AMBETTER HOME HEALTH FILING GUIDELINES

Managed Health Services (MHS) would like to remind providers of the Ambetter Home Health filing guidelines, effective January 2020, in accordance with CMS guidelines:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

- A prior authorization is required for all Home Health claims.
- Box 4 Type of Bill Code – 0329 - Home Health Services under a Plan of Treatment
    - Do not bill RAP claims. For periods of care beginning on or after January 1, 2020, the duration of a period is 30 days. Periods of care may be shorter than 30 days.
- Box 39 Value Codes and Amounts - Home health episode payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. To ensure these payment adjusts are applied accurately, the HHA reports the following codes:
    - Value 61 – CBSA number Location Where Service is Furnished (HHA and Hospice)
        - MSA number or Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents
    - Value 85 – FIPS Code (Federal Information Processing Standard) – 'County Where Service is Rendered'
        - Where required by law or regulation, report the FIPS State and County Code of the place of residence where the home health service is delivered
- Revenue Code 0023 with HIPPS (Home Health PPS) – must report zero charges on this line
    - Only 1 Rev 0023 can be reported per claim
- Corresponding HH visits by Rev code - Note that modifiers indicating services delivered under a therapy plan of care (modifiers GN, GO or GP) are not required on HH PPS claims
    - Physical Therapy Rev 042X – G0151, G0157, G0159 or G2168
    - Occupational Therapy Rev 043X – G0152, G0158, G0160 or G2169
    - Speech-Language Pathology Rev 044X – G0153, G0161
    - Skilled Nursing Rev 055X – G0299, G0300, G0162, G0493, G0494, G0495 or G0496
        - For all Skilled Nursing and Skilled Therapy Visits - HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.
    - Medical Social Services Rev 056X – G0155
    - Home Health Aide Rev 057X – G0156
- HHA's must report where home health services were provided, along with the first visit reported on the claim:
    - In addition to reporting a visit line using the G codes as described above, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit and a nominal covered charge ($.01)
    - If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.
        - 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