

## Home Health Services Provider Guide

Use this guide as a supplement to Home Health Services Oregon Administrative Rules ([Chapter 410 Division 127](#)). See current Home Health Services administrative rules for official policies regarding billing.

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### Client eligibility and enrollment

Refer to [General Rules](#) and [OHP Rules](#) for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

The [OHP eligibility verification page](#) explains how to verify eligibility using the Provider Web Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

### Prior authorization

Prior authorization (PA) is not required for clients enrolled in Medicare Part A.

- For PA related to home enteral/parenteral and IV services, refer to the [Home Enteral/Parenteral and IV Services](#) provider guidelines.
- For PA related to Group 2 pressure-reducing support surfaces, refer to the [DMEPOS](#) provider guidelines.

Refer to the program-specific administrative rules and supplemental information for specific details and required forms. Submit prior authorization (PA) requests to DMAP using the [Provider Web Portal \(instructions\)](#) or the [MSC 3971 \(instructions\)](#).

- For OHP coordinated care organization (CCO) or managed care plan members, contact the CCO/plan for PA instructions.
- For complete instructions on how to submit PA requests to DMAP, see the [Prior Authorization Handbook](#).

## Information needed to request PA

DMAP may automatically deny requests that do not include one or more of the following pieces of information.

- Information in **bold** is required for correct processing.
- If using the [MSC 3971](#) to submit the request, fax the completed form to 503-378-5814 for routine requests or 503-378-3435 for immediate/urgent requests.

Information needed	New PA	Existing PA	
		Continue	Change
<b>Section I - Provider number</b>	X		
<b>Section II - Type of PA request - "Home Health"</b>	X		
<b>Section III</b>			
<ul style="list-style-type: none"> <li>■ <b>Client ID -The 8-digit Medicaid ID.</b></li> <li>■ Client's name</li> </ul>	X	X	
<b>Section IV</b>			
<ul style="list-style-type: none"> <li>■ <b>Diagnosis code -The reason chiefly responsible for the service being provided as shown in the medical records; provided for each diagnosis for which the patient receives home care</b> <ul style="list-style-type: none"> <li>○ Use ICD-9-CM codes for dates of service on or before 9/30/2015.</li> <li>○ Use ICD-10-CM codes for dates of service on or after 10/1/2015.</li> </ul> </li> <li>■ <b>Revenue codes</b></li> <li>■ <b>Frequency of service</b></li> </ul>	X		
<b>Section V - Units of service</b>	X		
<b>Section VIII - Performing provider number</b>	X		
<b>Section IX - Date of request; service begin/end dates</b>	X		
<b>Notes</b>			
<ul style="list-style-type: none"> <li>■ <b>New PA: Goals and objectives; assessment of availability of other resources to care for the client</b></li> <li>■ <b>Change to PA: The needed change and reason for change</b></li> </ul>	X		X
<b>Attachments</b>			
Describe and attach the following medical justification from the prescribing practitioner: <ul style="list-style-type: none"> <li>■ <b>Assessments/reassessments for which the patient is receiving home care.</b></li> <li>■ <b>Reason home care is the most medically effective service.</b></li> <li>■ <b>Most recent visit notes to support the PA</b></li> </ul>	X	X	X

## Billing for Home Health services

Use the institutional claim format.

- **Billing instructions** are available on the [OHP provider billing tips page](#).
- **For information about electronic billing**, go to the [Electronic Business Practices Web page](#).

## Type of Bill codes

- **321 - (Admit through discharge claim):** Encompasses an entire home health span of service for which the agency expects reimbursement.
- **322 (First claim):** Use this code for the first of an expected series of payment claims for the same home health start of care.
- **323 (Interim-continuing claim):** Use when one or more claims for the same home health start of care have already been submitted, and further claims are expected to be submitted at a later date.
- **324 (Interim-last claim):** Use for a claim which is the last of series for a home health start of care. The “through” date of this claim is the discharge date or date of death for this service span.

## Revenue codes

On paper claims, enter “0001” in line 23. For each remaining line on the claim, enter the revenue code which most accurately describes the service provided.

- 421—Physical therapy visit
- 424—Physical therapy evaluation or reevaluation
- 431—Occupational therapy visit
- 434—Occupational therapy evaluation or reevaluation
- 441—Speech-language pathology visit
- 444—Speech-language pathology evaluation or reevaluation
- 551—Skilled nursing visit
- 559—Skilled nursing evaluation
- 571—Home Health Aide visit
- 270—Medical/surgical supplies, general classification
- 271—Medical/surgical supplies, non-sterile supplies
- 272—Medical/surgical supplies, sterile supplies

## Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the [OHP remittance advice page](#).

For information about how to adjust a claim, refer to the [Claim Adjustment Handbook](#).