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**Start Smart with Home Health Billing-**
**Learn how to bill right from the start**

by

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1

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## Who am I?

Our job is to handle the entire billing & coding process so you can focus on growing the business while ensuring you are getting paid fast and accurately.

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## Learning Objectives

- Discuss detailed billing process for Medicare claims
- Tips on how to avoid revenue loss
- Timing on when your first payment will be released

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## Patient-Driven Groupings Model (PDGM) Effective 2020

- In 2000, Medicare determined that HHA will be paid a predetermined base payment.
- Biggest change to Medicare Home Health in 20 years
- Effective January 1, 2020
- The payment is adjusted for the health condition and care needs of the patient.
- The payment is also adjusted for the geographic differences in wages for HHAs across the country.

So what does this mean?

- Home health is paid on 30 day payment periods NOT per visit.

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## How Is Our Reimbursement Determined?

- Medicare bundles our payment to cover all HHA services provided in a 30 day period
- Level of payment is determined by an equation model
- Different payments are issued for patients with different needs and resource use
- Your payment is based on the clinical characteristics and other patient information to place home health period of care into a payment categories

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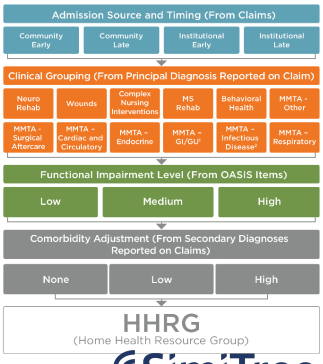
## How the Patient-Driven Groupings Model Works

**Five main case-mix variables**

- Admission
- Timing: early or late
- Clinical grouping
- Functional Level
- Comorbidity

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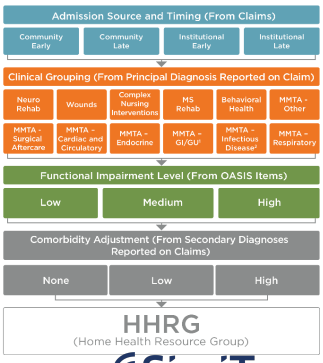
## HHRG = Home health resource group

- A 30-day period is grouped into **one** subcategory in each color category
- This results in **432 possible payment groups** into which a 30-day period can be placed
- Payment can range for a 30 day period $1,200-$3,500



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## Grouping model- Admission Source

- To determine admission source correctly for each 30 day period of payment
- Community= NO acute or post acute care in the 14 days prior to the HHA admission
  - physician office, lower resource use, lower payment
- Institutional= YES, the HHA SOC must be within 14 days of a inpatient acute care hospital, SNF, IRF (inpatient rehab facility), inpatient psychiatric facility, LTCH (long term care hospital) discharge.
  - No observation days or ED visits
  - Higher payment due to higher resource use



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## Grouping model- Timing (Early and Late Episode)

- First 30-day period is classified as early.
- All subsequent 30-day periods in the sequence (second or later) are classified as late.
- If there is a gap of 60-days or more between the end of one 30-day period and the start of the next. Then that payment period is considered early again
- Early episode- higher payment
- Late episode- lower payment



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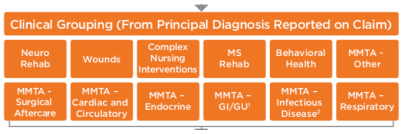
## Grouping model- Clinical Group




- 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis.
- Principal diagnosis provides information to describe the primary reason for which patients are receiving home health services
- Diagnosis code must support the need for HH services.
- List of all 42,000 + PDGM dx codes look up tool on our website
- https://imarkbilling.com/tools/pdgm-icd- lookup/



10

## Grouping model- Clinical Group

| CLINICAL GROUP | PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE: |
|---|---|
| Musculoskeletal Rehabilitation | Therapy (PT/OT/SLP) for a musculoskeletal condition |
| Neuro/Stroke Rehabilitation | Therapy (PT/OT/SLP) for a neurological condition or stroke |
| Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care | Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions |
| Complex Nursing Interventions | Assessment, treatment and evaluation of complex medical and surgical conditions |
| Behavioral Health Care | Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions |
| Medication Management, Teaching and Assessment (MMTA)<br>• MMTA –Surgical Aftercare<br>• MMTA – Cardiac/Circulatory<br>• MMTA – Endocrine<br>• MMTA – GI/GU<br>• MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases<br>• MMTA –Respiratory<br>• MMTA – Other | Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment. |



11

## Grouping model- Clinical Group

| Clinical | Primary Reason for HH Encounter: |
|---|---|
| Musculoskeletal Rehabilitation | Therapy (PT/OT/SLP) -Mostly therapy only cases but still can have nursing if needed |
| Neuro/Stroke Rehabilitation | Therapy (PT/OT/SLP) -Mostly therapy only cases but still can have nursing if needed |
| Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care | Higher paying group, but keep in mind will have much higher resource use and supplies are included |
| Behavioral Health Care | Lowest paying group, psych conditions |
| Complex Nursing Interventions | Including IV, TPN, enteral nutrition, ventilator, and ostomies ...maybe a higher paying group |
| MMTA – Surgical Aftercare | More than 50% of your cases will fall into this group |
| MMTA – Cardiac/Circulatory | |
| MMTA – Endocrine | |
| MMTA – GI/GU | |
| MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases | |
| MMTA – Respiratory | |
| MMTA – Other | |



12

## Grouping model- Functional Impairment Level


- The PDGM designates a functional impairment level for each 30-day period based on the answers to certain OASIS items
- The more impaired the patient is the higher the score
- The higher the level of impairment the higher the resource use
- Oasis data must be transmitted to CMS otherwise a 4% rate reduction will be imposed.
- OASIS Accuracy is critical

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## Grouping model- Functional Impairment Level

| VARIABLE # | DESCRIPTION |
|---|---|
| M1800 | Grooming |
| M1810 | Current ability to dress upper body safely |
| M1820 | Current ability to dress lower body safely |
| M1830 | Bathing |
| M1840 | Toilet transferring |
| M1850 | Transferring |
| M1860 | Ambulation and locomotion |
| M1033 | Risk for hospitalization |

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## Grouping model- COMORBITITIES


- Comorbidity adjustment is taken from the presence of a secondary dx reported on the CLAIM Form
- NONE, LOW, HIGH adjustment for each 30 day episode
- 24 slots on claim form for dx comorbidities opportunity
- List of Dx codes that drive co-morbidity

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## Grouping model- COMORBITITIES

- Medicare expects that about 80% of 30 day payment periods will have NO comorbidity adjustment
- Low/High adjustments are expected to approx. increase your payment 20%
- Clinicians need to put all diagnosis on claim or in the software that can affect the plan of care. (not just Oasis)
- 24 secondary Dx codes must be entered into your home health software or on claim, if not using software.
- Ask referring physicians for H+P in order to get all of the diagnosis needed to code.
- Do chart reviews in facilities, if possible
- Secondary Dx coding needs to be clinically appropriate



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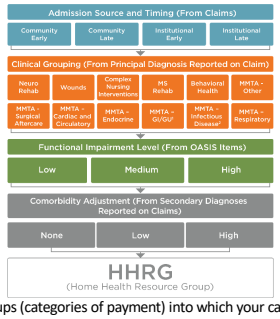
STRUCTURE OF THE PATIENT-DRIVEN GROUPINGS MODEL




- 432 case mix groups (categories of payment) into which your case can fall.
- 30-day unit of payment rate from CMS is $2,031.64



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## Case Study

Mr. Smith was newly diagnosed by his primary care physician with type 2 diabetes with hyperglycemia (E11.65). Mr. Smith's doctor made a home health referral for diabetic management teaching, medication review and evaluation of compliance and response to new medications. Mr. Smith also has a documented history of chronic, systolic (congestive) heart failure (I50.22), cerebral atherosclerosis (I67.2), and benign prostatic hypertrophy (N40.0)



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## Case Study

Step 1: Select Timing and Admission Source of the 30-period
- Community: No acute or post acute care in the last 14 days prior to HHA admit
- Early, 1st 30 day period

Step 2: Primary Dx E11.65 = clinical group of MMTA_ENDO
Step 2: Input secondary Dx codes I50.22, I67.2, N40.0
The HHA completed the initial OASIS assessment (SOC) Start of Care: (provides points)

- M1033 Risk of Hospitalization: Responses 4-7
- M1800 Grooming
- M1810 Upper body dressing
- M1820 Lower body dressing
- M1830 Bathing
- M1840 Toilet transferring
- M1850 Transferring
- M1860 Ambulation/ locomotion

HHRG payment group = Early-Community-Medication Management, Teaching and Assessment, Endocrine-Low Functional Impairment-High Comorbidity
Calculates a HIPPS CODE=1IA31= $2,757.71

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## Episode Exceptions

- LUPA
- PEP
- Outliers

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## LUPA
### Low Utilization Payment Adjustment

- LUPA thresholds will vary for a 30 day period depending on the payment group to which it is assigned
- LUPA thresholds range from 2-6 visits

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## Episode Management

- Visit Frequency Management:
  - Spread out visits throughout the 60 day episode rather than front load to ensure the capture of a subsequent payment *period (not be careful for lupa)*
- Compass from SimiTree

https://www.awesomescreenshot.com/video/16134126?key=2dbcf518ad0cd33a996317ab8c1e7132

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## 2024 Per visit LUPA Rates

**TABLE B26: CY 2024 NATIONAL PER-VISIT PAYMENT AMOUNTS**

| HH Discipline | CY 2023 Per-Visit Payment Amount | CY 2024 Wage Index Budget Neutrality Factor | CY 2024 Labor-Related Share Neutrality Factor | CY 2024 HH Payment Update | CY 2024 Per-Visit Payment Amount |
|---|---|---|---|---|---|
| Home Health Aide | $73.93 | 1.0012 | 0.9999 | 1.030 | $76.23 |
| Medical Social Services | $261.72 | 1.0012 | 0.9999 | 1.030 | $269.87 |
| Occupational Therapy | $179.70 | 1.0012 | 0.9999 | 1.030 | $185.29 |
| Physical Therapy | $178.47 | 1.0012 | 0.9999 | 1.030 | $184.03 |
| Skilled Nursing | $163.29 | 1.0012 | 0.9999 | 1.030 | $168.37 |
| Speech-Language Pathology | $194.00 | 1.0012 | 0.9999 | 1.030 | $200.04 |

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## PEP
Partial Episode Payments

### 3 Trigger Event

- Patient transfers to another HHA.
- Patient is discharged & readmitted to your agency.
- Patient enrolls in an HMO during 30 days.

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## Outlier
### Definition

Additional payments to the 30-day episode payments for beneficiaries who incur unusually large costs. These outlier payments will be made for episodes whose imputed cost exceeds a threshold amount for each case-mix group.

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## Outlier
### 10% CAP

Effective for episodes ending and beginning in 2010, the outlier payments made to each home health agency will be subject to an annual limitation:

- Outlier payments cannot comprise more than 10% of an HHA's total payments.
- HHPPS episode payment will be paid as normal; it is just the additional outlier payment that will not be paid at the time.
- Fiscal intermediaries will perform a quarterly reconciliation in May, August and November, whereby outlier payments that did not initially pay will be reprocessed and if they will not cause the HHA to exceed the CAP, will pay at the time.
- No partial portions of the outlier payment will be made at any time.

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## Outliers-What you need to know

- Make sure that you document all of the visits you performed during the episode
- Confirm that the visit time IN and time OUT are correct
- No other action is required portions of the outlier payment will be made at any time.

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## Certification Process vs Payment Process

- Certification period workflow (*episode*)
  - 60-day timing for certification periods (60 day episodes)
  - Plan of Care corresponds with 60-day certification
  - SOC Oasis covers for 60 days episode
  - Recert OASIS continues if extending initial 60 days
- Payment work flow (*payment period*)
  - Two 30-day payment periods within a 60-day certification period

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## Billing Process

- When a patient is admitted a 60 day episode is created (certification episode)
- Billing is done for every 30 days the patient is on service (payment period)
- NOA (Notice of Admission) at the beginning of the admission period
- Bill once at the end of the 30 days or earlier if services are over (FINAL or EOE)

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## NOA (Notice of Admission)

- Establishes Home Health "Admission Period"
  - *From date through the D/C date*
- Only one NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge.
- If a patient is D/C and then readmitted to the agency a new NOA is required within 5 calendar days of the new SOC
- Final Claims for every 30 day period are still required for payment

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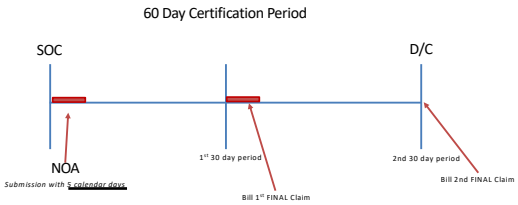
## NOA & Claim Submission

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## Billing Process

### NOA BILLING REQUIREMENTS

To bill a NOA 2 criteria must be met:

1. The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented.
2. The initial visit has been made and the individual is admitted to HH care (SOC visit)

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## NOA Penalty for Non-Timely Filling

- There will be a non-timely submission payment reduction when the HHA does not submit the NOA within 5 calendar days from the start of care date
- This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

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## NOA Penalty Exceptions

CMS exceptions policy for failure to meet timely filing of the NOA; an HH may be eligible for an exception to the consequences of late filing of the NOA if it documents and requests an exception based on 4 circumstances listed below and the MAC grants the exception:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;
- An event that produces a data filing problem due to a CMS or MAC systems issue beyond the control of the HHA;
- A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or
- Other circumstances determined by CMS to be beyond the control of the HHA





## Final

Before billing final perform a billing audit to ensure:

- Orders are signed.
- Discipline and frequency match schedule.
- Pull pre-bill report to match visits being billed with schedule.
- Face 2 Face (only for SOC)





## Pre-bill Process for Final

- FINAL can be bill on or before 30 day period is over.
- Final should be sent as soon as possible. Goal of 3 to 9 days after the 30 day period.

## Final

Once the final is billed, will receive the money within 14 to 30 days.

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## 30 DAY UNIT OF PAYMENT

- 30 day payment period = days 1-30 of a current 60 day episode
  - "day 1" is the current 60 day episode's *From Date*
  - Second period is days 31 and above.
  - Monthly billing
- Average 30 day unit of payment $2,031.64

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## Billing Process

- When using SimiTree steps are as follows:
- SimiTree would get a user and password for software (if you decide to use a software)
- SimiTree has a prebilling 'cheat sheet' that you would enter into our website
- This 'cheat sheet' triggers the SimiTree billers to log into software and bill claims. (Daily billing performed)
- SimiTree sends reports of daily billing, payment, projected payments and also reviews claims daily for corrections if required

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## Understanding DDE

CMS software that allows Medicare providers direct access to information on their claims

- Type and send claims directly
- View, correct, adjust, and cancel claims
- View payment information

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## Remittance Advice

What is an RA?

- A notice of payments and adjustments sent to providers.
- Must review RA every day and post in your software everyday.
- Must review every claim payment for accuracy, fiscal intermediaries make mistakes!

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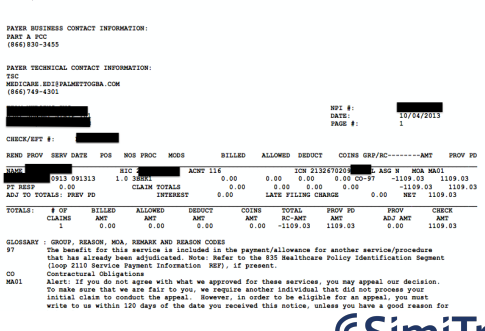
## Remittance Advice



PAYER BUSINESS CONTACT INFORMATION:
PART A PCC
(866)830-3455

PAYER TECHNICAL CONTACT INFORMATION:
TSC
MEDICARE.EDI$PALMETTOGBA.COM
(866)749-4301

[redacted]

NPI #: [redacted]
DATE: 10/04/2013
PAGE #: 1

CHECK/EFT #: [redacted]

| RENDG PROV | SERV DATE | POS | NOS | PROC | MODS | BILLED | ALLOWED | DEDUCT | COINS | GRP/RC-------AMT | PROV PD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NAME: [redacted] | | | | RIC: [redacted] | ACNT 116 | | | ICN 213267020[redacted] | | ASG N | MOA MA01 |
| [redacted] | 0913 091313 | 1.0 | 3HEX | | | 0.00 | 0.00 | 0.00 | 0.00 | CO-97 -1109.03 | 1109.03 |
| PT RESP | 0.00 | | | CLAIM TOTALS | | 0.00 | 0.00 | 0.00 | 0.00 | -1109.03 | 1109.03 |
| ADJ TO TOTALS: PREV PD | | | | INTEREST | 0.00 | | LATE FILING CHARGE | | 0.00 | NET 1109.03 | |

| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COINS AMT | TOTAL RC-AMT | PROV PD AMT | PROV ADJ AMT | CHECK AMT |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 0.00 | 0.00 | 0.00 | 0.00 | -1109.03 | 1109.03 | 0.00 | 1109.03 |

GLOSSARY : GROUP, REASON, MOA, REMARK AND REASON CODES
97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
CO Contractural Obligations
MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for

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## Common Claim Rejections

How to avoid them

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## Impact of Claim Rejections

**Cash Flow**

- No claim payment on first-time submission
- Delays in claim payments if adjustment claim required

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## Common Denials

Overlapping With Another Agency

- Agency XYZ D/C patient on 4/1 an your SOC is 4/1.
- Your agency D/C patient on 4/1 and claim gets rejected because agency XYZ billed a SOC of 3/28.

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## Common Rejections

Submitting a claim for a patient on an HMO plan

**Verify patient's insurance information at the time of admission and before billing Medicare**

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## Common Denials

Beneficiary information not correct
Patient information does not match CWF
Including name, dob, Medicare #

*Patient information must match the Medicare Eligibility even if it incorrect!!!*

**Always verify eligibility records before submitting claim**

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## You are Accredited….what's next?

- Once you have your Accreditation date you may discharge all your patients.
- You will discharge and readmit all Medicare eligible patients.
- You will need to make arrangements for a billing company to check Medicare eligibility on any patients you admit.
- You will be able to bill Medicare for services provided, **retroactive to your accreditation date** once you receive your Submitter ID Number (Billing Number).

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## Let's Review

| Event | Timeline |
|---|---|
| Discharging and re-admitting patients | Receipt of an Accreditation date |
| Obtaining your CCN/PTAN or Provider number | 4-6 months depending on the regional CMS payer and MAC |
| Obtaining your Submitter ID or Billing number/EDI Application | 2 weeks to 30 days depending on the regional CMS payer |
| Releasing your Capitalization fund | 90 days after your 1st payment is issued by the regional CMS payer |

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## Claims Processing Time

Claims for patients that were admitted **BEFORE** your agency has their billing number

- NOA have to be filed with exceptions codes takes 2-3 days for the NOA to get accepted
- Once NOA accepted, then the Final claim is billed the claim also filed with exceptions will take 30-50 days for review by MAC*
- Payment issued 50-65 days

**time is dependent on MAC*

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## Claims Processing Time

Claims for patients that were admitted **AFTER** your agency has their billing number

- NOA have to be filed with 5 calendar days, takes 2-3 days for the NOA to get accepted
- Once NOA accepted, then the Final claim is billed at the end of every 30 days for the previous months services
- Payment issued approx. 14 days

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51

Thank You for Attending

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52