Home Health Medicare Billing
3 part Series:
Part 1 of 3 – Basic Billing

Debbie Cunningham, RN, HCS-D, HCS-O

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Home Health Medicare Billing

Objectives:

- Identify how Medicare home health is billed
- Identify a patient's eligibility for home health
- Discuss each type of bill and the exceptions
- Discuss the Electronic Remittance Advice
- Discuss timely filing of claims
- Tips for billing

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How is Home Health Paid?

Prospective Payment System (PPS):

PPS only allows one home health agency to bill an episode of care for all services and supplies (DME excluded)

- Basic Principles
  - Based on a predetermined per-episode amount which is case mix , wage index adjusted and includes the Core Based Statistical Area (CBSA).
  - Unit of payment is for a 60 day episode
  - Payments are made in a split payment approach
    - Initial episode 60/40
    - Subsequent episode 50/50

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What is CBSA

Core Based Statistical Area (CBSA)

- Metropolitan and micropolitan statistical areas
- A core area containing a substantial population nucleus together with adjacent communities having a high degree of economic and social integration with the core
- At least one urban area of 10,000 or more population
- This is established by the patient's **zip code** of the residence they live in at the time services are rendered.

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What is a 60 Day Episode

60 Day Episode

- It is the basic unit of payment under PPS
- Continuous episodes or recertifications are allowed for patients who continue to be eligible for the Medicare home health benefit.

The following is an example of continuous 60 day episodes:

- Day 1-60 Episode 1
- Day 61-120 Episode 2
- Day 121-180 Episode 3
- Day 181-240 Episode 4

And so on until patient no longer requires Home Health Services

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60 Day Episode Continued

- First 60 day episode begins with the start of care (SOC), which is the first billable service date, and includes the 60th day from start of care date.
- The 60 day episode payment covers one individual for 60 days of care regardless of the number of days care is actually provided during the 60 day period, **unless** there is an episode exception.

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Home Health eligibility

Home Health eligibility:

Medicare Part A

or

Medicare Part B **only !**

The patient must be eligible for one of the above payers to have the benefit of Medicare Home Health services.

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Home Health eligibility

Eligibility must be verified using one of these inquiry areas of the direct data entry systems (DDE):

HIQH or HIQA

1. HIQH – Health Insurance Query for Home Health & Hospice.
2. HIQA - Health Insurance Query Access.

Or

The software utilized for your patient record may have eligibility reporting features that obtains this information from the DDE.

This information in the Common Working File (CWF) is updated to the last time a provider has billed for services for the patient.

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Home Health eligibility

Medicare Information that can be obtained:

- Most recent **Hospice** benefit periods
- Provider number
- Start and end dates of benefit period(s)
- Earliest and latest billing action dates
- Number of days used
- Revocation indicator

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Home Health eligibility

Medicare Information that can be obtained:

- Most recent **Home Health** benefit periods
- Provider number
- Last two episodes
- Earliest and Latest Billing dates
- Any MSP (Medicare Secondary Payer) or HMO (Health Management Organization) with effective dates

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Home Health eligibility

- Patient must be home bound
- Place of Residence:

  Anywhere he or she makes their home other than a nursing home.

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Home Health eligibility

Under the Care of a Physician:

- Medical Doctor
- Osteopath
- Podiatrist

The physician must also be PECOS (Provider Enrollment Chain and Ownership System) certified.

- The medical treatment plan or Plan of Care(POC) must be established by the attending physician in conjunction with nurses and/or therapists.
- This is done with the OASIS assessment and communication with all clinicians to establish a Plan of Care.

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Home Health eligibility

Skilled Service:

- Services needed must be medically reasonable and necessary for the treatment of a patients illness or injury
- Patient must require one of the following skilled services to establish the start of care:
  - SN(Skilled Nurse)
  - PT(Physical Therapy)
  - SLP(Speech Licensed Pathologist)
- This information is gather with an OASIS assessment (**O**utcomes **As**sessment **I**nformation **S**et)

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What is an OASIS Assessment ?

- A set of statistical questions incorporated with the head to toe assessment done by the qualifying clinician at set times at the beginning and during the episode of care.
- The questions have a scoring depending on the answers selected.
- This score is added up and referred to as **HHRG score** (Home Health Resource Group) or **HIPPS code** on the bill (Health Insurance Perspective Payment System code)

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OASIS Assessment continued

The questions are broken down into three domains

- Clinical
- Functional
- Service

Each domain gets a score and will be referred to as a HHRG score example: C3F1S2

This HHRG score translates to a HIPPS code when entered on the claim when submitted for payment

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There are 4 Regression Models

4 equation models with 4 different types of episodes

1. Early/low therapy (0-13 visits projected)
2. Early/high therapy (14-19 visits projected)
3. Late/low therapy (0-13 visits projected)
4. Late/high therapy(14-19 visits projected)

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What is an Early Episode

Definition: Early Episode

- Initial and next adjacent episode
- An early episode **must have more than 60 days** separating it from a previous episode
- The 60 day separation pertains to your own agency episode or any other agency's episode

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What is an Late Episode

Definition: Late Episode

- All adjacent episode beyond the 2nd episode
- Later episodes are determined by less than 60 days between them and a previous episode
- The less than 60 days between them and a previous episode is your own agency or any other agency's episode

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HHRG score vs. HIPPS code

The HHRG score is only part of the HIPPS code that informs the Medicare Administrative Contractor (MAC) what the payment should be for this episode of care.

The HIPPS code grid on the next slide also includes the non-routine supply added payment if supplies are needed.

The supply codes are represented in the 5th column and supply rates are also included on the following slide.

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How does HRRG score relate to HIPPS code

	Position #1	Position #2	Position #3	Position #4	Position #5		
	Grouping Step	Clinical Domain	Functional Domain	Service Domain	Supply Group – supplies provided	Supply Group – supplies not provided	Domain Levels
Early Episodes (1st & 2nd)	1 (0-13 Visits)	A (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	S (Severity Level: 1)	1 (Severity Level: 1)	= min
	2 (14-19 Visits)	B (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	T (Severity Level: 2)	2 (Severity Level: 2)	= low
Late Episodes (3rd & later)	3 (0-13 visits)	C (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	U (Severity Level: 3)	3 (Severity Level: 3)	= mod
	4 (14-19 Visits)			N (HHRG: S4)	V (Severity Level: 4)	4 (Severity Level: 4)	= high
Early or Late Episodes	5 (20 + Visits)			P (HHRG: S5)	W (Severity Level: 5)	5 (Severity Level: 5)	= max
					X (Severity Level: 6)	6 (Severity Level: 6)	
	6 thru 0	D thru E	I thru J	Q thru R	Y thru Z	7 thru 0	Expansion values for future use

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Non-Routine Supplies

HIPPS Code 5th digit/letter	Severity	Points	NRS – Rural	NRS - Urban
S	1	0	$ 14.91	$14.47
T	2	1-14	$53.83	$52.27
U	3	15-27	$147.61	$143.31
V	4	28-48	$219.30	$212.92
W	5	49-98	$338.18	$328.33
X	6	99+	$581.63	$564.69

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Types of Bills

- RAP – Request for Anticipated Payment
- EOE – End of Episode or final claim
- PEP – Partial Episode Payment
- LUPA – Low Utilization Payment Adjustment
- Outliers – High utilization of services

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Request for Anticipated Payment (RAP)

A RAP must be submitted for each episode that qualifies for full or partial episode payment.

- Begins the 60 day episode
- Posts the episode at the Common Working File (CWF)
- Usually pay in 5-6 days, on average
- Includes the HIPPS code used to determine the payment of the episode
- Defines the patient's source of admission

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Request for Anticipated Payment (RAP)

Raps are submitted after:

- Oasis assessment is completed
- Verbal orders have been received and documented - sent to physician
- Plan of Care has been established and sent to physician
- First Billable visit has been performed and confirmed

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End of Episode (EOE)or Final Claim

- EOE or Final claim must be submitted for every 60 day episode
- RAP must be billed before submission of EOE
- Subject to payment floor (14 days)
- Subject to Medical Review

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End of Episode (EOE)or Final Claim

Final claim can be submitted after:

- OASIS assessments completed and submitted to state
- Orders have been signed and dated from the physician.
- All billable visits for the episode have been provided and confirmed

Reminder:

All verbal orders must be signed and dated by the physician and all OASIS assessments and visits performed completed prior to the agency billing the final claim

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End of Episode (EOE)or Final Claim

- If patient is discharged or transferred and discharged prior to the end of the episode, the final claim EOE may be billed upon discharged or transfer discharged date
- Claim represents actual service utilization and must contain all line item details for all visits provided during the episode and a single line total amount of non-routine supplies utilized during the episode if applicable

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End of Episode (EOE)or Final Claim

- If a final claim is not received **120 days** after the start of episode or **60 days after the paid date of the RAP** (whichever is greater), the RAP payment will be automatically cancelled and payment recouped
- The RAP will have to be re-billed before the EOE can be billed and the counter will start over again.

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Codes Required for Services

Skilled Nurse Visits	Revenue Code	HCPCS Code
SN Direct Patient Care	0551	GO154
SN Manage/Evaluation	0551	GO162 RN only visit
SN Observation/Assessment	0551	GO163
SN Teaching/Training	0551	GO164

Codes Required for Services

Medical Social Worker	Revenue Code	HCPCS Code
MSW Evaluation/Regular Visit	0561	GO155
Home Health Aide	**Revenue Code**	**HCPCS Code**
HHA visit	0571	GO156
Speech Therapy	**Revenue Code**	**HCPCS Code**
ST Evaluation/Re-Evaluation	0441	GO161
ST Routine Visit	0441	GO153

Codes Required for Services

Occupational Therapy	Revenue Code	HCPCS Code
OT Evaluation/Re-Evaluation	0431	GO160
OT Routine Visit	0431	GO152
OTA Routine Visit	0431	GO158

Non-Routine Supplies	Revenue Code
All NR supplies except wound care	0270's except 0274
Wound care supplies	0623

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Codes Required for Services

Physical Therapy	Revenue Code	HCPCS Code
PT Evaluation/Re-Evaluation Management/Evaluation	0421	GO159
PT Routine Visit	0421	GO151
PTA Routine Visit	0421	GO157

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Episode Exceptions

There are Three intervening events that can occur during the course of an episode to further alter the final payment amount that the home health agency ultimately receives

The following episode exceptions apply only to final claims, never to RAP claims:

- PEP – Partial Episode Payment
- LUPA – Low Utilization Payment Adjustment
- Outlier – High Utilization of services

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Partial Episode Payment (PEP)

PEP can occur three ways:

- Patient elects a transfer to another home health agency within your agency's 60 day episode period
- Patient is discharged and returns to home health services within the same 60 day episode period
- Patient becomes HMO eligible and is discharged from traditional Medicare during a episode of care

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Partial Episode Payment (PEP)

- Original episode ends as of the last billable visit prior to the discharge.
- Episode payment for the original episode is proportionally adjusted to reflect the actual length of time that the patient was in the care of the home health agency.
- A new, full episode will begin on the date of readmission to home health, whether with the same home health agency or another home health agency.

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Partial Episode Payment (PEP)

HIPPS code value = $3000.00

- Patient transfers on Day 35 to a different home health agency
- Last billable service is on Day 30
  - Ends the 60 day episode
- Initial home health agency receives a PEP
  - Payment is 30/60 ($1500.00 out of $3000.00)

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Low Utilization Payment Adjustment (LUPA)

- If patient is on service for the entire episode and no more than 4 visits are made then the RAP claim would be sent then the EOE claim would be sent but payment is adjusted as a LUPA
- Claim is paid on a **per-visit** basis according to the national average payment rates for each service discipline
- Although not case mix adjusted, they are still wage adjusted to reflect the patient’s site of service

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Outlier

- Additional payments made when an agency has incurred unusually large costs for care rendered.
- Costs exceed a threshold amount (45% currently)
- Threshold amount for each HHRG is identified in review
- Agency may identify the Outlier on EOE claim with value code 17
- No provider action is required, calculations handled by DDE (Direct Data Entry) system

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Outlier – Rule

January 1, 2010 changes were made to the Outlier payment with change request transmittal 1883

- Limitation on Home Health PPS Outlier Payments
- The CMS policy now limits the annual payments on Outliers to 10 percent of **total** amount billed and paid on all claims submitted.

This will be reconciled on a quarterly bases four times per year in the following months:

- **February, May, August and November**

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Outlier – Rule

- Potential payments can be track on the DDE system.
- Billers must be aware of all outliers and keep track of billing totals
- Once the 10% has been reach no more outlier payments will be made, until the account is reconciled again and then if have enough paid claims to add to the potential 10% bank for payments.
- There will not be any partial payments made if the total amount is over the allowed 10% either.

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Outlier – Rule

Example 1:

Total amount billed/paid is:

$40,000.00

Total potential Outlier bank for payments is:

$4,000.00

Example 2:

Total amount billed/paid is:

$50,000.00

Total potential Outlier bank for payments is:

$5,000.00

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Outlier – Rule

No partial payments will be made example:

- Total amount of potential Outlier payments is $4,000.00
- Total payments received $3,500.00
- Another Outlier was billed resulting in $600.00 of additional Outlier payment but only $500.00 is left in the bank of $4000.00
- The $600.00 will not be paid as it would be a partial payment since there is only $500.00 remaining to be potentially paid out

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REMITTANCE ADVICE

- Remittance Advice are statements that explain what an agency was paid or not paid, listed per patient for each episode by the claim submitted
- Most providers are submitting electronic claims so their remittance advice are called Electronic Remittance Advice or ERA's

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Electronic REMITTANCE ADVICE

- There are 10 columns on the ERA's that have information that may pertain to each claim.
- The columns that will be reviewed today are:
  1,2,3,5 & 10
- These are the main areas of concern when reviewing an ERA for Home Health

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Electronic Remittance Advices

ERA Column 1

- **Patient name -** Last name with first initial and sometimes middle initial only
- **ICN –** Internal Claim Number is assigned by the MAC and is a unique number with the date the claim was received.
- **Claim # -** Assigned by PC-Print software used to print the ERA's

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Electronic Remittance Advice

ERA Column 1 – cont.

- **Claim Status –** Indicates status of the claim by codes from the ERA manual.

Most common codes used for home health are 1,19 & 22.

- Code 1 = Paid as Primary
- Code 19 = Medicare Paid Primary and the MAC sent claim to another insurer
- Code 22 = Adjustment to prior claim, reversal to previous payment, also shows claim cancelled including RAP's that have auto cancelled

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Electronic Remittance Advice

ERA Column 1 cont.

- **Name change –** Indicates whether the beneficiary's name was changed during the processing of the claim.

  Codes are as follows:

  QC = No name change occurred

  74 = Name change

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Electronic Remittance Advice

ERA Column 2

- **Patient CNTRL Number –** Patient control number that was assigned by providers (usually by own software) when the claim was generated and submitted
- **HIC NUMBER –** Patients HIC/Medicare number that was submitted with claim
- **MEDICAL REC NUMBER –** This number is the providers internal coding number when a claim was submitted
- **HIC CHG –** HIC/Medicare number change since claim was initially submitted

  The codes are as follows:

  HN = No change in HIC number

  C = HIC number change

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Electronic Remittance Advice

ERA Column 2 cont,

TOB – Type of Bill. A 3 digit numeric code that identifies the type of bill and in what sequence

1ST digit begins with a 3 that indicates it is a Home Health bill
2Nd digit a 2 that indicates a Part A bill
3rd digit indicates the bill status.
Main codes as follows:

- **2 = RAP bill**
- **7 = Replacement or adjustment of prior claim**
- **8 = Void/Cancel of prior claim**
- **9 = PPS Episode final claim or EOE**

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Electronic Remittance Advice

ERA Column 3

- **FRM DT** – Indicates the start of services or the start of episode date
- **THR DT** – Indicates the last date of services or the end of episode
  Except on RAP's, this date will be the same as start date.
- **PAT ST** – Patient status code that was billed on the claim. This is for institutional inpatients, usually left blank for Home Health
- **CV LN** – Indicates the number of covered lines billed on the claim

Sample below:
Home Health RAP = Field will show 0
Home Health EOE = Field will show number of covered visits

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Electronic Remittance Advice

ERA Column 5

- **REPTD CHGS -** Shows the dollar amount of charges submitted by the provider. For cancel claims this amount is negative.
- **NCVD/DENIED -** Identifies the dollar amount of non-covered or denied charges.
- **CLAIM ADJS –** The amount in this field reflects an outlier payment
- **COVD CHGS -** This field displays the dollar amount of covered charges.
  - For cancel claims, this amount is negative.
  - For denied claims, this field displays a zero.

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Electronic Remittance Advice

ERA Column 10

- **INTEREST** – Displays amount of interest Medicare has paid on a claim. Interest is paid when a clean claim is not paid in a timely manner.
- **PAT REFUND** – Indicates a patient refund. This is the amount owed to the beneficiary by the provider for overpaid deductible and coinsurance.
- **PERDIEM AMT** – Indicates per diem amount paid for an individual claim for providers that get reimbursed by per diem
- **NET REIMB** – This field displays the net reimbursement for the total claim. This can be a positive or negative number depending on TOB.

  Bottom line – What did you get paid or not paid.

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Timely Claim Filing

All claims must be submitted to Medicare within one calendar Year from the **end** date of service.

Example:

Claims Ending on January 1, 2014
must be billed by January 1, 2015 and so on

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Tips and Resources

- Follow up on claims sent to the DDE frequently to make sure they are processing through the system
- Build reference sheets for easy access to frequently used codes, definitions, billing acronyms and timely filing standards
- Begin your library of billing manuals, either electronic or paper product
- Have a routine for billing each type of bill
- Utilize the posting notes to reference for any billing problems on the claims
- Monitor CMS and/or MAC (Medicare Administrative Contractor) for changes in regulations

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Resources

www.cms.hhs.gov/regulations
- Conditions of Participation (regulations)
- Remittance Advice manual
- DDE Manual
- Chapter 10 – Home Health Agency Billing (Medicare Claims Processing manual)

http://questions.cms.hhs.gov
- Frequently asked questions

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Questions

Debbie Cunningham

dcunningham@axxessconsult.com

Thank You for attending!

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