 OTHER NPI LAST FIRST QUAL | |
| | | | | b | | 79 OTHER NPI LAST FIRST QUAL | | | |
| | | | | c | | 79 OTHER NPI LAST FIRST QUAL | | | |
| | | | | d | | 79 OTHER NPI LAST FIRST QUAL | | | |

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 2a: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

NOTES

Home and Community-Based Services

Program Description

Home and Community-Based Services (HCBS) waiver services are designed to provide in-home care and support to recipients who would otherwise require institutionalization in a medical facility for a prolonged period of time.

Another goal is to ensure recipients' medical needs can be met appropriately and safely in a home environment by providing recipients an enhanced and enriched quality of life rather than receiving services in an institution.

Background

The Department of Health Care Services (DHCS) administers the In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) HCBS waivers for Medi-Cal eligible frail seniors and persons with disabilities.

These programs are approved by the Centers for Medicare & Medicaid Services (CMS), and must continuously provide cost-effective alternatives to institutionalized care in order for the state to receive federal matching funds.

HCBS Provider Participants

The following is a list of professionals allowed to provide HCBS waiver services:

- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Home Health Aide
- Nursing Care, in the home. Private Duty Nursing provided in home by RN or LVN.
- HCBS Waiver RN or LVN that provides individual nursing services. Individual nurse provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of patient.
- HCBS Benefit Provider. A Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT) or licensed psychologist. The provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of patient.
- Profession Corporation. A provider who employs a LCSW, MFT or licensed psychologist, meets HCBS waiver requirements.
- HCBS Nursing Facility. A congregate Living Health Facility or Intermediate Care Facility for the Developmentally Disabled/Continuous Nursing.
- Personal Care Services. An unlicensed individual employed by a HHA, Employment or Personal Care Agency.

Home and Community-Based Eligibility

To be eligible to receive HCBS waiver services, recipients must meet Medi-Cal's financial eligibility requirements. Medi-Cal eligibility can be met through the regular Medi-Cal eligibility or the special waiver eligibility rules.

Regular Medi-Cal Eligibility Rules

Regular Medi-Cal rules require the income and resources of the family in determining whether the potential waiver service recipient is eligible for Medi-Cal when residing in the home.

The appropriate County Welfare Department or Supplemental Security Income (SSI) office is responsible for making Medi-Cal eligibility determinations.

Special Waiver Eligibility Rules

Special waiver eligibility rules require only the income and resources of the individual seeking HCBS waiver services in determining Medi-Cal eligibility. When using special waiver eligibility, In Home Operations (IHO) first must assess the individual's income and resources to determine if they meet the medical necessity criteria for the HCBS waiver. If the determination is made, IHO coordinates with the appropriate County Welfare Department for the Medi-Cal eligibility determination.

Authorization of HCBS Services

The authorization of HCBS waiver services depends on the agreement of the following in the decision to provide services in the home in lieu of institutional care.

- Recipient
- Guardian or authorized representative
- Primary care physician
- HCBS waiver provider

A recipient may be enrolled in only one HCBS waiver program at a time. If enrolled in the Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled (DD) Waiver or AIDS Waiver, a recipient must first disenroll to be eligible for one of IHO's HCBS waivers.

Recipients are not required to disenroll from managed care plans (MCPs) to remain or enroll in a Medi-Cal waiver program (MCWP) authorized under Section 1915(c) of the Social Security Act.

HCBS Waivers and IHO and NF/AH Waivers Defined

HCBS waiver services provide in-home care to recipients who otherwise require prolonged institutionalization in one of the following facility types:

- Acute care hospital
- Adult or pediatric subacute nursing facility
- Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B)
- Intermediate Care Facility for Developmentally Disabled

In-Home Operations (IHO) and Nursing Facility/Acute Hospital (NF/AH) Waivers

In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) waivers provide services in the home to Medi-Cal recipients who would otherwise receive care in an intermediate care facility. IHO and the NF/AH waivers also provide services to Medi-Cal recipients in an intermediate care facility for the developmentally disabled who require continuous nursing, a skilled nursing facility, a subacute nursing facility or an acute care hospital.

Diabetes Prevention Program (DPP) Benefit

Medi-Cal providers who meet the Centers for Disease Control and Prevention (CDC) standards to offer DPP services and wish to render diabetes prevention services in addition to their other Medi-Cal services must submit a Medi-Cal Supplemental Changes Form (DHCS 6209) to DHCS. Upon approval, providers will be designated as DPP providers. Only enrolled DPP providers may be reimbursed for DPP services rendered by peer coaches who have been trained to deliver the required curriculum and have the skills, knowledge and qualities specified in the National Diabetes Prevention Program guidelines. Information about provider requirements is located in the *Diabetes Prevention Program* section of the Part 2 manual.

Diabetes prevention services can be offered through the following delivery methods:

- In person: Participants are physically present in a classroom or classroom-like setting and peer coaches provide training.
- Distant learning: Peer coaches deliver sessions via remote classroom where the coach is present in one location and participants are calling or video-conferencing from another location.

NOTE

Providers may refer to the Frequently Asked Questions (FAQs) for DPP services on the DHCS website for additional information.

Providers are required to meet all state and federal translation and interpretation standards. Providers include the following:

- Medi-Cal provider-designated agents
- Public and private agencies and/or individuals engaged in planning, providing or securing Medi-Cal services for recipients seeking diabetes prevention services

NOTE

Information about interpretation and translation services is located in the *Provider Regulations* section of the Part 1 manual.

DPP Billing Codes

| Core Sessions (months one through six): | | |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------|
| A core session is approximately one hour and adheres to the CDC curriculum for core sessions. | | |
| HCPCS Code | Description | Notes |
| G9873 | First Medi-Cal DPP core session was attended by a DPP recipient | Payment is without regard to weight loss |
| G9874 | Four total Medi-Cal DPP core sessions were attended by a DPP recipient | |
| G9875 | Nine total DPP core sessions were attended by a DPP recipient | |

NOTE

For the complete list of billable codes for core and ongoing maintenance sessions delivered in months 7-24, refer to the *Diabetes Prevention Program* section of the Part 2 manual.

Special Billing Instruction Reminders

- All HCBS services require an approved *Treatment Authorization Request (TAR)*.
- All services billed on the claim must be approved on the TAR for the dates of service referenced on the claim.
- TAR Control Numbers (TCN) for services that have a negotiated reimbursement rate must end in "3."
- Provider number on the claim must be identical to the provider number on the TAR or claims will receive Remittance Advice Details (RAD) code 0267.
- Providers are reimbursed only for prior authorized waiver services for recipients enrolled in one of IHO's HCBS waivers. Claims for non-authorized waiver services will be denied.

For more information, refer to the *Home and Community Based Services (HCBS) (home)* and *Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates (home cd)* in the Part 2 provider manual.

NOTES

Knowledge Review

1. Home and Community-Based Services (HCBS) provide in-home care to recipients who require services for a short duration period.
True False
2. Who administers the HCBS waiver services to Medi-Cal eligible frail seniors and persons with disabilities? _____
3. Two goals of the Medi-Cal Waiver Program are:
 - a. _____
 - b. _____
4. All HCBS services require prior authorization.
True False

NOTES

Answer Key: 1) False; 2) Department of Health Care Services (DHCS); 3) Ensure recipients' medical needs can be met safely in a home environment; For the recipients to experience enhanced and enriched quality of life in their homes 4) True

Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

OBRA and IRCA (obra)

Part 2

Home and Community-Based Services (HCBS) (home)

Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates
(home cd)

Home Health Agencies (HHA) (home hlth)

Home Health Agencies (HHA) Billing Codes and Reimbursement Rates (home hlth cd)

Home Health Agencies (HHA) Billing Examples (home hlth ex)

UB-04 Completion: Outpatient Services (ub comp op)

Other References

Department of Health Care Services (DHCS) *Criteria for Home Health Agency Services*