Medicare Billing Basics for Home Health Agencies

An introductory guide to Medicare home health billing, PDGM, OASIS, and claims submission

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Introduction: Medicare Home Health Billing Overview

Medicare is the primary payer for home health services in the United States, covering skilled nursing, physical therapy, occupational therapy, speech-language pathology, medical social work, and home health aide services for eligible patients. For any home health agency seeking long-term financial viability, understanding Medicare's billing system is not optional—it is essential. Billing errors, coding mistakes, and documentation gaps are among the most common reasons agencies face claim denials, delayed payments, and compliance audits.

This guide provides an introductory overview of the key components of Medicare home health billing, including the Patient-Driven Groupings Model (PDGM), the episode of care structure, OASIS assessment requirements, common billing codes, the claims submission process, and the most frequent billing errors agencies encounter. Whether you are launching a new home health agency or looking to strengthen your existing billing operations, this resource will give you a solid foundation to build on.

> **Important Distinction**
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> This guide covers Medicare billing for **home health agencies** that provide skilled services (nursing, therapy). Non-medical home care agencies that provide only personal care, companionship, and homemaker services typically do not bill Medicare. If you operate a non-medical home care agency, Medicare billing does not apply to your service line unless you expand into skilled home health.

PDGM (Patient-Driven Groupings Model) Explained

The Patient-Driven Groupings Model (PDGM) is the current Medicare payment system for home health services. It replaced the previous Prospective Payment System (PPS) effective January 1, 2020, and represents a fundamental shift in how Medicare determines payment for home health episodes of care.

Under PDGM, payment is based on **patient characteristics**—not the volume of services provided. This means agencies are paid based on who the patient is and what their clinical needs are, rather than how many therapy visits they deliver. This was a deliberate move by CMS to eliminate incentives for over-utilization of therapy services.

Five Factors That Determine PDGM Payment

Each 30-day payment period is classified into a case-mix group based on the following five factors:

1

Admission Source

Was the patient admitted from the **community** (living at home, assisted living, etc.) or from an **institutional setting** (hospital, skilled nursing facility, inpatient rehabilitation)? Institutional admissions typically receive higher payment due to greater acuity and care needs.

2

Timing

Is this an **early** 30-day period (the first period in a certification) or a **late** period (any subsequent 30-day period)? Early periods are generally paid at a higher rate because patients typically require more intensive care at the start of their home health episode.

3

Clinical Grouping

The patient's principal diagnosis is mapped into one of **12 clinical groupings**: Musculoskeletal Rehabilitation, Neuro/Stroke Rehabilitation, Wound Care, Complex Nursing Interventions, Behavioral Health, Medication Management/Teaching/Assessment (MMTA)—Surgical Aftercare, MMTA—Cardiac/Endocrine, MMTA—Infectious Disease/Neoplasms/Blood Disorders, MMTA—Respiratory, MMTA—Other, MMTA—Gastrointestinal Tract/Genitourinary System, and MMTA—Orthopedic.

4

Functional Impairment Level

Based on specific OASIS assessment items, the patient is classified into one of **three functional impairment levels** (low, medium, or high). This reflects the patient's ability to perform activities of daily living and their overall functional status.

5

Comorbidity Adjustment

Secondary diagnoses are evaluated for comorbidity adjustments at three levels: **none, low, or high**. Certain diagnosis combinations trigger higher payments to account for the increased complexity of caring for patients with multiple conditions.

These five factors create **432 possible case-mix groups** under PDGM, each with its own payment weight that determines how much Medicare will pay for that 30-day period.

> **Key Change Under PDGM**

Under PDGM, therapy volume no longer determines payment. Agencies must focus on accurate coding and OASIS assessment rather than maximizing therapy visits. This means your clinical and coding staff must work closely together to ensure that every patient's diagnoses, functional status, and comorbidities are accurately documented and coded from the start of each episode.

Episode of Care Structure

Understanding the episode of care structure is critical for accurate billing and cash flow management. Medicare home health operates on a system of certification periods and 30-day payment periods.

Key Structural Elements

- **30-Day Payment Periods:** Effective January 1, 2020, Medicare home health uses 30-day payment periods (changed from the previous 60-day episode structure). Each 30-day period has its own payment calculation and generates its own claim.
- **Early vs. Late Periods:** The first 30-day period in a new certification is classified as "early" and is typically paid at a higher rate. All subsequent 30-day periods within the same certification are classified as "late."
- **60-Day Certification Periods:** While payment is calculated in 30-day increments, the physician's plan of care (certification) still covers a 60-day period. Recertification is required at the end of each 60-day certification period if the patient continues to need home health services.
- **Homebound Criteria:** The patient must meet Medicare's homebound criteria throughout the episode. Homebound status means leaving home requires considerable and taxing effort, and the patient generally does not leave home except for medical appointments or infrequent, short-duration outings.
- **Skilled Service Requirement:** The patient must need at least one skilled service (skilled nursing, physical therapy, occupational therapy, or speech-language pathology) to qualify for the Medicare home health benefit. Home health aide services alone do not qualify a patient for coverage.

> **Cash Flow Consideration**
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> Under PDGM, CMS eliminated the Request for Anticipated Payment (RAP) system as of January 1, 2022. Agencies now submit a Notice of Admission (NOA) within 5 days of the start of care, but do not receive any upfront payment. Full payment comes only after submitting the final claim at the end of each 30-day period. This change significantly impacts agency cash flow, particularly for new agencies without financial reserves.

OASIS Assessment Requirements

The Outcome and Assessment Information Set (OASIS) is a standardized patient assessment tool required by CMS for all Medicare and Medicaid home health patients (excluding maternity patients and patients

under 18 years of age). OASIS data serves a dual purpose: it drives both payment (by determining the case-mix group under PDGM) and quality reporting (by generating the agency's Star Ratings on Medicare's Home Health Compare website).

Key OASIS Assessment Time Points

OASIS assessments must be completed at specific points during a patient's home health episode. Missing or late assessments can delay payment and trigger compliance issues.

TIME POINT	ABBREVIATION	TIMING REQUIREMENT	PURPOSE
Start of Care	SOC	Within 5 days of referral date or within 5 days of the start of care date	Establishes baseline patient status; drives initial PDGM payment group
Resumption of Care	ROC	Within 2 calendar days of the patient's return from an inpatient facility	Reassesses patient status after hospitalization; may change payment group
Recertification	Recert	Within the last 5 days of each 60-day certification period	Reassesses patient for continued need for home health services
Transfer	Transfer	When patient transfers to an inpatient facility	Documents patient status at time of transfer; triggers payment adjustment
Discharge	DC	Within 2 calendar days of discharge from home health	Captures final patient outcomes; used for quality reporting

> **OASIS Accuracy Matters**
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> Because OASIS data directly determines your PDGM payment group, accurate and thorough assessment is critical. Under-documenting functional impairment or missing comorbidities can result in lower payment. Over-documenting can trigger audits and potential fraud allegations. Train your clinical staff to assess and document accurately—not to "upcode" or "downcode."

Common Billing Codes

Home health agencies submit claims using revenue codes and HCPCS (Healthcare Common Procedure Coding System) codes. The following table lists the most commonly used codes in Medicare home health billing.

Revenue Codes

TYPE	CODE	DESCRIPTION
Revenue Code	**0023**	Skilled Nursing — General
Revenue Code	**0042**	Physical Therapy
Revenue Code	**0043**	Occupational Therapy
Revenue Code	**0044**	Speech-Language Pathology
Revenue Code	**0055**	Home Health Aide
Revenue Code	**0056**	Medical Social Services

HCPCS Codes

TYPE	CODE	DESCRIPTION
HCPCS	**G0151**	Services of physical therapist in home health, per visit
HCPCS	**G0152**	Services of occupational therapist in home health, per visit
HCPCS	**G0153**	Services of speech-language pathologist in home health, per visit
HCPCS	**G0154**	Services of skilled nurse in home health, per visit
HCPCS	**G0156**	Services of home health aide in home health, per visit
HCPCS	**G0299**	Direct skilled nursing services in home health, per visit

Coding Tip

Each visit must be documented with the correct revenue code and HCPCS code combination. Mismatched codes are a common cause of claim rejections. Ensure your billing staff is trained on proper code pairing and that your EHR system automatically maps the correct codes based on the discipline and visit type.

Claims Submission Process

Submitting a clean claim to Medicare requires coordination across clinical, coding, and billing departments. The following seven-step process outlines the standard workflow from patient intake to payment receipt.

1

Verify Patient Eligibility

Before admitting a patient, verify their Medicare Part A and Part B enrollment status through the Common Working File (CWF) or your Medicare Administrative Contractor's (MAC) provider portal. Confirm the patient meets homebound criteria and requires at least one skilled service. Document eligibility verification in the patient record.

2

Complete OASIS Assessment and Transmit to CMS

Complete the Start of Care OASIS assessment within the required timeframe. Review the assessment for accuracy and completeness, then transmit the OASIS data to CMS through the OASIS Assessment Submission and Processing (ASAP) system. OASIS must be transmitted within 30 days of the assessment completion date. Late submissions trigger a 2% payment reduction.

3

Obtain Signed Physician Plan of Care

The certifying physician must sign the plan of care (also called the 485 form) and document a face-to-face encounter. The face-to-face encounter must occur within 90 days before or 30 days after the start of care. The signed plan of care must include all required elements: patient diagnoses, types of services needed, frequency and duration of visits, and functional limitations.

4

Provide Services Per the Plan of Care

Deliver skilled services and home health aide visits according to the plan of care within the 30-day period. Document each visit thoroughly, including clinical findings, interventions performed, patient response, and progress toward goals. Ensure visit notes support medical necessity and homebound status.

5

Submit Notice of Admission (NOA)

Submit the Notice of Admission (NOA) to Medicare within 5 calendar days of the start of care date. The NOA replaced the Request for Anticipated Payment (RAP) effective January 1, 2022. Unlike the former RAP, the NOA does not generate an upfront payment—it simply notifies Medicare that the patient has been admitted to your agency. Late NOA submission results in a per-day payment reduction.

6

Submit Final Claim

At the end of the 30-day period, submit the final claim in UB-04 format to your Medicare Administrative Contractor (MAC). The claim must include all visit line items with correct revenue codes, HCPCS codes, dates of service, and total charges. Ensure the claim is consistent with the OASIS data and plan of care. Review the claim for common errors before submission.

7

Receive Payment

Clean claims are typically processed and paid within 14–30 days of submission. Payment is deposited via electronic funds transfer (EFT). Review your Remittance Advice (RA) for each claim to verify the payment amount matches the expected PDGM case-mix weight. If a claim is denied or paid at a lower rate than expected, follow up promptly with your MAC to understand the reason and submit an appeal if warranted.

Common Billing Errors and How to Avoid Them

The following eight errors are among the most frequent causes of claim denials, delayed payments, and compliance issues in Medicare home health billing. Implementing internal controls to prevent these errors will protect your agency's revenue and reduce audit risk.

1. **Missing or Expired Physician Orders**
   Ensure all physician orders are signed and dated before submitting claims. Unsigned or expired orders are one of the top reasons claims are denied. Implement a tracking system that flags unsigned orders and escalates them to the appropriate staff. Set up a 48-hour follow-up process for any order sent to a physician for signature.

2. **OASIS Submission Delays**
   Transmit OASIS data within 30 days of the assessment completion date to avoid the 2% payment penalty. Late OASIS submissions also delay your ability to submit the final claim. Build OASIS transmission into your standard workflow with a target of submitting within 5–7 days of completion, leaving a buffer for corrections.

3. **Incorrect Diagnosis Coding**
   Use the most specific ICD-10 code available and ensure it matches the plan of care. Vague or unspecified diagnosis codes can trigger claim rejections and may result in a lower PDGM payment group. Invest in ongoing coder education and consider periodic coding audits to identify patterns of error.

4. **Homebound Status Not Documented**
   Document homebound criteria clearly in clinical notes for every visit. Homebound status must be supported in the clinical record throughout the episode of care. Train clinicians to document specific reasons the patient is homebound—not just to check a box, but to describe the considerable and taxing effort required for the patient to leave home.

5. **Face-to-Face Encounter Missing**
   The certifying physician must document a face-to-face encounter within 90 days before or 30 days after the start of home health care. Without this documentation, the claim cannot be paid. Track face-to-face encounter completion as part of your intake workflow and do not submit claims until it is confirmed.

6. **Duplicate Claims**
   Implement internal controls to prevent submitting the same claim twice. Duplicate claims trigger automatic rejections and can flag your agency for heightened audit scrutiny. Use your billing software's duplicate detection features and require supervisor approval before resubmitting any claim.

7. **Therapy Reassessment Not Completed**
   Complete functional reassessments at required intervals for therapy patients. CMS requires periodic reassessment to justify continued therapy services. Missing reassessments can result in denial of therapy visits and potential recoupment of payments already received. Build reassessment due dates into your scheduling system.

8. **Late Claim Submission**
   Medicare claims must be submitted within 12 months of the date of service (the timely filing deadline). Claims submitted after this deadline will be denied with no appeal rights. While 12 months may seem generous, claims that are held up by missing documentation, unsigned orders, or coding issues can easily approach this deadline. Monitor your aging claims report weekly and escalate any claim older than 90 days.

> **Best Practice: Weekly Billing Audit**
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> Conduct a brief weekly review of all open claims, unsigned orders, pending OASIS transmissions, and missing face-to-face encounters. A 30-minute weekly audit can prevent the vast majority of billing errors and ensure your agency maintains a clean claims rate above 95%.