20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing

(Rev. 1988, Issued: 06-14-10, Effective: 10-01-10, Implementation: 10-04-10)

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources. The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

Additionally, information about current home health episodes may be available from Medicare contractors. Institutional providers (providers who bill using the institutional claim format) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists or suppliers who bill using the professional claim format also have access to a similar electronic inquiry via the HIPAA standard eligibility transaction – the 270/271 transaction.