Medicare Billing 101

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Wisconsin Association for Home Health Care (WiAHC)

Disclaimer

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Medicare Billing 101

Objectives

- Learn what Medicare is, what the Medicare number looks like and who NGS is
- Explore Guidelines/Regulations for
  - Mandatory Claims Submission
  - Timely Filing
  - Consolidated Billing
  - How supplements apply
- Understand what is required on the UB-04 so that when working in our software systems we will know the required parts of a claim
- Breakdown of the RAP, the Final Claim and some claims variations
- Talk about Medical Review and the process for responding to the ADR
- Hospice to Home Care for Medicare Advantage Patients
- ICD-10-CM Implementation

FUN FACT!

- What is over 900 changes

What is Medicare

- Federal Health Insurance Program
- People who are 65 and older
- Certain younger people with disabilities
- People with End Stage Renal Disease (ESRD)
- Signed into law by President Johnson July 30, 1965
- Most significant legislative change on December 8, 2003
  - Medicare Modernization Act (MMA)
- Signed into law by President George W. Bush
- Added the outpatient prescription drug benefit

The 4 Parts of Medicare

- Part A - Hospital Insurance
  - Inpatient Hospital Stays
  - Skilled Nursing Facility
  - Hospice
  - Home Health Care
- Part B - Medical Insurance
  - Certain doctors’ services
  - Outpatient care
  - Medical supplies
  - Preventive services
The 4 parts of Medicare (Cont.)

- Part C - Medicare Advantage Plans
  - Offered by private companies
  - Contract with Medicare
  - Provide ALL Part A and Part B Benefits
  - Include
    - HMO's
    - PPO's
    - Private Fee-For-Service Plans
    - Special Needs Plans
    - Medicare Medical Savings Account Plans
  - Most MC services covered through the plan, not paid by original MC
  - Most have prescription drug coverage

The 4 Parts of Medicare (Cont.)

- Part D - Prescription Drug Coverage
  - Adds prescription drug coverage to Original Medicare
  - Also adds coverage to some
    - Medicare Cost Plans
    - Medicare Private Fee-For-Service Plans
    - Medicare Medical Savings Account Plans
  - Offered by insurance companies and private companies approved by Medicare
  - Medicare Advantage Plans may also offer prescription drug coverage
    - Follow same rules as Medicare Prescription Drug Plans

The Medicare Number

- Health Insurance Claim Numbers (HICN)
  - Issued by Social Security Administration (SSA)
  - 9-digit numbers with at least one letter suffix (called a beneficiary identification code or BIC) in the 10th position i.e. 123-45-6789A
  - If has 11th position, may be letter or number i.e. 123-5-678904
  - HICN issued by the U.S. Railroad Retirement Board (RRB)
    - May contain 6 or 9 digit numbers with up to a 3-position letter prefix i.e. A123456 or MA123-45-6789
    - If a beneficiary's entitlement changes it is possible for the 9-digit number, the prefix, the suffix, or all three to change
    - Also possible to go from an SSA issued HICN to a RRB HICN or vice versa

The Medicare Number (Cont.)

- Suffixes we most often see - Medicare suffixes
  - D = Aged Widow, 1st claimant, female
  - D1 = Widower, 1st claimant, male
  - M = Uninsured, not qualified for deemed Health Insurance benefits, male or female
    - Entitled to Part B, but eligible for Part A but may purchase Part A coverage
    - May provide home care to their beneficiaries
  - M1 = Uninsured, qualified but refused Health Insurance benefits, male or female
  - T = Uninsured, entitled to Health Insurance benefits under deemed or renal provisions, male or female
    - Entitled to both or usually through ESRD
  - W = Disabled widow, 1st claimant, female
  - WH = Disabled widower, 1st claimant, male

The Medicare Number (Cont.)

- Prefixes we most often see - RRB
  - A = Railroad retiree - file established when employee was alive
  - AA = Spouse of the railroad retiree
  - WA = Widow(er) of the retiree - file established when the employee was alive

**Who is National Government Services (NGS)?**

- Medicare Contractor who administers our claims for payment
- Wisconsin is J6
- Formed by merging of 5 separate companies
  - AdminStar Federal, Inc. (Anthem)
  - Anthem Health Plans of New Hampshire (Anthem)
  - Associated Hospital Services (Anthem)
  - Empire Medicare Services (WellChoice)
  - United Government Services (WellPoint Health Networks)
- Headquartered in Indianapolis, IN
- Current name since 2007

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**Mandatory Claims Submission Requirement**

- **Section 1848(g)(4) of the Social Security Act**
  - Must submit claims for all of your Medicare patients for services rendered
  - May not charge your patients for preparing or filing a Medicare claim
  - Compliance is monitored by the carriers (NGS)

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**Timely Filing**

- Reimbursement will not be made for claims filed outside of the timely filing limits
- Costs for these claims are the responsibility of the provider
- Reimbursements cannot be billed
- Claims must be filed within one calendar year after the date of service
- Claims requiring line item dates of service use the line item date to determine the date of service
- Long-term claims (Date of service 2/29) must be filed by February 28th the next year to be timely

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**Consolidated Billing**

- **Home Health Agency must bill for all home health services**
  - Skilled Nursing
  - Home Health Aide
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Routine and Non-routine supplies
- Payment is made to the primary home health agency regardless of whether or not the service was furnished by the agency

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**Consolidated Billing (Cont.) Home Health Agency Responsibilities**

- **HHA Agency provides all services directly or under arrangement**
- Requires knowledge of the services provided during the episode
- Beneficiary may have financial liability if they were properly notified of liability and obtain services elsewhere
- Notification of consolidated billing begins at admit
- HHA Agency must advise the patient in advance of the disciplines that will furnish care, frequency of visits, and that all services and supplies will be provided by the primary agency. CoP: 42 CFR 484.10 (e)(3)
- HHA Agency is responsible for advising the patient in advance, about payments received from Medicare or other sources, including the patient. This information must be provided by the HHA Agency both orally and in writing. CoP: 42 CFR 484.10 (e)
Consolidated Billing (Cont.)
Provider/Supplier Responsibilities

- Providers and suppliers need to determine if patient is in a home health episode
- Ask beneficiary or his/her authorized representative
- Common Working File (CWF)
  - RAP been filed opening a home health episode?
  - Payment made to a physician for certification/recertification (G0180/G0179) of a home health plan of care?
- If provider/supplier learns of home health episode or believes they don’t have reliable information they should advise the beneficiary that if they choose to receive services/supplies not provided by the home health agency they could be liable
  - Provide ABN

Consolidated Billing (Cont.)
Billing Edits in the Medicare System

- Types of services most affected
  - Non-routine supplies
  - Outpatient therapies
- Edits applied when the episode claim has been received and processed in CWF
- Edits applied differently depending on whether or not patient was transferred/discharged at the end of the episode
  - If not discharged/transferred edits apply to dates of service between the episode start/end date
  - If discharged/transferred edits apply to dates of service between the episode start date and the last billable service date for the episode
  - Excluding the start date and the last service date

Consolidated Billing (Cont.)
Billing Edits in the Medicare System (Cont.)

- If another provider has provided supplies or services identified on the home health claim subject to consolidated billing, CWF sends information to the contractors to enable them to reject or deny those claims
- Rejections and denials can be done pre or post payment
  - Pre-payment claims are simply denied or rejected
  - Post-payment claims are recovered automatically
- Remittance Advice Remark Codes alert provider/supplier of line item actions
  - Claim Adjustment Reason Code (CARC) 97
  - Remittance Advice Remark Code (RARC) N70

Consolidated Billing (Cont.)
Non-routine Supply Editing

- Non-routine supplies identified as a list of items by HCPCS code
- Claims submitted by providers using the institutional claim format (UB-04) may include non-routine HCPCS codes in addition to other services provided.
- They are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered and therefore do not fall under the bundling provisions of HH PPS

Consolidated Billing (Cont.)
Outpatient Therapy Editing

- CWF enforces consolidated billing for providers using the institutional claim format (UB-04) for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, and 044x.
- These revenue codes are subject to consolidated billing when submitted on types of bills 013x, 023x, 034x, 074x, 075x or 085x.
- CWF enforces consolidated billing for providers using the professional claim format using a list of HCPCS codes representing therapies.
- Therapy services on professional claims are not subject to consolidated billing when performed by a physician.
- CWF bypasses the therapy edit when there is a specialty code on the claim indicating the therapy was performed by a physician.

Consolidated Billing (Cont.)
RAP Received

- If a RAP has been received and services fall within 60 days after the start date of the RAP, CWF will return an alert to the Medicare contractor that the claim may be subject to consolidated billing
- Medicare processes the claim for payment and passes on the alert to the provider on the remittance advice using remark code N88
- The remark code indicates to the provider that the services may be denied and claim payment recouped if the claim is indeed subject to consolidated billing
Consolidated Billing (Cont.)

No RAP Received, Therapy Rendered in the Home

- Independent therapy providers billing on professional claims for therapy provided in the home receive remark code N116 on their remittance advice when there is no RAP in CWF.
- N116 – Payment being made conditionally and could be recouped.
- Medicare provides this message when the place of service on the claim = 12 (home) and the HCPCS code is subject to consolidated billing.

Consolidated Billing (Cont.)

Billing for Arranged Services

- Home Health Agency may bill for services under arrangement.
  - When an agency, in order to be approved to participate in the Medicare program, makes arrangements with another agency/provider to provide nursing/therapy it cannot provide directly.
  - When an agency, which is already approved for participation in the Medicare program, makes arrangements with another agency/provider to provide services it does not provide.
  - When an agency, which is already approved for participation in the Medicare program, makes arrangements with a hospital, skilled nursing facility, or rehab center for services on an outpatient basis because the services involve the use of equipment that cannot be made available to the patient in their home.

Consolidated Billing (Cont.)

Billing for Arranged Services (Cont.)

- Have formal contract unless the other provider is within their own company.
- Home Health Agency and the providing agency must agree not to charge the beneficiary for covered services/items.
- Home Health Agency must exercise professional responsibility over the arranged services and ensure compliance with the Home Health CoPs.
  - Agency must accept patient for treatment in accordance with its administrative policies.
  - Maintain a complete and timely clinical record that includes diagnostic, medical history, physician’s orders, and progress notes relating to all services provided.
  - Maintain and ensure the physician is periodically reviewing/approving the plan of care.
- Ensure that medical necessity of services is reviewed by agency staff.
- Also need to have some kind of service log of visits in order to bill units appropriately on claim.

Consolidated Billing

How do Supplements Apply?

- Medicare certified Home Health Agencies agree to:
  - Be paid by Medicare.
  - Accept only the amount Medicare approved for their services.
- Therefore supplements do not apply to Medicare covered home health services.

Understanding the UB-04

The RAP

- The RAP (Request for Anticipated Payment) may be submitted when:
  - The OASIS assessment is complete, locked or export ready, or agency policy establishes that the OASIS is finalized for transmission.
  - The physician’s verbal orders for home care have been received and documented.
  - A plan of care has been established and sent to the physician.
  - The first service visit has been delivered.
- When the RAP has been submitted an episode will be opened on CWF.
- Submission of the RAP establishes you as the primary HHAgency for the beneficiary.
- Receive a split percentage payment 60% on admits, 50% on recerts.

Understanding the UB-04

The RAP (Cont.)

Required Fields/FL#

<table>
<thead>
<tr>
<th>Field/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name, Address, Telephone Number - FL 1</td>
<td>Minimum entry is Agency Name, City, State and Zip Code.</td>
</tr>
<tr>
<td>Patient Control Number - FL 3a</td>
<td>Number assigned by the HHAgency for reference purposes.</td>
</tr>
<tr>
<td>Type of Bill - FL 4</td>
<td>0122 = RAP 4 digit code. 1st 3 digits indicate the base type of bill, 4th digit indicates the sequence of this bill in the episode of care.</td>
</tr>
</tbody>
</table>
Understanding the UB-04
The RAP (Cont.)

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement Covers Period (From-Through) - FL 6</td>
<td>Contains the same date in both the “from” and “through” date fields</td>
</tr>
<tr>
<td>Patient Name/Identifier - FL 8</td>
<td>Patient’s last name, first name, middle initial. Goes on line b. on the UB. Name should match name on IC Card</td>
</tr>
<tr>
<td>Patient Address - FL 9</td>
<td>Patient’s full mailing address. Line a = street address, b = city, c = state, d = zip code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Birth Date - FL 10</td>
<td>MM/DD/CCYY</td>
</tr>
<tr>
<td>Patient Sex - FL 11</td>
<td>M = Male, F = Female</td>
</tr>
<tr>
<td>Admission/Start of Care Date - FL 12</td>
<td>Date the patient was admitted to home care. On the 1st RAP this should match the statement covers “from” date.</td>
</tr>
<tr>
<td>Admission Type - FL 14</td>
<td>Most often 3 - Elective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of Origin for Admission - FL 15</td>
<td>Indicates where the patient was admitted from.</td>
</tr>
<tr>
<td>1 - Physician Referral</td>
<td></td>
</tr>
<tr>
<td>2 - Crowd Referral</td>
<td></td>
</tr>
<tr>
<td>3 - Transfer from Hospital</td>
<td></td>
</tr>
<tr>
<td>4 - Transfer from Skilled Nursing Facility</td>
<td></td>
</tr>
<tr>
<td>5 - Transfer from another health care facility</td>
<td></td>
</tr>
<tr>
<td>9 - Information not available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Patient Discharge Status - FL 17</td>
<td>30 - Still a patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Code/Revenue Description - FL 42-43</td>
<td>0023 - HIPPS - Home Health PPS</td>
</tr>
<tr>
<td>Not submitted with a charge amount</td>
<td></td>
</tr>
<tr>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes - FL 44</td>
<td>Report the HIPPS code for the anticipated payment (from your OASIS grouper)</td>
</tr>
<tr>
<td>Service Date - FL 45</td>
<td>First billable visit date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Charges - FL 47</td>
<td>Enter a 0 on the 0023 rev code line</td>
</tr>
<tr>
<td>Transactions standards require the reporting of a number 0 as the units. However, Medicare systems will disregard the submitted units in processing the RAP.</td>
<td></td>
</tr>
</tbody>
</table>

Understanding the UB-04
The RAP (Cont.)

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Service Units - FL 46</td>
<td>Enter a 1 on the 0023 rev code line</td>
</tr>
</tbody>
</table>

6/5/2015
### Understanding the UB-04
The RAP (Cont.)

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Name/Health Plan ID - FL 30-51</td>
<td>Enter Medicare on line a in field locator 50 and your Medicare assigned number in field locator 51</td>
</tr>
<tr>
<td>Release of Information Certification Indicator - FL 52</td>
<td>Y = provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. Usually found on the service agreement signed by patient on admission</td>
</tr>
<tr>
<td>National Provider Identifier - FL 56</td>
<td>Enter your NPI number here</td>
</tr>
</tbody>
</table>

### Required Fields/FL#

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured's Name - FL 58</td>
</tr>
<tr>
<td>Insured’s Unique Identifier - FL 60</td>
</tr>
<tr>
<td>Treatment Authorization Code - FL 63</td>
</tr>
</tbody>
</table>

### Required Fields/FL#

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX - FL 66</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Diagnosis Codes - FL A-Q</td>
</tr>
</tbody>
</table>

### Required Fields/FL#

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Provider Name and Identifiers - FL 76</td>
</tr>
<tr>
<td>Other Attending Provider Name and Identifiers - FL 78</td>
</tr>
</tbody>
</table>

### Understanding the UB-04
The Final Claim

- The remaining episode payment is made when the final claim is submitted
- At the end of the 60-Day period, or after the patient is discharged, whichever is earlier
- May submit claim when
  - All services for episode have been provided
  - Physician has signed the plan of care (Including the Face-to-Face)
  - Physician has signed ANY subsequent verbal order
- The final claim includes elements submitted on the RAP and all other line item details for the episode
The final claim is processed in Medicare as a debit/credit adjustment against the record created by the RAP.

- A 100% payment for the episode was made on the claim.
- Results a net remittance of the balance due for the episode.

Example: RAP paid $1000, Episode payment is $1900, you will see a net remittance ($ paid to you) of $900.

- Therapy is up and/or down-coded automatically when the final claim is paid.
- Currently payments are reduced by 2% due to sequestration.
- Claims may span calendar and fiscal years.

Remittance advice will show the RAP payment was recouped in full.

Medicare claims processing systems will determine if the claim should be paid from the Medicare Part A or Part B trust fund.

- After the final payment for an episode has been calculated.
- If claim has been paid by one trust fund and needs to shift to the other Medicare claims processing systems will do an automatic adjustment.

Signified on your remittance advice as TOB 3XG or 3XI - Contractor Adjustment.

A-B shift determination only made on claims (Not RAPS).

HH Agency payment amounts are not affected by this process.

**Required Fields**

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<td>Patient Control Number</td>
<td>FL 3a</td>
<td>Number assigned by the HH Agency for reference purposes.</td>
</tr>
</tbody>
</table>

**Type of Bill**

- FL 4
  - 0329 = Final
  - A 4 digit code: 1st 3 digits indicate the base type of bill, 4th digit indicates the sequence of this bill in the episode of care.

<table>
<thead>
<tr>
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<td>Patient Name/Identifier</td>
<td>FL 8</td>
<td>Patients last name, first name, middle initial. Goes on line b. on the UB. Name should match name on HC Card.</td>
</tr>
<tr>
<td>Patient Address</td>
<td>FL 9</td>
<td>Patient’s full mailing address. Line a = street address, b = city, c = state, d = Zip code.</td>
</tr>
<tr>
<td>Patient Birth Date</td>
<td>FL 10</td>
<td>MM/DD/YYYY</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>FL 11</td>
<td>M = Male, F = Female</td>
</tr>
<tr>
<td>Admission Type</td>
<td>FL 14</td>
<td>Enter the same admission type that was submitted on the RAP for the episode.</td>
</tr>
<tr>
<td>Admission Start of Care Date</td>
<td>FL 12</td>
<td>Enter the same date of admission that was submitted on the RAP for the episode.</td>
</tr>
<tr>
<td>Statement Covers Period (From-Through)</td>
<td>FL 6</td>
<td>The beginning and ending dates of the period covered on the claim. “From” date must match the date submitted on the RAP.</td>
</tr>
<tr>
<td>Patient Name/Identifier</td>
<td>FL 8</td>
<td>Patients last name, first name, middle initial. Goes on line b. on the UB. Name should match name on HC Card.</td>
</tr>
</tbody>
</table>
Understanding the UB-04
The Final Claim (Cont.)

Required Fields/FL# Comment
Patient Discharge Status FL 17 Enter the code that most accurately describes the patient’s status as of the “Through” date of the billing period. Any applicable NUBC approved code may be used i.e., 01 - Discharge to Home or Self-care (routine discharge) 04 - Discharge/transfer to ICF 30 - Still a patient 31 - Discharge/transfer to home care of another HHAgency OR discharge and readmit to the same HHA within a 60-day episode

Understanding the UB-04
The Final Claim
Notes on Patient Status Code 06

 Should be reported in all cases where the HHAgency is aware that the episode will be paid as a PEP adjustment
 Transferred to another agency within the 60-day episode
 Patient discharged with the goals of the original POC met and has been readmitted within the 60-day episode
 Sometimes HHAgency is unaware of these situations at the time of billing the discharge
 Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

Notes on Patient Status Code 06 (Cont.)

 Patient will become enrolled in a Medicare Advantage (MA) Organization
 If HHAgency is aware in advance the provider should submit a claim for the shortened period prior to the MA organization enrollment date
 Claim should be coded with the Patient Status Code of 06

Understanding the UB-04
The Final Claim (Cont.)

Required Fields/FL# Comments
Revenue Code and Revenue Description FL 42-43 • 0223 Revenue Code Line - only 1 per claim
• 0271 Medical/Surgical Supplies - Report only Non-routine supplies
• 0823 Wound Care Supplies - You can choose to separately identify wound care supplies. Report as you would 27x supplies
• 042x Physical Therapy
• 043x Occupational Therapy
• 044x Speech Language Pathology
• 025x Skilled Nursing
• 027x Home Health Aide
• 042x-057x are all reported with one line item for each DOS

Understanding the UB-04
The Final Claim (Cont.)

Required Fields/FL# Comments
HCPCS/Accommodation Rates/HIPPS Rate Codes FL 44 • 0023 Rev Code Line - The 1st 4 positions of the HIPPS code must match the HIPPS code submitted on the RAP.
• The 5th position represents the NRS (Non-Routine Supply) severity level. This 5th position may differ to allow the HHAgency to change a code that signifies supplies were provided to a code that represents that supplies were not provided during the episode.
• The 5th position code may only change between the two values that represent the same NRS severity level.
Understanding the UB-04 The Final Claim (Cont.)

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes: FL 44 (Cont.)</td>
<td></td>
</tr>
</tbody>
</table>

**Q5001** Care provided in patient’s home/residence
**Q5002** Care provided in Assisted Living Facility
**Q5007** Care provided in place not otherwise specified

In the course of a single visit more than one service may be provided. You may not report more than one code for a single visit. Use the G-code which reflects the service for which the clinician spent the most time (Excludes G0157 - PTA).

Understanding the UB-04 The Final Claim (Cont.)

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<tbody>
<tr>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes: FL 44 (Cont.)</td>
<td></td>
</tr>
</tbody>
</table>

**Q5009** Care provided in place not otherwise specified

In the course of a single visit more than one service may be provided. You may not report more than one code for a single visit. Use the G-code which reflects the service for which the clinician spent the most time (Excludes G0157 - PTA).

Understanding the UB-04 The Final Claim (Cont.)

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
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<tr>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes: FL 44 (Cont.)</td>
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</tr>
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In the course of a single visit more than one service may be provided. You may not report more than one code for a single visit. Use the G-code which reflects the service for which the clinician spent the most time (Excludes G0157 - PTA).

Understanding the UB-04 The Final Claim (Cont.)

<table>
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<tr>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes: FL 44 (Cont.)</td>
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</table>

In the course of a single visit more than one service may be provided. You may not report more than one code for a single visit. Use the G-code which reflects the service for which the clinician spent the most time (Excludes G0157 - PTA).
### Understanding The UB-04 The Final Claim (Cont.)

<table>
<thead>
<tr>
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</table>
| HCPCS/Accommodation Rates/HIPPS Rate Codes - FL 44 (Cont.) | Rev. Code 066 - Medical Social Services  
- All Codes reported on claim in 15 minute increments  
- G0155 Services provided by a clinical social worker  
- G0156 Services provided by a home health aide  
- All Codes reported on claim in 15 minute increments  
- G0156 Services provided by a home health aide  
- Rev. Code 0001 Total Charges  
- If entering via DDE remember to use this line to report the total charges |
| Service Date - FL 45 | Rev. Code 0023 - Date of the first service provided under the HIPPS code  
All other Rev. Codes - Report applicable date of service for all line items.  
For visits that begin in one calendar day and end in the next calendar day report 1 visit using the date the visit ended as the service date |
| Service Units - FL 46 | Rev. Code 0023 - use a unit of 1 - Medicare claims processing systems will ignore it  
All other Rev. Codes - Report the appropriate number of units in 15 minute increments for each line item |

#### Required Fields/FL#

- **Service Date - FL 45**
  - **Rev. Code 0023** - Date of the first service provided under the HIPPS code
  - All other Rev. Codes - Report applicable date of service for all line items.
  - For visits that begin in one calendar day and end in the next calendar day report 1 visit using the date the visit ended as the service date.

- **Service Units - FL 46**
  - **Rev. Code 0023** - use a unit of 1 - Medicare claims processing systems will ignore it.
  - All other Rev. Codes - Report the appropriate number of units in 15 minute increments for each line item.

- **Total Charges - FL 47**
  - **Rev. Code 0023** - Report zero (000) charges on the 0023 line item.

- **Q Codes**
  - Report a nominal charge, i.e. 1 cent (001) on the line item containing the Q code.

- **All other Rev. Codes** - Report the agency’s charge for each visit.

Medicare claims processing systems will not make any payments based upon submitted charge amounts. All payments are episodic based on your HIPPS code and the amount of therapy visits provided.

#### Required Fields/FL#

- **Insured’s Name - FL 58**
  - Enter the patient’s name as shown on the Medicare card on line a.

- **Insured’s Unique Identifier - FL 60**
  - Enter Insured’s Unique Identifier on the same line as their name (line a).

- **Treatment Authorization Code - FL 43**
  - Enter the claim OASIS matching key output by the grouper software.

- **DX - FL 66**
  - Use ICD-9-CM codes (UB-04 only).

According to Pub. 100-04 Medicare Claims Processing Manual, Chapter 10 Home Health Agency Billing, Section 40.2 HH PPS Claims Insured’s Name & Unique Identifier are only required if MSP is involved.
Understanding the UB-04 The Final Claim (Cont.)

### Required Fields/FL# Comment
- **Attending Provider Name and Identifiers - FL 76**
  - Enter the name and the NPI of the PECOS enrolled attending physician that established the plan of care with verbal orders
- **Other Attending Provider Name and Identifiers - FL 78**
  - Enter the name and NPI of the PECOS enrolled physician who made the Face-to-Face visit ONLY if different from the attending physician

### Claim Variations

#### “No-RAP LUPA” Claim
- LUPA: episode with 4 or fewer visits
- If the HHAgency is aware the episode will be a LUPA prior to billing they have the option to bill a “No-RAP LUPA” claim
- Looks exactly like any other “FINAL” Claim
- You can bill RAP/Final if you prefer but it will result in the recoupment of funds for the episode once the payment for a RAP will exceed payment for 4 or fewer visits. You are paid per visit on a LUPA
- If you choose to File a “No-RAP LUPA” be aware that there is no RAP to open and establish your agency as the primary agency in CWF
- Once the “No-RAP LUPA” has been received you will be established as the primary agency providing no other agency has a RAP record in CWF for the same time period

#### Final Claim with Non-covered Charges

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-covered Charges - FL 48</strong></td>
<td>HHAgency reports the total non-covered charges pertaining to the related Rev. Code Non-covered charges may include:</td>
</tr>
<tr>
<td></td>
<td>• visits provided exclusively to perform OASIS</td>
</tr>
<tr>
<td></td>
<td>• visits provided exclusively for supervisory or administrative purposes</td>
</tr>
<tr>
<td></td>
<td>• therapy visits provided prior to required re-assessments</td>
</tr>
</tbody>
</table>

#### Cancelling a RAP

<table>
<thead>
<tr>
<th>Required Fields/FL#</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Bill - FL 4</strong></td>
<td>28B: Void/Cancel of a Prior RAP Claim</td>
</tr>
<tr>
<td></td>
<td>• Use to indicate this bill is an exact duplicate of an incorrect bill previously submitted</td>
</tr>
<tr>
<td></td>
<td>• Once cancelled must resubmit a new RAP in order to be paid</td>
</tr>
<tr>
<td><strong>Condition Codes - FL 16-28</strong></td>
<td>Claim Change Reason Code</td>
</tr>
<tr>
<td></td>
<td>• D1: Cancel to correct Provider/HIC</td>
</tr>
<tr>
<td></td>
<td>• D8: Cancel duplicate or OIG overpayment</td>
</tr>
<tr>
<td></td>
<td>• If canceling the RAP via FISS DDE you will also need to report the Adjustment Reason Code on page 3</td>
</tr>
<tr>
<td><strong>Remarks - FL 80</strong></td>
<td>Enter “Remarks” indicating the reason for cancellation</td>
</tr>
</tbody>
</table>

#### Transfer from another HHAgency

- In order to accept a beneficiary elected transfer:
  - The receiving HHAgency must document that the beneficiary has been informed that the initial HHAgency will no longer receive Medicare payment on their behalf and will no longer provide Medicare covered services to them after the date of their elected transfer
  - The receiving HHAgency must also document in the record that it accessed the Medicare contractor’s inquiry system to determine whether or not the patient was under an established HH POC
  - The receiving HHAgency must contact the initial HHAgency on the effective date of transfer.
Claim Variations
Transfer from another HHAgency (Cont.)

- What if the transfer is disputed by the other HH Agency?
  - The Medicare contractor is responsible for working with both HH Agencies to resolve.
  - If the receiving HH Agency can provide:
    - Documentation of its notice of patients rights or 67 payment liability provided to the patient upon transfer.
    - Documentation of the initial HH Agency's transfer date.
    - Documentation of the initial HH Agency's RAP.
  - If the receiving HH Agency cannot provide the appropriate documentation:
    - Forwarding agency's RAP notice to the claim will be cancelled, and full episode payment will be provided to the initial HH Agency.

Claim Variations
Transfer from another HHAgency (Cont.)

- What is the proper documentation?
  - Basic Beneficiary Information
  - Personnel contact
  - Dates and times
  - Your information should be similar to the initial HH Agency's documentation of the transfer.
  - If the initial HH Agency disputes, they must call the Medicare contractor for resolution.

- What should I maintain on file for a valid claim?
  - If adjusting the claim via FISS DDE:
    - Enter "Remarks" indicating the reason for the HIPPS code change.
    - Make corrections to the claim before submitting.

Claim Variations
Transfer from another HHAgency (Cont.)

- Final Claim - Adjustment of a Previously Paid Claim

<table>
<thead>
<tr>
<th>Required Field</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Bill</td>
<td>327 - Adjustment Claim</td>
</tr>
<tr>
<td>Code</td>
<td>Replacement of a prior claim</td>
</tr>
</tbody>
</table>

Condition Code
- Claim Change Reason Codes:
  - 00 - Change in patient status
  - 01 - Changes in revenue/HICP/HIPPS Codes
  - 02 - Changes in patient status
  - 03 - Change in revenue/HICP/HIPPS Codes
  - 04 - Any other (multiple changes)
  - 05 - Change in service dates

Claim Variations (Cont.)
Final Claim - Cancel a Previously Paid Claim

<table>
<thead>
<tr>
<th>Required Field</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Bill</td>
<td>128 - Void/Cancel Prior RAP CLAIM</td>
</tr>
<tr>
<td>Code</td>
<td>This bill is an exact duplicate of an incorrect bill previously submitted</td>
</tr>
</tbody>
</table>

Condition Code
- Claim Change Reason Code:
  - 01 - Cancel to correct provider/HICP/HIPPS Codes
  - 02 - Change in service dates
  - 03 - Change in service dates
  - 04 - Changes in revenue/HICP/HIPPS Codes
  - 05 - Change in patient status

Remarks
- Enter "Remarks" indicating the reason for the HIPPS code change.

Medical Review
Additional Development Requests (ADR)

- Medical review of records for services billed by Medicare contractor (NGS).
- To obtain records from provider a request is generated known as an ADR.
- Respond to ADRs in a complete and timely manner to avoid claims processing delays.
  - Within 45 days of the date of the ADR (if sent to you via mail).
  - Forward the requested documentation to the correct mailing address.
  - Send each response separately.
  - Include all records necessary to support the services you provided.
  - Do not include additional correspondence, mail it separately.
  - Records must be complete & legible. Include both sides of double-sided documents.
  - All documentation must include the necessary signature and credentials of professionals.
Medical Review
Additional Development Requests (ADR) (Cont.)

- Can also find ADRs on the FISS/DDE Provider Online System—Instructions as on NGS’ web site under Medical Review
  1. Access the claims through the Claims Inquiry screen/option
  2. Type 01 at the FISS/DDE Main Menu & then type 12 on the Inquiry Menu for claims
  3. At the Claims Inquiry screen, type SB6001 in the 5/LOC field and press <Enter>—all claims in the SB6001 status & location will be displayed (SB6001 status indicates that an ADR has been generated for a claim)
  4. At the desired claim, type S to the left of the claim under the SEL field and press <Enter>
  5. The ADR letter follows claim page 06 of the claim
  6. The online ADR letter consists of two pages, to view the second page, press the <P8>/<PF8> key to move forward to the next page
  7. Please be sure to not press the <P9>/<PF9> key while viewing a claim in the SB6001 status—this will cause the claim to recycle and generate a second ADR letter

- NOTE: If using the ADR printed from FISS/DDE, the copies of requested records are due to NGS 30 days from the date the claim went to 5/LOC SB6001

NGS Website www.ngsmedicare.com—Choose the Medical Policy tab and then choose Medical Review. Instructions for ADRs are here.

Billing Medicare for Medicare Advantage (MA) Patients

- Medicare Advantage patients who are admitted prior to the end of the month in which they have revoked their hospice benefit need their home care services billed to original Medicare through the end of that month.
- Medicare Advantage plan coverage then starts on the 1st day of the next month.

ICD-10-CM Implementation

- Coming October 1, 2015
- Special Billing Circumstances
- Guidance as of today is given in MLN Matters article number SE1410 Revised issued on August 1, 2014
- Three factors affect how ICD-10-CM will be used for episodes whose services span the October 1st date
  1. The claim “From” date (episode start date)
  2. OASIS completion date (item M0090)
  3. The claim “Through” date

ICD-10-CM Implementation (Cont.)

- REFERENCES
  - CMS IOM Manuals
    - Publication 100-01
    - Publication 100-02
    - Publication 100-04
  - MLN Matters
    - No. W40743
    - No. SE1410
  - Uniform Billing Editor by Ingenix
    - WML.gov
    - www.medicare.gov
    - www.wpsmedicare.com
    - www.caahabga.com
Thank You!