HOME HEALTH
BILLING MANAGED CARE
TRAINING MANUAL

August 2022

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NEW CLAIM
Billing/Managed Care_Other Insurances

Managed Care/Other Insurances allows for the creation, billing and updating of all non-episodic payers. The menu contains two sub-menus. Claims must be added manually for patients who have a managed care/other insurance payer. This can be done in two ways:

- *Managed Care/Create Claims*
- *Managed Care/Claims History/New Claim* (below)

Select **New Claim**, which will open a new window. Choose the insurance from the drop-down menu and enter/choose the date range for the claim.

NOTE: See Admin manual for how to add new insurance.

The default date range is 60 days. Then select **Add Claim** to create the claim or **Cancel** to disregard the information.

Once the claim has been added, it will appear in the lower half of the Claim History page for the patient. The information displayed in the claim line item includes Service Dates**,** Status**,** Created Date, Billed Date, Claim Amount, Total Payments**,** Positive and Negative Adjustments**,** Balance**,** Details**,** Visits**,** Supply and Action**.**

The upper portion of the Claims History page displays information for the selected claim. It includes the patient name, medical record number (Patient ID #), insurance/payer and billing/payment information. This section also allows users to easily post a payment or adjustment, as well as create an invoice using the buttons presented in the information screen.

Patient Name: **Fiona Arellano**
Patient ID #: **56473**
Patient Insurance Id #:
Patient DOB: **07/20/1945**
Payment Date:

Insurance/Payer: **123Health Insurance**
Health Plan Id: **56473**
Authorization Number:
Billed Date:
Claim Type: **Primary**

[Post Payment] [Post Adjustment] [Create Patient Invoice]
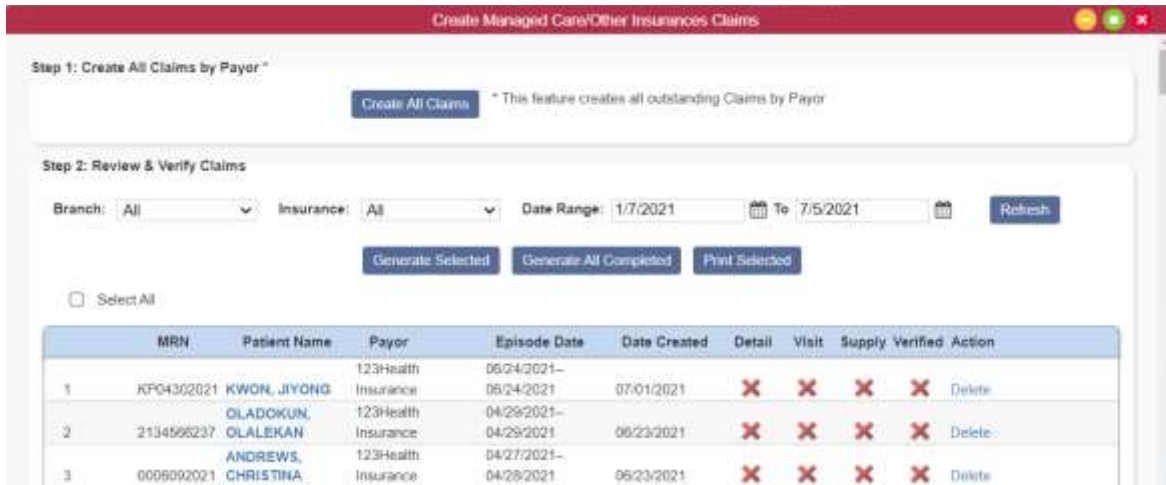
To the right of the patient information are quick reports associated to the claim selected. The reports provide a quick way to View Payments, View Adjustments, Activity Logs and Deleted Claims.

Quick Reports
View Payments
View Adjustments
Activity Logs
Deleted Claims

VERIFY CLAIM

The next step in the process is to validate the claim. To complete this process, select the **Open Claim** hyperlink located in the left-hand column of the claim line. This action opens the claim and allows for completion of the five-step verification process. This process must be completed prior to invoicing the claim. Users can validate the claim on the Create Claims tab and after the claim has been created for the patient.

Insurance: All

	Service Dates
Open Claim	10/01/2021 - 10/13/2021

The five-step claim verification process:

Step 1 (Demographics): All the required fields with red asterisks (*) are pulled into the claim based on the information that was entered in the Patient Chart. Users can select the **Claim Notes** button at the top of the screen to document a claim note. Once all information is updated and/or verified, select **Verify and Next**.

Step 2 (Verify Insurance)**:** This step allows users to add locator information as needed. Selecting **Reload Insurance** will update the payer information if any changes were made at the payer level. Once all information is updated and/or verified, select **Verify and Next**.

Step 3 (Verify Visits): Displays the date range for the claim and all visits associated to the claim. The visits are shown by discipline in descending date order. Each visit line item indicates the visit description, scheduled date, visit date, HCPCS, rev code, modifiers, diagnosis pointers, visit status, number of units and charge rate for the visit. All billable visits are defaulted with a check mark in the billable check box. Deselect any visits that should not be billed. Select **Verify and Next** to move to Step 4.

Step 4 (Verify Supplies): Gives the opportunity to review, add, edit, and delete supply items from the bill. Most insurance companies include supply cost in the visit rate. Most supplies are non-billable unless the organization received authorization to bill supplies or has a contract specifying supplies may be billed. Select **Verify and Next** to move on to Step 5.

Step 5 (Summary): This is the final step in the verification process. This step provides a summary of the claim and is broken down into sections. The first two sections display the demographic information for the patient. Visits and any Supplies are listed below the demographic information. The total claim charges are presented at the bottom of the page. Once everything is verified and deemed accurate, select **Complete** to finalize the verification process.

Upon completion, all steps that were verified within the five-step process will have a green check mark on the Claim History page. Two new hyperlinks are now present: the claim type and **Download**. In this example, the claim type is a UB-04. Selecting the **UB-04** hyperlink opens the claim with the UB-04 formatting. The claim may be printed and mailed if the organization chooses to

bill in this manner. The **Download** hyperlink opens the claim in a text format for uploading to a payer website.

ELECTRONIC CLAIM SUBMISSION

From the Create Claims window, select the check box right beside the patient's name. Then select **Generate Selected**. This can be done for one or multiple claims for submission.

Once the **Generate Selected** button is chosen, there will be an option to **Submit Electronically**.

DOWNLOAD CLAIM SUBMISSION

The following is for agencies that have chosen not to electronically submit claims through Axxess Home Health.

1. Select the **Download Claim(s)** button.
2. Save to the computer.
3. Upload to the payer.
4. Select **Mark Claim(s) as Submitted**.

Marking the claims as submitted removes the claim from the *Managed Care_Other Insurance/Create Claim*s screen.
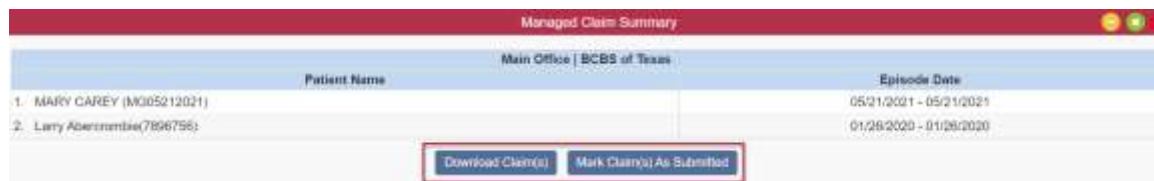
HELP CENTER

A great resource available any time, any day is our Help Center. Get answers to frequently asked questions and watch tutorial videos on all our Axxess products. Our Help Center can be accessed by going to *Help/Help Center* or https://www.axxess.com/help/