

**The How-To Guide to
HOME HEALTH BILLING**
SECOND EDITION

Joan L. Usher, BS, RHIA, ACE

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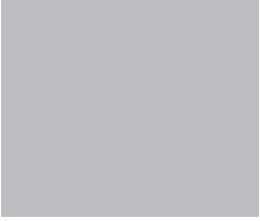
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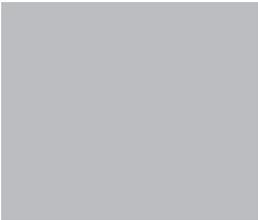
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About the Author

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Joan L. Usher, BS, RHIA, ACE, president of JLU Health Record Systems in Pembroke, Massachusetts (www.jluhealth.com), is a nationally recognized expert in the field of health information management and home health ICD coding. She has a degree in health information management and is a registered health information administrator. Her career began at a visiting nurse association, and she has been president of JLU for more than 29 years. She has been a certified Outcome and Assessment Information Set (OASIS) specialist in the clinical realm for more than nine years.

Usher is a past president of the Massachusetts Health Information Management Association (MaHIMA), a component state organization of the American Health Information Management Association (AHIMA). She was the recipient of the 2008 Professional Achievement Award from MaHIMA. Usher is on the board of directors of the Home and Health Care Alliance of Massachusetts and for the Hospice and Palliative Care Federation of Massachusetts. She is also a regular lecturer in Massachusetts, Connecticut, Rhode Island, and New Hampshire. Usher has taught ICD coding in home health for more than 24 years and has educated more than 15,000 people nationwide. She has authored several publications, including the *Rapid Reference Coding Guide*, which provides homecare and hospice organizations with an easy way to look up the most frequently used ICD-10-CM codes in home health care, *ICD-9 Coding for Home Health: A Guide to Medical Necessity & Payment* (HCPro, 2010), *ICD-9 Coding for Home Health: A Comprehensive Guide* (HCPro, 2008), and *ICD-10 Essentials for Home Care: Your Guide to Preparation & Implementation* (HCPro, 2011), *ICD-10 Coding for Home Health: A Guide to Medical Necessity and Payment* (HCPro 2014). Usher is the author/editor of three online e-learning coding courses for AHIMA: Home Health Diagnostic Coding, Home Health Reimbursement Methods, and Home Health Documentation & Health Record Requirements, 2011. She was also a contributing author to Schraffenberger & Kuhn, *Effective Management of Coding Services* (AHIMA, 2010) and the *MaHIMA Medicolegal Guide to Health Record Information* (MaHIMA 2016). Usher's other accomplishments include multiple presentations, teleconferences, and webinars on ADRs, electronic health records (EHR), HIPAA, performance improvement, and data quality. She also serves on the Beacon Institute's Ask-the-Expert Panel.

ACKNOWLEDGEMENTS

Acknowledgements

I would like to acknowledge and give thanks Marylynne Maloney for her work on the first edition of the *How-to Guide to Home Health Billing* (HCPro, 2012). My appreciation also is extended to John G. Albert, President/CEO, Home Health Foundation in Lawrence, MA, for contributing job descriptions for billers in home health.

1

Home Health Billing Overview

A biller has an important role in homecare: to ensure that the information submitted on claims is precise and appropriate. Medical billing translates all of the healthcare service provided to a patient into a billing claim. The billing department is responsible for ensuring that the homecare agency has received accurate reimbursement based on information submitted. The billing department is the last quality control check before submitting the claim to the insurance company.

Biller's Role and Required Skills

The financial health of an agency is dependent on the performance of the billing department. Billers must understand requirements for eligibility, the claims submission and payment process, and how to participate in the appeals process.

Many skills are needed to be a home health biller. Billers should know how to do the following:

- Establish eligibility with the understanding of a variety of insurance rules
- Verify patients' insurance coverage
- Reduce risk of late or nonpayment by following timely filing guidelines
- Creating a clean claim (i.e., one that follows rules and is accurate) for submission
- Develop procedures to reduce accounts receivable (AR) days as much as possible
- Follow a claim from initial payment to zero balance
- Identify any appeals/denials and unpaid claims on remittance advice

CHAPTER 1

- Understand requirements for refunds/paybacks
- Handle collections on unpaid accounts
- Use data and reports as performance indicators for potential areas of improvement
- Answer patients' billing questions
- Manage the agency's accounts receivable reports

See Figures 1.1 and 1.2 for examples of some billing job descriptions.

Home Health Billing Overview

A certified home health agency is authorized by the Centers for Medicare & Medicaid Services to accept Medicare and Medicaid reimbursement. Certified home health agencies must follow the *Conditions of Participation* 42 CFR 484 requirements.

Certified home health agencies provide skilled and intermittent services to individuals in their home environment. Home health allows people to stay in the comfort of their own home while receiving active treatment or routine care during the healing and recovery phase of their illness or injury.

Certified home health agencies offer many services, including the following:

- Skilled nursing
- Physical therapy
- Occupational therapy
- Speech language pathology
- Social worker services
- Home health aide services

Home health providers negotiate contracts with private health insurances. The contract will have a list of the reimbursement rates along with the specific billing codes required for the claims. The federal government determines the reimbursement rate for Medicare and Medicaid. Medicare releases the reimbursement rates each year. These rates are found in the annual Prospective Payment System (PPS) home health final

HOME HEALTH BILLING OVERVIEW

Figure 1.1: Lead Biller Job Description and Performance Appraisal Example

HOME HEALTH FOUNDATION
COMPETENCY BASED
Job Description and Performance Appraisal

POSITION: **LEAD BILLER**

Reports To: **Patients Account Manager**

Employee Name: _____

Appraisal Period: **From**_____ **To**_____

Position Definition: Acts as a resource to billing staff for problem solving different accounts, computer issues and specific training needs. Assists Patient Accounts Manager in daily coordination of billing process. Responsible for being cross-trained in all billing staff duties

Evaluation Guidelines: Circle one of the grades or indicate not applicable for each responsibility.

| | |
|--|--|
| 1. Performance needs focused improvement in order for competence to be reached. | 2. Competent and dependable level of performance. Meets the competence-based performance standards of the job. |
| 3. Results clearly exceed most position requirements. Performance is of particularly high quality and is achieved on a consistent basis. | N/A This standard is not applicable to this individual’s daily activities. |

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CHAPTER 1

Figure 1.1: Lead Biller Job Description and Performance Appraisal Example (cont.)

| <u>RESPONSIBILITIES:</u> | | | | |
|---|---|---|---|-----|
| 1. Provides billing staff with guidance regarding general work flow processes. | 1 | 2 | 3 | N/A |
| 2. Demonstrates ability to provide coverage for all billing staff in the event of absences. | 1 | 2 | 3 | N/A |
| 3. Provides additional training to staff as needed when new processes are implemented by the agency or third party payers. | 1 | 2 | 3 | N/A |
| 4. Acts as an intermediary for resolving customer requests, inquiries or concerns. | 1 | 2 | 3 | N/A |
| 5. Provides assistance to billing staff to resolves issues with clients and payers. | 1 | 2 | 3 | N/A |
| 6. Acts as a resources to agency employees in the absence of the Patient Accounts Manager. | 1 | 2 | 3 | N/A |
| 7. Assists in development and revision of departmental operating procedures. | 1 | 2 | 3 | N/A |
| 8. Recommends solutions with process issues that need improvement. | 1 | 2 | 3 | N/A |
| 9. Review all outstanding AR balances to ensure collection activity apprioraite and mentor staff with guidance on solutions. | 1 | 2 | 3 | N/A |
| 10. Prepare schedule on all claims over 90 days and report to Patient Account Manager. Status of claims, potential risk(s), and payment should be included. | 1 | 2 | 3 | N/A |
| 11. Review and reconcile credit balances for quarterly Medicare review. | 1 | 2 | 3 | N/A |
| 12. Run “Pending List” daily to ensure SLA for verifications are met. | 1 | 2 | 3 | N/A |
| 13. Maintains all necessary HW tables per agency protocol. This would include (but not limited too: fee schedule, insurance). | 1 | 2 | 3 | N/A |
| 14. Alerts Patient Account Manager to any | 1 | 2 | 3 | N/A |

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HOME HEALTH BILLING OVERVIEW

Figure 1.1: Lead Biller Job Description and Performance Appraisal Example (cont.)

| | | | | |
|--|---|---|---|-----|
| financial, staff, or agency risk(s). | | | | |
| 15. Keeps current with all incoming cash and unapplied via the cash log for visibility to the staff and assistance in the collection process. | 1 | 2 | 3 | N/A |
| Fundamental Employment Responsibilities | | | | |
| 1. Demonstrates knowledge of the CQI process. | 1 | 2 | 3 | N/A |
| 2. Demonstrates a knowledge and understanding of what to report to the supervisor or Director of Quality Improvement when concerns of corporate compliance arise. | 1 | 2 | 3 | N/A |
| 3. Ensures compliance within guidelines set forth by regulatory agencies (JCAHO, DPH, ERISA etc.) and demonstrates compliance with Home Health Foundation policies and procedures. | 1 | 2 | 3 | N/A |
| 4. Practices confidentiality principles set by the agency and federal HIPAA guidelines. | 1 | 2 | 3 | N/A |
| 5. Maintains professionalism with colleagues, peers and customers. Puts forth a positive agency image. | 1 | 2 | 3 | N/A |
| 6. Participates in all mandatory inservices. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| <u>SKILL AND ABILITY LEVELS:</u> Evaluate the employee on the following factors: | | | | |

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CHAPTER 1

Figure 1.1: Lead Biller Job Description and Performance Appraisal Example (cont.)

| | | | | |
|---|--|---|---|-----|
| 1. Judgment/Decision Making: identifies/evaluates issues; reaches sound conclusions; generates alternatives; understands consequences; makes accurate and timely decisions; attends to details. | 1 | 2 | 3 | N/A |
| 2. Drive and Commitment: tackles tough assignments; strives for personal improvement and success. | 1 | 2 | 3 | N/A |
| 3. Initiative: self-starting; creative; searches for new ideas; takes calculated risks. | 1 | 2 | 3 | N/A |
| 4. Interpersonal skills: establishes and maintains effective relationships with relevant individuals and groups. | 1 | 2 | 3 | N/A |
| 5. Communication Skills: presents information verbally and in written form that is clear, concise and accurate; keeps associates and supervisors informed; listens. | 1 | 2 | 3 | N/A |
| 6. Adaptability: adjusts practices in changing environment; adapts to new ideas and procedures. | 1 | 2 | 3 | N/A |
| NOTE: | <hr/> <hr/> <hr/> <hr/> | | | |
| <u>QUALIFICATIONS:</u> | <ol style="list-style-type: none"> 1. Three years medical billing experience-preferably in a home health agency. 2. Demonstrated organizational skills and proven ability to multi-task and work effectively in a fast-paced, high volume environment. 3. Proven ability to work independently with moderate supervision. 4. High school graduate or equivalent-Associates degree in business or related field a plus. 5. Current knowledge of rules and regulations governing third party payers and working knowledge of various billing tasks. 6. Knowledge of computerized billing and A/R systems and various PC based programs (Excel, MS Word) 7. Demonstrated excellence in interpersonal skills, and effective oral and written communication skills. 8. Positive customer service skills 9. Ability to work effectively as a member of an interactive team. | | | |

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HOME HEALTH BILLING OVERVIEW

Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example

HOME HEALTH FOUNDATION
COMPETENCY BASED
Job Description and Performance Appraisal

POSITION: **PATIENT ACCOUNTS REPRESENTATIVE/MEDICAL COLLECTOR**

Reports To: **Patients Account Manager**

Employee Name: _____

Appraisal Period: **From** _____ **To** _____

Position Definition: Responsible for timely submission of home health and hospice billing for multiple third party payers including, but not limited to, Medicare, Medicaid, commercial carriers and self pays. Manages accounts receivables from admission through satisfaction of balance.

Evaluation Guidelines: Circle one of the grades or indicate not applicable for each responsibility.

| | |
|--|--|
| 1. Performance needs focused improvement in order for competence to be reached. | 2. Competent and dependable level of performance. Meets the competence-based performance standards of the job. |
| 3. Results clearly exceed most position requirements. Performance is of particularly high quality and is achieved on a consistent basis. | N/A This standard is not applicable to this individual's daily activities. |

Pt Accounts Rep.doc

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Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | |
|---|---|---|---|-----|
| pg. 2 -Job Description & Appraisal Pt. Account Rep | | | | |
| <u>RESPONSIBILITIES:</u> | | | | |
| A. Generation of monthly insurance invoices. | | | | |
| 1. All payer source changes and additional information edited in system as directed by the Patient Accounts Manager or when identified with other patient accounts staff. | 1 | 2 | 3 | N/A |
| 2. Generate claims immediately as soon as directed by Patient Accounts Manager once knowledge that all DAR's are verified. | 1 | 2 | 3 | N/A |
| 3. Screen bills for correct rates, policy insurance company/HMO names and addresses. | 1 | 2 | 3 | N/A |
| 4. Enter information in HW collection screen identifying batch and assign a due date to follow-up on collection activity. | 1 | 2 | 3 | N/A |
| 5. Enter payor authorizations in HW/UR module as needed (Elder Services etc.). | 1 | 2 | 3 | N/A |
| 6. Generate RAP's and final invoices on a weekly basis for Medicare billing. | 1 | 2 | 3 | N/A |
| 7. Screen invoicing for 485's and VFO's and for various QA rules and functions. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| B. Daily review of explanation of benefits summaries. | | | | |
| 1. Review accounts listed on the HealthWyse collections report and prioritize accounts that need inquiry for | 1 | 2 | 3 | N/A |

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HOME HEALTH BILLING OVERVIEW

Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | |
|--|---|---|---|-----|
| pg. 3 -Job Description & Appraisal Pt. Account Rep | | | | |
| collection of accounts and to prevent untimely filing. Match against EOB's. | | | | |
| 2. Bill secondary copay immediately upon receipt of payer source EOB if necessary. | 1 | 2 | 3 | N/A |
| 3. Act immediately on all requests from payer sources for additional information in order to process claims. | 1 | 2 | 3 | N/A |
| 4. Resubmit claims or adjustment forms for unpaid claims when appropriate. | 1 | 2 | 3 | N/A |
| 5. Researches error claims and makes necessary correction for clean claim productions. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| C. Monthly review of aged receivables | | | | |
| 1. Review accounts listed on outstanding Invoice Report or HW Collections Report over 60 days and prioritize accounts. For Medicare, use FISS to verify inquiries. | 1 | 2 | 3 | N/A |
| 2. Prepare information on all claims over 90 days and report to supervisor as required. | 1 | 2 | 3 | N/A |
| 3. Telephone insurance companies and HMO's to discuss status of unpaid, past due claims. Follows up on delinquent accounts according to established policies and procedures. | 1 | 2 | 3 | N/A |
| 4. Submit write-off and/or allowance adjustment requests to supervisor for | 1 | 2 | 3 | N/A |

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Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | |
|--|---|---|---|-----|
| pg. 4-Job Description & Appraisal Pt. Account Rep | | | | |
| approval and processing. | | | | |
| 5. Run FISS generated reports on a weekly basis to check RAP's and claims that are in a return to provider location and work to release into a payment status for Medicare claims. | 1 | 2 | 3 | N/A |
| 6. Review credit balances for quarterly MCR review. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| E. Insurance verification | | | | |
| 1. Runs pending list daily to determine priority of insurance verification. | 1 | 2 | 3 | N/A |
| 2. Verifies Commercial/HMO eligibility in cases where there is an insurance change. | 1 | 2 | 3 | N/A |
| 3. Electronically verifies insurance eligibility to ensure appropriate insurances are billed to avoid the need for re-bills. | 1 | 2 | 3 | N/A |
| 4. Verifies enrollment in other insurances when Medicare is listed as a payor for patient. | 1 | 2 | 3 | N/A |
| 5. Calls on all other third party payers and identifies home care coverage. Makes inquiries of co-payments and deductibles. | 1 | 2 | 3 | N/A |
| 6. Sends certified mail indicating fiscal responsibility to clients with insurances that require co-pays and deductibles. | 1 | 2 | 3 | N/A |

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HOME HEALTH BILLING OVERVIEW

Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | |
|--|---|---|---|-----|
| pg. 5 -Job Description & Appraisal Pt. Account Rep | | | | |
| 7. Maintains insurance screen in system per agency protocol. | 1 | 2 | 3 | N/A |
| 8. Alerts Patient Accounts Manager of issues concerning questionable coverage or potential non-payment. | 1 | 2 | 3 | N/A |
| 9. Keeps all involved departments informed of verifications on all new admissions. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| F. Maintenance of commercial and HMO patient billing files | | | | |
| 1. Keeps all folders with adjustments, resubmissions (if appropriate) and EOB's orderly and easy to acquire. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| G. Fundamental Employment Responsibilities | | | | |
| 1. Demonstrates knowledge of the CQI process. | 1 | 2 | 3 | N/A |
| 2. Demonstrates a knowledge and understanding of what to report to the supervisor or Director of Quality Improvement when concerns of corporate compliance arise. | 1 | 2 | 3 | N/A |
| 3. Ensures compliance within guidelines set forth by regulatory agencies (JCAHO, DPH, ERISA etc.) and demonstrates compliance with Home Health Foundation policies and | 1 | 2 | 3 | N/A |

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Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | | |
|---|--|---|---|---|-----|
| pg. 6 -Job Description & Appraisal Pt. Account Rep | | | | | |
| | procedures. | | | | |
| 4. | Practices confidentiality principles set by the agency and federal HIPAA guidelines. | 1 | 2 | 3 | N/A |
| 5. | Maintains professionalism with colleagues, peers and customers. Puts forth a positive agency image at all times. | 1 | 2 | 3 | N/A |
| 6. | Participates in all mandatory inservices. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| <u>SKILL AND ABILITY LEVELS:</u> Evaluate the employee on the following factors: | | | | | |
| 1. | Judgment/Decision Making: identifies/evaluates issues; reaches sound conclusions; generates alternatives; understands consequences; makes accurate and timely decisions; attends to details. | 1 | 2 | 3 | N/A |
| 2. | Drive and Commitment: tackles tough assignments; strives for personal improvement and success. | 1 | 2 | 3 | N/A |
| 3. | Initiative: self-starting; creative; searches for new ideas; takes calculated risks. | 1 | 2 | 3 | N/A |
| 4. | Interpersonal skills: establishes and maintains effective relationships with relevant individuals and groups. | 1 | 2 | 3 | N/A |

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HOME HEALTH BILLING OVERVIEW

Figure 1.2: Patient Accounts Rep/Medical Collector Job Description and Performance Appraisal Example (cont.)

| | | | | |
|---|---|---|---|-----|
| pg. 7 -Job Description & Appraisal | | | | |
| Pt. Account Rep | | | | |
| 5. Communication Skills: presents information verbally and in written form that is clear, concise and accurate; keeps associates and supervisors informed; listens. | 1 | 2 | 3 | N/A |
| 6. Adaptability: adjusts practices in changing environment; adapts to new ideas and procedures. | 1 | 2 | 3 | N/A |
| NOTE: _____ | | | | |
| _____ | | | | |
| _____ | | | | |
| <u>QUALIFICATIONS:</u> | | | | |
| 1. High school graduate or equivalent-Associates degree in business or related field a plus. | | | | |
| 2. Current knowledge of rules and regulations governing third party payers and working knowledge of various billing tasks. | | | | |
| 3. Knowledge of computerized billing and A/R systems and various PC based programs (Excel, MS Word) | | | | |
| 4. Demonstrated excellence in interpersonal skills, and effective oral and written communication skills. | | | | |
| 5. Positive customer service skills | | | | |
| 6. Ability to work effectively as a member of an interactive team. | | | | |

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CHAPTER 1

rule. Medicaid lists the rates on the Medicaid website. Medicaid does not change the reimbursement rates every year. See Chapter 10 for website information on Medicare and Medicaid rates.

Understanding the federal regulations and billing requirements of each insurance plan is essential to home health agencies receiving accurate reimbursement for the services provided. As billing requirements change so often, it is challenging for agencies to remain financially stable. Home health agencies must continuously review billing best practices to be able to provide the best care to beneficiaries.

Home health providers are assigned to Medicare Administrative Contractor (MAC) jurisdictions. Each MAC offers providers ways to stay informed regarding requirement updates, manuals, and provider support. MACs are sometimes referred to as Fiscal Intermediaries (FI).

Each MAC will have a listserv registration on the home page of their provider site. On the registration page, select the type of updates you would like to receive. General electronic data interchange (EDI) and education updates offer important information to the biller. Once registered, updates will auto-populate and be sent to your email address as the information is posted to the MAC site.

Each MAC also offers customer service. Billers should contact their fiscal intermediary (FI) customer service department for claim status issues or EDI department for electronic claims and report issues.

Who Is Your MAC?

See Figure 1.3 to identify your MAC.

Types of Insurance Plans

There are several types of insurance plans, and most insurance companies offer plan levels. These plans have different types of coverage. Understanding the differences between the plans is essential in the coordination of care and reimbursement. These differences can include prior authorizations, billing codes, and time file limits.

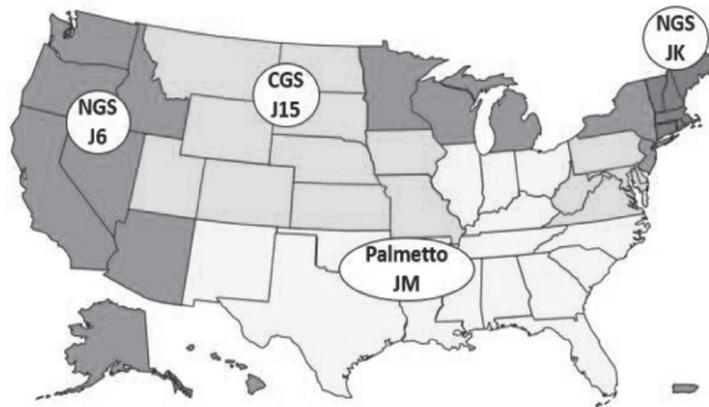
Insurance plans that include home health coverage include the following:

- Preferred provider organizations (PPO)

HOME HEALTH BILLING OVERVIEW

- Consumer selects a primary care physician from a list of preferred or network providers
- Plan may have copay, deductible, and/or coinsurance
- Referrals require prior approval from the primary physician

Figure 1.3: Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)



Source: The Centers for Medicare & Medicaid Services

- Point of service (POS)
 - Consumer selects a primary care physician
 - Plan may have copay, deductible, and/or coinsurance
 - Consumer is able to refer themselves to another physician
- Health maintenance organizations (HMO)
 - Consumer selects a primary care physician from a list of preferred or network providers
 - Most plans have copays; some may have an additional deductible
 - Referrals require prior approval from the primary care physician
- Medicare prospective payment system (PPS)
 - Sixty-day episode of care
 - Covered 100%; may have copays in the future
 - Prior authorization of visits is not required

CHAPTER 1

- Medicaid
 - Sixty-day episode of care
 - Covered 100%
 - Some states require prior authorization of visits
- Private insurance fee-for-service
 - Sixty-day episode of care
 - Some plans may have a deductible
 - Some plans may require prior approval from the primary physician
- Accountable care organizations (ACO)
 - Consumer selects a primary care physician from a group of coordinated healthcare providers
 - Plan may have copay, deductible
 - Referrals are usually made to members of the ACO network; however, the consumer may go to any healthcare provider

ACOs are becoming more prominent among healthcare providers. An ACO is a network of physicians, hospitals, and post-acute providers that share financial and medical responsibility for providing coordinated care to patients with a goal of limiting unnecessary spending. See Chapter 10 for website information.

Medicare Health Benefit

The Medicare Health Benefit covers the following individuals:

- Age 65 or older
- Younger than 65 with a disability
- With end-stage renal disease (any age)

The Medicare home health benefit pays for homecare services under Part A and B. Beneficiaries do not have to have both Part A and B to receive homecare services.

Medicare Advantage plans

Medicare also contracts with a private company to offer patients their Part A and Part B benefits. Medicare Advantage Plans include HMOs, PPOs, private fee-for-service plans, special needs plans, and Medicare medical savings account plans. Services are paid for by the private company and not under Original Medicare.

Medicare Part A

Medicare Part A helps cover hospital inpatient care, skilled nursing facilities, hospice care, and home health care. Beneficiaries must meet certain required conditions to qualify for these benefits. Individuals and their spouses who paid the Medicare tax while working do not pay a monthly premium for the Medicare Part A benefit. Most people meet the requirement for a premium-free Part A; however, if they don't meet the requirements for a premium-free Part A, it is available for a monthly fee.

Medicare Part A covers eligible home health services such as intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational services, social services, home health aide services, and medical supplies used in the home.

Medicare doesn't pay for the following:

- 24-hour-a-day care at home
- Meals delivered to the home
- Homemaker services
- Personal care

Medicare Part B

Most people pay a monthly premium for Medicare Part B. Medicare Part B helps cover doctors' services, outpatient care, outpatient therapy services, and limited home health care. Medicare Part B helps pay for these covered services and supplies when they are deemed to be medically necessary.

The Prospective Payment System (PPS)

Medicare Part A and Medicare Part B reimburse home health agencies a lump sum, which is divided into two payments for a 60-day episode of care. The bundled services provided during the 60-day episode include all skilled nursing, therapy, and home health aide visits along with nonroutine supplies. Some

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outpatient therapy services may be covered under the PPS benefit as well. The total payment is based on the Outcome and Assessment Information Set (OASIS) assessment scoring with geographical location using core-based statistical area (CBSA) codes. Chapter 10 of the Medicare Claims Processing Manual provides details on how to process Medicare claims. See Chapter 10 of this book for website information.

Home health resources groups (HHRG)

The federal prospective payment system for home health began on October 1, 2000, established by the Balanced Budget Act of 1997. This system created a case mix severity index that is adjusted for the health condition, clinical characteristics, and care needs of the patient. There are 153 different HHRGs. (See “Calculating the Episode.”) Also see Chapter 10 for website information.

PPS payment types

There are many different types of payment under the PPS. These include the following.

Request for anticipated payment (RAP)

A RAP is the first payment received. The home health agency may submit a request for the initial anticipated payment based on receiving verbal orders from the physician and delivering at least one service to the patient. The RAP pays 60% of the episode’s worth for the initial episode and 50% of the episode’s worth for all subsequent episodes. Use “0322—Type of Bill (TOB)” (form locator 4) for RAP submission only. RAPs may be paid zero percent if Medicare is the secondary payer or if the patient is enrolled in a Medicare Advantage program.

RAP According to CMS

According to Chapter 10 Medicare Claims Processing Manual Home Health Billing:

10.1.10.3 - Submission of Request for Anticipated Payment (RAP) (Rev. 2977, Issued: 06-20-14, Effective: 09-23-14; ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14; ICD-10: Upon Implementation of ICD-10) The HHA can submit a Request for Anticipated Payment, or RAP, to Medicare when all of the four following conditions are met.

- *After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the State;*
- *Once a physician's verbal orders for home care have been received and documented;*
- *A plan of care has been established and sent to the physician; and*
- *The first service visit under that plan has been delivered.*

If canceling a RAP, HHAs must enter the control number (internal control number [ICN] or document control number [DCN]) that the contractor assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case.

Final claim payment

The remaining split percentage payment due for the episode will be made based on a claim submitted at the end of the 60-day period, or after the patient is discharged, whichever is earlier. The claim may not be submitted until after all services are provided for the episode and the HHA has signed the plan of care on file at the agency. Use “0329—Type of Bill (TOB)” (from locator 4) for final claims.

Medicare will recoup the RAP and submit final claim payment in full to the agency. The related remittance advice will show the RAP payment was recouped in full and a 100% payment for the episode was made on the final claim. The final claim payment is based upon the HHRG conversion to Health Insurance Prospective Payment System (HIPPS) code calculation, which is defined in this chapter, and the claim detail. The claim detail includes all visits provided and nonroutine supplies. The reimbursement often changes from the RAP estimate due to the number of therapy visits provided being different than what was projected at the beginning of the episode.

Partial episodic payment (PEP)

This payment occurs when a patient is transferred/discharged and readmitted to the same home health agency within a 60-day period. The original episode payment is adjusted according to the length of time the patient received care and the services provided. This is a proportional payment amount based on the number of days of service provided (i.e., the total number of days counted from and including the day of the first billable service to and including the day of the last billable service). The readmission episode starts a new 60-day episode for full payment.

What CMS Says About PEP

According to Chapter 10 Medicare Claims Processing Manual Home Health Billing:

10.1.15 - Adjustments of Episode Payment - Partial Episode Payment (PEP) (Rev. 1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

PEP adjustments occur as a result of the two following situations:

- a. When a patient has been discharged and readmitted to home care within the same 60-day episode, which will be indicated by using a Patient Discharge Status code of 06 on the final claim for the first part of the 60-day episode; or*
- b. When a patient transfers to another HHA during a 60-day episode, also indicated with a Patient Discharge Status code of 06 on their final claim.*

Low-utilization payment adjustment (LUPA)

LUPA payments occur when there are fewer than five visits provided to the patient in the 60-day episode. LUPA payments are paid per visit and not according to the home health resource group (HHRG) calculation. Nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. The LUPA add-on is an additional reimbursement for the first early episode when calculating as a LUPA episode.

Outlier payments

Outlier payments occur when the patient has received a high utilization of services greater than the average home health services. The term “outlier” has been used by Medicare to address exceptional cases both

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in terms of cost and length of stay. The cost of caring for this patient is much higher than the episode's designated reimbursement. The combined operating and capital costs of a case must exceed the fixed-loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. Outliers are calculated if the total product that results from multiplying the number of the visits and the national standardized visit rate is greater than the sum of the case-mix specific payment amount plus the fixed-loss threshold amount. The fixed-loss threshold amount is a set percentage (known as the loss-sharing ratio) of the amount by which the product exceeds the sum that will be paid to the HHA as an outlier payment in addition to the episode.

HHAs do not submit anything different on their claims to be eligible for outlier consideration. The outlier payment will be included on the remittance advice and will be identified separately on the claim in history using value code 17, with an associated dollar amount representing the outlier payment. Medicare reimbursement has an annual 10% cap on outlier payments per home health agency. Outlier payments cannot exceed 10% of the home health agency's total PPS revenue for the year.

Health Insurance Prospective Payment System (HIPPS)

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) by which payment determinations are made under several healthcare prospective payment systems. This system allows for the payment system of different healthcare settings, such as skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies, to be converted to a universal HIPPS code.

Calculating the Episode

The clinical assessment for home health is known as the OASIS. This assessment is completed at the time of admission. Each question on the OASIS associated with payment has a weight value. The completion of the OASIS assessment calculates the case mix weight to provide the HHRG score.

The Home Health Resource Group (HHRG) code is comprised of the following:

- Clinical domain
- Functional domain

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- Service domain
- Nonroutine supply

The HHRG code is combined with the episode timing question (M0110) and the total number of therapy services (M2200) provided in the episode to calculate the billing HIPPS code. The HIPPS code is an alpha-numeric five-digit code.

Below is the HIPPS code breakdown. The information has been consolidated in Table 1.1 for a quick view.

Table 1.1: HIPPS Code Breakdown

| | |
|-----------------|---|
| First position | Numeric - Episode timing combined with number of therapy visits 1 = First/second early episode with 0-13 therapy visits 2 = First/second early episode with 14-19 therapy visits 3 = Late episode with 0-13 therapy visits 4 = Late episode with 14-19 therapy visits 5 = Early or late episode with 20 or more therapy visits |
| Second position | Alpha – Clinical domain score A B C |
| Third position | Alpha – Functional domain score F G H |
| Fourth position | Alpha – Service domain (therapy services) K L M N P |
| Fifth position | Alphanumeric – Nonroutine supply score S or 1 T or 2 U or 3 V or 4 W or 5 X or 6 |

Source: *The Centers for Medicare & Medicaid Services*

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The core-based statistical area (CBSA) code is the geographical part of the PPS episode calculation. The codes are assigned by ZIP codes and based on state county. Some of these changed for home health in 2015. Each CBSA code has a wage index. You can find the Medicare calendar year (CY) 2016 CBSA codes, including wage index, at the CMS website, under CMS-1625-F for the CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (final rule). See Chapter 10 for website information.

The nonroutine supply (NRS) points are calculated from several OASIS questions. The NRS adds additional reimbursement to the base episodic amount depending on the score. There are six NRS levels. The fifth character of the HIPPS code represents the NRS score. If there is supply charges included on the claim, the last character will be alpha (S–X). If there are no supply charges on the claim, the code will be numeric (1–6). The episode is reimbursed the additional payment whether there are supply charges on the claim or not.

| Last digit of HIPPS code | | | |
|------------------------------------|--------------------------------|--------|------------------|
| Severity level—supplies not billed | Severity level—supplies billed | Points | Additional money |
| 1 | S | 0 | \$14.22 |
| 2 | T | 1–14 | \$51.35 |
| 3 | U | 15–27 | \$140.80 |
| 4 | V | 28–48 | \$209.18 |
| 5 | W | 49–98 | \$322.57 |
| 6 | X | 99+ | \$554.79 |

PC Pricer

The PC Pricer is free software available to providers. The HH PPS PC Pricer is a tool to assist home health agencies in determining the Medicare payment for a particular episode of home health care.

This software is used to calculate individual episodes for any CBSA code. Simply enter a few details, and the PC Pricer will calculate the reimbursement rate. See Chapter 10 for download information. Once the detail is entered, the program will calculate the reimbursement rate for the episode.

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The software may be utilized to predict the payment for services to be provided or to calculate the payment an agency will receive for the episode. The software also may be used to validate that the agency received correct payment for a claim listed on the Medicare remittance advice.

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SECOND EDITION

Joan L. Usher, BS, RHIA, ACE

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