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

by

Lynn Labarta, BS
Home Health & Hospice Billing Specialist

## Learning Objectives

- Discuss detailed billing process for Medicare claims
- Discuss detailed billing process for non-Medicare claims

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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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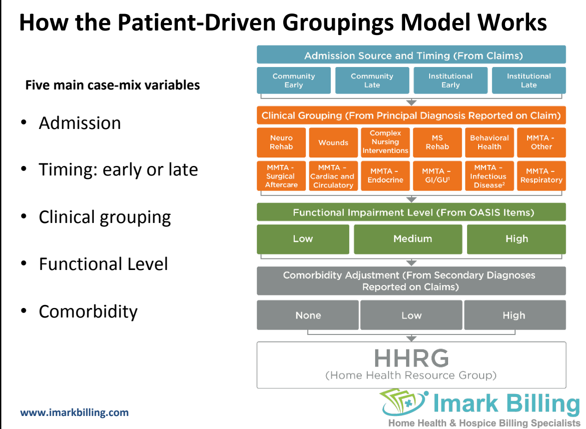


## HHRG = Home health resource group

- 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-$2,500

Admission Source and Timing (From Claims): Community Early, Community Late, Institutional Early, Institutional Late

Clinical Grouping (From Principal Diagnosis Reported on Claim): Neuro Rehab, Wounds, Complex Nursing Interventions, MS Rehab, Behavioral Health, MMTA - Other, MMTA - Surgical Aftercare, MMTA - Cardiac and Circulatory, MMTA - Endocrine, MMTA - GI/GU, MMTA - Infectious Disease, MMTA - Respiratory

Functional Impairment Level (From OASIS Items): Low, Medium, High

Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims): None, Low, High

HHRG (Home Health Resource Group)

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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
- Institutional= YES acute or post acute care in the 14 days prior to the HHA admission

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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

| Clinical Grouping (From Principal Diagnosis Reported on Claim) | | | | | |
|---|---|---|---|---|---|
| Neuro Rehab | Wounds | Complex Nursing Interventions | MS Rehab | Behavioral Health | MMTA - Other |
| MMTA - Surgical Aftercare | MMTA – Cardiac and Circulatory | MMTA – Endocrine | MMTA – GI/GU[1] | MMTA – Infectious Disease[2] | MMTA – Respiratory |

- 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/

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## 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 substance 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. |

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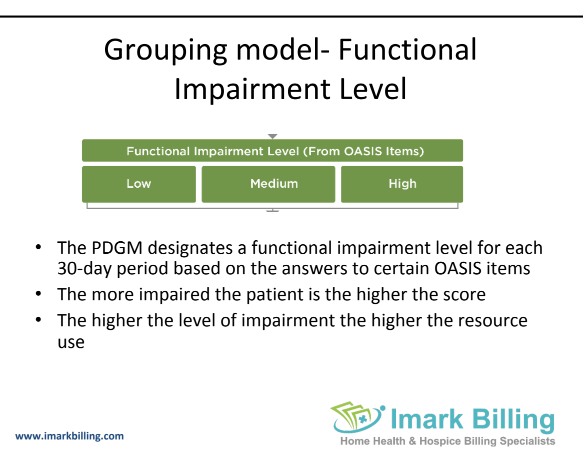


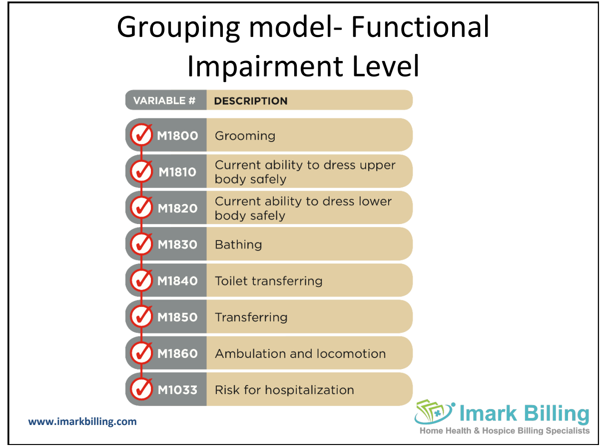

Grouping model- Functional Impairment Level

| 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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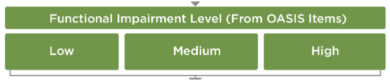
## Grouping model- Functional Impairment Level




- 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 2% rate reduction will be imposed.
- OASIS Accuracy is critical

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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
- https://imarkbilling.com/tools/pdgm- comorbidity-adjustment/

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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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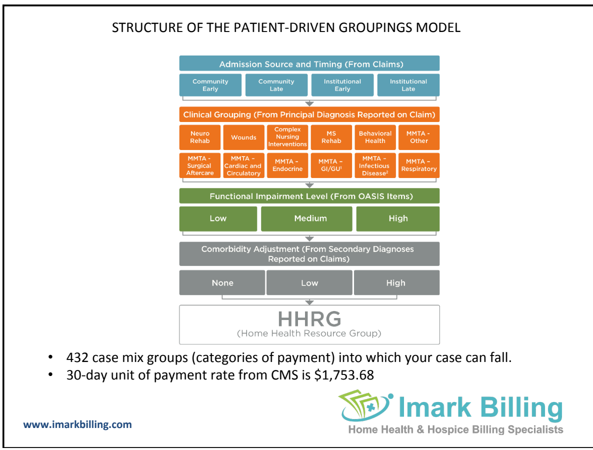
STRUCTURE OF THE PATIENT-DRIVEN GROUPINGS MODEL




- 432 case mix groups (categories of payment) into which your case can fall.
- 30-day unit of payment rate from CMS is $1,753.68

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# Case Mix HIPPS codes
# HIPPS codes under PDGM

| Position 1 | Position 2 | Position 3 | Position 4 | Position 5 |
|---|---|---|---|---|
| Timing/admission | Clinical group | Functional level | Comorbidity adjustment | Static placeholder |
| 1 - Early/community<br>2 - Early/institutional<br>3 - Late/community<br>4 - Late/institutional | A - MMTA other<br>B - Neuro/stroke<br>C - Wound<br>D - Complex nursing<br>E - MS rehab<br>F - Behavioral health<br>G - MMTA - surgical<br>H - MMTA - cardiac<br>I - MMTA - endocrine<br>J - MMTA - GI/GU<br>K - MMTA - infectious<br>L - MMTA - respiratory | A - Low<br>B - Medium<br>C - high | 1 - None<br>2 - Low<br>3 - High | 1 |

Example hipps: 1AB11= $$$

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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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## LUPA
### Low Utilization Payment Adjustment

In PDGM, in order for an agency to know if the case will be a Lupa they need to know the Hipps code from the OASIS and then use Imark's look up tool on our website to see how many visits would be considered a Lupa for that particular claim.

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## LUPA- PDGM Look UP Tool

https://imarkbilling.com/tools/pdgm-lupa-look-up-tool/

Find Your LUPA Threshold

1aa11 | Search

HIPPS 1AA11

| | |
|---|---|
| Clinical Group and Functional Level | MMTA - Other - Low |
| Timing and Admission Source | Early - Community |
| Comorbidity Adjustment | None |
| Visit Threshold | 4 |

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## LUPA Rates 2019

| HH Discipline | CY 2019 Per-Visit Payment |
|---|---|
| Home Health Aide | $66.34 |
| Medical Social Services | $234.82 |
| Occupational Therapy | $161.24 |
| Physical Therapy | $160.14 |
| Skilled Nursing | $146.50 |
| Speech- Language Pathology | $174.06 |

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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)
- Bill once at the beginning of the payment period (RAP)
- Bill once at the end of the 30 days or earlier if services are over (FINAL or EOE)

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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 $1,753.68

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## Billing Process
### Pre-bill Process for RAPS
Request for Anticipated Payment

To bill a RAP 3 criteria must be met:

- OASIS assessment is complete, locked, export ready or exported.

- A plan of care has been established and sent to the physician.
- First service visit delivered and documented in your homecare software.

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## RAPs

Rush !!

RAPs should be sent as soon as possible.
Goal of 5 to 10 days

- RAP claims will not have a payment but they must be billed and in a "paid" status before a FINAL claim is billed
- Your payment will be received once your Final claim is billed

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## 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.

Final must be billed 60 days from the end of the 30 day period or the RAP payment date, whichever is greater, or the RAP will be cancelled and the funds will be taken back.

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## Billing Process

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

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## Performance Measures

| Performance Measures | DTR | DTF |
|---|---|---|
| **Description** | Days rap billed | Days final billed |
| **Goals/Benchmark "Healthy Agency"** | 5-10 days | 3-9 days |
| Your Agency | | |

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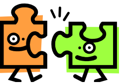
## Understanding DDE



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

NPI #:
DATE: 10/04/2013
PAGE #: 1

CHECK/EFT #:

REND PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/RC--------AMT PROV PD

NAME HIC ACNT 116 ICN 2132670209 L ASG N MOA MA01
0913 091313 1.0 3BHK1 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

Not identifying transfers from other HHA

•Transfer from another agency must be documented on claim

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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 <u>at the time of admission</u> and before billing Medicare**

## Common Denials

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

*<u>Patient information must match the Medicare Eligibility even if it incorrect!!!</u>*

**Always verify eligibility records before submitting claim**

## Common Denials

Rap and final HIPPS code do not match

- This occurs when SOC OASIS was completed, rap billed, and on a later date SOC OASIS reopened and corrected, bill final and HIPPS codes don't match.
- Once you bill a rap and you are going to reopen OASIS must be sure that HIPPS code does not change.
- If it changed then RAP must be canceled and resent in order for your final to be paid

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## Common Denials

Hospice Overlap

HHA can treat patient in hospice as long as services being rendered are unrelated to terminal illness.

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

Commercial Insurance Billing for skilled and non skilled agencies

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## Payer Diversification

- Payer diversification is a must in today's environment
- The fact is that Medicare is squeezing our reimbursement and increasing regulatory requirements and compliance
- Consider alternative sources of revenue
  - Commercial payers
  - Managed Care
  - Medicaid HMOs
  - Workers Comp insurances

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## Contracting with Insurance Companies

Contracting MYTH

- Do not always have to be "in-network" or contracted with an insurance company to be able to accept the patient

You need to know your market if you are going to contract with insurance companies. Priority number one is to find out which insurance companies operate in your area.

- Large companies like UHC, AETNA, HUMANA, BCBS, etc.
- Smaller, local companies in your area

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## Contracting with Insurance Companies

- Most commercial payers will require accreditation with an Accreditation Organization to be a contracted provider. You will need to contact them to find out what they require.
- Applying to an insurance company is not automatic guarantee that they will accept your application
- Many times, admission to insurance companies is determined by specialty, regional need and demand. If you offer special services such as IV therapy, wound care specialist, pediatrics or something that may set you apart from other home health, be sure to let them know!

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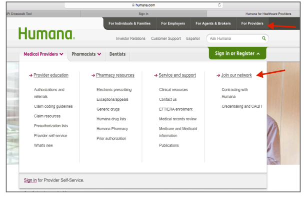
## Contracting with Insurance Companies




- GO to insurance company's website, go to provider section, enrollment
- Call insurance company and ask for enrollment department
- It is not a difficult process it just takes time

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## Contracting with Insurance Companies

Important questions to ask payers:

- What is their fee schedule?
- Do they accept electronic claims?
- What is their payer id?
- What type of claim form do they want you to use?

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## Contracting with Insurance Companies

Important questions to ask payers:

- What are the visit codes and revenue codes they want you to bill?
- Where can you find them?
- What are the timely filing deadlines

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## Eligibility

- Eligibilities must be performed before the patient is admitted to the agency
- There are many circumstances that can cause non-payment of claim if eligibility is not properly done or understood
- Eligibility errors are the one of the top reasons for claim rejections

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## Eligibility Process - Steps

Once you've got the insurance information in-hand, you should contact the insurance company to verify the following pieces of information:

1. Patient is indeed covered by the insurance and for Home Care services
2. Insurance coverage effective dates
3. In-network or out-of-network coverage
4. Service(s) you are seeing the patient for are covered - do they need pre-authorization?
5. Amount of co-pay for services, if any
6. Deductible amount: has the deductible been met for the year?
7. Communication of charges is required

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## Accepting Insurance

- Staff education is a must for success
- It is important to understand that Medicare HMOs and Commercial insurances are different and will have different requirements
- Read the contracts--- they will indicate the specific requirements the insurance is requesting

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## Types of Insurance

- Payers can be Complex
- Each insurance company can have hundreds of plans so know what plan the patient has
- Best practice is to obtain a copy of the patient's insurance card helps identify the type of plan

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## Types of Insurance

- Medicare HMO also known as Medicare advantage or Medicare replacement plans
  - Typically follows Medicare guidelines

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## Types of Insurance

- Commercial Insurance
  - PPO
  - Not related to Medicare

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## Types of Insurance

- Medicare HMO
  - Must do OASIS and transmit OASIS to CMS
  - Require HIPPS codes and treatment auth codes
  - Billed episodically like Medicare
  - Raps and Finals required
  - May or may not need F2F or PECOS

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## Types of Insurance

- Commercial insurance
  - Do not require OASIS
  - No HIPPS codes or treatment authorization required
  - Pre-visit payers
  - Typically billed weekly or monthly

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## Billing Process – Audit Claims

- Before you submit claim review the claim to ensure that it follows the requirements

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## Payer Setup Process

Payers must be setup in software
- Add "payer rules" in the software so you can subsequently bill these claims correctly

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6815 Biscayne Boulevard
Suite 103-230
Miami, FL 33138
888-370-3339
info@imarkbilling.com

## Billing Process - EDI

- Possibly may need to fill out EDI application for some payer (*electronic data interchange*)
- Insurance companies portals
- Direct submissions using a clearinghouse (such as Availity)

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## Billing Process – Timely Filing

- Know when is it too late to submit claim
- 90-180 days - timely filing deadlines
- Commercial insurances – bill weekly or monthly
- Medicare HMOs- episodically or monthly

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## Billing Process – Follow Up

- Without a timely follow up process you will have reimbursement issues and cash flow problems.
- They key is having billers that are properly training and familiar with each step of every insurance company's billing process.
- Most insurance companies use stall tactics to delay payment. Don't let them get away giving you inaccurate information. Don't be afraid to challenge the insurance representatives.
- If you are not happy with the response you get from the insurance representative try to reach their supervisor or call again to get another rep on the phone.

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## Billing Process – Follow Up

- Follow up with submitted claims within 1-2 weeks (some payers 30 days)
  - Can be done by phone or by logging into portals/Availity
- Claims payment time frames are 30-90 days depending on payer

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## Billing Process – Follow Up

- Correspondence- corrections maybe required
- EOB- (*Explanation of Benefits*) payment info and denial info
- Checks sent by mail
- Sign up for EFT (*electronic funds transfer*)

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## Billing Process – Follow Up

- When you receive payment on a claim-- check that it's paid according to contract
- Check for underpayments

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## Denial Management

- Most denials are related to billing errors
- You may be able to correct this denial with a simple phone call, refilling the claim electronically or submit an appeal letter
- File your corrected claim as soon as possible (about 7 days from denial) to avoid timely filling deadlines

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## Common Denials and How to Handle Them

- Claim not on file
- Incorrect patient identifier info
- No Authorizations
- Coverage terminated
- None Covered services
- Missing or invalid CPT/ HCPCS codes
- Timely filling

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## Thank You for Attending

6815 Biscayne Blvd
Suite 103-230
Miami, FL 33138
888-370-3339 ext 101
labarta@imarkbilling.com
www.imarkbilling.com