

# Home Health Billing Basics

10/26/2022

# Welcome

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



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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

# HH PPS Overview

# Home Health Certification Period

- Up to 60 days
  - Recertification if required

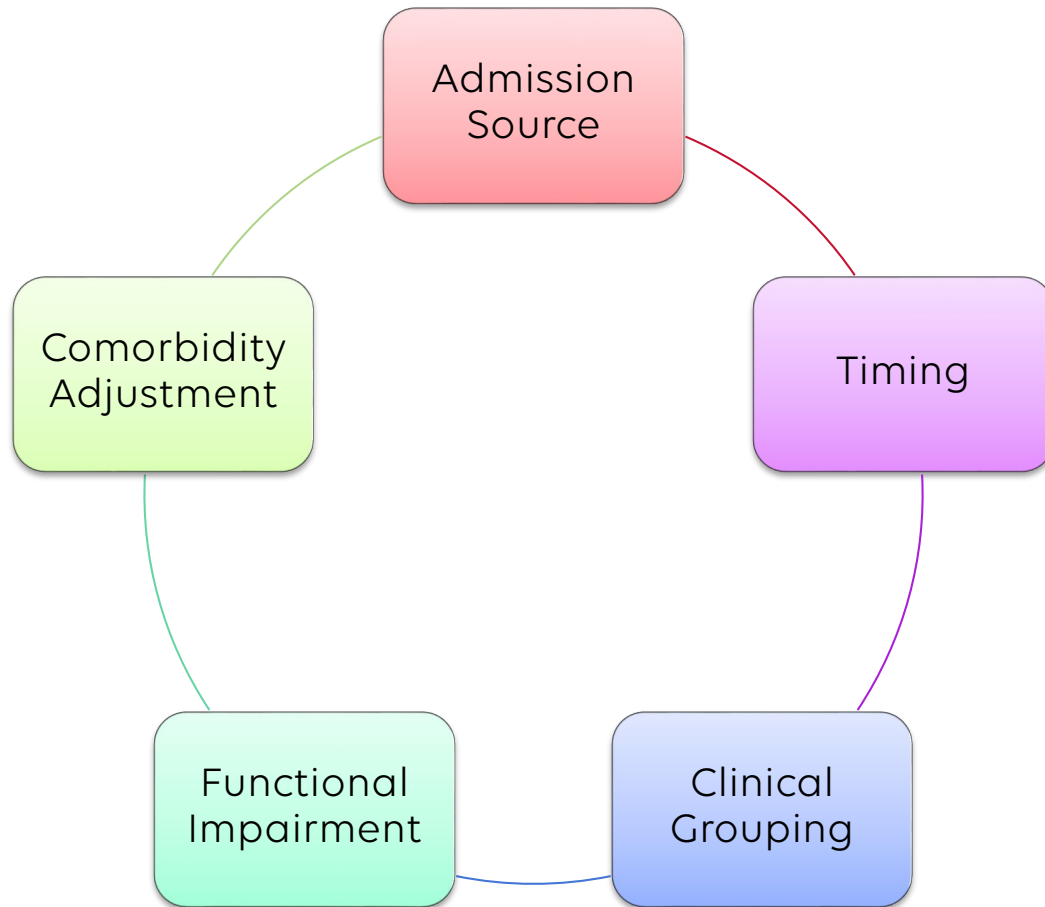




# Patient-Driven Groupings Model (PDGM)

- 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

**Note:** Periods of care considered subsequent when there are no more than 60 days between the end of one period and the start of the next period.

# 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

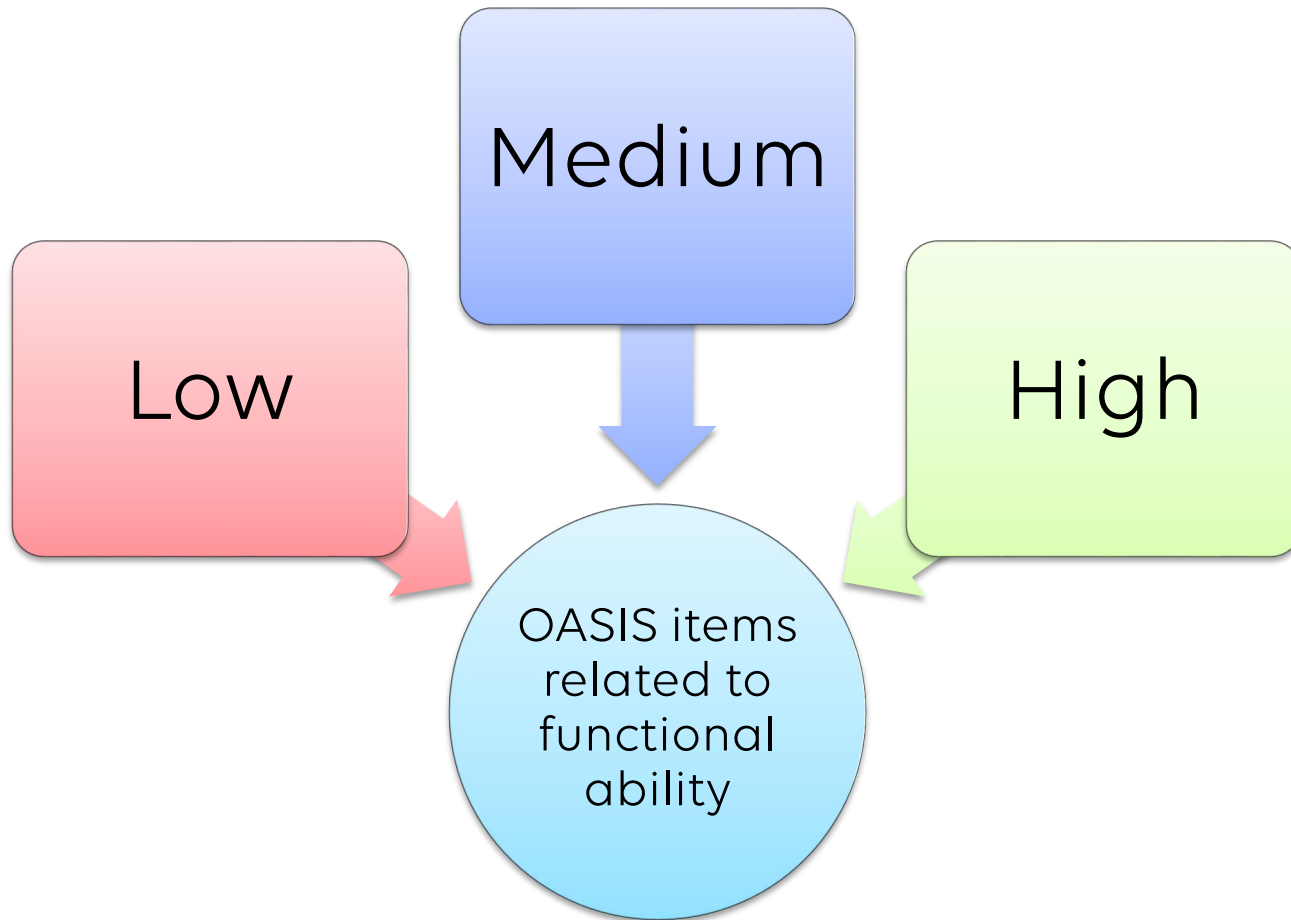
# Clinical Groups

Primary reason for home health care

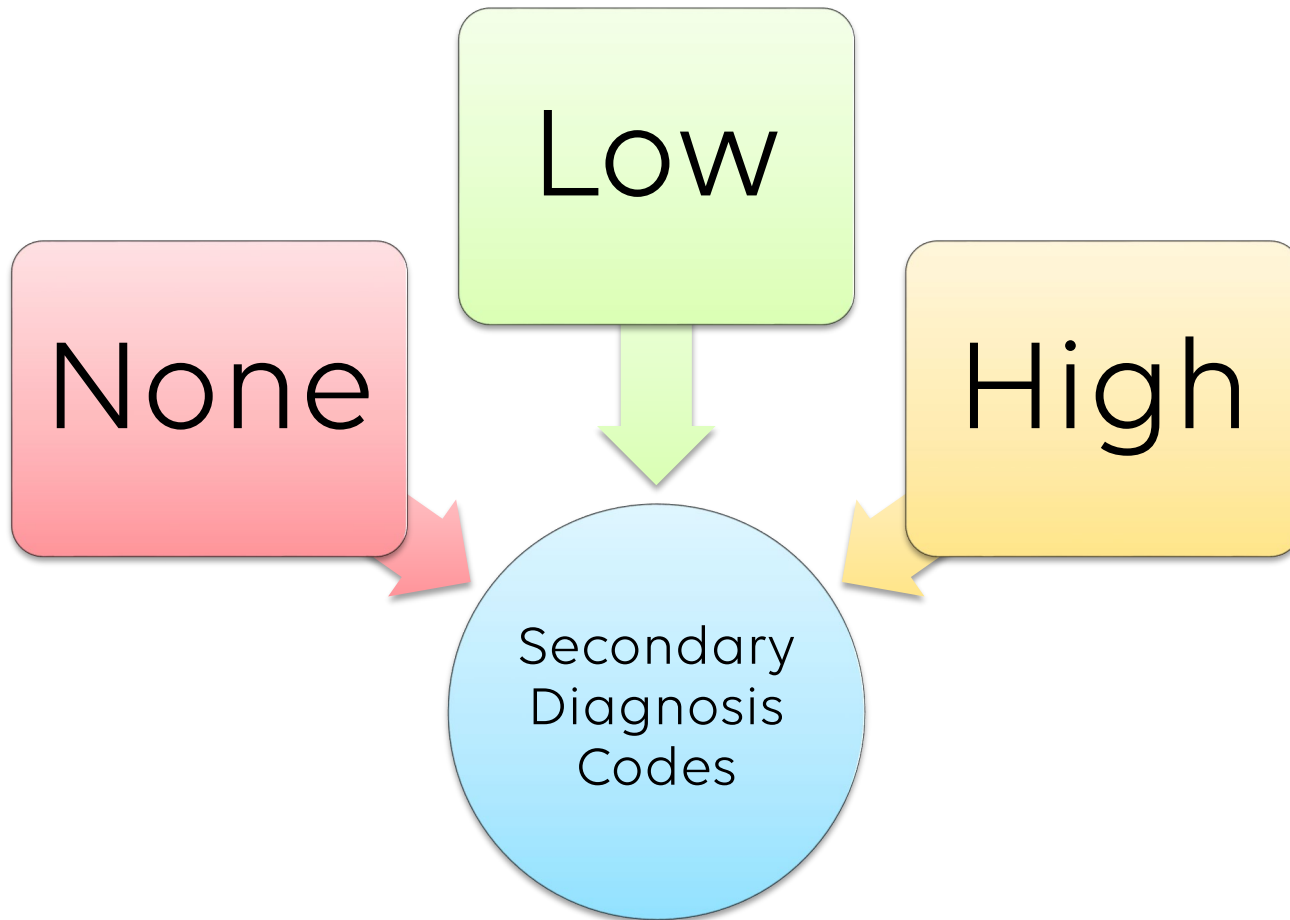
Based on principal diagnosis code

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 from OASIS and 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

# 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 §1861(kk) of the Act

NOA

# NOA

Must be submitted for any period of care that starts on or after 1/1/2022

NOAs only required for new admissions

- Admission period remains open until patient is either discharged or transferred out of home health care

Purpose: open a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission

# 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 and admitted patient to HH 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

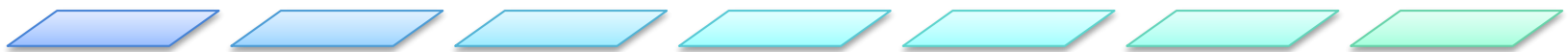
Fires, floods, earthquakes



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 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

# NOA Submission – Claim Page 1

Field	Description/Notes
MID Medicare ID Number	Enter the Medicare Beneficiary Identifier.
TOB Type of Bill	32A – Notice of Admission 32D – Cancellation of Admission
NPI National Provider Identifier Number	Enter your 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.

# NOA Submission – 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	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.
SRC <i>(837I ONLY)</i> Source of Admission	Submit a default value of "1."
STAT <i>(837I ONLY)</i> Patient Status	Submit default value of "30."

# NOA Submission – Claim Page 1

Field	Description/Notes
COND CODES Condition Codes	<p>Enter condition code 47 for a patient transferred from another HHA.</p> <p>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.</p>
FAC. ZIP	Facility ZIP Code of the provider or subpart (9 digit code).

# NOA Submission – Claim Page 2

Field	Description/Notes
REV (837I ONLY) Revenue Codes	Enter Revenue Code 0023, which indicates billing under HH PPS.
HCPC (837I ONLY) Healthcare Common Procedure Code	Submit HIPPS code 1AA11 as a placeholder value, since differing HIPPS codes may apply over the course of an HH admission.
TOT UNITS (837I ONLY) Total Services Units	Enter one unit
TOT CHARGE (837I ONLY) Total Charge	The total charge for the 0023 revenue line must be zero.
SERV DT (837I ONLY) Service Date	Must not be a future date. The admission date may be duplicated to satisfy this requirement.

# NOA Submission – Claim Page 3

Field	Description/Notes
PAYER (837I ONLY) Payer Identification	Enter "Medicare" on line A with payer code "Z."
RI (837I ONLY) Release of Information	Enter "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 (837I ONLY)	Enter the appropriate ICD code for the principal diagnosis code or submit any valid diagnosis code.

# NOA Submission – Claim Page 3

Field	Description/Notes
ATT PHYS ( <i>837I ONLY</i> ) Attending Physician	Enter the NPI and name (last name, first name, middle initial) of the attending physician who established the plan of care with verbal orders — this must be the individual physician's NPI, not a group NPI.



# NOA Submission – Claim Page 4

Field	Description/Notes
REMARKS	Remarks are not required on the NOA; however, remarks are recommended when canceling the NOA to indicate the reason for cancellation.

# NOA Submission – Claim Page 5

Field	Description/Notes
INSURED NAME (837I ONLY)	Enter the patient's name as shown on the Medicare card.
CERT/SSN/HIC (837I ONLY)	Enter the beneficiary's Medicare number as it appears on the Medicare card if it does not automatically populate.

# Period of Care Claim

# Final Period Claim

Submitted

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

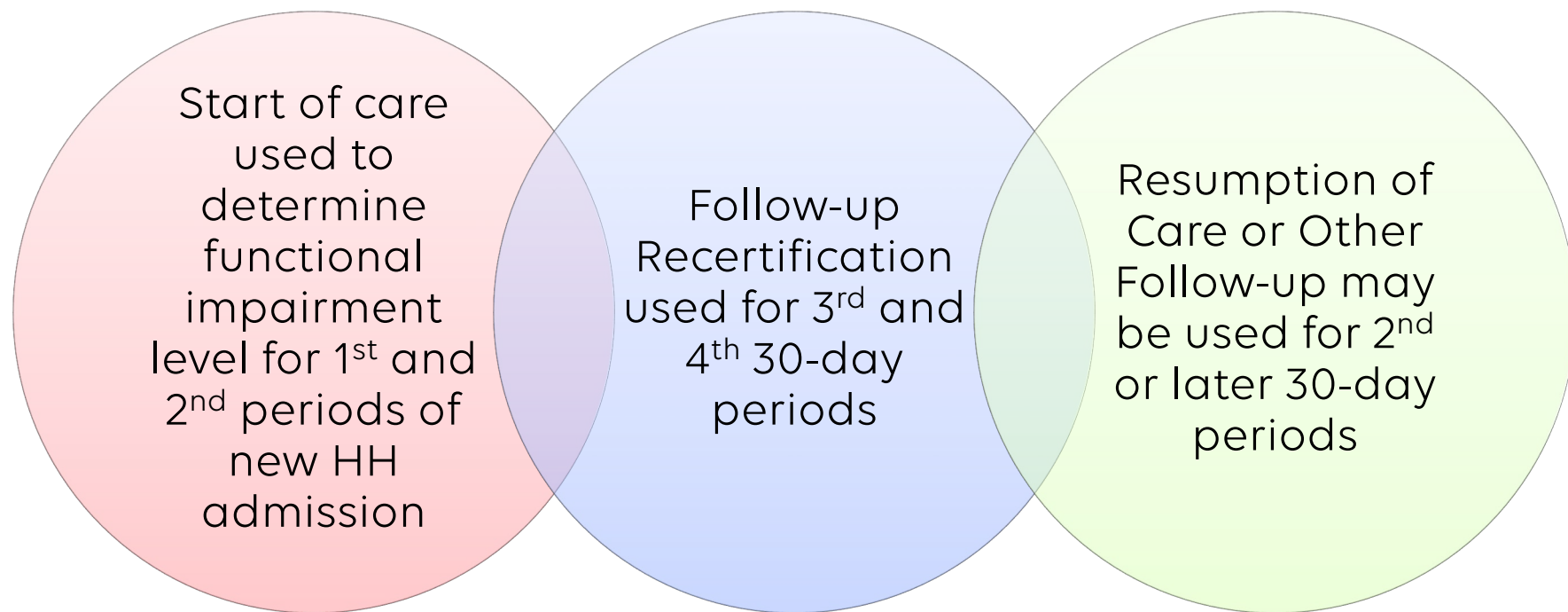
All services for the period must have been provided and physician has signed plan of care and all orders

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

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

# 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

```
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

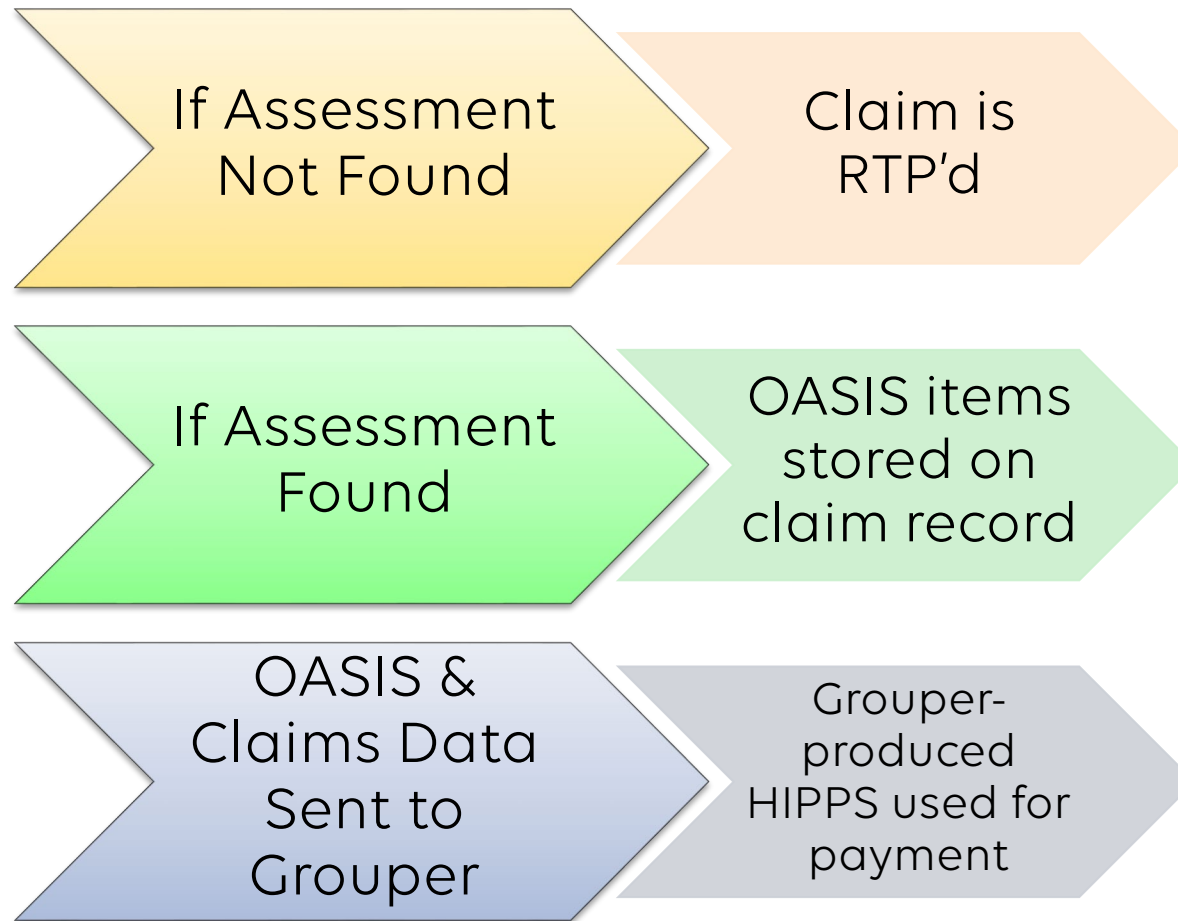
PROCESS COMPLETED  --  PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT
```

# 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")	<p>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.</p> <p>The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format</p>

# 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
    
```

# 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 Noncovered 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"><li>• Visits provided exclusively to perform OASIS assessments</li><li>• Visits provided exclusively for supervisory or administrative purposes</li><li>• Therapy visits provided prior to the required re-assessments</li></ul>

**Variety of services**

**Only one G-code per visit**

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

# 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 who 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

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

DUE FROM PATIENT

MEDICAL RECORD NBR				COST RPT	DAYS	NON COST RPT	DAYS		
<b>DIAGNOSIS CODES</b>	1	<b>XXXXX</b>	2	<b>XXXXX</b>	3	<b>XXXXX</b>	4	<b>XXXXX</b>	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
<b>ATT PHYS</b>		<b>NPI XXXXXXXXXXXX</b>	<b>L SMITH</b>		<b>F ROBERT</b>	<b>M S SC XX</b>
OPR PHYS		NPI	L		F	M SC
<b>OTH PHYS</b>		<b>NPI XXXXXXXXXXXX</b>	<b>L JONES</b>		<b>F SARAH</b>	<b>M R SC XX</b>
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/M BI	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 pro-rated 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 with transfer status '06'

- This claim will receive the partial payment adjustment

# Discharge and Readmission

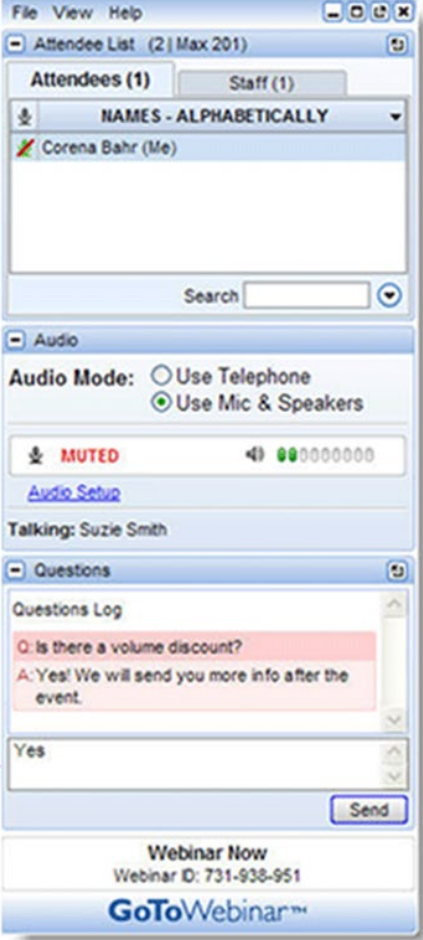
- Patient discharged before end of 30-day period and same agency readmits in the same 30 days
- Prorated first period – this is the claim with the partial payment adjustment (billed with “06” patient status code)
- New 30-day period begins based on NOA date

# LUPA

- 30-day periods with low number of visits paid on a per-visit basis using the national per-visit rates
- 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)
- 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)

# Resources

# Ask a Question Using the Question Box



The screenshot displays the GoToWebinar interface. At the top, there is a menu bar with 'File', 'View', and 'Help'. Below it, a window titled 'Attendee List (2 | Max 201)' shows a list of attendees, including 'Corena Bahr (Me)'. The 'Audio' section is visible, with 'Audio Mode' set to 'Use Mic & Speakers' and a 'MUTED' indicator. The 'Questions' section is highlighted, showing a 'Questions Log' with a question: 'Q: Is there a volume discount?' and an answer: 'A: Yes! We will send you more info after the event.' Below the log is a text input field containing 'Yes' and a 'Send' button. Two red arrows point to the input field and the 'Send' button, with the text 'Type questions here' and 'Then click Send' respectively.

Type questions here

Then click Send

# 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

# NGS Email Updates

- Subscribe to receive the latest Medicare information



The screenshot shows the top portion of the National Government Services website. The header is dark blue with white text. On the right side of the header, there are links for 'Contact Us', 'NGSConnex', 'Subscribe for Email Updates', and 'HH+H in Arizona (J6)'. Below the header is a navigation bar with the 'national government SERVICES' logo on the left and a search icon on the right. The navigation bar includes links for 'HOME', 'EDUCATION', 'RESOURCES', 'EVENTS', 'ENROLLMENT', and 'APPS'. The main content area features six white boxes with blue icons and text, arranged in a 2x3 grid. The boxes are: 'Medical Policies' (book icon), 'Enrollment' (document with pencil icon), 'Fee Schedules & Pricers' (dollar sign icon), 'Claims and Appeals' (document with magnifying glass icon), 'Overpayments' (dollar sign in a circle icon), and 'Medicare Compliance' (clipboard with checkmark icon).

Contact Us NGSConnex **Subscribe for Email Updates** HH+H in Arizona (J6) ▾

**national government SERVICES** HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

**Medical Policies**  
Find LCDs and related billing and coding articles

**Enrollment**  
Getting started, after you enroll, and revalidating your enrollment

**Fee Schedules & Pricers**  
Code pricing search, payment systems, limits, and fee schedule lookup

**Claims and Appeals**  
Learn about claims, top errors, fees, MBI and appeals

**Overpayments**  
Repayment schedules, and post-pay adjustment

**Medicare Compliance**  
Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more



# Provider Contact Center

- 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 <a href="#">TTY Contact Information</a>	866-277-7287	Monday–Friday* 8:00 a.m.–4:00 p.m. PT  *Closed for training on the 2 <sup>nd</sup> and 4 <sup>th</sup> Friday of the month 9:00 a.m.–1:00 p.m. PT
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-289-0423 <a href="#">TTY Contact Information</a>	866-275-7396	Monday–Friday* 8:00 a.m.–4:00 p.m. ET  *Closed for training on the 2 <sup>nd</sup> and 4 <sup>th</sup> 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 <a href="#">TTY Contact Information</a>	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 <sup>nd</sup> and 4 <sup>th</sup> 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 channel interface for NGS Medicare.com. The channel name is 'NGSMedicare.com' and it is marked as 'SUBSCRIBED'. The video list includes:

- 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 \(HHA\) 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?

