PMB institute

Module 7

STUDY GUIDE

PREPARE FOR SUCCESS

Home Health Medical Billing Certificate

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Once the episode of care is complete, HHAs can bill the final claim to Medicare. Upon adjudication, Medicare will pay the remaining amount of 80 percent. **Ensure a successful final bill reimbursement by checking these items off your list:**

- Plan of care/re-certification is signed and dated
- Physicians orders signed and dated that aren't included in the plan of care
- Appropriate, legible signatures
- Initial episode of care certification is in the QIES and plan of care with the same M0090 dates of service
- Subsequent episodes
- OASIS assessment has been submitted, locked and accepted
- A copy of the OASIS assessment is included in the documents submitted to support the HIPPS billed
- Verify the RAP has been paid and not canceled, and re-verify eligibility if necessary
- Complete documentation includes:
    - Accurate patient status
    - Medical necessity related information
    - Verified matched diagnosis
    - Individual visit support for each billed visit
    - Therapy assessments - verify accurate therapy codes
    - Necessary supplemental orders
    - Advanced Beneficiary Notice (ABN) - if necessary
    - If a patient's sole need is for skilled oversight of unskilled services, include physician's brief for clinical justification
- Face-to-Face encounter
  Medicare requires a Face-to-Face encounter with an approved practitioner no more than

90 days prior to the home health initial episode of care or within 30 days after the first episode

- Include documentation of clinical findings with legible signatures and dates
- Skilled services are supported through clinical findings
- Homebound status documentation
- Face-to-Face document for dates of service under review

PPA (formerly PEP)

This payment occurs when a patient is transferred/discharged and readmitted to the same home health agency within a 60-day period. The original episode payment is adjusted according to the length of time the patient received care and the services provided. This is a proportional payment amount based on the number of days of service provided (i.e., the total number of days counted from and including the day of the first billable service to and including the day of the last billable service). The readmission episode starts a new 60-day episode for full payment.

According to Chapter 10 Medicare Claims Processing Manual Home Health Billing:

10.1.15 - Adjustments of Episode Payment - Partial Payment Adjustment (PPA) (Rev. 1505, Issued: 05-16-08, Effective: 01-01-08, Implementation: 10-06-08)

PPA adjustments occur as a result of the two following situations:

a. When a patient has been discharged and readmitted to home care within the same 60-day episode, which will be indicated by using a Patient Discharge Status code of 06 on the final claim for the first part of the 60-day episode; or

b. When a patient transfers to another HHA during a 60-day episode, also indicated with a Patient Discharge Status code of 06 on their final claim.

LUPA

If an HHA provides 2-6 visits in a period, depending on which clinical grouping, they will be paid a standardized per visit payment instead of an episode payment for a 30-day period. Such payment adjustments are called Low Utilization Payment Adjustments (LUPAs). On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total

annual supply payments are factored into all payment rates. Since HHAs in such cases are likely to have received one split percentage payment, which would likely be greater than the total LUPA payment, the difference between these wage-index adjusted per visit payments and the payment already received will be offset against future payments

If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only episode of care the beneficiary received, Medicare will make an additional add-on payment. For LUPA episodes ending on or after January 1, 2014, Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if episodes are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated episode in the same sequence of adjacent episodes.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

View 2020 PDGM Case Mix Weights and LUPA Thresholds

10.1.18 - Adjustments of Episode Payment - Special Submission Case: "No-RAP" LUPAs (Rev. 1, 10-01-03)
HH-467.26, A3-3639.26

Normally, there will be two percentage payments (initial and final) paid for an HH PPS episode, the first paid in response to a RAP, and the last in response to a claim. However, there will be some cases in which a HHA knows that an episode will be four visits or less even before the episode begins or before the RAP is submitted, and therefore the episode will be paid a per-visit-based LUPA payment instead of an episode payment. In such cases and only in such cases,

the HHA may choose not to submit a RAP, foregoing the initial percentage payment that otherwise would later likely be largely recouped. Physician orders must be signed when these claims are submitted. If a HHA later needs to add visits to the claim, so that the claim will have more than four visits and no longer be a LUPA, the claim should be adjusted and the full episode payment based on the HIPPS code will be made.

Outlier

Adjustments of Episode Payment - Outlier Payments

HH PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 30- day periods, Medicare claims processing systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

For episodes ending before January 1, 2017, outlier determinations shall be made by comparing:

- The episode's estimated cost, calculated as sum of the products of the number of visits of each discipline on the claim and each wage-adjusted national standardized per visit rate for each discipline; with
- The sum of the episode payment and a wage-adjusted standard fixed loss threshold amount.

For episodes ending on or after January 1, 2017, outlier determinations shall be made by comparing:

- The episode's estimated cost, calculated as the sum of the products of number of units of each discipline on the claim and each wage-adjusted national standardized per unit rate for each discipline (1 unit = 15 minutes); with
- The sum of the episode payment and a wage-adjusted standard fixed loss threshold amount.

If the episode's estimated cost is greater than the wage adjusted and case-mix specific payment amount plus the wage adjusted fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the estimated episode cost exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode. For episodes ending on or after January 1, 2017, units considered for outlier payment are subject to a limit of 32 units (8 hours), summed across the six disciplines of care, per date of service.

For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in 1 day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of episode cost in order to cap the estimation of an episode's cost at 8 hours of care, summed across the six disciplines, per day.

The outlier payment is a payment for an entire episode, and therefore carried only at the claim level on the paid claim. It is not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment shall be included in the total payment for the episode claim on a remittance, but it will be identified separately on the claim using value code 17 with an associated dollar amount representing the outlier payment.

Outlier payments will also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HH PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

Outlier payments made to each HHA are subject to an annual limitation. Medicare systems ensure that outlier payments comprise no more than 10 percent of the HHA's total HH PPS payments for the year. Medicare systems track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier payments that each HHA has received. When each HH PPS claim is processed, Medicare systems compare these two amounts and determine whether the 10 percent has currently been met.

If the limitation has not yet been met, any outlier amount is paid normally. (Partial outlier payments are not made.) If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the episode are paid but any outlier amount is not paid.

The contractor shall use the following remittance advice messages and associated codes when not paying outlier amounts under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO CARC: 119 RARC: N/A MSN: N/A

Since the payment of subsequent claims may change whether an HHA has exceeded the limitation over the course of the timely filing period, Medicare systems conduct a quarterly reconciliation process. All claims where an outlier amount was calculated but not paid when the claim was initially processed shall be reprocessed to determine whether the outlier has become payable. If the outlier can be paid, the claim is adjusted to increase the payment by the outlier amount. Additionally, if any HHAs are found to have been overpaid outlier during the quarterly reconciliation process, claims are adjusted to recover any excess payments.

These adjustments appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (TOB 032I) and the coding that typically identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

Final Claims Pre-Billing Audit Form

PMB
precision medical billing

PATIENT NAME: _____ **DOB:** _____ **HIC:** _____

60 DAY EPISODE DATES: _____**TO**_____ **CBSA:** _____

30 DAY PERIOD #1: _____**TO** _____ **30 DAY PERIOD #2:** _____**TO**_____

RAP #1: FBV_____ **BILLED** _____ **HIPPS CODE** _____ **FINAL #1: BILLED**_____ **PAID HIPPS CODE**_____

RAP #2: FBV_____ **BILLED** _____ **HIPPS CODE** _____ **FINAL #2: BILLED**_____ **PAID HIPPS CODE**_____

OASIS TRANSFER? (circle one) YES NO **INPATIENT STAY DATES?**_____ | **61 or 62 NEEDED?** _____

INDICATOR	**30 days YES**	**NO** (must be corrected before billing)
1. POC complete with orders and goals for **all** services/care performed (i.e., visits, wound care, meds, teaching, therapy, aide, etc.)		
2. POC signed by physician (no signature stamps)		
3. All orders signed and dated by clinician and physician		
a. Skilled Nursing		
b. Home Health Aide		
c. Physical Therapy		
d. Occupational Therapy		
e. Speech Therapy		
f. Medical Social Work		
4. Frequency and duration met as ordered #OF VISITS		
a. Skilled Nursing		
b. Home Health Aide		
c. Physical Therapy		
d. Occupational Therapy		
e. Speech Therapy		
f. Medical Social Work		
5. Missed visit notes are complete/signed/dated for each missed visit. New orders written, signed and dated? NA ☐		
6. All supplies used or ordered? NA ☐		
7. All supplies used listed on appropriate visit notes? NA ☐		
8. ~~Are supplies charged on UB-04?~~		
COMMENTS		

Reviewer: _____ Date: _____