



Home Health Billing Scenarios - DRAFT



1493_1013

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.gov>.



Acronyms

- Please access the [Acronyms](#) page on the NGS Medicare.com Web site to view any acronym used within this presentation.

Objective

- Help providers gain a better understanding of home health billing guidelines which will in turn reduce the amount of incorrect claims submitted to Medicare

Agenda

- Review billing requirements
- Review consolidated billing guidelines
- Discuss scenarios that correspond to the highest error rates for home health RAPs and claims



5

National Government Services, Inc.

Billing the RAP

- Submitted as soon as possible after care begins to establish the primary HHA
- Initial split percentage payment for the HH episode
- Must be billed on type of bill 322
- Billed with revenue code 0023 and coding from OASIS
 - HIPPS code billed with 0023 and OASIS matching key submitted as treatment authorization code
- Always billed as Medicare primary



6

National Government Services, Inc.

Billing the Episode Claim

- Must be billed on type of bill 329
- Must be billed admit to discharge with appropriate patient status code or, if continuing care, 60 days with patient status code 30
- Must report revenue lines for all services received within the episode along with revenue code 0023 and HIPPS code
 - 0023 HIPPS must match RAP unless supplies not provided within episode



7

National Government Services, Inc.

Billing the Episode Claim

- OASIS matching key/treatment authorization must be billed same as RAP
- Both RAP and claim need to be submitted within timely filing limits



8

National Government Services, Inc.

Consolidated Billing

- Includes all services and supplies (except osteoporosis drugs and DME) covered under HH PPS for patients under a plan of care
- HHA required to provide covered services directly or under arrangement including:
 - Part-time or intermittent skilled nursing care
 - PT, SLP, OT
 - Home health aide services
 - Medical social services
 - Routine and non-routine medical supplies



9

National Government Services, Inc.

Payment for Services Under CB

- The primary HHA is paid for all services subject to consolidated billing (i.e., all services the physician has ordered under the plan of care)
 - HHA has to have knowledge of services provided
 - Inform beneficiary about care being furnished and possible payment liability
 - Open communication with other providers of care



10

National Government Services, Inc.

CB Scenario 1

- A HH patient goes to an outpatient therapy provider for PT. The plan of care includes orders for therapy. The HHA has an arrangement with the outside therapy provider and is aware of the PT services rendered to their patient.

CB Scenario 1: Who is Responsible?

- HHA CB guidelines state the HHA will be paid for all services under the plan of care in the HH PPS rate – the HHA will bill the PT services and arrange to pay the outside entity for their charges.

CB Scenario 2

- A HH patient goes to an outpatient therapy provider for PT. The plan of care includes orders for therapy. The HHA is not aware of the PT services being provided to their patient.

CB Scenario 2: Who is Responsible?

- The HHA is only responsible for services provided directly or under arrangement in which they have knowledge of the services being provided
 - Possible beneficiary liability if outside entity provided ABN
- It is in the best interest of both providers to discuss services under arrangements for future business

Key Reminders

- HHA responsible for explaining CB to the beneficiary
 - Potential beneficiary liability if services provided by outside entity without HHA knowledge
- HHA required to pay for services provided by an outside entity for which there is prior arrangement and prior knowledge
- HHA responsible for submitting RAP as soon as possible after first billable service provided so other providers aware of HH episode

Inpatient Services

- A home health patient may have inpatient services at either a hospital or skilled nursing facility during a 60-day episode but the home health services may not have dates of service that overlap inpatient care (excluding the day of admission or day of discharge)

Inpatient Scenario 1

- A beneficiary's home health episode begins on 1/21/2014. The beneficiary is admitted to the hospital on 1/27/2014 and is discharged to a skilled nursing facility on 2/3/2014. The beneficiary returns home on 2/22/2014 and resumes home health care with the same HHA. The beneficiary remains a home health patient until 5/31/2014.



17

National Government Services, Inc.

Inpatient Scenario 1: How is This Billed?

- The HHA bills the full episode, 1/21/2014-3/21/2014, with all services provided to the beneficiary under the plan of care. No dates of service should fall within either the hospital inpatient stay or SNF inpatient stay
- Note: All HH services provided in a complete 60-day episode – both before and after an inpatient stay – should be billed on one HH episode claim



18

National Government Services, Inc.

Inpatient Scenario 2

- A beneficiary's home health episode begins on 1/21/2014. The beneficiary is admitted to the hospital on 3/19/2014 and is discharged on 3/22/2014. The beneficiary returns home and resumes home health care with the same HHA in what is now a new episode. The HHA completes an OASIS assessment and delivers the first billable service on 3/25/2014.



19

National Government Services, Inc.

Inpatient Scenario 2: How is This Billed?

- The HHA must discharge the beneficiary since they did not return to home care within the same 60-day episode
- Episode claim:
 - 1/21/2014-3/19/2014
 - Patient status code reflecting discharge to hospital
- RAP for new episode:
 - Admit date: 3/25/2014
 - From date: 3/25/2014
 - Through date: 3/25/2014



20

National Government Services, Inc.

Inpatient Scenario 3

- A beneficiary's home health episode begins on 2/3/2014. The beneficiary is admitted to the hospital on 2/20/2014 and is discharged on 2/22/2014. The beneficiary returns home and has a home health service on 2/22/2014 but is readmitted to the hospital later that same day. The patient is finally discharged from inpatient hospital care on 3/4/2014 and resumes home health care once home.

Inpatient Scenario 3: How is This Billed?

- The HHA bills the episode with all services provided to the beneficiary within the episode, excluding any services that fall within the inpatient stay
- Note: The 2/22/2014 visit would be considered an inpatient stay date and should not be included on the HHA episode claim

How Can I Verify Inpatient Dates?

- Talk to the beneficiary about inpatient stays
- Verify inpatient information via the IVR
- Contact the provider contact center for your state

Medicare Advantage

- Once a beneficiary enrolls with a Medicare Advantage plan, that plan pays instead of traditional Medicare – services cannot be billed to both plans for the same period of time

MA Scenario 1

- A beneficiary's home health episode begins on 3/18/2014. The beneficiary enrolls with a MAO beginning 4/1/2014 and continues to receive home health care until 5/30/2014.

MA Scenario 1: How is This Billed?

- Episode claim dates billed to Medicare: 3/18/14-3/31/14
- Discharge patient status code
- Services 4/1/2014 and beyond billed to the MAO based on the MA plan's guidelines

MA Scenario 2

- A beneficiary is enrolled with a MA plan and has been receiving home health services since 12/9/2012. The beneficiary switches back to traditional Medicare on 2/28/2014 and continues to receive home care until 5/17/2014.



27

National Government Services, Inc.

MA Scenario 2: How is This Billed?

- MA plan is billed according to the MAO guidelines for dates of service 12/9/2012-2/28/2014
- HHA completes a new OASIS and submits a RAP once the first billable service in the episode has been delivered to the beneficiary



28

National Government Services, Inc.

Identifying MAO Coverage

- Ask the beneficiary about any insurance coverage they have besides Medicare
- Verify patient eligibility prior to billing Medicare

Duplicate RAPs/Claims

- Providers spend a lot of time researching and correcting duplicate claims when time spent prior to submitting claims can save work on the back end
- If a provider needs to correct a previously submitted (and paid) RAP, the incorrect RAP should be canceled and a new RAP submitted
 - Note: The RAP must be canceled—it cannot be adjusted
- If a previously paid episode claim need to be corrected, the provider must adjust the processed claim.
 - FISS can only process new/additional services and charges on an XX7 bill type

Preventing Duplicates

- Save Time! Do some background work before billing
 - Always check previous billing
 - FISS/DDE
 - Remittance Advice
 - Connex
 - HIQH



31

National Government Services, Inc.

HH Episode Open – Different Provider

- Providers taking preventive steps before billing could avoid many disputes with home health overlaps
 - Talk to the beneficiary about services already receiving in home
 - Check CWF for open HH episode
 - Coordinate transfer with primary HHA



32

National Government Services, Inc.

How is a Transfer Billed?

- Transferring HHA submits discharge claim with patient status code '06'
- Admitting HHA's RAP billed with condition code 47

Episode Billing Timeliness

- RAP should be submitted as soon as possible after the first billable service in the episode is rendered to the patient and must be in the system before claim is billed
- Episode claim must be billed within 60 days of the date the RAP processed or 120 days from the episode start date (whichever is greater) to be considered timely for episode billing
 - If episode claim is not submitted timely, FISS will auto-cancel the RAP for that episode



Thank You!

