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

Home Health PPS Claims Job Aid

Summary

The following data elements are required to submit a claim under home health PPS.

Home Health Required Data

Required Data Elements
Billing Provider Name, Address, and Telephone Number
Required – The HHA's minimum entry is the agency's name, city, state, and ZIP Code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. A/B MACs (HHH) use this information in connection with the provider identifier to verify provider identity.
Patient Control Number and Medical/Health Record Number
Required - The patient's control number may be shown if the patient is assigned one and the number is needed for association and reference purposes. ***Note:*** The HHA may enter the number assigned to the patient's medical/health record. If this number is entered, the A/B MAC (HHH) must carry it through their system and return it on the remittance record.
Type of Bill
Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this period of care. The types of bill accepted for HH PPS claims are: • **032X –** Home Health Services under a Plan of Treatment
4th digit – Definition • 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim. • 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement claim must be submitted for the period of care to be paid. • 9 - Final Claim for an HH PPS Period – This code indicates an HH original bill to be processed following the submission of an HH PPS Notice of Admission (TOB 032A) ***Note:*** HHAs must submit HH PPS claims with the 4th digit of "9." These claims may be adjusted with code "7" or cancelled with code "8." A/B MACs (HHH) do not accept late charge bills, submitted with code "5," on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

Statement Covers Period
Required - The beginning and ending dates of the period covered by this claim. For continuous care periods, the “through” date must be 29 days after the “From” date for a 30-day period of care. ***Note**:* In cases where the beneficiary has been discharged or transferred within the period, HHAs will report the date of discharge in accordance with internal discharge procedures as the “through” date. If the beneficiary has died, the HHA reports the date of death in the “through date.”
The HHA may submit claims for payment immediately after the claim “through” date. It is not required to hold claims until the end of the period of care unless the beneficiary continues under care.
Patient Name/Identifier
Required – The HHA enters the patient’s last name, first name, and middle initial
Patient Address
Required – The HHA enters the patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code
Patient Birth Date
Required - The HHA enters the month, day, and year of birth of patient. If the full correct date is not known, leave blank.
Patient Sex
Required - “M” for male or “F” for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.
Admission/Start of Care Date
Required - The HHA enters a date of admission matching the From date on the first period of care in an admission. On subsequent periods of care, the HHA continues to submit the admission date reported on the first period of care.
Point of origin for Admission or Visit
Required – The HHA enters the appropriate NUBC point of origin code
Patient Discharge Status
Required - The HHA enters the code that most accurately describes the patient’s status as of the “Through” date of the billing period. Any applicable NUBC approved code may be used.
Patient Status Code **06** Should be reported in all cases where the HHA is aware the period of care will be paid a partial period payment adjustment. ***Note:*** These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 30-day period, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the period. • Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. • In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the partial period payment adjustment, ***changing the patient status code on the paid claims record to 06.***
In cases where the ownership of an HHA is changing and the CMS certification number (CCN) also changes, the service dates on the claims must fall within the effective dates of the terminating CCN. • To ensure this, all periods of care with “from” dates before the termination date of the CCN that would extend beyond the termination date must be resolved by the provider submitting claims with “through” dates on or before the termination date. • ***The provider must code the claim with patient status 06.***

- Billing for the beneficiary is being "transferred" to the new agency ownership.
    - In changes of ownership which do not affect the CCN, billing is unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date.

- ***The provider must code the claim with patient status 06***
- Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

Condition Codes

Conditional – The HHA enters any NUBC approved code to describe conditions that apply to the claim

If the claim is for a patient transferred from another HHA:

- The HHA enters **Condition Code 47**

If the claim is for a period of care in which there are no skilled HH visits in the billing period but a policy exception that allows billing for covered services is documented at the HHA:

- The HHA enters **Condition Code 54**

HHAs that are adjusting previously paid claims enter one of the Condition Codes representing Claim Chage Reasons (code values D0 through E0).

- If adjusting the claim to correct a HIPPS code**, HHAs use Condition Code D2** and enter **"Remarks"** indicating the reason for the HIPPS code change.
    - HHAs use **D9** if multiple changes are necessary

When submitting an HH PPS claim as a demand bill

- HHAs use **Condition Code 20**

When submitting an HH PPS claim for a denial notice

- HHAs use **Condition Code 21**

Required - If canceling the claim (**TOB 0328**),

- HHAs report the **Condition Codes D5** or **D6** and enter **"Remarks"** indicating the reason for cancellation of the claim.

Occurrence Codes and Date

Required – The HHA enters **Occurrence Code 50** and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090).

- If **Occurrence Code 50** is not reported on a claim or adjustment, the claim will be returned to the provider for correction.

On claims for initial periods of care (i.e., when the From and Admission dates match), the HHA reports an inpatient admission that ended within 14 days of the "From" date by using one of the following below codes.

Code	Short Descriptor	Long Descriptor
61	Hospital Discharge Date	The Through date of a hospital stay that ended within 14 days prior to the From date this HHA claim.
62	Other Institutional Discharge Date	The Through date of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or

		inpatient psychiatric facility (IPF) stay that ended with 14 days prior to this HHA admission	

On claims for continuing periods of care, the HHA reports an inpatient hospital admission that ended within 14 days of the "From" date by using **Occurrence Code 61**
Note: To determine the 14-day period, include the "From" date, then count back using the day before the "From" date as a day

- **Example:** If the "From" date is January 20th, then January 19th is day 1. Counting back from January 19th, the 14-day period is January 6 through January 19.
  - If an inpatient discharge date falls on any date in that period or on the admission day itself (January 20), it is eligible to be reported on the claim.

If more than one inpatient discharge occurs during the 14-day period:

- The HHA reports only the most recent applicable discharge date
- Claims reporting more than one of any combination of **Occurrence Codes 61 and 62** will be returned to the provider for correction.

Conditional – The HHA enters any other NUBC approved code to describe occurrences that apply to the claim.

Occurrence Span Code and Dates

Conditional – The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim.

- Reporting of Occurrence Span Code 71 ***is not required*** to show the dates of an inpatient claim.

Value Codes and Amounts

Required – Home Health 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.

- For periods of care in which the beneficiary's site of service changes from one CBSA or county to another within the period, the HHA should submit the CBSA code or State and County code corresponding to the site of service at the end of the period.

Provider Submitted Codes:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the 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, and two zeros to the cents field if no cents.
85	County Where Service is Rendered	Where required by law or regulation, report the

		Federal Information Processing Standard (FIPS) State and County Code of the place of residence where the Home Health service is delivered.

Medicare Applied Codes:

The following codes are added during the processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the HHA.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. A/B MACs (HHH) always place **Condition Code 61** on the claim along with this **Value Code**
62	HH Visits – Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits – Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act
64	HH Reimbursement – Part A	The dollar amounts determined to be associated with the HH visits identified in a **Value Code 62** amount. This Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement – Part B	The dollar amounts determined to be

		associated with the HH visits identified in a **Value Code 63** amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.	
QF	Late-filed NOA penalty amount	The dollar amount the claim payment was reduced due to the NOA being filed more than 5 days after the HH From date.	
QV Value-based purchasing adjustment amount	Value-based purchasing adjustment amount	The dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. May be a positive or a negative amount.	

If information returned from the CWF indicates all visits on the claim are Part A, the shared system must place the below Value Codes on the claim record showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code V.

- **Value Code 62**
- **Value Code 64**

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place the below Value Codes on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code W.

- **Value Code 63**
- **Value Code 65**

If information returned from CWF indicates certain visits on the claim are payable form both Part A and Part B, the shared system must place the below Value Codes on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with Value Codes 64 and 65. The shared system will return the claim to CWF with RIC code U.

- **Value Code 62**
- **Value Code 63**
- **Value Code 64**
- **Value Code 65**

Revenue Code and Revenue Description
Required – HH PPS claims must report a 0023 Revenue code line which contains a HIPPS code. ***Note:*** HHAs enter only one 0023 Revenue code per claim in all cases
Claims must also report all services provided to the beneficiary within the period of care. • All services must be billed on one claim for the entire period The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.
Each service must be reported in line-item detail
Each service visit (Revenue Codes 042X, 043X, 044X, 055X, 056X, and 057X) must be reported as a separate line.
Any of the following revenue codes may be used:

Revenue Code	Revenue Description
027X	Medical/Surgical Supplies (Also see 062X, an extension of 027X) **Required detail**: Except for revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. ***NOTE***: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS claims
042X	Physical Therapy **Required detail:** One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
043X	Occupational Therapy **Required detail:** One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
044X	Speech-Language Pathology **Required detail:** One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
055X	Skilled Nursing

	Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
056X	Medical Social Services **Required detail:** The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
057X	Home Health Aide (Home Health) **Required detail:** The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15-minute increments that comprised the visit, and a charge amount.
Note	A/B MACs (HHH) will return claims to the provider if revenue codes 058x or 059x are submitted with covered charges on Medicare home health claims. They also return to the provider if revenue code 0624, investigational devices is reported on HH claims.

Revenue Codes for Optional Billing of DME

Billing of DME provided in the period of care is not required on the HH PPS claim

- Home Health Agencies retain the option to bill these services to their A/B MAC (HHH) processing Home Health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC.
- Agencies that choose to bill DME service on their HH PPS claims must use the revenue codes below.
    - These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule.

Revenue Code	Revenue Code Description
0274	Prosthetic/Orthotic Devices **Required detail:** The applicable HCPCS code for the item, a date of service, number of service units, and a charge amount.
029X	Durable Medical Equipment (DME) (Other Than Renal) **Required detail**: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. ***Note:*** Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.
060X	Oxygen (Home Health) **Required detail:** The applicable HCPCS code for the item, a date of service, number of service units, and a charge amount.

Revenue Codes for Optional Reporting of Wound Care Supplies	
0623	Medical/Surgical Supplies – Extension of 027X **Required detail:** Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.
HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies • Using Revenue Code 0623 Notwithstanding the standard abbreviation "surg dressings," HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.	
HHAs can assist Medicare's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under • Revenue center code 0623 HHAs should ensure that charges reported under revenue code 027x for nonroutine supplies are also complete and accurate.	

HCPCS/Accommodation Rates/HIPPS Rate Codes	
Required - On the **0023-revenue code line**, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code to meet this requirement.	
HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.	
Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changes based on medical review or other processes, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.	
For revenue code lines **other than 0023**, the HHA reports HCPCS codes as appropriate to that revenue code.	
To report HH visits, the HHA reports one of the following HCPCS codes to represent a visit by each HH care discipline:	

Physical Therapy (Revenue Code 042X)	
G0151	Services performed by a qualified physical therapist in the Home Health or Hospice setting, each 15 minutes.
G0157	Services performed by a qualified physical therapist assistant in the Home Health or Hospice setting, each 15 minutes.
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.
G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes.
Occupational Therapy (Revenue Code 043X)	
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.
Speech-Language Pathology (Revenue Code 044X)	
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.
Note	Modifiers indicating services delivered under a therapy plan of care below are not required on HH PPS claims. • GN • GO • GP
Skilled Nursing (Revenue Code 055X) – General Skilled Nursing	
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting.
G0300	Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.
Care Plan Oversight	
G0162	Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).
Training	
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.
Medical Social Services (Revenue Code 056X)	
G0155	Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (Revenue Code 057X)	
G0156	Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding all Skilled Nursing and Skilled Therapy Visits

During a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above.

- 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.

HHAs must report where Home Health serves were provided. The following codes are used for this reporting:

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

The location where services were provided must always be reported 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, one unit and a nominal covered charge (e.g., a penny):
  - Q5001
  - Q5002
  - Q5009
- If the location where services were provided changes during the period of care, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Modifiers

- If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty
  - Append modifier KX to the HIPPS code reported on the revenue code 0023 line

Service Date

Required – For initial periods of care

- The HHA reports on the 0023 Revenue Code line the date of the first covered visit provided during the period.
- For subsequent periods
  - The HHA reports on the 0023 Revenue Code the date of the first visit provided during the period, regardless of whether the visit was covered or non-covered.

For other line items detailing all services within the period

- The HHA reports service dates as appropriate to that Revenue Code

For services visits that begin in 1 calendar day and span into the next calendar day

- Report one visit using the date the visit ended as the service date

When the claim Admission Date matches the Statement Covers "From" Date

- Medicare systems ensure the Service Date on the 0023 Revenue Code line also matches these dates

Service units

Required – Transaction standards require the reporting of a number greater than zero as the units on the 00323 Revenue Code line.

• Medicare systems will disregard the submitted units in processing the claim For line items detailing all services within the period • The HHA reports units of service as appropriate to that Revenue Code • Coding detail for each Revenue Code under HH PPS is defined above under Revenue Codes
For the Revenue Codes that represent Home Health Visits • 042X • 043X • 044X • 055X • 056X • 057X The HHA reports as service units a number of 15-minute increments that comprise the time spent treating the beneficiary • Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported.
Visits of any length are to be reported • Round the time to the nearest 15-minute increment If any visits report over 96 units (over 24 hours) on a single line item • Medicare systems return the claim to the provider
Covered and noncovered increments of the same visit must be reported on separate lines. • This is to ensure only covered increments are included in the per-unit based calculation of outlier payments.
Total Charges
Required – The HHA must report zero charges on the 0023 Revenue Code line • The field must contain zero
For line items detailing all services within the period of care • The HHA reports charges as appropriate to that Revenue Code Coding detail for each Revenue Code under HH PPS is defined above under Revenue Codes • Charges may be reported in dollars and cents • Medicare claims processing systems will not make any payments based upon submitted charge amounts
Non-Covered Charges
Required – The HHA reports the total non-covered charges pertaining to the related Revenue Code here. Examples of non-covered charges on HH PPS claims may include: • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments
Payer Name
Release of Information Certification Indicator
National Provider Identifier – Billing Provider **Required** – The HHA enters their provider identifier
Insured's Name
The following are **required** only if MSP is involved: • Patient's Relationship to Insured • Insured's Unique Identifier • Insured's Group Name

• Insured's Group Number • Treatment Authorization Code • Document Control Number (DCN) • Employer Name **Conditional** – Treatment authorization codes are not required on all claims
Principal Diagnosis Code • **Required** – The HHA enters the ICD code for the Principal Diagnosis • The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by HIPAA. • The code must be the full diagnosis code, including all seven digits for ICD-10 CM   ○ Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros
Other Diagnosis Codes **Required** – The HHA enters the full diagnosis codes for additional conditions if they coexisted at the time of the establishment of the plan of care. • These codes may not duplicate the Principal Diagnosis as an additional or Secondary Diagnosis
Attending Provider Name and Identifiers **Required** – The HHA enters the name and National Provider Identifier (NPI) of the attending physician who signed the plan of care
Other Provider (Individual) Names and Identifiers **Required** – The HHA enters the name and National Provider Identifier (NPI) of the physician who certified/re-certified the patient's eligibility for Home Health services. ***Note:*** Both the attending physician and other provider fields should be completed unless the patient's designated attending physician is the same as the physician who certified/re-certified the patient's eligibility. When the attending physician is also the certifying/re-certifying physician, only the attending physician is required to be reported.
Remarks

Related Documents

Medicare Claims Processing Manual (cms.gov)

Control History

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