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Home Health and Hospice Frequently Asked Questions (FAQs) – February 2006

Q1. Can you explain how the therapy caps affect home health patients?

A1. The Centers for Medicare & Medicaid Services (CMS) implemented annual financial limitations for outpatient therapy services rendered on or after January 1, 2006, through December 31, 2006. This affects home health agency (HHA) patients that are not homebound, but are receiving outpatient Part B therapy services. A HHA bills a 34X type of bill for Part B outpatient therapy services to their fiscal intermediary. The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1740. The limit for occupational therapy is also $1740.

Q2. Can a beneficiary receive home health and hospice at the same time?

A2. A beneficiary may be eligible to receive home health care for a condition not related to their terminal illness, if the home health benefit criteria are met. The home health agency will bill their services to Medicare by including Condition Code 07 - Treatment of Non-Terminal Condition for Hospice Patient, on their claim.

Q3. Do the updated 2006 payments for home health apply to episodes ending on or after January 1, 2006 or just to episodes beginning on January 1?

A3. The 2006 Home Health Prospective Payment System (HH PPS) payment rates for home health apply to episodes ending on or after January 1, 2006. Any Request for Anticipated Payment (RAP) that begins an episode on or after 1/1/06, or any final claim which contains a through date on or after 1/1/06, are subject to the 2006 HH PPS payment rates. Please be advised that there is no payment increase for the Calendar Year 2006. Payments will be equal to the Calendar Year 2005 rates

Q4. Should our home health agency discharge a patient that elects a Medicare Health Maintenance Organization (HMO)?

A4. When a patient that is receiving the Medicare Home Health benefit elects a HMO during a home health episode, the patient's Medicare coverage is put on hold for the duration of the HMO election. The HHA must discharge the patient from Medicare services before the effective date of the HMO plan using a "06" patient status.

Q5: How do we handle billing when a HMO patient who is receiving home health services from us disenrolls from the HMO and is eligible for Medicare?

A5: If a patient disenrolls from a HMO and is eligible for Medicare home health benefits, a new start of care would begin as of the first billable visit after the termination date of the HMO election. The HHA should confirm that the termination date has been updated on the Common Working File by the HMO. This information is available for Direct Data Entry providers on page 1 of the Health Insurance Query A (HIQA) screen. If the termination date is not updated, Final Claims will reject.

Q6. Where can I find information regarding home health patients transitioning from and/or to HMOs?

A6. You may find this information including how to handle the OASIS assessments in the CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 10, Section 80. For more information regarding the OASIS requirements, you would need to contact your OASIS Education Coordinator. The name and telephone number of your representative can be found at the following Web site address:

http://www.cms.hhs.gov/OASIS/downloads/OASISeducationalcoordinators.pdf

Q7. We have a hospice patient who stays with family members in different counties throughout the month. How do we report this on the claim when there are actually two Core Based Statistical Area (CBSA) codes to report?

A7. According to CMS, home health and hospice agencies should report the CBSA code that was applicable for the last date of

service for the episode or claim.