



Home Health Billing Basics

2/10/2022



Welcome



National Government Services Provider Outreach & Education Home Health & Hospice Team

Today's
Presenter



A row of five colored rectangular boxes, each containing a circular portrait of a team member and their name and title. From left to right: a red box for Mike Davis (POE Manager), a purple box for Madeleine Collins (RN, CPHM; POE HHH Consultant), a blue box for Jan Wood (POE HHH Consultant), an orange box for Shelly Dailey (MSN, BSN, RN, CPHM; POE HHH Consultant), and a green box for Christa Shipman (POE HHH Consultant). A large, light-colored double-headed arrow is positioned below the boxes, pointing both left and right.



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Objectives

- Provide an explanation of the Home Health Prospective Payment System (HH PPS) and educate on basic billing of the Notice of Admission (NOA) and period of care claim for HH providers
- Review specific billing guidelines for NOA and claim billing

Agenda

- HH PPS Overview
- Billing the HH NOA
- Billing the HH Claim
- Claim Variations
- References and Resources
- Questions

Home Health Certification Period

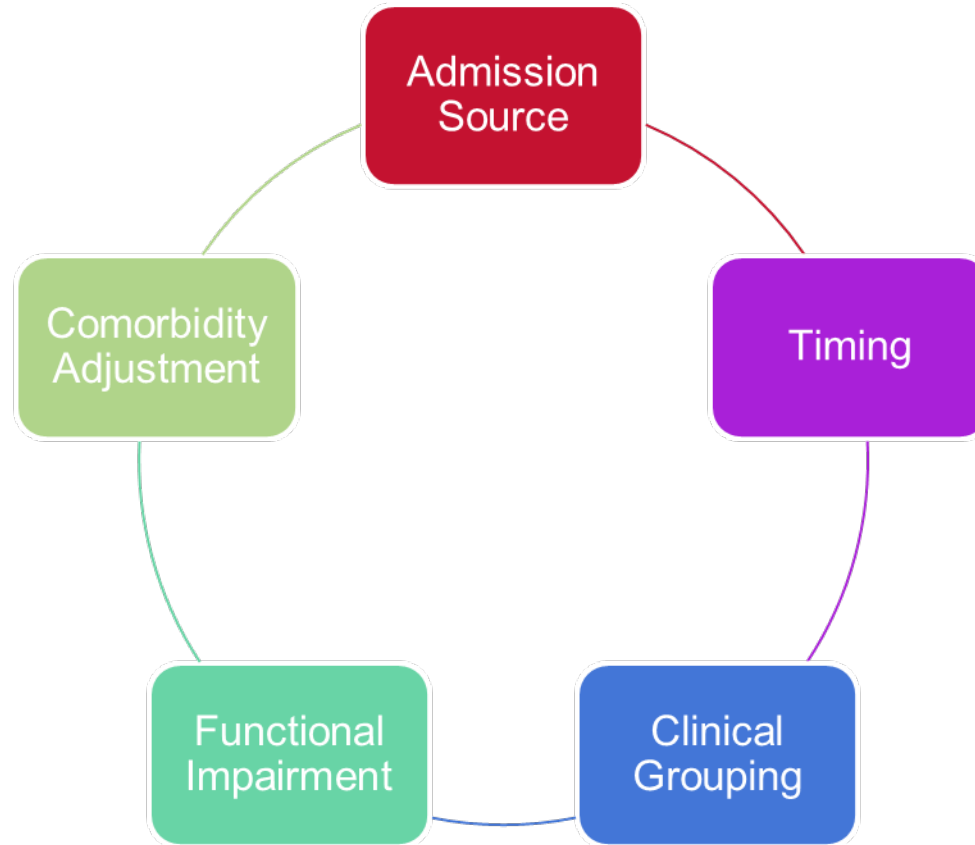
- Up to 60 days
 - Recertification if required



Patient-Driven Groupings Model (PDGM)

- PDGM effective 1/1/2020
- Payment model for HH PPS
 - 60-day certification/plan of care
 - Billed in two 30-day periods

PDGM Payment Groupings



Admission Source

Institutional

- Acute or post-acute admission within 14 days of “From” date

Community

- No acute or post-acute admission within 14 days of “From” date

Timing

Early Period

- First 30-day period

Late Period

- Second and later 30-day periods

Admission Source and Timing

- Late 30-day periods always classified as community admission unless there is an acute hospitalization 14 days prior to the period
 - HHAs have the option whether or not to discharge the patient if the patient is hospitalized for a short period of time
- Post-acute stay 14 days prior to late home health 30-day period only considered institutional if HHA discharged patient prior to post-acute stay
- HHAs have the option to include an occurrence code (61 or 62) on the claim to identify institutional admission source

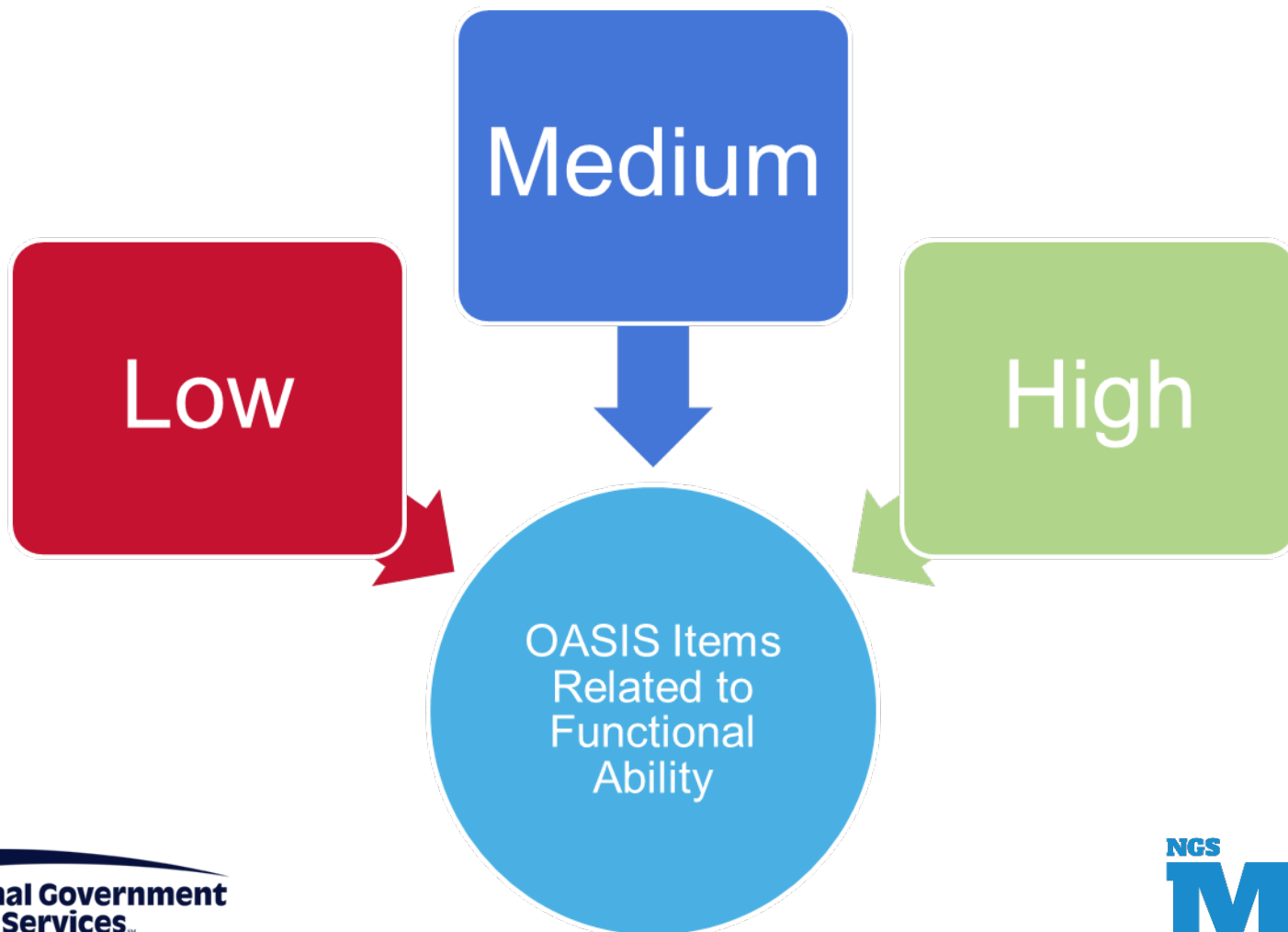
Clinical Groups

Primary Reason for Home Health Care

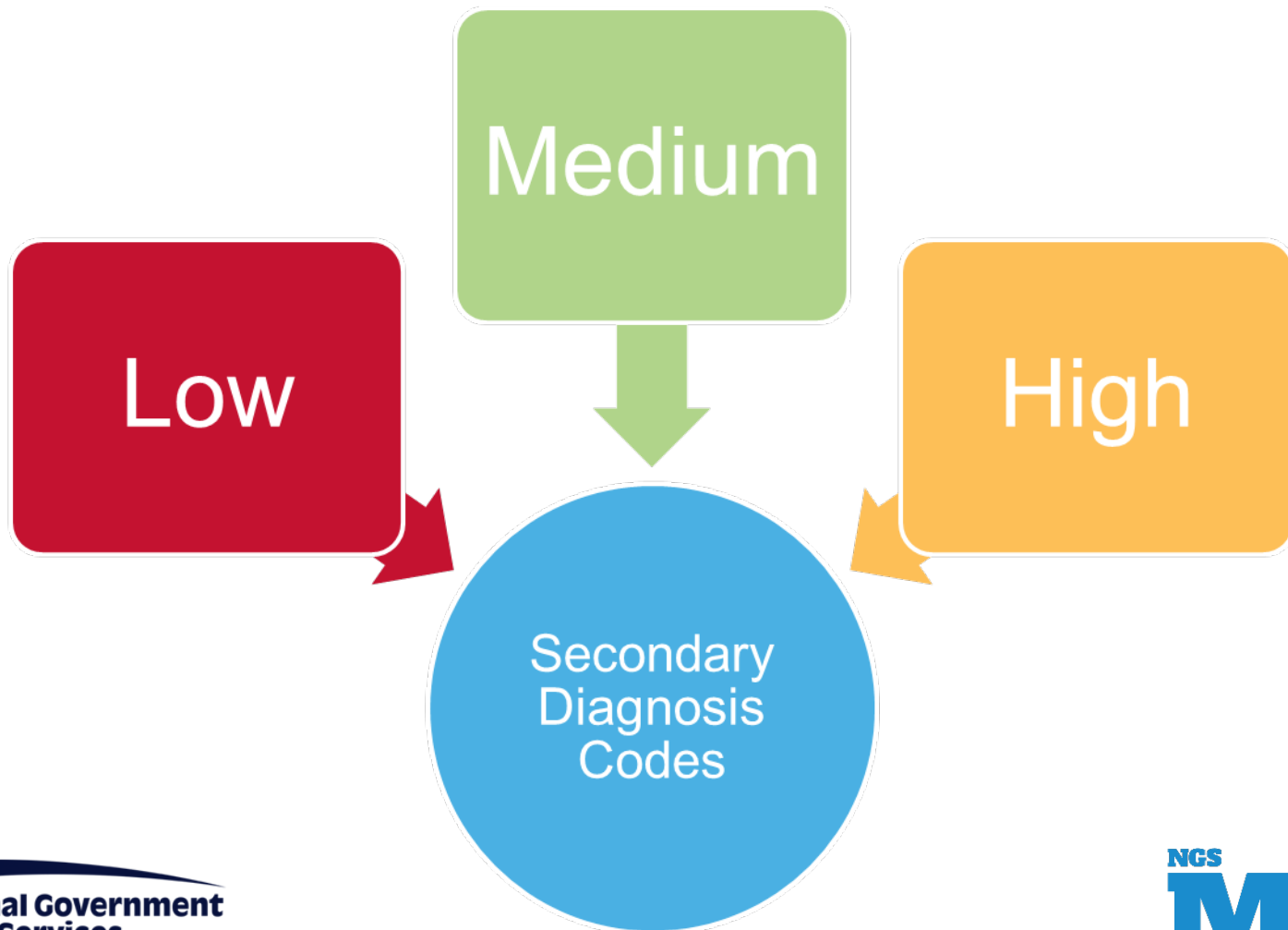
Based on Principal Diagnosis Code

12 Total Clinical Groups in PDGM Case-mix

Functional Impairment Levels



Comorbidity Adjustment



Case-mix HIPPS Coding

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1- Community Early	A- MMTA Other	A- Low	1- None	1
2- Institutional Early	B- Neuro Rehab	B- Medium	2- Low	
3- Community Late	C- Wounds	C- High	3- High	
4- Institutional Late	D- Nursing Complex Interv.			
	E- MS Rehab			
	F- Behavioral Health			
	G- MMTA Surgical Aftercare			
	H- MMTA Cardiac & Circulatory			
	I- MMTA Endocrine			
	J- MMTA GI/GU			
	K- MMTA Infectious Disease			
	L- MMTA Respiratory			

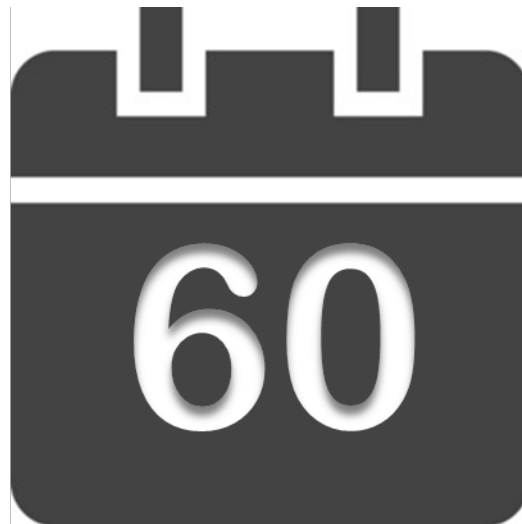
PDGM 30-day Periods

- Payment made for each 30-day period
 - Based on information submitted on period of care claim
 - NOA required at start of care to open home health admission period

Remember: OASIS, certification/recertification and plan of care based on 60 days

Period of Care Sequence/Timing

- First 30-day period classified as early
- All subsequent periods classified as late
- Periods considered subsequent as long as there are no more than 60 days between claims



Consolidated Billing

- HHA must bill for all home health services which include:

Part-time or intermittent skilled nursing services

Skilled therapy services (PT, OT, SLP)

Routine and nonroutine medical supplies

Part-time or intermittent home health aide services

Medical social services

NPWT furnished using a disposable device

Covered osteoporosis drugs as defined in [Section 1861\(kk\) of the Act](#)

NOA

- Must be submitted for any period of care that starts on or after 1/1/2022
- Purpose: open a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission
- Periods of care continuing into 2022 from 2021 need an NOA with a one-time artificial admission date that corresponds with the 'From' date of the new period of care in 2022

When to Submit the NOA

- HHA has received the appropriate physician's written or verbal order that contains the services required for an initial visit, and
- HHA has conducted the initial visit at the start of care
- NOA must be submitted within five calendar days from the start of care

Non-Timely Submission Reduction

- Payment reduction applies if HHA does not submit NOA within five calendar days from the start of care date

Note: The “From” date is day zero. Count five calendar days starting the day after the “From” date to determine timely NOA submission.

Non-Timely Submission Reduction

- Reduction in payment will be equal to a 1/30th reduction to the wage and case-mix adjusted 30-day period payment amount for all applicable periods of care until the date the HHA submits the NOA
 - The reduction would include any outlier payment
 - The reduction amount will be displayed with value code QF on the claim

Exception to Late NOA Penalty

Fires, floods, earthquakes



CMS or MAC system issue



Late certification



Circumstances determined by CMS or MAC



Exception to Late NOA Penalty

- An HHA may submit an exception request on the claim by:
 - Reporting the KX modifier with the HIPPS code on the revenue code 0023 line of Type of Bill 032x (other than 0322 and 0320) to indicate the HHA requests an exception to the late NOA penalty
 - Providing sufficient information in the remarks section of the claim to allow the MAC to research the exception request

Required Fields: NOA Claim Page 1 (DDE)

Field	Description/Notes
MID Medicare Identification	Enter the beneficiary's Medicare number.
TOB Type of Bill	32A – Notice of Admission 32D – Cancellation of Admission
NPI National Provider Identifier	Enter the home health agency's NPI number.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Report the date of the first visit provided in the admission as the "From" date. The "To" or "Through" date on the NOA must always match the "From" date.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)

Required Fields: NOA Claim Page 1 (DDE)

Field	Description/Notes
ADMIT DATE	Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date (MMDDYY). The Admission date on the NOA must always match the “From” date.
COND CODES Condition Codes	Enter condition code 47 for a patient transferred from another HHA. HHAs can also use cc 47 when the patient has been discharged from another HHA, but the discharge claim has not been submitted or processed at the time of the new admission.
FAC. ZIP	Facility ZIP Code of the provider or subpart (9 digit code).

NOA Claim Page 1

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MAP1711          M E D I C A R E  A  O N L I N E  S Y S T E M          CLAIM PAGE 01
  SC                      INST CLAIM ENTRY                      SV:
  MID                    TOB          S/LOC          OSCAR          UB-FORM
  NPI                    TRANS HOSP PROV          PROCESS NEW HIC
PAT.CNTL#:          TAX#/SUB:          TAXO.CD:
  STMT DATES FROM          TO          DAYS COV          N-C          CO          LTR
  LAST                    FIRST                    MI          DOB
  ADDR 1                    2
      3                    4
      5                    6
  ZIP          SEX  MS  ADMIT DATE          HR  TYPE  SRC  HM  STAT
  COND CODES 01  02  03  04  05  06  07  08  09  10
  OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
  SPAN CODES/DATES 01          02          03
04          05          06          07
08          09          10          FAC.ZIP
  DCN
  V A L U E  C O D E S  -  A M O U N T S  -  A N S I  MSP APP IND
01          02          03
04          05          06
07          08          09
  PLEASE ENTER DATA
  PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-EXIT
  
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Final Period Claim

Submitted

- at end of 30-day period, or
- when patient transferred, or
- when patient discharged

All services for the period must have been provided and physician has signed plan of care and all orders

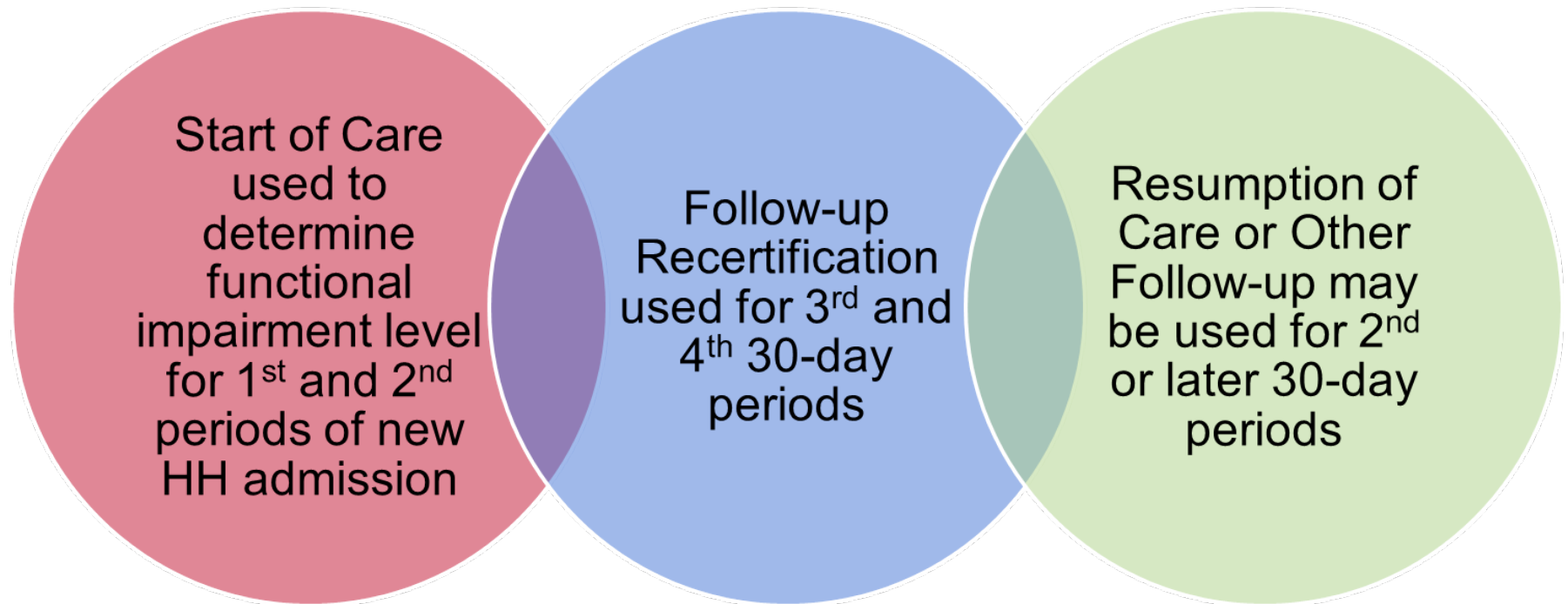
Face-to-face encounter must have been completed prior to submitting the claim

The OASIS must be submitted and accepted in the state repository (iQIES)

Claims processing system uses information from OASIS and claim to assign the HIPPS for full HH PPS payment

How OASIS Data is Used

- System looks at “From” date to find most recent OASIS



OASIS data and the claims system

- OASIS items used to determine the PDGM payment group are returned from iQIES and recorded on the claim record
- Information displayed on FISS screen MAP171G

MAP171G: OASIS Items from iQIES

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MAP171G    PAGE 03    NATIONAL GOVERNMENT SERVICES #06201 UAT    ACMFA722
KXT2938    SC                CLAIM INQUIRY                A2020300 06:45:3

MID                TOB 322    S/LOC                PROVIDER

QIES/OASIS INFORMATION

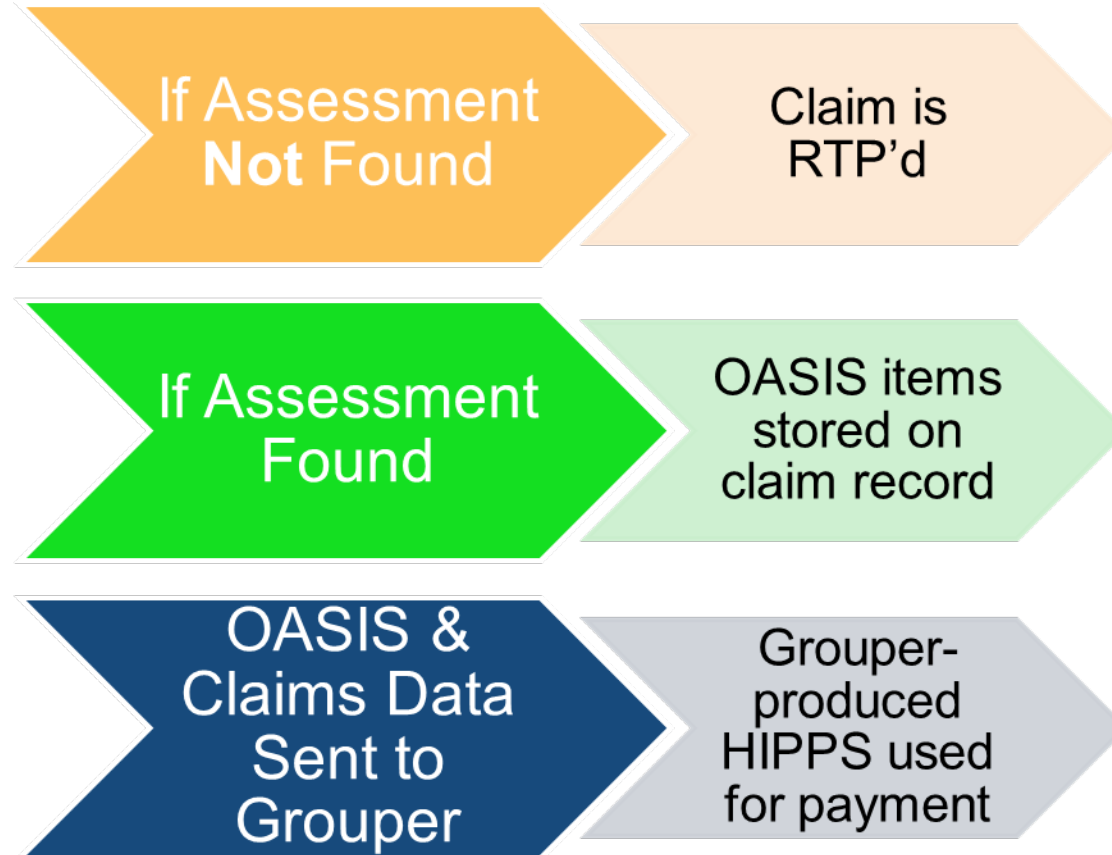
M1033-HSTRY-FALLS    OA    MR                M1033-WEIGHT-LOSS    OA    MR
M1033-MLTPL-HOSPZTN    OA    MR                M1033-MLTPL-ED-VISIT    OA    MR
M1033-MNTL-BHV-DCLN    OA    MR                M1033-COMPLIANCE    OA    MR
M1033-5PLUS-MDCTN    OA    MR                M1033-CRNT-EXHSTN    OA    MR
M1033-OTHER-RISK    OA    MR                M1033-NONE-ABOVE    OA    MR
M1800-CRNT-GROOMING    OA    MR                M1810-DRESS-UPPER    OA    MR
M1820-DRESS-LOWER    OA    MR                M1830-CRNT-BATHG    OA    MR
M1840-CRNT-TOILTG    OA    MR                M1850-CRNT-TRNSFRNG    OA    MR
M1860-CRNT-AMBLTN    OA    MR

PROCESS COMPLETED  --  PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT
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OASIS Corrections and Claim Adjustments

- OASIS information may be corrected after submitting a claim to Medicare
- No need to adjust claims every time a correction is made
- Only eight functional items (below) are used by the claims system, so claims only need to be adjusted if these items are corrected *and* the HHA believes the changes will have an impact on payment
 - M1033, M1800, M1810, M1820, M1830, M1840, M1850, M1860

Claim Match with OASIS



Required Fields: HH Period Claim Page 1

Field	Description/Notes
MID Medicare Identification	Enter the beneficiary's Medicare number.
TOB Type of Bill	329 – Home Health Final Claim for an HH PPS Period
NPI National Provider Identifier	Enter the HHA's NPI number.
PAT. CNTL# Patient Control Number	Enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From" and "Through")	Enter the beginning and ending date of the period covered by the claim. The "From" date must match the date submitted on the NOA for the initial period. MMDDYY format. The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format

Required Fields: HH Period Claim Page 1

Field	Description/Notes
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)
ADMIT DATE	The HHA enters the same date of admission that was submitted on the NOA for all periods until the patient is discharged (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC Source of Admission	Enter the appropriate NUBC code for the source of admission.
STAT Patient Status	Enter the code that most accurately describes the patient's status as of the "To" date of the billing period. Any applicable NUBC approved code may be used.
COND CODES (Condition Codes – optional field)	Some period claims may be billed with condition code 54 if there are no skilled services being billed, but there is a policy exception that allows billing covered services (e.g., home health aide services, medical social worker visits).

Required Fields: HH Period Claim Page 1

Field	Description/Notes
<p>OCC CDS/DATE Occurrence Codes and corresponding date</p>	<p>Dates entered in must be in MMDDYY format: Enter Occurrence Code 50 with OASIS completion date (OASIS item M0090).</p> <p>Enter Occurrence Code 61 if there is a hospital discharge date within 14 days of HHA admission.</p> <p>Enter Occurrence Code 62 if there is an other institutional discharge date (SNF, IRF, LTCH, or IPF) within 14 days of HHA admission.</p>
<p>FAC. ZIP</p>	<p>Facility ZIP Code of the provider or subpart (nine-digit code).</p>
<p>VALUE CODES</p>	<p>Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes.</p> <p>Enter Value Code 85 with the appropriate Federal Information Processing Standards (FIPS) code. The five-digit FIPS code must also be entered with two trailing zeroes.</p>

HH Period Claim Page 1

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MAP1711          M E D I C A R E  A  O N L I N E  S Y S T E M          C L A I M  P A G E  0 1
  SC                      I N S T  C L A I M  E N T R Y                      S V :
MID XXXXXXXXXXXX   TOB 329   S/LOC S B0100   OSCAR XXXXXX           UB-FORM
NPI XXXXXXXXXXXX   TRANS HOSP PROV           PROCESS NEW HIC
PAT.CNTL#: XX-XXXXXX   TAX#/SUB:           TAXO.CD:
  STMT DATES FROM 0217XX   TO 0317XX   DAYS COV           N-C           CO           LTR
  LAST BENE                      FIRST IMA                      MI           DOB XXXXXXXX
  ADDR 1      1234 HOPE LANE                      2 ANYWHERE, ST
        3                      4
        5                      6
ZIP XXXXXXXXXXXX SEX M MS   ADMIT DATE 0217XX HR   TYPE X SRC X   HM   STAT XX
  COND CODES 01   02   03   04   05   06   07   08   09   10
  OCC CDS/DATE 01 50 XXXXXX 02 61 XXXXXX 03           04           05
                06           07           08           09           10
  SPAN CODES/DATES 01           02           03
04           05           06           07
08           09           10           FAC.ZIP XXXXX XXXX
  DCN
  V A L U E  C O D E S   -   A M O U N T S   -   A N S I   M S P  A P P  I N D
01   61   XXXXX.00           02 85 XXXXX.00           03
04           05           06
07           08           09

PLEASE ENTER DATA
PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD   PF7-PREV   PF8-NEXT
    
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Reporting Occurrence Codes 61 and 62

- Report only one occurrence code 61 or 62 on a claim
- If two inpatient discharges occur during the 14-day window, report the later discharge date, for example:
 - HH claim “From” date — 1/20/2022
 - Inpatient hospital discharge date — 1/10/2022 (ten days prior)
 - SNF discharge date — 1/18/2022 (two days prior)
 - Report occurrence code 62 with 1/18/2022 date
- Claims with both occurrence code 61 and 62 will be returned

Required Fields: HH Period Claim Page 2

Field	Description/Notes
REV Revenue Code	Claims must report a Revenue Code line 0023 with a HIPPS code. Also required to report revenue lines for all services provided to the patient within the period of care.
HCPCS	Enter the Grouper produced HIPPS code or any valid HIPPS code under PDGM for the 0023 revenue line. For all other revenue lines, report HCPCS codes as appropriate for each revenue code.
SERV DT Service Date	For initial periods of care, report the date of the first covered visit provided during the period on the 0023 revenue line. For subsequent periods, report the date of the first visit provided during the period on the 0023 revenue line, regardless of whether the visit was covered or non-covered. Report all other service dates for additional revenue codes as appropriate. MMDDYY format.
TOT UNITS Total Service Units	Total service units – No units of service are required on the 0023 revenue line. Units of service for all other revenue codes are reported as appropriate.

Optional Field: HH Period Claim Page 2

Field	Description/Notes
TOT CHARGE Total Charges	The total charge for the 0023 revenue line must be zero. Total charges for all other revenue codes are reported as appropriate.
NCOV CHARGE Non-covered Charges	Report total noncovered charges related to the revenue line. Examples of noncovered charges on HH PPS claims may include: <ul style="list-style-type: none">• Visits provided exclusively to perform OASIS assessments• Visits provided exclusively for supervisory or administrative purposes• Therapy visits provided prior to the required re-assessments

HCPCS Codes

Discipline/Revenue Code	Applicable HCPCS Code
Physical Therapy (042X)	G0151, G0157, G0159
Occupational Therapy (043X)	G0152, G0158, G0160
Speech-Language Pathology (044X)	G0153, G0161
Skilled Nursing (055X)	G0299, G0300, G0162, G0493, G0494, G0495, G0496
Medical Social Services (056X)	G0155
Home Health Aide (057X)	G0156

Variety of services

Only one G-code per visit

Time Reporting Units

Units	Minutes (< means less than)
1	< 23 minutes
2	= 23 minutes to < 38 minutes
3	= 38 minutes to < 53 minutes
4	= 53 minutes to < 68 minutes
5	= 68 minutes to < 83 minutes
6	= 83 minutes to < 98 minutes
7	= 98 minutes to < 113 minutes
8	= 113 minutes to < 128 minutes
9	= 128 minutes to < 143 minutes
10	= 143 minutes to < 158 minutes

Site of Service Codes

- Required to be billed with first service on final period claim
- Revenue line with site of service Q-code should use the same revenue code and date of service as the first visit reported on the claim, one unit, and a nominal charge (e.g., a penny)
- If location changes during the period, new site of service code billed with first visit in new location

Site of Service Codes

HCPCS Code	Definition
Q5001	Hospice or Home Health Care Provided in Patient's Home/Residence
Q5002	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5009	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)

HH Period Claim Page 2

MAP1712 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 02
 SC INST CLAIM ENTRY REV CD PAGE 01

MID XXXXXXXXXXXX TOB 329 S/LOC S B0100 PROVIDER XXXXXX

CL	REV	HCPC	MODIFS	RATE	TOT UNIT	COV UNIT	TOT CHARGE	NCOV CHARGE	SERV DT
1	0023	2BBA1					0.00		0217XX
2	0421	G0151			00005	00005	150.00		0217XX
3	0421	Q5001			00001	00001	0.01		0217XX
4	0421	G0151			00004	00004	150.00		0223XX
5	0421	G0151			00004	00004	150.00		0301XX
6	0421	G0151			00004	00004	150.00		0303XX
7	0421	G0151			00004	00004	150.00		0308XX
8	0421	G0151			00004	00004	150.00		0310XX
9	0421	G0151			00004	00004	150.00		0315XX
10	0421	G0151			00004	00004	150.00		0317XX
13	0431	G0152			00005	00005	100.00		0302XX
14	0001						1500.01		

PLEASE ENTER DATA

PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF11-RIGHT



Required Fields: HH Period Claim Page 3

Field	Description/Notes
PAYER Payer Identification	If Medicare is the primary payer, enter “Medicare” on line A with payer code ‘Z’. Enter appropriate payer information for MSP situations.
RI Release of Information	Entering “Y”, “R” or “N” “Y” – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims “R” – Indicates the release is limited or restricted “N” – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code and any other diagnosis codes (up to 24 additional codes) to accurately record what is driving patient care. The diagnosis codes on the period claim may not always match the OASIS.

Required Fields: HH Period Claim Page 3

Field	Description/Notes
ATT PHYS Attending Physician	Enter the NPI and name (last name, first name, middle initial) of the attending physician signed the plan of care – this must be the individual physician’s NPI, not a group NPI. The physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.
OTH PHYS Other Physician	Name and NPI of the physician who certifies/recertifies the patient’s eligibility for home health care (this field only needs to be completed if the physician who certifies/recertifies is different than the physician who signs the plan of care). The individual physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.

HH Period Claim Page 3

MAP1713 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 03

SC INST CLAIM ENTRY

MID XXXXXXXXXXXX TOB 329 S/LOC S B0100 PROVIDER XXXXXX

CD	ID	PAYER	OSCAR	RI	AB	PRIOR	PAY	EST	AMT	DUE
A	Z	MEDICARE								
B				Y						
C										

DUE FROM PATIENT

MEDICAL RECORD NBR				COST RPT	DAYS	NON COST RPT	DAYS		
DIAGNOSIS CODES	1	XXXXX	2	XXXXX	3	XXXXX	4	XXXXX	5
	6		7		8		9		

ADMITTING DIAGNOSIS	E CODE	HOSPICE TERM	ILL	IND
IDE				
PROCEDURE CODES AND DATES	1	2		
3	4	5	6	

ESRD HOURS	00	ADJUSTMENT REASON	CODE	FC	REJECT CODE	NONPAY CODE
ATT PHYS		NPI XXXXXXXXXXXX	L SMITH		F ROBERT	M S SC XX
OPR PHYS		NPI	L		F	M SC
OTH PHYS		NPI XXXXXXXXXXXX	L JONES		F SARAH	M R SC XX
REN PHYS		NPI	L		F	M SC
REF PHYS		NPI	L		F	M SC

PLEASE ENTER DATA

PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT

Required Fields: HH Period Claim Page 5

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card (or the information for the primary insurer in MSP situations).
CERT/SSN/HIC/MBI	Enter the Beneficiary's Medicare number (or insured information for MSP claims) as it appears on the Medicare card if it does not automatically populate.

HH Period Claim Page 5

MAP1715 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 05

SC INST CLAIM ENTRY

MID XXXXXXXXXXXX TOB 329 S/LOC S B0100 PROVIDER XXXXXX

INSURED NAME REL **CERT-SSN-HIC-MBI** SEX GROUP NAME DOB INS GROUP NUMBER

A BENE IMA
XXXXXXXXXX

B

C

TREAT. AUTH. CODE

TREAT. AUTH. CODE

TREAT. AUTH. CODE

PLEASE ENTER DATA

PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT



Claim Variations

- Transfers
- Discharges and readmissions
- Low Utilization Payment Adjustment (LUPA)

Partial Payment Adjustment

- Beneficiary transfers from one HHA to another, or
- Beneficiary discharged and readmitted to the same agency within 30 days of the original 30-day period start date
- Case-mix adjusted payment for 30-day period prorated based on the length of the 30-day period ending in transfer or discharge and readmission

Transfers

Receiving agency coordinates with initial HHA

- Contact and coordinate transfer date
- Document communication
- Submit NOA with cc 47



Transferring agency submits discharge claim showing transfer status "06"

- * This claim will receive the partial payment adjustment

Discharge and Readmission

- Patient discharged before end of 30-day period and same agency readmits in the same 30 days
- Prorated first period – this is the claim with the partial payment adjustment (billed with “06” patient status code)
- New 30-day period begins based on NOA date

LUPA

- 30-day periods with low number of visits paid on a per-visit basis using the national per-visit rates
- LUPA periods that occur as the only period or the first period in a sequence of adjacent periods receive an increased payment for the front-loading of assessment costs and administrative costs (LUPA add-on)
- Each of the 432 different PDGM payment groups has a threshold that determines if the receives a LUPA (range is 2-6 visits in a 30-day period)

National Government Services Web Resources

- [NGS website](#)
- Events
 - Upcoming education sessions
 - Past events material
- Education
 - Medicare Topics
 - Home Health Billing (job aids)
- Medicare University
 - HH+H CBT courses

Provider Contact Center

- Resources > Contact Us > Provider Contact Center

State/Region	Toll-Free Number	IVR	PCC Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY Contact Information	866-277-7287	Monday-Friday* 8:00 a.m.-4:00 p.m. PT *Closed for training on the 2 nd and 4 th Friday of the month 9:00 a.m.-1:00 p.m. PT
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-289-0423 TTY Contact Information	866-275-7396	Monday-Friday* 8:00 a.m.-4:00 p.m. ET *Closed for training on the 2 nd and 4 th Friday of the month. 12:00-4:00 p.m. ET
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-590-6728 TTY Contact Information	866-275-3033	Monday-Friday* 8:00 a.m.-4:00 p.m. CT 9:00 a.m.-5:00 p.m. ET *Closed for training on the 2 nd and 4 th Friday of the month. 11:00 a.m.-3:00 p.m. CT 12:00-4:00 p.m. ET



NGS HHH On-Demand Videos

The screenshot displays the YouTube interface for the NGS Medicare.com channel. The main content area features a video player for "Physician Certification of Terminal Illness" with a "PLAY ALL" button. Below the player, the channel name "NGSMedicare.com" is shown as "SUBSCRIBED". A list of four videos is displayed on the right:

- 1. Hospice Documentation - Painting the Picture of the Terminal Patient (1:08:28)
- 2. Hospice - General Inpatient Documentation (1:02:34)
- 3. Home Health Eligibility Criteria - Documenting Homebound Status (44:12)
- 4. Responding to a Home Health & Hospice ADR (55:04)

CMS Resources

- [CMS website](#)
 - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
 - Chapter 7 (Home Health Services)
 - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
 - Chapter 1, Section 70 (Claim Processing Timeliness)
 - Chapter 10, Sections 40.1 and 40.2 (Home Health Agency Billing)
 - Medicare Learning Network
 - Resource Materials
 - Training
 - MLN Matters Articles

CMS Resources

- [Home Health Agency Center](#)
 - Coding and Billing Information
 - HH PPS Regulations and Notices
 - HH Change Requests/Transmittals
 - HHA Email Updates
 - Links to OASIS information

Thank You!

- Follow-up email
 - Attendees will be provided a Medicare University Course Code
- Questions?

