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.

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.

Electronic Visit Verification (EVV)

The EVV system verifies that all Medi-Cal funded Personal Care Services (PCS) and Home Health Community Services (HHCS) that require an in-home visit are captured using six identified data elements. EVV is a telephone and computer-based solution that electronically verifies all in-home service visits occur. The six data elements that must be captured are listed below:

1. Type of service performed
2. Individual receiving service
3. Date of service
4. Location of service delivery
5. Individual providing service
6. Time service began and ended

Visit the Electronic Visit Verification page on the DHCS website for up-to-date guidance and information related to the implementation of EVV in California.

Home Health Agencies Billing Codes

For additional billing information, refer to *Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* (home hlth cd) section in Part 2 of the Medi-Cal provider manual.

Table of Home Health Agencies Billing Codes

Current CPT/HCPCS Level II Code Description	Revenue Code Description	Current CPT/HCPCS Level II Code Description
A9999 (Miscellaneous DME supply or accessory, not otherwise specified)	0270 (medical/surgical supplies)	As authorized/TAR required
G0088 (Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological in the individual's home, each 15 minutes)	Not applicable	As authorized/TAR required
G0089 (Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological in the individual's home, each 15 minutes)	Not applicable	As authorized/TAR required
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

Table of Home Health Agencies Billing Codes (continued)

Current CPT/HCPCS Level II Code Description	Revenue Code Description	Current CPT/HCPCS Level II Code Description
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
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] in 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
G0299 (direct skilled nursing services of RN in 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)
G0300 (direct skilled nursing services of a Licensed Practical Nurse (LPN) in home health or hospice setting, each 15 minutes)	0551 (skilled nursing/visit)	Same as previous
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

Accessing the Medi-Cal Provider Homepage

The Medi-Cal Provider website home page can be accessed by opening an internet browser, typing *mcweb.apps.prd.cammis.medi-cal.ca.gov* in the address bar and press **Enter**.

To access provider communities and their associated reference materials, navigate to Publications from the Providers drop-down menu.

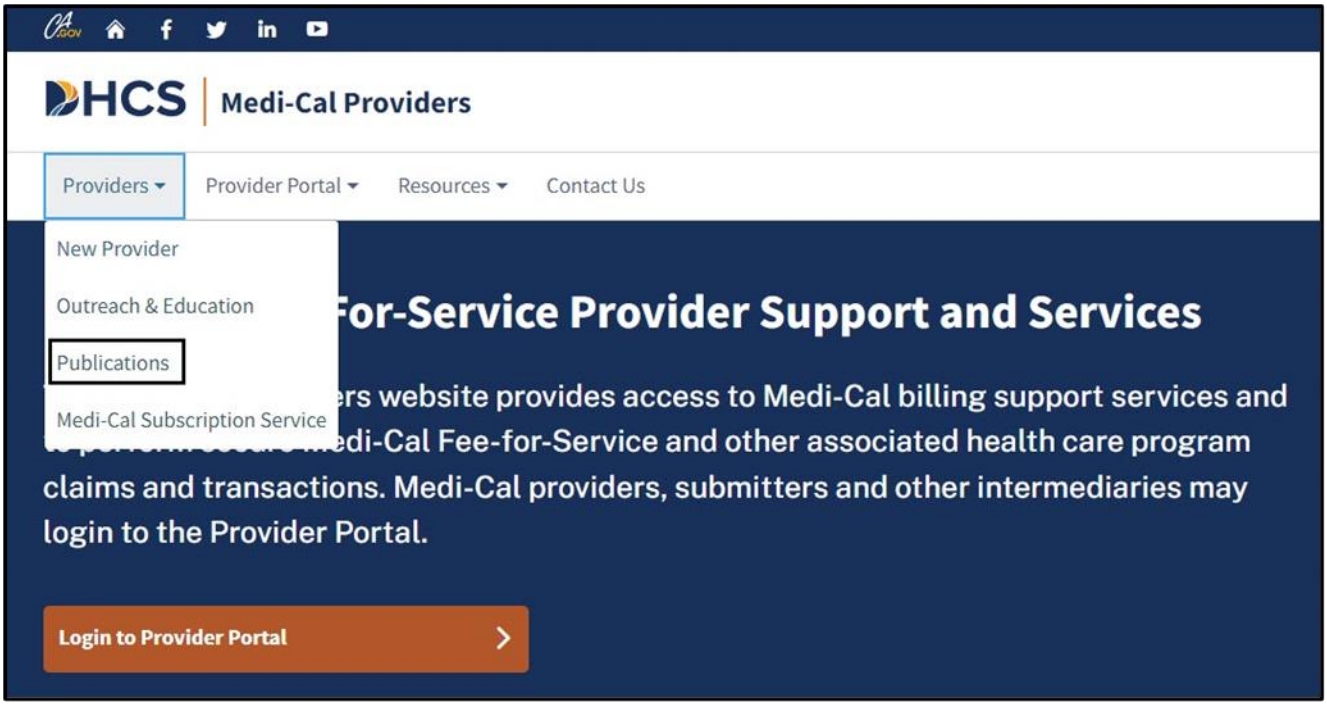


Figure 1.1: The Providers drop-down menu on the Medi-Cal Provider homepage.

Services offered within Medi-Cal are shown on the Publications page. Navigate to the Inpatient/Outpatient Community and select **Home Health Agencies/Home and Community-Based Services.**

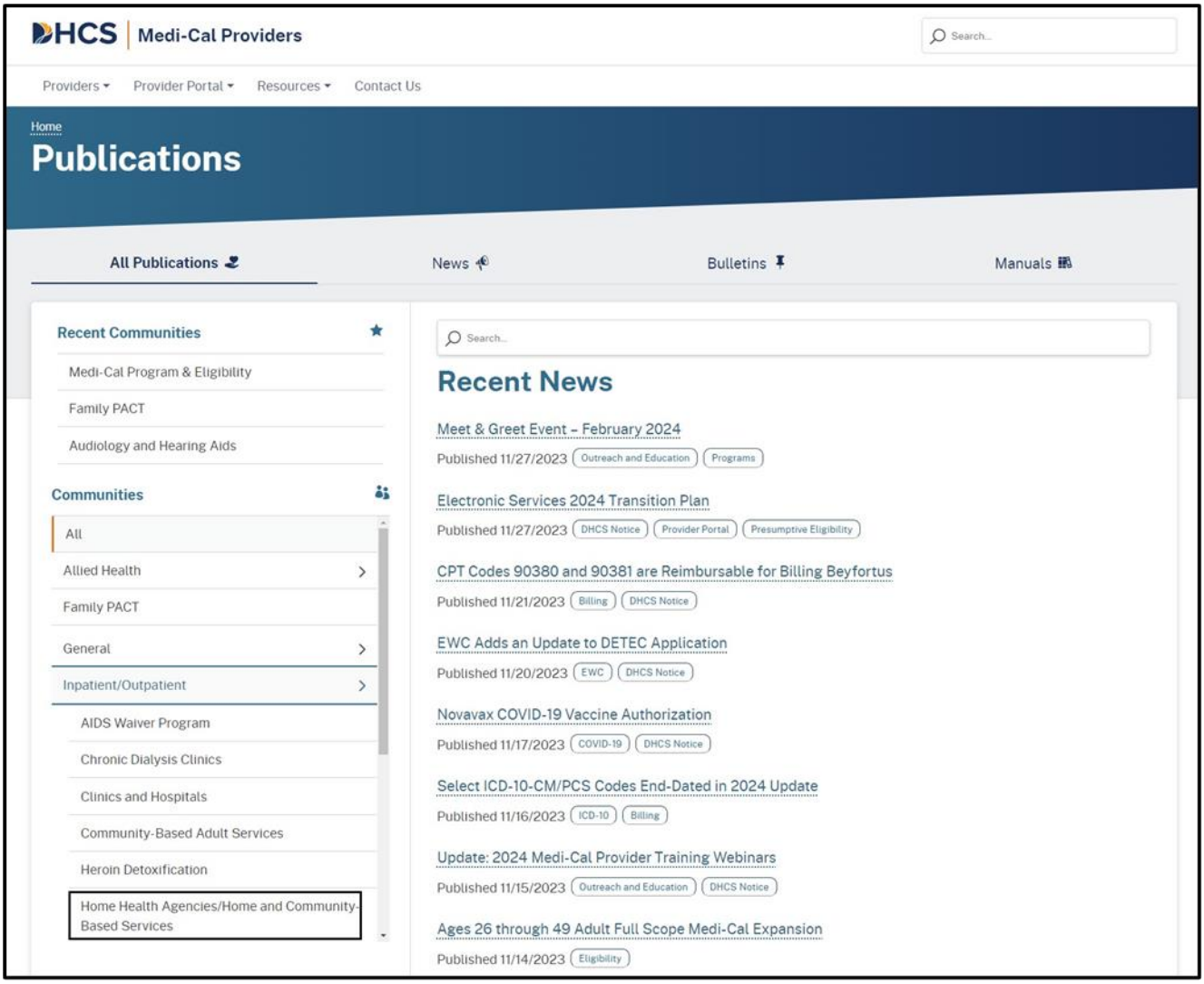


Figure 1.2: All provider communicates may be accessed individually from the Medi-Cal Provider Publications homepage.

Once you have clicked on your desired provider community, the community-specific page will appear. Every provider community page contains:

- News
- Bulletins
- Provider Manuals

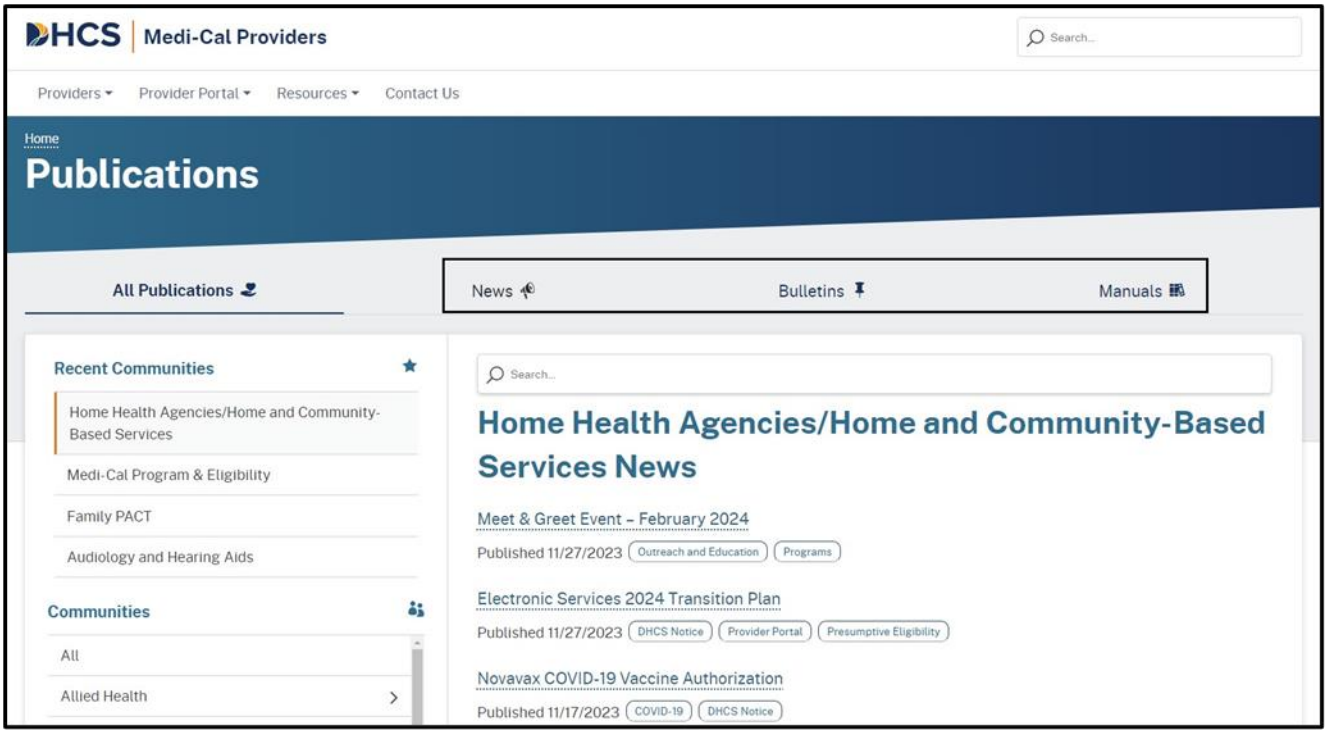


Figure 1.3: Publications Navigation Bar serves as a starting point for providers to access published materials for all communities.

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.

Face-to-Face Encounter

For all services delivered by a home health agency, a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist physician assistant or certified nurse midwife that is related to the primary reason the recipient requires the home health services is required. Face-to-face encounters may be done via telehealth.

The following conditions must be met in order for the face-to-face encounter to be satisfied:

- The provider performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician.
- The clinical findings from the face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record.
- The physician prescribing the home health agency services must document that the face-to-face encounter, which is related to the primary reason the recipient requires services by a home health agency, has occurred within 90 days prior to or within 30 days after the start of services.
- The physician writing the prescription for home health agency services must document who conducted the face-to-face encounter and the date of the encounter.

Knowledge Review 1

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. Most 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 ☐

See Appendix for Answer Key.

Same Day Services

Skilled Care Services

When performing any of the skilled care services (HCPCS codes G0151 through G0153, G0299, G0300 and 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	G0299 or G0300	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 G0299 or G0300.
- 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.

Each "per visit allowance" us 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	Payment is without regard to weight loss
G9875	Nine total DPP core sessions were attended by a DPP recipient	Payment is without regard to weight loss

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

Medical Supplies

Medical supplies given 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

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”

See samples below. 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 thru 28, 31 thru 37 and 39 thru 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 (December 1, 2022) in six-digit format as 120122 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 (12/1, 5, 8, 13, 20, 26 and 30) in the Description field (Box 43).
- Enter the procedure code (G0299) in the HCPCS/Rate field (Box 44).
- Enter the “through” date of service (December 1, 2022) in six-digit format as 120122 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).

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 120122 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 120122 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).

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 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 Home Health Agencies (HHA)* (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2	3a PAT. CNTL #	4 TYPE OF BILL: 331
		b MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD: FROM / THROUGH

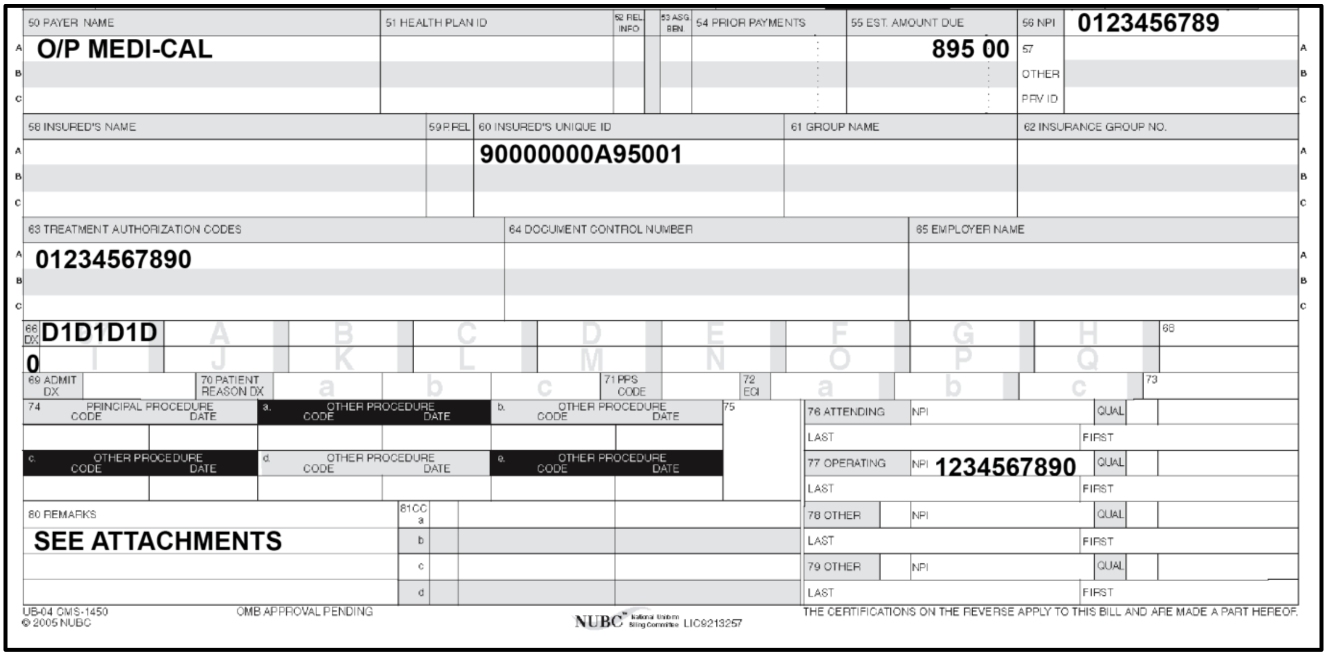
8 PATIENT NAME	9 PATIENT ADDRESS	10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE	30
b DOE, JOHN		08241980	M								

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						
b						

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a		
	b		
	c		
	d		

	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		120122				
2	0551	12/1, 5, 8, 13, 20, 26, 30	G0299	120122	28	770 00		
3	0589	ADMINISTERED DRUGS	99600	120122	1	100 00		
4	0270	MEDICAL SUPPLIES	A9999	120122	1	25 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	PAGE OF	CREATION DATE		TOTALS	895 00		

Sample: Partial Skilled Nursing Services. Please adapt to your billing situation.



50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A O/P MEDI-CAL					895 00	57
B						OTHER
C						PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		90000000A95001		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 01234567890		
B		
C		

66 DX 0 | D1D1D1D | A | B | C | D | E | F | G | H | 68
I | J | K | L | M | N | O | P | Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI 1234567890 QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
SEE ATTACHMENTS

81CC a b c d

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.

Sample: Partial Skilled Nursing Services. Please adapt to your billing situation.

Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

See samples below. 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 thru 28, 31 thru 37 and 39 thru 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 (December 1, 2022) in six-digit format as 12012022 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:

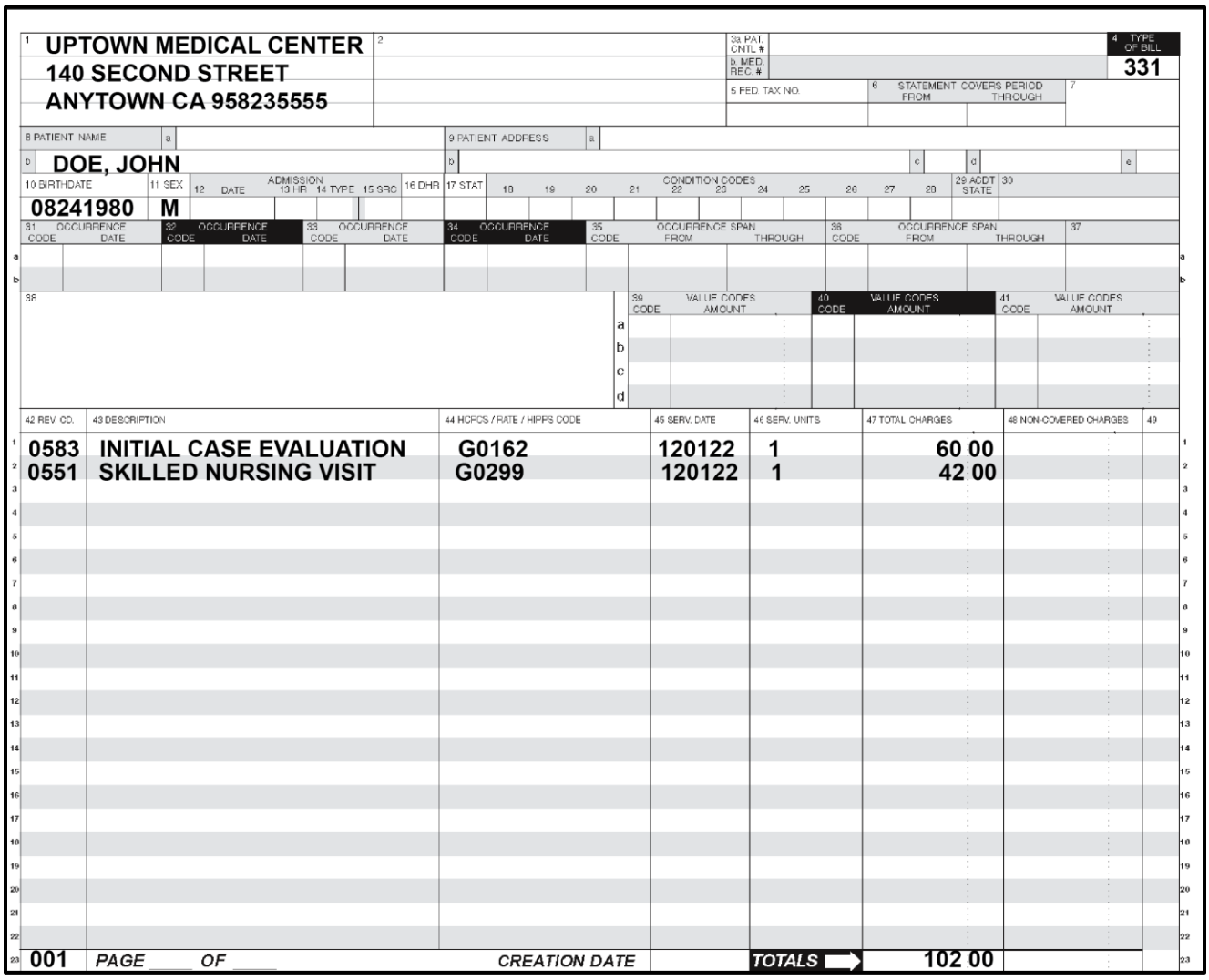
- Enter code "0551" in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the description of the service rendered (skilled nursing visit) in the *Description* field (Box 43).
- Enter the procedure code (G0299) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (December 1, 2022) in six-digit format as 120122 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 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.



1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2	3a PAT. CNTL # / b MED. REC. #	4 TYPE OF BILL: 331
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD: FROM / THROUGH

8 PATIENT NAME	9 PATIENT ADDRESS
b DOE, JOHN	

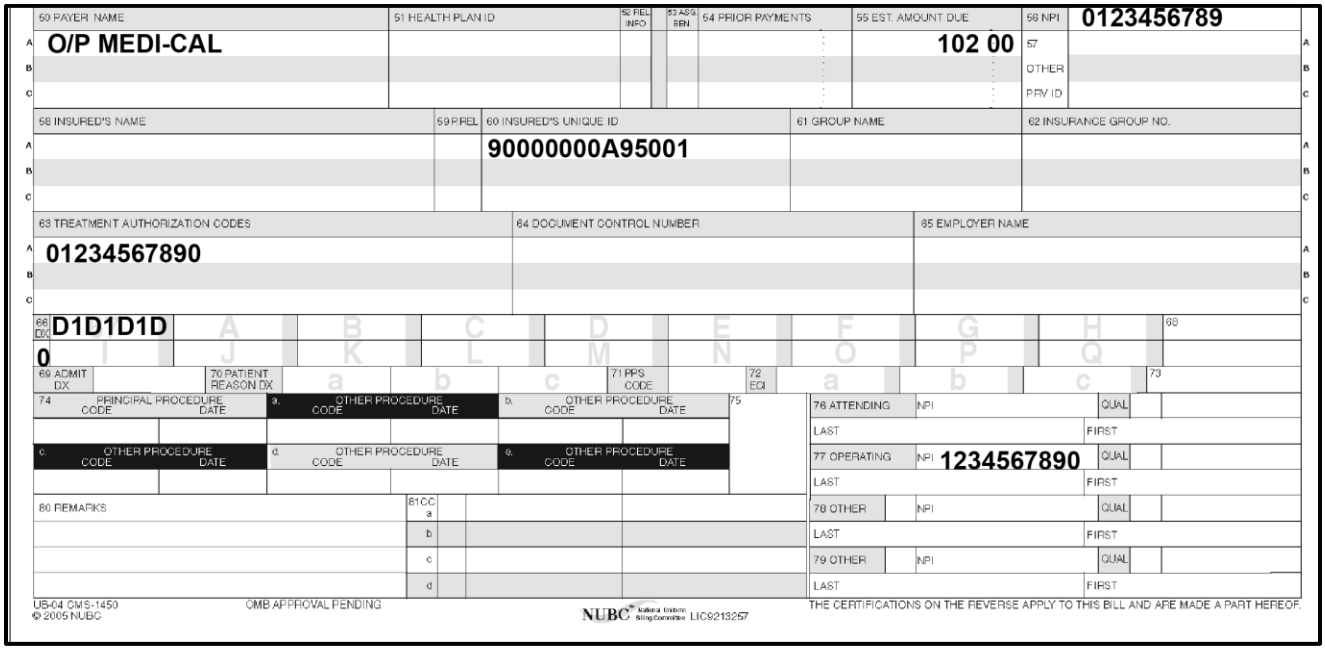
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
08241980	M									

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a		
	b		
	c		
	d		

	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	0583	INITIAL CASE EVALUATION	G0162	120122	1	60 00		
2	0551	SKILLED NURSING VISIT	G0299	120122	1	42 00		
3–22								
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS ➡	102 00		

Sample: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit. Please adapt to your billing situation.



50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789		
A O/P MEDI-CAL					102 00	57			A
B						OTHER			B
C						PRV ID			C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		90000000A95001		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 01234567890		
B		
C		

66 DX D1D1D1D A B C D E F G H 68
0 I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI 1234567890	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

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.

Sample: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit. Please adapt to your billing situation.

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.

HCBCS 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.

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.
- Recipient ID Number must be identical to the number on the recipient’s Benefits Identification Card (BIC).

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.

Knowledge Review 2

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 □

See Appendix for Answer Key.

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)

Remittance Advice Details and Medi-Cal Financial Summary (remit)

- *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*

Part 2

Diabetes Prevention Program (diabetes)

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)

Palliative Care (palli care)

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

Other References

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

Module A Answer Key

Knowledge Review 1

Question 1: HHA services are provided as outpatient services.

Answer 1: True

Question 2: Treatment plans must be reviewed every:

Answer 2: 60 days

Question 3: Most HHA claims require the use of revenue codes when submitting claims for adjudication.

Answer 3: True

Question 4: A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

Answer 4: True

Knowledge Review 2

Question 1: Home and Community-Based Services (HCBS) provide in-home care to recipients who require services for a short duration period.

Answer 1: False

Question 2: Who administers the HCBS waiver services to Medi-Cal eligible frail seniors and persons with disabilities?

Answer 2: Department of Health Care Services (DHCS)

Question 3: Two goals of the Medi-Cal Waiver Program are:

Answer 3: A) Ensure recipients' medical needs can be met safely in a home environment; B) For the recipients to experience enhanced and enriched quality of life in their homes.

Question 4: All HCBS services require prior authorization.

Answer 4: True