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National Government Services

Avoiding Top Home Health Billing Errors
Session Nine

April 22, 2022

DATASOFTLOGIC
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

NGS Provider Experience
Innovative Solutions • Meaningful Education • Reduced Burden

National Government Services
Provider Outreach & Education
Home Health & Hospice Team

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Objectives

- Review the top rejection and return to provider (RTP) reason codes assigned to home health claims
- Educate on correcting the reason code errors and the billing guidelines behind the NOA 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

Notice of Admission

Purpose: Opens a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission

When to Submit the NOA

HHA has received the appropriate physician's written or verbal order that contains the services required for an initial visit

HHA has conducted the initial visit at the start of care and admitted the patient to HH care

Must be submitted within five calendar days from the start of care

Requirements Prior to Billing Claim

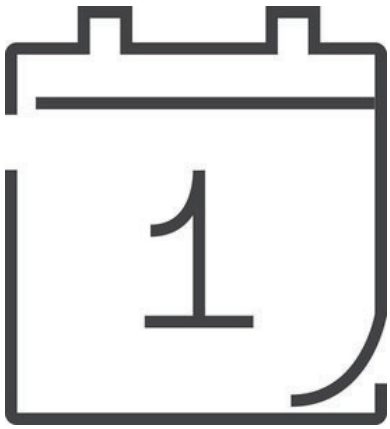
- Submitted after all services for the period have been provided
- Physician has signed plan of care and all orders
- Face-to-face encounter has been completed
- OASIS has been submitted and accepted by iQIES
  - Any warnings, regardless of the OASIS being accepted, should be investigated and corrected
- 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 be billed with a Grouper-produced HIPPS or any valid HIPPS under PDGM
- 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

- Period of care claims must be received in the FISS claims processing system within one (1) calendar year of the period end date

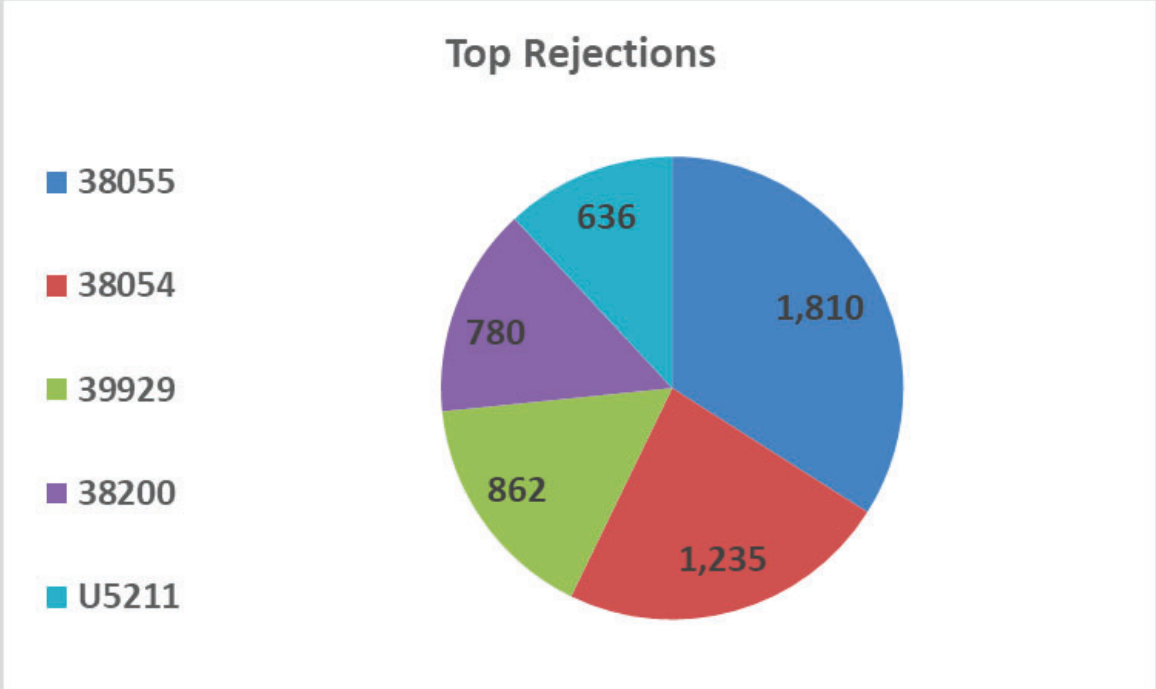


Claim Status/Locations

- 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

Rejected Claims



Rejection Reason Code 38055/38054

- 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
- 38054: This home health claim was submitted as a Medicare primary claim and contains dates of service which overlap a previously submitted claim for the same provider with at least one matching revenue code

Provider Action for Reason Codes 38055/38054

Verify the claim history to determine claim causing overlap

FISS/DDE

NGSConnex

Remittance advice

Correcting Reason Codes 38055/38054

Submit adjustment bill (3X7 TOB) 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

Always verify previously billed information prior to submitting any new billing to Medicare

- Avoid overlap edits for your own claims

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Rejection Reason Code 39929

- Each line of charges on this claim has been rejected and/or rejected and denied

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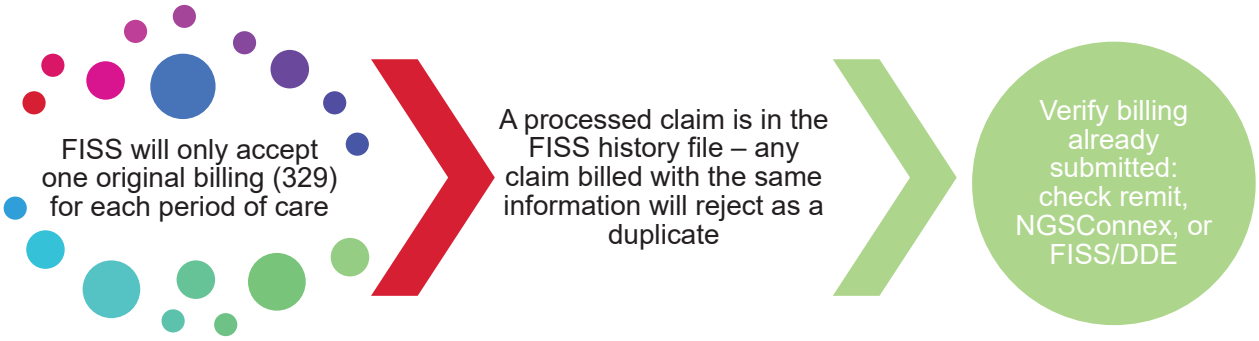
Provider Action for Reason Code 39929

- Verify line level rejection information to determine the rejection for each line of the claim
- Access MAP171D for line item detail information
  - Hit F2 once or F11 twice from page two of the claim to access MAP171D
  - Since it is possible for each line item to have a different line item reason code, review the additional lines by using F6 to forward to the next claim line and F5 to go back through previous claim lines

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



Rejection Reason Code U5211

- The statement from/through date is greater than the date of death on the beneficiary master record

Correcting Reason Code U5211

HHAs can bill and receive full payment for a period of care when a beneficiary dies during the period

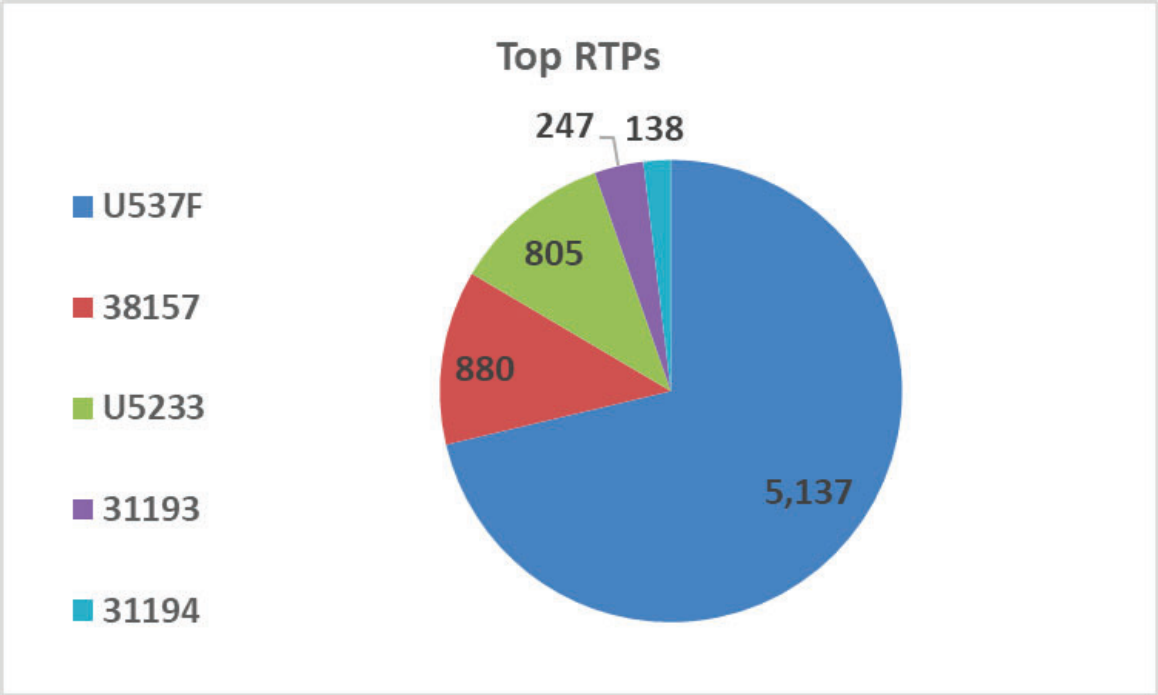
- Through date on the claim should reflect the date of death

Verify Medicare number billed and the date of death showing on CWF

- If date of death reported in error to the Social Security office, SSA must be contacted to correct the date
- If beneficiary still alive, he/she must contact SSA for an interview - these cases cannot be corrected through the MAC

Top Billing Errors - RTPs

Return to Provider Claims



RTP Reason Code U537F

- The From date on the HH NOA falls within an existing home health admission period

Correcting Reason Code U537F

Assigned Incorrectly

- Some NOAs edited in error due to CWF not recognizing discharges (patient status other than 30)

Assigned correctly on duplicate NOAs for the same admission period

- NOA should not already be in the system pending processing or finalized prior to submitting a new NOA for a beneficiary
- HHAs should not submit multiple NOAs for same admission

Assigned correctly on NOAs if the provider CCN does not match the CCN on the prior HH episode posted at CWF

- When opening a new admission for a transferred patient, the NOA should be billed with condition code 47

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Provider Action for Reason Code U537F

- Always verify billing before submitting a new NOA for a beneficiary admission.
- Effective 4/4/2022, providers can resubmit any HH NOAs (32A) that RTP'd incorrectly
  - Submit the KX modifier on the affected final HH claim(s)
  - Add Remarks to request an exception to the late-filing penalty, e.g., "RAP was late due to System Problem –CWF CR35441

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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 may fire due to the RAP and final claim being submitted at the same time and are editing against each other

Background/Correcting Reason Code 38157

RAPs must 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	• Look at FISS/DDE, NGSConnex, or remittance advice before submitting any new billing
Final claim has processed and needs to be corrected	• RAP should not be resubmitted; send adjustment to finalized paid claim
Final claim has been denied	• Use the appeals process, if appropriate

RTP 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

Patient starts period of care under MA plan then switches to Original Medicare	Complete new OASIS	Submit NOA to open admission period under Original Medicare
Patient starts period of care under Original 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

RTP Reason Code 31193/31194

- 31193: TOB is equal to Home Health Notice of Admission (NOA) TOB 32A or 32D and the statement From date is prior to 01/01/2022
- 31194: Statement From date on TOB 322 is on or after 01/01/2022

Background/Correcting Reason Code 31193/31194

NOAs required for all periods of care starting on or after 01/01/2022

- Claims processing system will not accept NOAs with DOS prior to 01/01/2022

RAPs must not be billed for any dates of service on or after 01/01/2022

- HHA must cancel any RAP billed with DOS 01/01/2022 or later

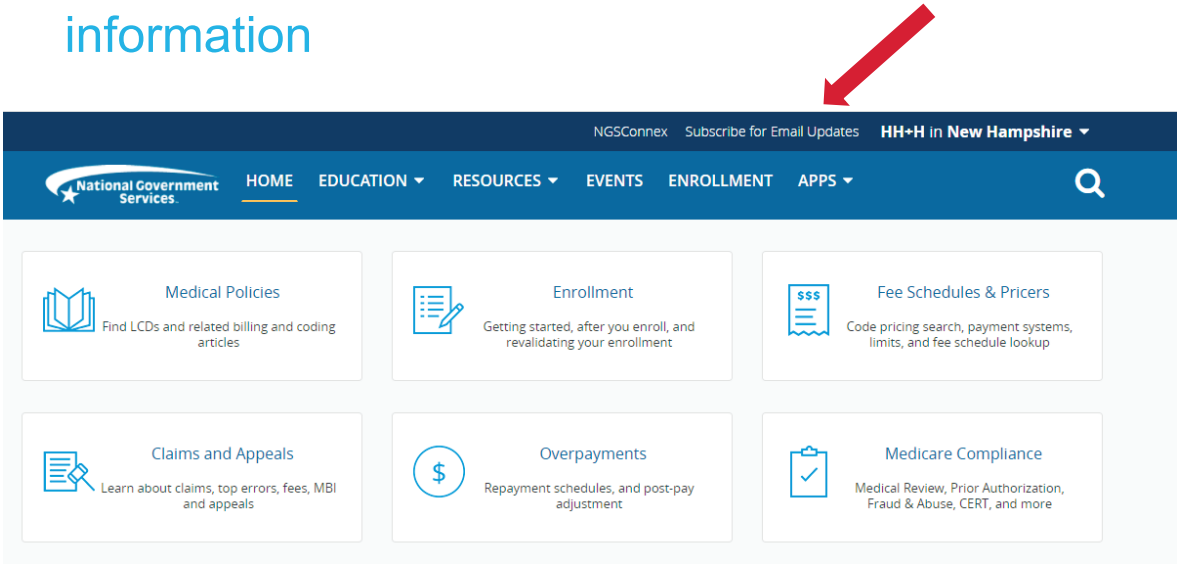
Home Health & Hospice References and Resources

NGS Website

- NGS Website
  - Articles and Job Aids
  - Resources
  - Medicare Compliance
  - Fraud and Abuse

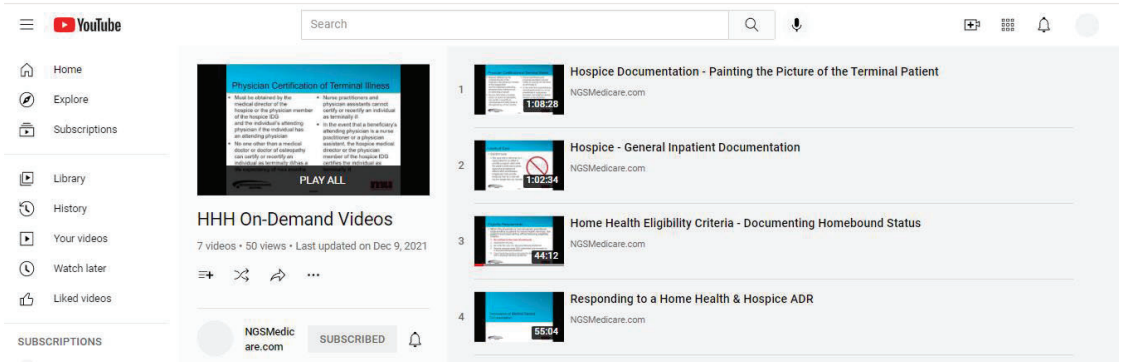
NGS Email Updates

- Subscribe to receive the latest Medicare information



YouTube

NGS HHH On-Demand Videos



Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs

Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

Thank You!

- Questions?

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