Top Home Health Claim Billing Errors

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Today's Presenter

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Objectives

- Review the top rejection and return to provider (RTP) reason codes assigned to claims June-August 2021
- Educate on correcting the reason code errors and the billing guidelines behind the RAP and claim

Agenda

- Billing Reminders
- Top Rejection Reason Codes
  - How to correct and background billing guidelines
- Top RTP Reason Codes
  - How to correct and background billing guidelines
- Resources
- QA

Some Basic Reminders

Requirements Prior to Billing RAP

- The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented
- The initial visit within the 60-day certification period has been made and the individual is admitted to HH care

RAP Billing Reminders

- 322 type of bill
- Must be submitted at the beginning of each 30-day period
  - Must be submitted within 5 calendar days of the “From” date
- HIPPS may be produced by Grouper software or be any valid HIPPS code
- Submitted after receiving physician’s orders for home care and after delivering the initial visit to the beneficiary
- Always billed as Medicare primary

Requirements Prior to Billing Claim

- Must be submitted after all services for the period have been provided and physician has signed plan of care and all orders
- Face-to-face encounter has been completed
- OASIS has been submitted and accepted by iQIES
  - Any warnings, regardless of the OASIS being accepted, should be investigated and corrected
- HIPPS code must match the RAP for the same 30-day period
- Claim submission:
  - At the end of a 30-day period of care, or
  - When patient is discharged for meeting goals under plan of care (if before 30-day period end date), or
  - When patient transfers from one HHA to another

Claim Billing Reminders

- 329 type of bill
- 0023 revenue line must match RAP for the same period
- Must report revenue lines for all services (covered and noncovered) provided to the beneficiary during the period of care
  - Includes services provided directly and/or under arrangements
- Must contain a revenue line with a site of service code

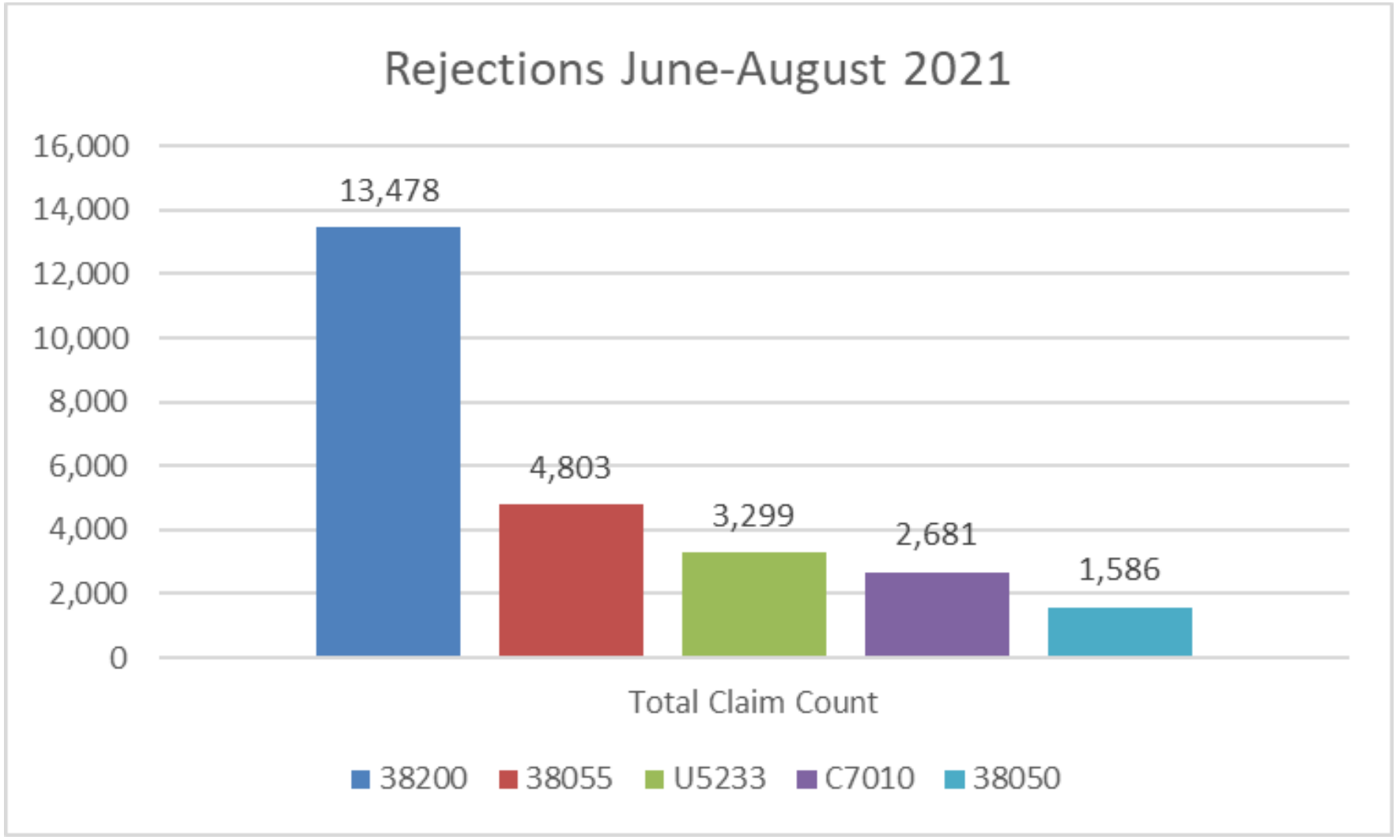
Claim Billing Timeliness

- Both RAP and claim must be received in the FISS claims processing system within one (1) calendar year of the period end date

Claim Status/Locations

- Rejections (R B9997)
  - Claims are resubmitted (in very limited situations, claims are adjusted)
- Returned to Provider (T B9997)
  - Claims are corrected and resubmitted

Top Billing Errors - Rejections


Rejections June-August 2021
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,478
4,803
3,299
2,681
1,586
Total Claim Count
38200
38055
U5233
C7010
38050

Rejection Reason Code 38200

- This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same:
  - HIC Number
  - TOB (all three positions of any TOB)
  - Provider number
  - Statement from date of service
  - Statement through date of service
  - Total charges (0001 revenue line)
  - Revenue code
  - HCPCS and modifiers (if required by revenue code file)

Background/Correcting Reason Code 38200

- The FISS system will only accept one original billing (322 or 329) for each period of care that needs to be submitted
- A processed RAP or claim is in the FISS history file – any RAP or claim billed with the same information will reject as a duplicate
- Verify the billing already submitted by checking your reports (e.g., remittance advice) and FISS

Rejection Reason Code 38055

- This home health claim was submitted as a Medicare primary claim and contains exact service dates corresponding to a previously submitted claim for the same provider with at least one matching revenue code

Provider Action for Reason Codes 38055

- Verify the claim history using the FISS/DDE Provider online system, your remittance advice and/or the CWF to determine the claim that is causing the overlap
- Services that should have been included on a processed/paid claim must be submitted on an adjustment claim (3X7 bill type) to add any services not included on the original claim
  - All services provided to a beneficiary within the home health period of care must be submitted on one claim

Tips for Preventing Reason Codes 38055

- Always verify previously billed information via the claims processing system or remittance advice prior to submitting any new billing to Medicare in order to avoid overlap edits

Rejection Reason Code U5233

- No Medicare payment can be made because the services on this claim fall within or overlap a Medicare Advantage Organization (MAO) enrollment period

Background/Correcting Reason Code U5233

- Services can only be paid by traditional Medicare or an MA plan for the period a beneficiary is entitled/enrolled in either plan
- If patient starts period of care under MA plan then switches to traditional Medicare:
  - Complete new OASIS
  - Submit RAP to open period of care
- If patient starts period of care under traditional Medicare then switches to MA plan:
  - Bill Medicare up to the MAO enrollment date
  - Submit claim with patient status code 06

Background/Correcting Reason Code U5233

- HHAs should submit a claim prior to the MAO enrollment date with patient status code '06' when the HHA is aware the patient will become enrolled in an MAO
- Always verify MA plan information prior to rendering services/billing the period of care
- Billing guidelines: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10, Sections 10.1.5.2 and 40.2

MA Complaints

- HHAs can call 1-800-MEDICARE to file a complaint about a Medicare Advantage Plan
- Press ‘0’ or say, ‘Agent’ to speak to a live customer service agent 24/7
- Be very specific and clear and advise 1-800-MEDICARE you have been working with the MA Plan either through their provider contact center or through the appeals process but no resolution could be settled
- Request the complaint be elevated to the appropriate CMS Regional office’s account representative over the MA Plan to mediate
- If the 1-800-MEDICARE customer service agent does not understand the complaint intake process, ask to be transferred to a supervisor

Rejection Reason Code C7010

- The service dates on this claim overlap a hospice election period and condition code 07 is not present

Background/Correcting Reason Code C7010

- There are times when a patient may elect the hospice benefit while in a home health period of care – a hospice patient may receive home health services for a condition that is unrelated to the reason the patient elected the hospice benefit

Background/Correction Reason Code C7010

- Verify beneficiary eligibility information for an open hospice period and verify if the hospice dates overlap the dates of service billed on the home health claim
- Any services not related to hospice care can be billed with condition code 07
  - Using condition code 07 on the initial claim submission will bypass the hospice edit if there are services not related to the patient's terminal condition that should be paid under traditional Medicare

Rejection Reason Code 38050

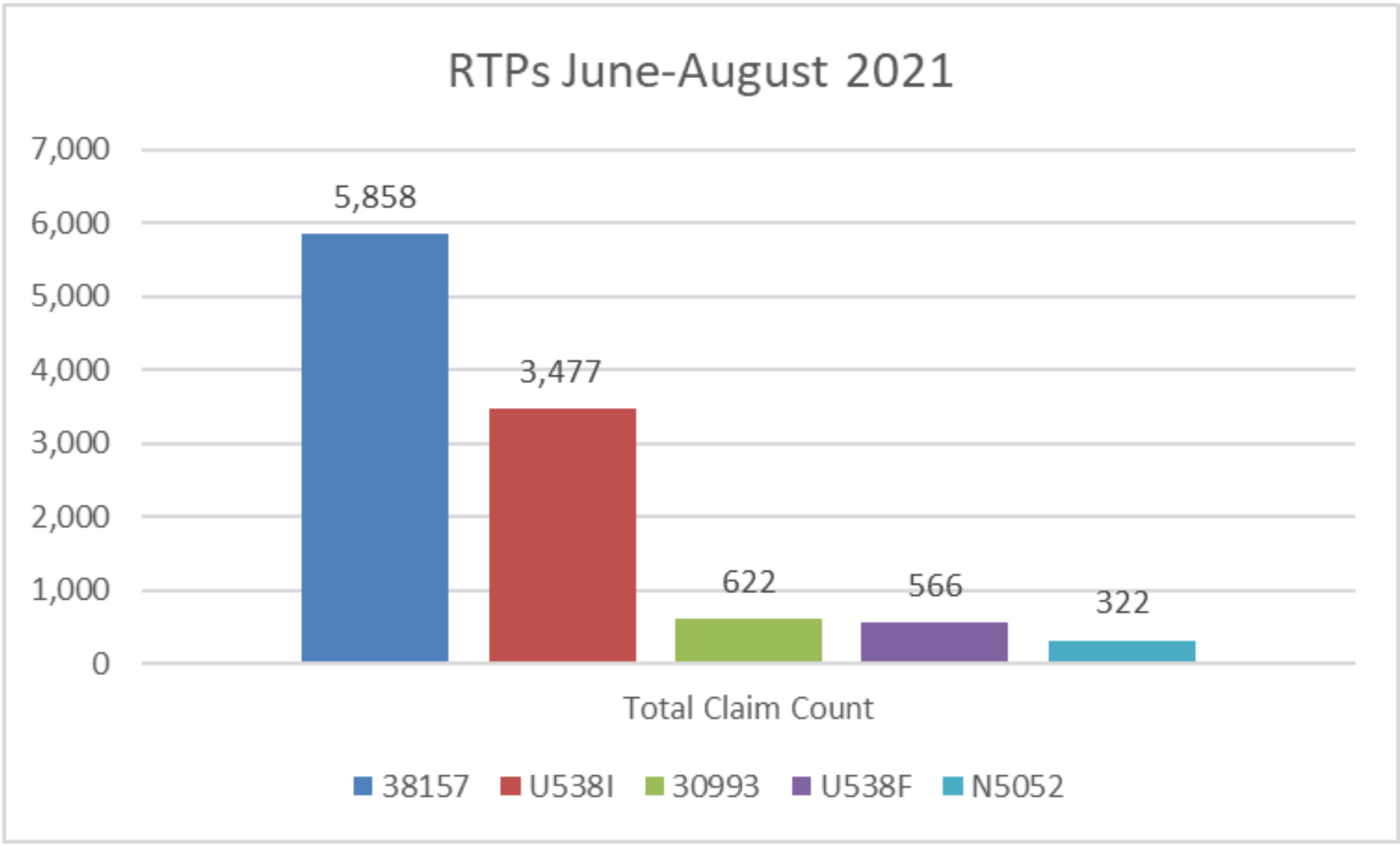
- This claim is a duplicate of a previously submitted home health claim and the following fields on the history and processing claim are the same:
  - HIC Number
  - Provider number
  - Statement From DOS
  - Statement Thru DOS
  - Revenue Code
  - HCPCS and Modifiers (if required by revenue code file)

Background/Correcting Reason Code 38050

- Verify the claim history using the FISS/DDE Provider online system, your remittance advice and/or the CWF to determine the claim that is causing the overlap
- Services that should have been included on a processed/paid claim must be submitted on an adjustment claim (3X7 bill type) to add any services not included on the original claim
  - All services provided to a beneficiary within the home health period must be submitted on one claim

Always verify previously billed information via the claims processing system or remittance advice prior to submitting any new billing to Medicare in order to avoid overlap edits

Top Billing Errors - RTPs


RTPs June-August 2021
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,858
3,477
622
566
322
Total Claim Count
38157
U538I
30993
U538F
N5052

RTP Reason Code 38157

- This RAP is a duplicate to a paid RAP or to a paid, suspended, or denied home health claim for the same provider, same Medicare number, and same statement ‘From’ date and does not contain a cancel date
  - This edit is applied when RAP and final claim are submitted at the same time, when RAP is submitted after one has already processed, or when RAP is resubmitted after claim has processed

Background/Correcting Reason Code 38157

- The RAP needs to be submitted and processed prior to submitting the matching period claim
  - Always submit the RAP and wait for it to complete processing before submitting the final claim
- Always verify prior records (e.g., FISS/DDE, remittance advice) before submitting any new billing
- If a final claim has processed and needs to be corrected, the RAP should not be resubmitted – send an adjustment to the finalized paid claim
- If the final claim has been denied, use the appeals process, if appropriate

RTP Reason Code U538I

- A RAP or home health claim (final or LUPA) is overlapping an existing episode with a different provider number

Background/Correcting Reason Code U538I

- Verify open certification period via NGSConnex/HETS/IVR
- Contact HHA with open certification period to verify transfer
- Use appropriate claim coding
  - Condition code 47 should be used on the admitting agency's RAP when patient is transferred from one HHA to another

Background/Correcting Reason Code U538I

- Only one HHA can be the primary HHA for a beneficiary's home health care
  - Primary HHA bills and receives payment for all services under the POC provided to the patient directly by the HHA and under arrangements with the HHA
- If the period is for a transferred patient, each HHA must follow appropriate transfer protocol (CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 10.7-D)

Background/Correcting Reason Code U538I

- There are times when the previous HHA has discharged the patient and the new HHA is beginning care within the same certification period, or within the same 30 days; this follows the same coding guidelines as a transfer – the HHA starting the new certification for home health care needs to bill the RAP with condition code 47 (CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 10, Sections 10.1.13 and 40.2).
- The initial HHA may also have a RAP for an unused 30-day period that may cause overlap; in this case, the RAP for the unused period may be canceled by the initial HHA.

RTP Reason Code 30993

- A claim has been submitted with an MBI and the MBI/HIC combination was not found on the MBI cache or CWF MBI crosswalk

Background/Correcting Reason Code 30993

- The beneficiary Medicare number billed on the RAP and claim must be a valid MBI
  - Most of the time this error is caused by numbers/letters of the Medicare number being inverted or mistyped
  - Verify the MBI submitted and ensure it matches what is on the beneficiary's Medicare card/CWF

RTP Reason Code U538F

- A RAP or home health claim overlaps an existing period with the same provider number and the 'From' date equals the period start date

Background/Correcting Reason Code U538F

- When billing subsequent period of care claims, the ‘From’ date needs to reflect the first day of the new billing period
  - Only the initial period of care billing should reflect the same date in the ‘Admit Date’ (i.e., period start date) and ‘From’ date fields

RTP Reason Code N5052

- CMS' CWF indicates the beneficiary's name and health insurance card number do not match

Background/Correcting Reason Code N5052

- The beneficiary information billed on the RAP and claim must match the beneficiary information in CWF
- Verify the Medicare number, spelling of the beneficiary's name and other beneficiary information, and that the information is submitted in the proper claim fields
  - Send claim back through system with correct information
- Check CWF for a corrected Medicare number; resubmit with the correct number

Resources

National Government Services Web Site Resources

NGS Website

- Events Tab
  - Upcoming education sessions
  - Past Events
- Education Tab
  - Medicare Topics > Home Health Billing (home health job aids)
  - Medicare University > Medicare University Course List
- Apps
  - YouTube
- Resources
  - Tools & Calculators > Claims and Appeals > Top Claim Errors

Provider Contact Center

- Provider Contact Center numbers, IVR numbers and hours of availability found under Resources > Contact Us > Provider Contact Center

CMS Resources

CMS Website

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 7 (Home Health Services)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 70 (Claim Processing Timeliness)
  - Chapter 10, Sections 40.1 and 40.2 (Home Health Agency Billing)
- Medicare Learning Network®
  - Resource Materials
  - Training
  - MLN Matters® Articles

CMS Resources

- Home Health Agency (HHA) Center
  - Coding and Billing Information
  - HH PPS Regulations and Notices
  - HH Change Requests/Transmittals
  - HHA Email Updates
  - Links to OASIS information

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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