Welcome to Medicare Cost Avoidance Claim Submission Virtual Classroom Training

Presented by
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Today's Agenda

- Medicare Cost Avoidance
 - Background
- Claim Submission Requirements
 - Effective Date of Compliance
 - Impact for failure to Comply
 - Claim Denials
 - Third Party Liability (TPL) Other Insurance Audit
- Claim Submission Format Requirements
 - ASC X12N 837 Health Care Claim Institutional Format
 - Web Claim Submission
 - Provider Electronic Solutions Batch Submission
 - UB-04 Paper Claim Submission Format
- Questions

Home Health Medicare Cost Avoidance

Federal Medicaid regulations require the Department of Social Services (DSS) to cost avoid (deny) claims when a client has known Third Party Liability (TPL) coverage, including Medicare that is:

- Not indicated on the claim
- Indicated on the claim as partially paid or denied without an adjustment reason code or occurrence code (code 24 for OI denial on UB-04) and corresponding date of payment or denial

Previously DSS did not require providers to indicate why a Home Health Advanced Beneficiary Notice (HHABN) was being issued to a client who did not meet specific Medicare criteria for Home Health coverage.

Claim Submission Requirements

Claims for dually eligible clients who are traditional Medicare or Medicare Managed Care (A, B or A & B benefit eligible) and title 19 eligible, must contain:

- at least one HIPAA Adjustment Reason Code (150, 151 or 152)
- date the associated HHABN or MCO Notice of Medicare Non-Coverage (NOMNC) was issued

Note: This does not include Medicare clients who are State Funded CT Home Care eligible

Home Health Agency Reasons to Issue Advanced Beneficiary Notice	HIPAA Adjustment	HIPAA Adjustment Reason Code Description		
	Reason Code			
Client determined to be not homebound; either at the start of care or after Medicare-covered services have been provided.		Payment adjusted because the payer deems the information submitted does not support this level of service.		
Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.		
Client receiving thirty-five (35) hours per week of Medicare- covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.	151	Payment adjusted because the payer deems the information submitted does not support this many services		
Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.		
Client's continued care determined to not be Medicare- coverable. CMS required Annual HHABN issued.	152	Payment adjusted because the payer deems the information submitted does not support this length of service.		

Home Health Medicare Cost Avoidance

Effective for dates of service February 17, 2010 providers who have not yet had time to modify their billing systems to comply with the new Medicare Cost Avoidance requirements will see their claims for dually eligible clients:

- Post Explanation of Benefit Code (EOB) 2522 "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of HHABN or NOMNC"
- Appear as a paid claim on the provider's Remittance
 Advice (RA) without regard to EOB 2522. (providing the claim does not fail any other edit)

Home Health Medicare Cost Avoidance

Effective for dates of service April 1, 2010
Home Health claims for dually eligible clients
that do not comply with the new Medicare Cost
Avoidance requirements will:

- Post Explanation of Benefit Code (EOB) 2522
 "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of HHABN or NOMNC"
- Appear as a denied claim on the provider's Remittance Advice (RA)

Claim Auditing – HHABN or NOMNC

- Monthly TPL (other insurance audit) will include:
 - Random selection of claims containing at least one of the HIPAA Adjustment Reason Codes (150, 151, 152)
 - Providers will be required to submit a copy of the original signed and dated HHABN or NOMNC associated with the selected claim

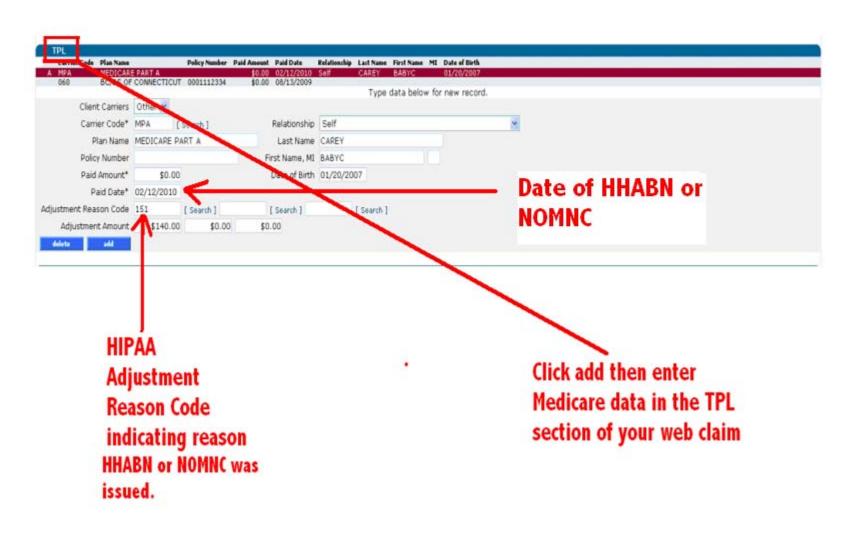
Claim Auditing cont.

- Claims with an HHABN or NOMNC with an issue date different from the signature date may be recouped.
 - When a home health agency cannot deliver a HHABN or NOMNC timely and in-person to the client or client's authorized representative the home health agency would be required to demonstrate it delivered proper notice by either telephone contact, secure fax machine, or internet e-mail.
 - Agency would be required to produce documentation to support the contact was made in a timely manner.

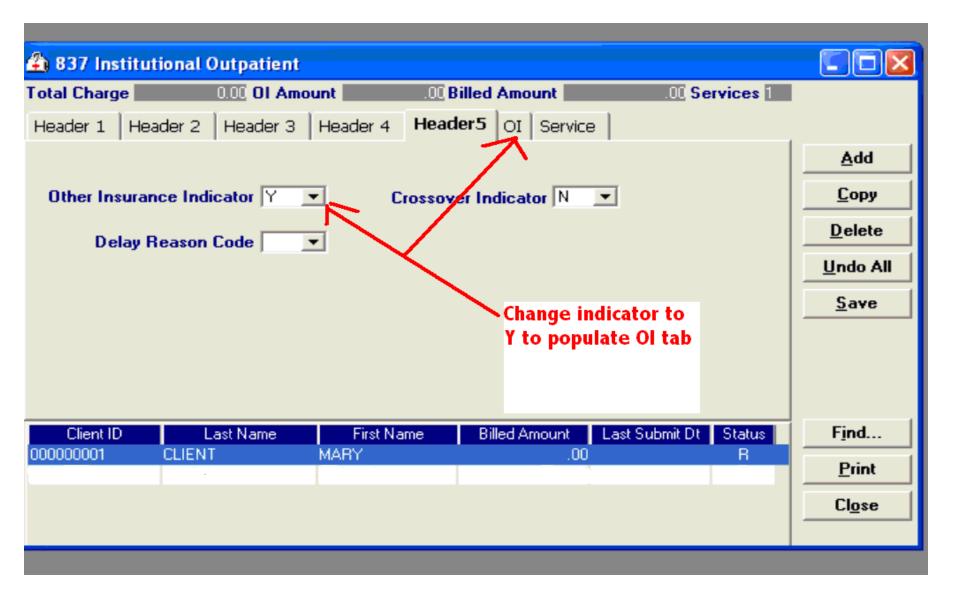
Electronic Claim Submission Format

Loop	Segment	Position	Description
2320	CAS	01	Claim Adjustment Group code = CO (claim header)
2320	CAS	02	Adjustment Reason Code = 150, 151, 152 (claim header)
2430	CAS	01	Claim Adjustment Group code = CO (claim detail)
2430	CAS	02	Adjustment Reason Code = 150, 151, 152 (claim detail)
2330B	DTP	03	HHABN or NOMNC issue date (claim header)
2430	DTP	03	HHABN or NOMNC issue date (claim detail)

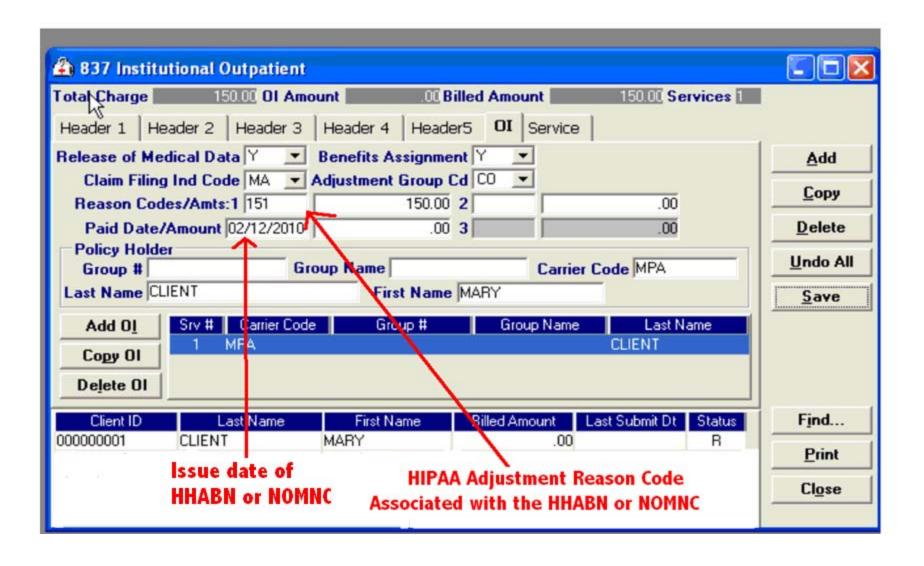
Web Claim Submission



Provider Electronic Solutions



Provider Electronic Solutions



UB-04 Paper Claim Format

3a PAT. CNTL#								4 TYPE OF BILL
b. MED. REC. #				u.tu. renderlie	en Jerostillik a svenil sville		-0.00	
5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM THROUGH				7	
				С	d			e
ODES 24 25 26	26	27	28	29 ACDT STATE	30			
						151		
			-	-		T		

Enter Adjustment Reason Code 150, 151 or 152 associated with the reason the HHABN or NOMNC was issued.

UB-04 Paper Claim Format cont.

50 PAYER NAME	51 HEALTH PLAN ID	62 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MPA N/A 02/12/2010				- H - G - H - H - H - H - H - H - H - H	
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Enter the date the HHABN or NOMNC was issued for the Adjustment REason Code indicated in field 30.

Resources

- Connecticut Medical Assistance Program Web site <u>www.ctdssmap.com</u>
 - All Formats
 - Institutional Other Insurance/Medicare Billing Guide
 - From the home page > Publications > Claims Processing Information > <u>Institutional Other Insurance/Medicare Billing Guide</u>
 - Electronic Claim Format
 - Implementation Guide
 - From the home page > Trading Partner Documents > EDI Documents > <u>Implementation Guide</u>
 - Web Claim Submission
 - Instructions for submitting Institutional claims
 - From your Provider Secure Web Account home page > claims > Institutional > Instructions for submitting Institutional claims

Resources cont.

- Connecticut Medical Assistance Program Web site <u>www.ctdssmap.com</u> cont.
 - Provider Electronic Solutions Billing Instructions
 - From the home page > Trading Partner > Provider Electronic Solutions Billing Instructions > Outpatient/Home Health > <u>HP</u> <u>Provider Electronic Solutions Billing Instructions</u>
 - Home Health Paper Claim (UB-04) Instructions
 - From the home page > Publications > Provider Manuals > Chapter 8 > select Home Health > view chapter 8 > <u>Home Health Services Claim Submission Instructions</u>

Resources cont.

- HP Provider Assistance Center (PAC):
 - Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
 - 1-800-842-8440 (in-state toll free)
 - (860) 269-2028 (local to Farmington, CT)
- EDI Help Desk
 - Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
 - 1-800-688-0503 (in-state toll free)
 - (860) 269-2026 (local to Farmington, CT)

Time for Questions