

# Table of Contents

## About the Author

Melinda A. Gaboury, COS-C Chief Executive Officer ..... vii

## Chapter 1: Intro to home health billing..... 1

Overview of home health payments ..... 1  
 Regulatory changes that impact billing..... 4  
 Review and update of recent regulatory changes..... 5

## Chapter 2: Understand home health payment..... 15

Is your patient eligible for services?..... 16  
 How home health PDGM works ..... 20  
 Funding for beneficiaries with Part A and/or Part B ..... 21  
 Stages of the home health billing system ..... 21  
 HCPCS codes..... 22  
 Annual home health payment changes ..... 24

## Chapter 3: Improve OASIS accuracy and outcomes..... 25

IMPACT Act..... 25  
 OASIS ..... 26  
 OASIS and the impact on CMS surveys..... 28  
 How do I avoid OASIS-related billing errors?..... 29  
 OASIS and payment-related issues..... 30  
 Avoid OASIS errors that impact payment..... 32  
 What's required for home health eligibility..... 34  
 Training resources for OASIS ..... 35  
 Tools..... 36  
 OASIS/claim-related risk analysis form..... 40

## Chapter 4: Billing in the ICD-10 world ..... 41

High-level view of ICD-10 code changes ..... 41  
 Maintain productivity with ICD-10 changes ..... 42  
 Targeted reviews ..... 42  
 How to minimize productivity losses ..... 43  
 Use tools to self-evaluate..... 46  
 How to reduce payment delays ..... 47  
 Keep up-to-date with FISS-DDE user manuals ..... 47  
 Tools..... 48

Sample referral form for skilled pulmonology patients..... 48  
 Sample referral form for skilled orthopedic patients ..... 49

**Chapter 5: Master HHRGs, PDGM and HIPPS.....51**

Intro to HHRGs and HIPPS..... 51  
 OASIS submission is a condition for payment..... 51  
 Validate HIPPS code on the claim..... 54  
 HHRGs and HIPPS..... 54  
 Effect of HHRG/HIPPS on Medicare payments ..... 55  
 Five components to determine PDGM case mix ..... 56  
 Maximize accuracy to ensure correct payment ..... 67

**Chapter 6: File NOAs and claims .....69**

Monitor your MAC ..... 69  
 Examine multiple Medicare manuals ..... 69  
 Outliers in 2020 and beyond..... 74  
 Understand UB-04 ..... 76  
 What is the CWF? ..... 77  
 Conditions to meet before Notice of Admission (NOA) can be filed ..... 78  
 UB-04 Overview ..... 79  
 Electronic claim submission..... 80  
 Commonly rejected front-end edits..... 81  
 Pre-payment edits ..... 81  
 Avoid the most common EDI claim edits..... 82  
 Medicare FFS home health required form CMS-1450 (UB-04) data element checklist..... 83  
 HCPCS G codes for home care..... 89  
 Common revenue codes with related disciplines..... 89  
 Medicare “clean claim” pre-billing checklist..... 92  
 How to contact your MAC ..... 93

**Chapter 7: Make sense of claims adjustments .....95**

Claims adjustments: Are they worth the trouble? ..... 95  
 Reasons to file accurate claims..... 95  
 Types of adjustments..... 96  
 CMS changes to outliers ..... 99  
 More details on adjustments..... 100  
 Payments to agencies that don’t submit quality data ..... 101  
 Basic rule about adjustments..... 101

**Chapter 8: Avoid common billing errors ..... 105**

Pick up your PEPPER.....	105
ICD-10 and claim edits/rejections .....	107
More on the biller's role.....	108
Common billing errors .....	109
More tools offered by MACs .....	117
Terms to reflect status of claims.....	118
Actions to handle rejected, denied or RTP claims .....	119
Other common status and locations .....	119
More notes on RTP and rejected claims .....	119
Timely filing requirements.....	120
Overpayments .....	123
TOB codes .....	125
Use LCDs and NCDs to reduce payment denials.....	128
Billing issues related to ADRs and medical review .....	134
Other common medical review findings .....	134
Best practices for OASIS impact on billing.....	134
Top home health Medicare claim error reason codes .....	135

**Chapter 9: Reduce face-to-face denials ..... 141**

Face-to-face encounter documentation .....	141
Documentation suggestions when appealing denials .....	145
Tips to comply with specific MAC expectations .....	146
Homebound status verification .....	146

**Chapter 10: Survive claims audits ..... 153**

ADR overview .....	153
Prepare for audits .....	154
Common coding errors agencies experience .....	157
Take steps to remain in compliance .....	159
ADR avoidance, preparedness and response .....	160
Disclosure and self-reporting .....	160
How to handle, prepare for ADRs .....	162
Steps to manage audit letters .....	163
Establish compliance tracking systems.....	165
Stop recoupment .....	166
What happens following reconsideration by a QIC? .....	167
Appeals .....	167
Common Home health medical review denial reasons .....	171
More on medical review denial reasons.....	173
ADR resources .....	173

Pre-billing audit checklist ..... 174  
Tools..... 176

**Chapter 11: Medicare Advantage ..... 179**

Options under the Medicare benefit ..... 180  
Medicare plans overview ..... 180  
Impact of increased enrollment ..... 181  
MA plans must include HIPPS code ..... 182  
Managing payer source changes ..... 182  
Many MA claims are being reviewed ..... 183  
How Medicare Advantage affects traditional Medicare ..... 184  
Coordinated care plans ..... 184  
Other plans..... 186  
Improvements under Part C..... 187  
MA and non-skilled coverage ..... 188  
Managed Care and the insurance maze ..... 188  
Determination of the primary payer ..... 192  
Effect of election of MA organization, eligibility changes ..... 194

**Chapter 12: Patient-Driven Groupings Model..... 195**

PDGM overview..... 195  
Model specifics..... 196  
Filing a NOA in 2022..... 200  
Increase efficiency of billing under PDGM ..... 203  
A recap of billing under PDGM..... 203