PMB institute

## Module 2

# STUDY GUIDE

PREPARE FOR SUCCESS

## Home Health Medical Billing Certificate

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When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get your Medicare coverage—Original Medicare (Part A and Part B) or a Medicare Advantage Plan (Part C). Some people need to get additional coverage, like Medicare prescription drug coverage or Medicare Supplement Insurance (Medigap).

## What's Medicare?

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some **home health care.**

# Home Health Acronyms & Terminology

**Certified Nursing Assistant (CNA)**: A CNA or certified nursing assistant is an individual who studied and passed the licensure exam for nursing assistant. He or she assists the patients in providing health care needs and supervised by a Licensed Practical Nurse or a Registered Nurse.

**Skilled Care**: Residents in need of skilled care receive skilled nursing care or rehabilitation and 24-hour medical supervision, but do not require hospitalization. A physician order is required for admission.

**Custodial Care or Personal Care**: Residents depending upon custodial care receive supervision and assistance with personal care and other activities of daily living. This level of care is suitable for people who do not need the care of a practical nurse. Often this level of care is provided for people suffering from illnesses such as Alzheimer's disease.

**Palliative Care:** This term is used to describe a type of comprehensive medical care for people with life-ending illnesses. The goal is to ease the patient's physical, emotional, social and spiritual suffering, as well as to support families. Like hospice, this type of care can be provided in various settings such as hospitals, nursing homes, or the patient's home. Palliative care can begin after a doctor certifies a patient's life expectancy is six months or less.

**Activities of Daily Living:** These are the everyday tasks that individuals do to manage their own personal care. Examples include eating, dressing, using the bathroom and walking.

**Instrumental Activities of Daily Living:** These are tasks that enable people to live independently in the community. Examples include shopping, cooking and house cleaning.

**Adult Day Care:** This service provides a protective setting for individuals who are functionally impaired. This care is generally provided during daytime hours and offers a planned program that includes a variety of health, social and support services.

**Aides for Independent Living:** These devices or tools make living easier and safer for older persons. Some examples include long-handled shoehorns, touch fasteners on clothing, bathtub stools, and telephone amplifiers. Senior service and healthcare agencies often provide booklets describing such aids and where to purchase them.

**Assisted Living:** This senior housing option for older adults combines housing, personal care services, and light medical care in an atmosphere of safety and privacy. Based on a monthly fee, basic services typically include meals, laundry, housekeeping, recreation and transportation. Additional services might include help with dressing, bathing, and medication management. Some facilities offer housing to recently discharged hospitalized patients who need to regain strength in a supportive environment before returning to their own home. Assisted living is primarily an out-of-pocket, private pay option, although some facilities accept Medicaid.

**Board and Care Home (also known as a residential care facility):** These homes provide older persons with room and board and, if required, personal assistance with activities of daily living such as medication supervision, meal preparation and other supportive services. This type of housing is typically paid for privately by the individual unless the home accepts and the person qualifies for Medicaid.

**Companion Services:** Intermittent or round-the-clock personnel provide support, encouragement and companionship to older adults in their own homes or institutional settings. Some services may provide assistance with daily living activities such as meal preparation, dressing and grooming.

**Congregate Housing:** This housing option offers private living quarters, usually in a multiunit complex, along

**Continuing Care Retirement Community:** This senior housing option offers a comprehensive continuum of care from independent living to skilled care in a nursing home. Typically, the able-bodied person enters an apartment or cottage and, as needs increase, proceeds through increasing levels of care. There are requirements for incoming residents based on age, financial assets, income, as well as physical health and mobility. All require substantial entrance fees in addition to fluctuating monthly rent.

**Durable Medical Equipment (DME):** Doctors can order this medical equipment for home use. These items are reusable such as walkers, wheelchairs, or hospital beds. The equipment is available for rent or purchase depending upon the user's financial status and insurance coverage.

**Geriatric Care Manager:** This professional is trained to assess a person's total-care needs and to arrange necessary services. Care managers typically evaluate the older person's situation, make recommendations, arrange appropriate services and keep family members informed. Since care problems rarely occur one at a time and services may be fragmented, this service can be used by caregivers to coordinate a care plan. There is a fee for this service and each individual care manager determines rates.

**Health Care Staffing:** Health Care Staffing typically includes the following positions, among others: physicians, nurses, medical technicians, therapists, home health aides, and custodial care workers.

**Home Care:** Trained personnel from home-health agencies, the Visiting Nurses Association, and public health departments provide in-home health and supportive services including nursing, therapies, and assistance with personal care.

**Home health aides** provide personal care for patients who need assistance for a variety of reasons including illness, advanced age, disability, or cognitive impairment. Home health aides may work with patients as part of a hospice care program also.

**Hospice:** This program provides supportive care with an emphasis on pain relief and comfort for terminally ill persons and their families. Services may be provided at home or in a facility.

**Long-Term Care Insurance:** These privately sold insurance policies help pay for long-term care services such as home-health care, adult day care, respite care and nursing home care.

**Medicaid:** This state administered health program is designed to cover the healthcare needs of low-income people. It is financed with federal, state and local tax funds. Medicaid pays an eligible patient's medical bills, in whole or in part, directly to the provider of healthcare services and suppliers (physicians, hospitals, pharmacists, etc.).

**Medicare Managed Care:** Also known as Medicare HMO, Medicare managed care is a healthcare option available as part of Medicare benefits. When enrolled in a Medicare managed care plan, the person selects a doctor from the plan's list of primary care physicians. The chosen primary care physician is responsible for coordinating all of the person's healthcare needs.

**Medicare:** This is a federal health insurance program for people 65 years old or over and for certain disabled people under 65. A person is automatically enrolled in Medicare hospital insurance (Part A) when he or she applies for Social Security benefits upon reaching 65. Part A covers inpatient care in a hospital or skilled nursing facility for a limited period of time. Part B covers doctor's services and outpatient hospital services. This is paid for out of the enrollee's Social Security. Medicare does not pay full cost of some covered services. For this reason, it is important to have a Medicare Supplement or Medigap insurance (see definition below).

**Medicare Supplement:** Also known as Medigap insurance, this privately sold insurance policy fills the "gaps" in Medicare coverage. There are 10 standardized policies labeled Plan A through J. Medigap policies only work with the Medicare plan.

**Nursing Home:** Also known as a long-term care facility or nursing and rehabilitation center, this facility provides continuous nursing care or 24-hour supervision. Most nursing homes provide rehabilitation programs as well as social activities. Care is generally provided on two or three levels including the following.

**Intermediate Care:** Residents requiring intermediate care receive assistance with activities of daily living, some health services and nursing supervision, but not constant nursing care. Care is ordered by a physician and supervised by a registered nurse.

**Skilled Care:** Residents in need of skilled care receive skilled nursing care or rehabilitation and 24-hour medical supervision, but do not require hospitalization. A physician order is required for admission.

**Custodial Care or Personal Care:** Residents depending upon custodial care receive supervision and assistance with personal care and other activities of daily living. This level of care is suitable for people who do not need the care of a practical nurse. Often this level of care is provided for people suffering from illnesses such as Alzheimer's disease.

**Palliative Care:** This term is used to describe a type of comprehensive medical care for people with life-ending illnesses. The goal is to ease the patient's physical, emotional, social and spiritual suffering, as well as to support families. Like hospice, this type of care can be provided in various settings such as hospitals, nursing homes, or the patient's home. Palliative care can begin after a doctor certifies a patient's life expectancy is six months or less.

**A Personal Care Assistant (PCA):** variously known under alternate names such as caregiver, personal care attendant, patient care assistant, personal support worker and home care aide – is a paid, employed person who helps persons who are disabled or chronically ill with their activities of daily living (ADLs) whether within the home, outside the home, or both. They assist clients with personal, physical mobility and therapeutic care needs, usually as per care plans established by a rehabilitation health practitioner, social worker or other health care professional.

**Rehabilitation Services:** Trained professionals provide treatment to help disabled individuals attain maximum function, a sense of well being and a personally satisfying level of independence. Any disease or injury that causes mental or physical impairment serious enough to result in disability may require rehabilitation.

**Senior Center:** These community centers provide social, recreational and educational activities.

**Transitional Care:** Also known as sub-acute care, this comprehensive inpatient rehabilitation program is designed for individuals in need of special care due to illness, injury or disease (ie. a stroke, head trauma or

kidney disease). Typically, the patient has a specific course of treatment and does not require intensive diagnostic or invasive procedures. In many cases, patients who participate in sub-acute care are rehabilitated and returned home.

**Agency's initial date of Medicare certification:** requirements to provide home health care. This date may differ from the date that the home health agency was licensed by an official agency within your State.

This information is included because you may wish to know how long the agency has met all Medicare requirements to provide home health care services. This date is associated with the agency's current Medicare provider number. An agency may request to change their provider number if there's a change in ownership. You should contact the agency to find out how long it has been Medicare certified.

**Certified (Certification):** State government agencies inspect health care providers, including home health agencies, hospitals, nursing homes, and dialysis facilities, as well as other health care providers. These providers are approved or "certified" if they pass inspection. Medicare and Medicaid only cover care given by providers who are certified by Medicare. Being certified isn't the same as being accredited.

**Episode of Care:** In a Medicare certified Home Health Agency, an episode of care begins when an assessment is completed during the patient Start of Care or Resumption of Care and ends when the patient is transferred or discharged from home health care. At the end of the patient's episode of care, a transfer assessment or a discharge assessment is completed.

**Home health aide services:** Part time or intermittent services to help you with your daily living activities.

**Homebound:** You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury **OR** Leaving your home isn't recommended because of your condition **AND** You're normally unable to leave your home and leaving home is a major effort

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.

**Medical social services:** Services to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.

**Medical supplies:** Essential items that the home health team uses to conduct home visits or to carry out services the physician has ordered to treat or diagnose a patient's illness or injury. Examples include: cotton balls, adhesive and paper tape, thermometers, dressings for wound care, sterile gloves, catheters, and syringes. The home health agency provides these supplies for their use with the patient.

**Medically necessary:** Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

**Occupational therapy:** Services given to help you return to usual activities (like bathing, preparing meals, and housekeeping) after illness either on an inpatient or outpatient basis.

**Physical therapy:** Treatment of injury and disease by mechanical means, like heat, light, exercise, and massage.

**Plan of care:** Written doctors orders for home health services and treatments based on the patient's condition. The plan of care is developed by the doctor, the home health team, and the patient. The home health team keeps the doctor up-to-date on the patient's condition and updates the plan of care as needed. It's the doctor, and not the home health team, that authorizes what services are needed and for how long.

**Skilled care:** A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Nursing, physical therapy, occupational therapy, and speech therapy are considered skilled care by Medicare. In addition to providing direct care these professionals manage, observe, and evaluate your care. Any service that could be safely done by a non-medical person (or by yourself) without the supervision of a nurse isn't considered skilled care.

**Skilled nursing care:** Care given or supervised by registered nurses. Nurses provide direct care; manage, observe, and evaluate a patient's care; and teach the patient and his or her family caregiver. Examples include: giving IV drugs, shots, or tube feedings; changing dressings; and teaching about diabetes care. Any service that could be done safely by a non-medical person (or by yourself) without the supervision of a nurse isn't skilled nursing care. Medicare covers home health skilled nursing care that's part time and intermittent.

**Skilled nursing facility:** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Speech therapy:** This is the study of communication problems. Speech therapists assist with problems involving speech, language, and swallowing. Communication problems can be present at birth or develop after an injury or illness, like a stroke.

**State Survey Agency:** A state agency that oversees health care facilities that participate in Medicare and/or Medicaid. The State Survey Agency inspects health care facilities and investigates complaints to ensure that health and safety standards are met.

### AAAs -- Area Agencies on Aging

Sometimes also called "Triple A" -- but completely different from auto agencies -- AAAs are nonprofit agencies that serve older adults in a certain geographic area, usually a city or county, or district. Established by the Older Americans Act, AAAs coordinate local services such as free ride services, Meals on Wheels, and other services that help older adults remain in their homes. To find the one nearest you, search our Area Agency on Aging Directory.

**ADL -- Activities of daily living**
The term ADLs is used to define a cluster of basic personal care tasks such as feeding, using the toilet, getting dressed, and bathing.

**AHCD -- Advance health care directive**
Also known as a living will, an AHCD is the document that lays out a person's wishes for end-of-life care. The AHCD is important because it's used in medical situations when a patient can't speak for himself.

**CCRC -- Continuing care retirement community**
Sometimes also called a "life-care community," a CCRC refers to a retirement community that provides a continuum of care options from independent living to end-of-life hospice care. To find a CCRC near you, search our CCRC Directory.

**DME -- Durable medical equipment**
Used in hospitals, assisted living facilities, and when making a discharge plan, the term DME covers oxygen tanks, wheelchairs, lifts, hospital beds, and other medical equipment used in the home. Get tips on where to buy or borrow medical equipment.

**EHR or EMR -- Electronic health record or electronic medical record**
There are two types of electronic records used to compile medical records: EHRs and EMRs. The terms are used interchangeably, but there's a slight difference. EMRs are computerized files used within one healthcare organization, while EHRs can be shared among different health agencies. From the patient's perspective, however, they mean the same thing.

**GCM -- Geriatric care manager**
A geriatric care manager is someone you consult to help you make decisions about your future living arrangements, or those of a family member. A good GCM is familiar with the full range of services and housing options in an area and can make assessments, access resources, and assist with placement. Search our Geriatric Care Manager Directory to find a GCM near you.

**HIPAA -- Health Insurance Portability and Accountability Act**
Pronounced "hippa," a signed HIPAA release form is required by doctors and medical personnel before they'll release medical information to another person, even a close family member.

**IADLs -- Instrumental activities of daily living**
This term is sometimes used interchangeably with ADLs, but technically it refers to a list of more complex activities. IADLs include handling transportation, using the telephone, managing finances, shopping and meal preparation, and home maintenance.

**LTC -- Long-term care**
This is an umbrella term used in planning future healthcare and living arrangements for seniors and people with disabilities. Long-term care can take place in the home (with an in-home caregiver) or in an assisted living facility or nursing home.

**OT -- Occupational therapy/therapist**
Learning or relearning the skills required for independent living is called occupational therapy. OT is included in rehabilitation after surgery, stroke, and many other conditions. Search our Home Healthcare Directory to find an occupational therapist near you.

**PRN -- *Pro re nata***
This is a Latin term meaning "according to the circumstances." It's used by medical staff to describe a medication, treatment, or service that's recommended on an as-needed basis.

**PT -- Physical therapy/therapist**
PT consists of exercise, massage, therapeutic equipment, and other services to build strength and regain movement that's been lost due to injury or illness. To find a physical therapist near you, search our Home Healthcare Directory.

**RCF -- Residential care facility**
This term refers to living arrangements that include 24-hour supervision but may not include full medical services. RCFs are designed to serve seniors who need help with activities of daily living (ADLs). A related term is board and care homes or facilities; also known as RCFE (residential care facility for the elderly). If you need a residential care facility for your loved one, start your search in our Assisted Living Directory.

**ROM -- Range of motion**
Doctors use this term when talking about joints such as elbows, knees, hips, wrists, and shoulders, to define the full amount of potential movement in the joint. Learn more about how physical therapists improve range of motion.

**SNF -- Skilled nursing facility**
A skilled nursing facility is usually defined as one that provides round-the-clock nursing care and rehabilitation services. SNFs are certified by Medicare and are typically the highest level of care available after hospitalization. The term may be used interchangeably with nursing home, but not all nursing homes are SNFs. For more about SNFs and nursing homes, see Nursing Homes Explained.

### Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

### Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

### Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

### Home Health Care

Health care services a person receives at home.

### Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

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| Primary Care Physician<br><br>A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient. |
| Primary Care Provider<br><br>A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services. |
| Provider<br><br>A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.<br>Rehabilitation Services |

| |
|---|
| Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. |
| Skilled Nursing Care<br><br>Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home. |
| Specialist<br><br>A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care. |

Case Mix Diagnoses—Certain diagnoses were chosen by Medicare to contribute to the case mix or HHRG score. A case mix variable table indicates the number of points, if any, that diagnosis may provide in that particular equation (episode and therapy).

Case Mix—term used to identify resource use for Medicare providers. For Medicare home health, certain M items indicate clinical severity, functional status and service utilization and determine the case mix score.

HHRG—Home Health Resource Group (pronounced 'Herg'). Also known as the case mix score, it is determined by answering certain OASIS data items in the clinical severity, functional status and service utilization domains. Home Health Resource Groups (HHRGs) are represented by CMS HIPPS coding on claims and are the basis of payment for each episode. HHRGs are produced through publicly available Grouper software (HAVEN or similar) that determines the appropriate HHRG when results of comprehensive assessments (made incorporating the OASIS data set) are input or 'grouped' in the software.

M0 or M—(pronounced 'Moo' at times) Is actually an M for Medicare and a zero, not an O. Of the M0 questions (now mostly just M), M1010, M1012, M1016, M1020, M1022 and M1024 are considered the diagnosis Moos.

OASIS— agencies began collecting **O**utcome **As**sessment **I**nformation **S**et in1999. A collection of data items (originally referred to as M0s) developed for the purpose of outcomes. In 2000, OASIS also became a means of determining payment under the new home health prospective payment system. There have been several 'refinements' since then.

Palmetto, NGS, CGS —Regional Home Health Intermediary (RHHI), aka MACs (Medicare Administrative Contractors). Contracted with Medicare to pay claims and review medical records for medical necessity and other eligibility criteria

Basics
The unit of payments are two 30 day periods within a 60 day episode;
Each episode is anticipated to be paid in two split payments, one billed on a Request for Anticipated Payment (RAP) at the beginning of the episode and one on a claim at the end of the episode; Only claims provide line-items detailing the individual services delivered. A claim can only be submitted once the physician's orders have been signed.
Documentation of a face to face encounter with the physician is required prior to submitting a claim for a SOC episode.

If beneficiaries choose to transfer to another HHA or if a patient is discharged and subsequently readmitted during the same 60 day period, the agency may receive a partial payment adjustment (PPA).

LUPA stands for Low Utilization Payment Adjustment. LUPA thresholds are determined by Clinical Groupings

There are cost outliers, in addition to episode payments. There are special requirements for obtaining an outlier episode payment.

Accreditation – The granting of approval given by a credible organization, of the processes, policies and procedures utilized by the entity seeking such approval. Various organizations in the healthcare industry grant accreditation's, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), CHAPS, and ACHC

Assessment – Diagnostic procedures, history, physical services and tests for the purpose of determining whether or not an eligible Insured is an appropriate candidate for specified healthcare services.

Assignment of Benefits – When a covered person authorizes his or her health benefits plan to directly pay a health care provider for covered services.

Attending Physician – 1) The physician with defined clinical privileges who has the primary responsibility for diagnosis and treatment of the patient. 2) A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case.

Care Plan – A plan-of-care developed from the assessment of the patient and his/her diagnosis. The care plan takes into consideration items such as; living conditions and other situations with the potential to affect the outcome of the treatment plan.

Claim – Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made.

Denials – Occurs when, during the course of reviewing a patient's treatment, the medical necessity cannot be validated based upon clinical guidelines or due to lack of information provided by the treating provider.

Diagnosis – The identification of a disease or condition through examination.

Disability – Any medical condition that results in functional limitations that interfere with an individual's ability to perform his or her

JCAHO Joint Commission on the Accreditation of Healthcare Organizations) – This is the peer review organization which provides the primary review of hospitals and healthcare providers. Many insurance companies require providers to have this accreditation in order to seek 3rd party payment, although, many small hospitals cannot afford the cost of accreditation.

Medically Necessary – Medical Necessity – Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider, and, They are the most appropriate level or supply of service which can safely be provided.

Medicare - An entitlement program run by the Health Care Financing Administration of the federal government through which people aged 65 years or older receive health care insurance. Part A covers home health, among other services

Patient – The person under medical treatment.

Primary Care Physician – Referred to as a "gatekeeper" within home health. This physician is responsible for orchestrating the medical care process, by referring a patient on for specialized diagnosis and treatment, or by caring for that patient then and there.

Principal Diagnosis – The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a clinical grouping. This diagnosis may differ from the admitting and major diagnoses.

# Home Health and Home Care Associations

## Federal and State Associations

**Alabama**
Alabama Hospital Association
http://www.alaha.org

**Alaska**
Alaska State Hospital and Nursing Home Association
http://www.ashnha.com

**Arizona**
Arizona Hospital and Healthcare Association
http://www.azhha.org

**Arkansas**
Arkansas Hospital Association
http://www.arkhospitals.org

**California**
California Association for Health Services at Home
http://www.cahsah.org

**Colorado**
Home Care Association of Colorado
http://www.hcaconline.org

**Connecticut**

**Delaware**
Delaware Association for Home and Community Care
http://www.dahcc.org

**Florida**
Home Care Association of Florida
http://www.homecarefla.org

**Georgia**
Georgia Association for Home Health Agencies Inc.
http://www.gahha.org

**Hawaii**
Healthcare Association of Hawaii
http://www.hah.org

**Idaho**
Idaho Association of Home Health Agencies
http://www.idahohomecare.org

**Illinois**
Illinois Home Care & Hospice Council
http://www.ilhomecare.org

**Indiana**
Indiana Associations for Home and Hospice Care, Inc.
http://www.iahhc.org

**Iowa**
Iowa Alliance in Home Care
http://www.iowahomecare.org

**Kansas**
Kansas Home Care Association
http://www.kshomecare.org

**Kentucky**
Kentucky Home Health Association
http://www.khha.org

**Louisiana**
Home Care Association of Louisiana
http://www.hclanet.org

**Maine**
Home Care & Hospice Alliance of Maine
http://www.homecarealliance.org

**Maryland**
Maryland National Capital Homecare Association
https://www.mncha.org

**Massachusetts**
Home Care Alliance of Massachusetts
http://www.thinkhomecare.org

Massachusetts Council for Home Care Aide Services
http://www.mahomecareaides.com

**Michigan**
Michigan Home Health Association
http://www.mhha.org

**Minnesota**
Minnesota Home Care Association
http://www.mnhomecare.org

**Mississippi**
Mississippi Association for Home Care
http://www.mahc.org

**Missouri**
Missouri Alliance for Home Care
http://www.homecaremissouri.org

**Montana**
Montana Hospital Association: An Association of Montana Health Care
http://www.mtha.org

**Nebraska**
Nebraska Association of Home & Community Health Agencies
http://www.nebraskahomecare.org

**Nevada**
Nevada Home Care Association
http://www.nvhca.org

**New Hampshire**
Home Care Association of New Hampshire
http://www.homecarenh.org

**New Jersey**
Home Care Association of New Jersey
http://www.homecarenj.org
New Jersey Hospital Association
http://www.njha.com

**New Mexico**
New Mexico Association for Home and Hospice Care

http://www.nmahc.org

**New York**
Home Care Association of New York State
http://www.hca-nys.org
New York State Association of Health Care Providers, Inc.
http://www.nyshcp.org
Health Care Association of New York State
http://www.hanys.org
Home Care Council of New York City
http://www.hccnyc.org
Hospice & Palliative Care Association of New York State
http://www.hpcanys.org

**North Carolina**
Association for Home & Hospice Care of North Carolina, Inc.
http://www.homeandhospicecare.org
Carolinas Center for Hospice and End of Life Care
http://www.carolinasendoflifecare.org

**North Dakota**
North Dakota Association for Home Care
http://www.aptnd.com/ndahc

**Ohio**
Ohio Council for Home Care and Hospice
http://www.homecareohio.org

**Oklahoma**
Oklahoma Association for Home Care
http://www.oahc.com

**Oregon**
Oregon Association for Home Care
http://www.oahc.org

**Pennsylvania**
Pennsylvania Homecare Association
http://www.pahomecare.org

**Rhode Island**
Rhode Island Partnership for Home Care, Inc.
http://www.riphc.org

**South Carolina**
South Carolina Home Care & Hospice Association
http://www.schomehealth.org

**South Dakota**
South Dakota Association of Healthcare Organizations
http://www.sdaho.org

**Tennessee**
Tennessee Association for Home Care, Inc.
http://www.tahc-net.org/
Tennessee Hospital Association Home Care Alliance
http://www.tha.com/

**Texas**
Texas Association for Home care & Hospice
http://www.tahc.org

**Utah**
Utah Association for Home Care
http://www.ua4hc.org

**Vermont**
Vermont Assembly of Home Health Agencies
http://www.vnavt.com

**Virginia**
Virginia Association for Home Care & Hospice
http://www.vahc.org

**Washington**
Home Care Association of Washington
https://hcaw.wildapricot.org/

**West Virginia**
West Virginia Council of Home Care Agencies, Inc.
http://www.wvhomecareassociation.com

**Wisconsin**
Wisconsin Association for Home Health Care
http://www.wiahc.org/

**Wyoming**

Home Health Care Alliance of Wyoming
http://www.wyominghomehealth.org

## NAHC

## Home Care Association of America

## Council of State Home Care & Hospice Association

## Home Health and Hospice Areas (HH+H)

There are four A/B MACs that process home health and hospice claims in addition to their typical Medicare Part A and Part B claims. Please note that the four HH+H areas do not coincide with the jurisdictional areas covered by these four A/B MACs.

**Jurisdiction 6 — National Government Services, Inc.**
(Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, US Virgin Islands, Wisconsin and Washington)
**Jurisdiction 15 — CGS Administrators, LLC**
(Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming)
**Jurisdiction M —Palmetto GBA, LLC**
(Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas)
**Jurisdiction K — National Government Services, Inc.**
(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

## MAC PORTALS

There are 3 MAC PORTALS platform for all 4 MACs:

- **NGS Connex:** NGS (Jurisdiction 6 and K)
- **My CGS:** CGS (Jurisdiction 15)
- **eServices**: Palmetto (Jurisdiction M)

## WHAT IS A MAC?

A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.
CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the healthcare providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. MACs perform many activities including:

- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

Currently there are 12 A/B MACs and 4 DME MACs in the program that process Medicare FFS claims for nearly 68% of the total Medicare beneficiary population, or 38.5 million Medicare FFS beneficiaries. The MACs serve more than 1.5 million health care providers enrolled in the Medicare FFS program. Collectively, the MACs process more than 1.2 billion Medicare FFS claims annually, 218 million Part A claims and more than 1 billion Part B claims, and paid $386 billion in Medicare benefits.

## A/B MACs

A/B MACs process Medicare Part A and Medicare Part B claims for a defined geographic area or “jurisdiction,” servicing institutional providers, physicians, practitioners, and suppliers.

## Home Health and Hospice Areas (HH+H)

There are four A/B MACs that process home health and hospice claims in addition to their typical Medicare Part A and Part B claims. Please note that the four HH+H areas do not coincide with the jurisdictional areas covered by these four A/B MACs.

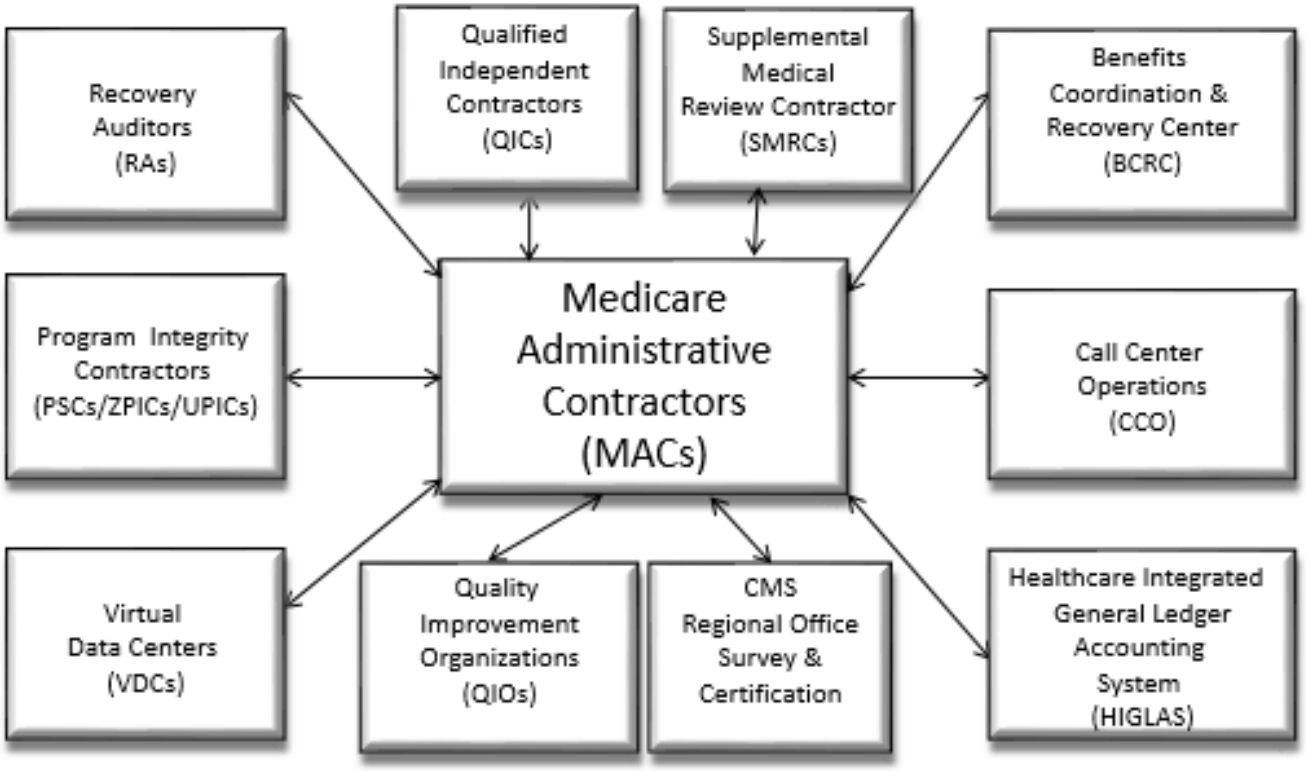
## DME MACs

The DME MACs process Medicare Durable Medical Equipment, Orthotics, and Prosthetics (DMEPOS) claims for a defined geographic area or "jurisdiction," servicing suppliers of DMEPOS. r

## Relationships between MACs and Functional Contractors

MACs work with multiple functional contractors to administer the full FFS operational environment. Learn more about the relationships between the MACs and the functional contractor by viewing the diagram of MACs: The Hub of the Medicare FFS Program(FFS Medicare Administrative Contractor October 2016) and reading about what the functional contractors do at Functional Contractors Overview October 2016.

# Medicare Administrative Contractors "The Hub of the Medicare FFS Program"



**Functional Contractors Overview**
Within the Medicare Fee-for-Service (FFS) operating environment, the Medicare Administrative Contractor (MAC) is the central point of contact for providers of health care services. The establishment and monitoring of the MAC's relationships with a number of other function specific CMS contractors is critical to the integrity of the MAC contract administration. Functional contractors play an essential role.

**Call Center Operations (CCO)**
The CCO responds to inquiries from the Centers for Medicare & Medicaid Services'(CMS') customer service population. The Contractor supports multi-channel operations that receive and respond to inquiries, providing information and services through various channels including telephone, mail, email, TDD/TTY, fax, and web chat. The CCO fields inquiries for CMS programs such as 1-800 Medicare, the Medicare Modernization Act (MMA), the Health Insurance Marketplace, and other relevant programs.

**Virtual Data Center (VDC)**
A data center serves as a platform for claims processing software systems for Medicare claims. Traditionally, the Medicare contractors either operated their own data centers or contracted out for these services. As part of CMS' contracting reform initiative, CMS reduced the number of data centers from more than one dozen separate smaller centers to two large VDCs. CMS manages these contracts. CMS migrated the entire FFS claims processing workload to the VDCs by March 2014.

**Healthcare Integrated General Ledger and Account System (HIGLAS)**
HIGLAS is the general ledger accounting system that replaced the former cash accounting systems used by Medicare Fiscal Intermediaries and carriers. All A/B MACs now utilize the HIGLAS system to account for Medicare benefit payments. Durable Medical Equipment (DME) MACs do not use HIGLAS.

**Benefit Coordination and Recovery Center (BCRC)**
The BCRC performs liability insurance (including self-insurance), no-fault insurance, and workers' compensation (Non-Group Health Plan) recovery case work.

The BCRC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The BCRC takes actions to identify the health benefits available to a Medicare beneficiary and coordinates the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any group health plan related mistaken payment recoveries or claims specific inquiries. The MACs, are responsible for processing claims submitted for primary or secondary payment. Once the BCRC has completed its initial Medicare Secondary Payment (MSP) development activities, it will notify the Commercial Repayment Center (CRC) regarding a GHP MSP occurrence and will notify the BCRC regarding a liability, workers' compensation, or no-fault MSP occurrence (i.e., a Non-GHP MSP occurrence).

**Program Integrity Contractors**
The Program Integrity Contractors perform functions to ensure the integrity of the Medicare Program. Most MACs will interact with one Program Integrity Contractor in support of the CMS audit, oversight, and antifraud, waste and abuse efforts.

**Qualified Independent Contractors (QICs)**
The QICs are responsible for conducting the second level of appeals of Medicare claims. The MAC is responsible for handling the first level of appeals. There are 5 QIC jurisdictions: Part A East, Part A West, Part B North, Part B South, and one DME Jurisdiction QIC.

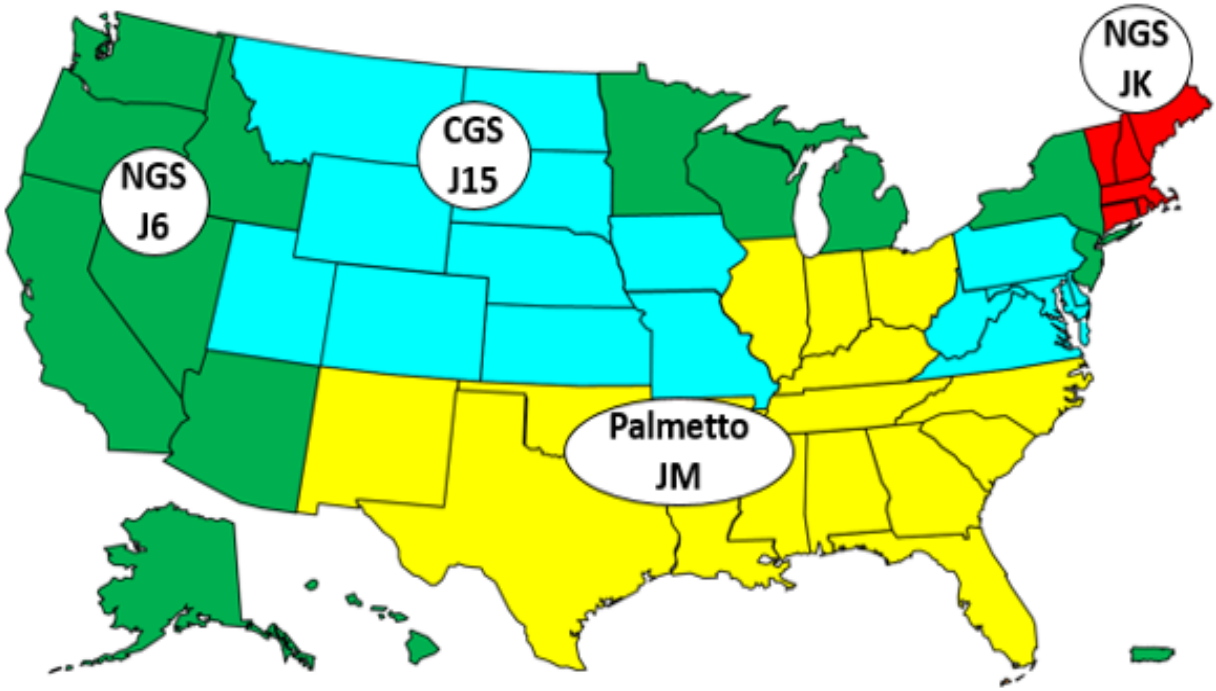
**Quality Improvement Organization (QIO)**
CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

They protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law. QIOs protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

**Recovery Auditor (RAs)**
The RAs are responsible for reviewing paid Medicare claims to identify improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.

**Supplemental Medical Review Contractor (SMRC)**
The SMRC conducts nationwide medical review as directed by CMS. The medical review will be performed on Part A, Part B, and DME providers and suppliers. Services/Provider Specialties to be reviewed will be selected by CMS. The SMRC will evaluate medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices. The SMRC will perform medical review in accordance with CMS regulations, CMS Publication 100-08 (known as the Program Integrity Manual) and other current and future CMS Provider Compliance Group/Division of Medical Review and Education initiatives.

# Home Health & Hospice MAC Areas as of October 2019



**What is PDGM?**

Changes to Home Health Payment

Since October 2000, Home Health Agencies (HHAs) have been paid under a Home Health Prospective Payment System (HH PPS) for 60-day episodes of care that include all covered home health services. The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included: a clinical dimension; a functional dimension; and a service dimension, in which payment would increase if certain thresholds of therapy visits were met.

The Bipartisan Budget Act of 2018 (BBA of 2018) includes several requirements for home health payment reform, effective January 1, 2020. These requirements include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day unit of payment. The mandated home health payment reform resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients' care needs.

The Importance of Diagnosis Reporting and Physician Documentation under the PDGM

Under the Medicare home health benefit, the patient must be under the care of a physician and must be receiving home health services under a plan of care established and periodically reviewed by a physician. Physicians play an important role in the provision of home health services and HHAs rely on documentation from the certifying physician (and/or the acute/post acute care facility) to confirm home health eligibility, substantiate diagnoses that are populated on the home health claim and factor into the payment amount, and to help demonstrate the medical necessity of the home health services provided.

The principal diagnosis code on the home health claim will assign the home health period of care to a clinical group that explains the primary reason the patient is receiving home health services. For example, if the reported principal diagnosis is a "stage 2 pressure ulcer of the left heel", the home health period of care would be assigned to the "wound" clinical group, meaning the primary reason for home health services is for wound care. Payment varies between each of the clinical groups to account for the differences in resource use associated with the primary reason for home health care.

There are certain diagnoses that are vague, unspecified, or not allowed to be reported as a principal diagnosis by ICD-10 coding guidelines that will not be assigned into a clinical group. If a home health claim is submitted with a principal diagnosis that would not be assigned to a clinical group under the PDGM, the claim would be returned to the HHA for more definitive diagnosis coding.

Reported secondary diagnoses (that is, comorbidities) also factor into the case-mix adjustment methodology under the HH PPS. For example, if there is a reported secondary diagnosis of "heart failure," home health payment is increased for the period of care to account for the additional resource needs associated with this condition. Additionally, HHAs can report up to 24 secondary diagnoses that may be eligible for additional payment under the PDGM.

Complete, accurate, and specific diagnosis reporting by physicians, along with clinical documentation supporting all diagnoses, is important to make sure that patient characteristics are fully captured under the PDGM. However, this does not mean that the certifying physician would be required to perform additional diagnostic testing solely to certify a patient for home health services or establish a home health plan of care. Complete and comprehensive documentation of the patient's diagnoses and other clinical conditions by the physician will help to ensure that such diagnoses support medical necessity and Medicare payment aligns with your patient's home health resource needs.

30-Day Periods of Care under the PDGM:

While the unit of payment for home health services will be a 30-day period starting on January 1, 2020; there are no changes to timeframes for re-certifying eligibility and reviewing the home health plan of care, both of which still need to occur every 60-days (or in the case of updates to the plan of care, more often as the patient's condition warrants). Physicians are separately paid by Medicare for certification and recertification for home health services.

Because the unit of payment is now 30-days, instead of 60-days, HHAs may have more frequent contact with the certifying physician to communicate any changes in the patient's condition to ensure that home health payment is adjusted to account for those changes. Furthermore, the certification and the home health plan of care must be signed timely by the certifying physician because HHAs will submit a final claim with each 30-day period of care and need this important signed documentation in order to bill for home health services.

Home health services are not limited to a single 30-day period of care. An individual can continue to receive home health services for subsequent 30-day periods as long as the individual continues to meet home health eligibility criteria.

Overview of the Patient-Driven Groupings Model:

Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment under the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- Admission source (two subgroups): community or institutional admission source
- Timing of the 30-day period (two subgroups): early or late
- Clinical grouping (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; Medication Management, Teaching, and Assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA- other; behavioral health; or complex nursing interventions
- Functional impairment level (three subgroups): low, medium, or high
- Comorbidity adjustment (three subgroups): none, low, or high based on secondary diagnoses.

In total, there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups.

Admission Source:

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.

Timing of the 30-Day Period:

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

Clinical Groups:

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis as reported on home health claims. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that Home Health Agencies (HHAs) provide.

**Table 1: PDGM Clinical Groups**

| Clinical Groups | The Primary Reason for the Home Health Encounter is to Provide: |
|---|---|
| **Musculoskeletal Rehabilitation** | Therapy (physical, occupational or speech) for a musculoskeletal condition |
| **Neuro/Stroke Rehabilitation** | Therapy (physical, occupational or speech) for a neurological condition or stroke |
| **Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care** | Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions |
| **Behavioral Health Care** | Assessment, treatment & evaluation of psychiatric conditions, including substance use disorder |
| **Complex Nursing Interventions** | Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies |

| Clinical Groups | The Primary Reason for the Home Health Encounter is to Provide: |
|---|---|
| **Medication Management, Teaching and Assessment (MMTA)--**<br>• **MMTA –Surgical Aftercare**<br>• **MMTA – Cardiac/Circulatory**<br>• **MMTA – Endocrine**<br>• **MMTA – GI/GU**<br>• **MMTA – ID/Neoplasms/ Blood Diseases**<br>• **MMTA –Respiratory**<br>• **MMTA – Other** | Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment. |

While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), these groups represent the primary reason for home health services during a 30-day period of care, but not the only reason for home health care. Home health remains a multidisciplinary benefit and payment is bundled to cover all necessary services identified on the individualized home health plan of care.

Functional Impairment Level:

The PDGM designates a functional impairment level for each 30-day period based on responses to the OASIS items in M1033 Risk for Hospitalization, M1800 Grooming,M1810 Current ability to dress upper body safely, M1820 Current ability to dress lower body safely, M1830 Bathing, M1840 Toilet transferring, M1850 Transferring, M1860 Ambulation and locomotion .

Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with higher resource use and are therefore assigned higher points. These points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level.

Comorbidity Adjustment:

The PDGM includes a comorbidity adjustment category based on the presence of certain secondary diagnoses (for example, congestive heart failure) associated with increased resource use. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- Low comorbidity adjustment: There is a reported secondary diagnosis that is associated with higher resource use, or;
- High comorbidity adjustment: There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.
- No comorbidity adjustment: A 30-day period would receive no comorbidity adjustment if no secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment.

With the implementation of the PDGM in CY 2020, the physician continues to play an invaluable role in making sure that needed home health services are provided to eligible Medicare beneficiaries through accurate, specific diagnosis reporting, developing a patient-specific home health plan of care identifying all services and disciplines to provide care, and communicating with home health agencies in a timely-fashion to ensure that all Medicare requirements are met.

**Accountable Care Organizations (ACOs)**

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.
The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.

Managed Care Organization (MCO)

A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans. It is a health organization that contracts with insurers or self-insured employers and finances and delivers health care using a specific provider network and specific services and products.

Health Maintenance Organization (HMO)

A health maintenance organization (HMO) is a network or organization that provides health insurance coverage for a monthly or annual fee. An HMO is made up of a group of medical insurance providers that limit coverage to medical care provided through doctors and other providers who are under contract to the HMO. These contracts allow for premiums to be lower—since the healthcare providers have the advantage of having patients directed to —but they also add additional restrictions to HMO members. HMO plans require that participants first receive medical care services from an assigned provider known as the primary care physician (PCP).

# Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.