

AMBETTER HOME HEALTH FILING GUIDELINES

Ambetter from MHS would like to remind providers of the Ambetter Home Health filing guidelines:

- Provider must use type of bill (TOB) 329.
 - We only pay final claim for the 60 days. Do not bill RAP or interim claims
- CBSA number must be listed in box 39.
- Treatment authorization code (TAC) must be listed in box 63.
- A prior authorization is required for all Home Health claims.
- Revenue code 023, with the appropriate HIPPS Code, must be billed along with any additional revenue codes that are appropriate.
- Regarding all skilled nursing and skilled therapy visits –
 - In the course of 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.**
 - To report HCPCS (G) codes as appropriate to each HH visit revenue code, please review <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf>
 - In the fifth digit of the HIPPS code, a letter (S-X) indicates NRS (non-routine supplies) were provided by the HHA during the episode, while a number is used to indicate the NRS were NOT provided to the beneficiary. The HIPPS code is generated by the Grouper software
 - Note that all NRS may be reported as one line item on the final claim. It is not necessary to report each NRS on a separate revenue code line. https://www.cgsmedicare.com/hhh/education/materials/billing_nonroutine_supplies.html
- HHAs must report where services were provided, using appropriate HCPCS code,
 - 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 (Q5001, Q5002, and Q5009), one unit and a nominal covered charge (e.g., a penny). 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.