Effective Date…….…… **January 1, 2022**
Last Updated Date…… **May 1, 2022**

Home Health Requirements Job Aid

Summary

Proper requirements for providers billing Home Health services to the AHF.

Ensuring the claim matches an OASIS Assessment

1. Before submitting an HH claim, HHAs should ensure the OASIS assessment has completed processing and was successfully accepted into iQIES. HHAs can verify this by reviewing their OASIS Final Validation Report (FVR).
2. HHAs should take the following steps:
    a. Double-check the FVR to confirm the receipt date shows the OASIS was accepted by iQIES before you submitted your claim. This date is shown on Page 1 of the report, in the field labeled, “Completion Date/Time.” Also, ensure that the assessment has not been inactivated.
        i. If the OASIS was submitted after the claim, resubmit the claim
        ii. If the assessment was inactivated, resubmit the assessment
3. Ensure the assessment is one that is used for determining payments.

Reason for Assessment (RFA) (OASIS Item M0100)

Must be equal to
01
03
04
05
Note: If the claim matches an assessment that is for another reason, update the Occurrence Code 50 date on the claim to correspond to the M0090 date of the applicable assessment and resubmit the claim.

1. Ensure you have submitted occurrence code 50 on any claims, reporting the assessment completion date (item M0090) as the associated date.
    a. If the Occurrence Code is missing, update the claim and resubmit it.

When an OASIS Assessment has not been submitted

1. If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:
    a. Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,
    b. Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period
    c. Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.
2. Condition Code 21 must not be used in these instances since it would result in inappropriate beneficiary liability.
3. The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.
    a. **Group Code:** CO
    b. **CARC:** 272
    c. **RARC:** N211
    d. **MSN:** 41.17

Related Documents

Medicare Claims Processing Manual (cms.gov)

Control History

Home Health OASIS Assessment Job Aid				
Departmental Owner:		Claims		Not Applicable
Effective Date:	January 1, 2022	Modify Date:	May 1, 2022	AHF