Resolving Medicare Questions for Claims Needing Correction

One of the most common questions received from home health providers is understanding the reason code narrative for claims needing correction or help in working a Request for Anticipated Payment (RAP) or final claim out of the Return to Provider (RTP) file. Reason codes 38107, U538G, and U538I are the reason codes about which home health providers inquire most frequently.

Before calling Cahaba for assistance in resolving these types of issues, please refer to the information below, which is taken from the following Cahaba GBA, LLC Web pages:

"Frequently Asked Questions Return to Provider (RTP) / Reason Codes"
http://www.cahabagba.com/part_a/education_and_outreach/faq_rtp.htm

"Top Claim Submission Errors and How to Resolve" http://www.cahabagba.com/part_a/claims/errors.htm
http://www.cahabagba.com/part_a/claims/errors_38107.htm
http://www.cahabagba.com/part_a/claims/errors_U538G.htm
http://www.cahabagba.com/part_a/claims/errors_U538I.htm

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Why does my RAP or claim need correction?

A RAP or final claim is returned to you for correction because the information contained on them is incomplete, incorrect or missing. These billing transactions reside in the claims correction file, which is also known as the Return to Provider (RTP) file. Claims in your RTP file are found in FISS status/location T B9997. By viewing the reason code narrative in FISS, you can determine the reason why your claim needs correction.

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I can't figure out how to fix my claim. The reason code doesn't make any sense.

Some reason code narratives are easy to interpret. Others are more difficult to decipher to know what exactly needs correction. The following tips may help when working with the more difficult reason codes:

- If you are unsure what errors need correction after reading the reason code narrative, pick a few key words mentioned and then check the field locators or appropriate screens that correspond to verify the data listed is valid and doesn't conflict with what you billed.

- Make a cheat sheet of the reason codes that are unclear or that a Cahaba customer service representative has assisted you with, and record notes in your own words that will help you resolve the same type of billing issue in the future.
- If one reason code continually causes problems for you, mention the code to a customer service representative the next time you call Cahaba GBA and obtain further clarification on the narrative and what causes this reason code to occur.

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What causes home health claims to need correction for reason code 38107? How can this reason code be prevented?

Home health claims are frequently returned to providers for correction with reason code 38107 because:

- A Request for Anticipated Payment (RAP) was required; however, a RAP was not billed, or a processed RAP was not found in the Fiscal Intermediary Standard System (FISS) when the final claim was submitted. RAPs are required when 5 or more visits are provided to the beneficiary during a home health episode of care.
- Key information on the final claim did not match the information submitted on the RAP.
- The RAP auto-canceled because the final claim was not received timely. If the final claim is not received timely, FISS will automatically cancel the RAP and Medicare will recoup the RAP payment. Under the Home Health Prospective Payment System (HH PPS), a final claim must match to a processed RAP within the greater of 60 days from the:
  - End of the episode or
  - Date the RAP paid.

To prevent this billing error from occurring in the future, we encourage you to implement the following billing processes:

- Prior to submitting the final claim, access the FISS Claim Inquiry option (Option 12) to determine if the RAP (when required) is in FISS status/location (S/LOC) P B9997. Information on using this option is available in the "Inquiry Menu" section of the *FISS Reference Guide* at http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_menu.pdf
- Prior to submitting the final claim, ensure the following key information matches what was submitted on the RAP:
  - Statement Covers Period – From date (FL 6 on the UB-04 claim form)
  - Admission Date (FL 12 on the UB-04)
  - First four positions of the HIPPS code billed with revenue code 0023 (FL 44 on the UB-04)
  - Earliest date of service billed with revenue code 0023 (FL 45 on the UB-04). This must be the date of the first Medicare-covered service in the episode.
  - Provider Number (57 on the UB-04)

- Submit the final claim prior to the greater of 60 days from when the RAP paid or the end of the episode.
- Prior to submitting the final claim, ensure the RAP has not auto-cancelled. For step-by-step instructions on using FISS to check for auto-cancelled RAPs, access the quick reference tool, *Avoiding Reason Code 38107*, which can be accessed at http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_homehealth_code38107.pdf (A copy of this tool is attached at the end of this tip sheet.)

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What causes home health RAPs/claims to need correction for reason code U538G? How can this reason code be prevented?

RAP or claims need correction for this reason code when they overlap an existing episode with the same provider number. This situation most commonly occurs when the same patient is discharged and readmitted to the same home health agency during the same 60 day episode and an incorrect source of admission code used.

To prevent this billing error from occurring in the future, we encourage you to implement the following billing processes:

- Access the *"Avoiding Billing Errors Caused By Overlapping Home Health Episodes"* quick reference tool, which is accessible from http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_homehealth_overlap.pdf (A copy of this tool is attached at the end of this tip sheet.)
- Access the "Special Billing Situations Under HH PPS" quick reference tool, which is accessible from http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_homehealth_special.pdf (A copy of this tool is attached at the end of this tip sheet.)
- Prior to admission or submitting RAPs/claims to Medicare, access ELGH page 3 or ELGA page 4 to review established episodes for the beneficiary, which may impact your dates of service. For more information on using these screens, access the "Checking Beneficiary Eligibility" section of the *FISS Reference Guide* at: http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf
- Check previous billing transactions your facility submitted for the beneficiary using FISS Inquiry Menu Option 12. Information on using this option is available in the "Inquiry Menu" section of the *FISS Reference Guide* at http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_menu.pdf
- Ensure that you have billed a discharge claim.
- Ensure source of admission code "C" (Readmission to the same HHA (discharge/readmit w/in same 60-day episode)) is entered in FL 15 on the first RAP and final claim that is submitted for the second admission date.

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What causes home health RAPs/claims to need correction for reason code U538I? How can this reason code be prevented?

RAP or claims need correction for this reason code when they overlap an existing episode with the same provider number. This situation most commonly occurs when a beneficiary elects to transfer from one HHA to another during a 60 day episode and the receiving HHA submits the initial RAP/claim using an incorrect source of admission code.

To prevent this billing error from occurring in the future, we encourage you to implement the following billing processes:

- Access the *"Avoiding Billing Errors Caused By Overlapping Home Health Episodes"* quick reference tool, which is accessible from http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_home health_overlap.pdf (A copy of this tool is attached at the end of this tip sheet.)
- Access the "Special Billing Situations Under HH PPS" quick reference tool, which is accessible from http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_home health_special.pdf (A copy of this tool is attached at the end of this tip sheet.)
- Prior to admission or submitting RAPs/claims to Medicare, access ELGH page 3 or ELGA page 4 to review established episodes for the beneficiary, which may impact your dates of service. For more information on using these screens, access the "Checking Beneficiary Eligibility" section of the *FISS Reference Guide* at: http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf
- Check previous billing transactions your facility submitted for beneficiary using FISS Inquiry Menu Option 12. Information on using this option is available in the "Inquiry Menu" section of the *FISS Reference Guide* at http://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_menu.pdf
- Ensure that you have billed a discharge claim.
- Ensure source of admission code "B" (Transfer from another HHA (for use by 'receiving' agency)) is entered in FL 15 on the first RAP and final claim that is submitted for the beneficiary's initial episode of care with your agency.

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Do you publish information about claim submission errors (CSEs) and how to resolve them? If so, where can I find it?

The Cahaba GBA Web page, "Top Claim Submission Errors and How to Resolve" (http://www.cahabagba.com/part_a/claims/errors.htm) is available for providers to review the top CSEs. Each reason code contains the reason for the error and provides an explanation and/or links to resources to assist in resolving/preventing the error in the future.

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Avoiding Reason Code 38107

Check for Processed RAP

Prior to submitting the final home health claim for an episode, check for a processed RAP by following the steps below:

1. Log on to FISS
2. Enter "01" and press <Enter>
3. Enter "12" and press <Enter>
4. MAP 1741 will appear
5. Enter Patient's HIC Number
6. Enter NPI/Provider Number
7. Enter "322" in TOB
8. Enter "FROM DATE" and "TO DATE" of RAP and press <Enter>

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MAP1741          M E D I C A R E  A  O N L I N E  S Y S T E M
SC                          CLAIM SUMMARY INQUIRY
                                    NPI
      HIC                 PROVIDER                S/LOC          TOB
 OPERATOR ID XXXXXXX      FROM DATE          TO DATE              DDE SORT
 MEDICAL REVIEW SELECT
      HIC              PROV/MRN   S/LOC     TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
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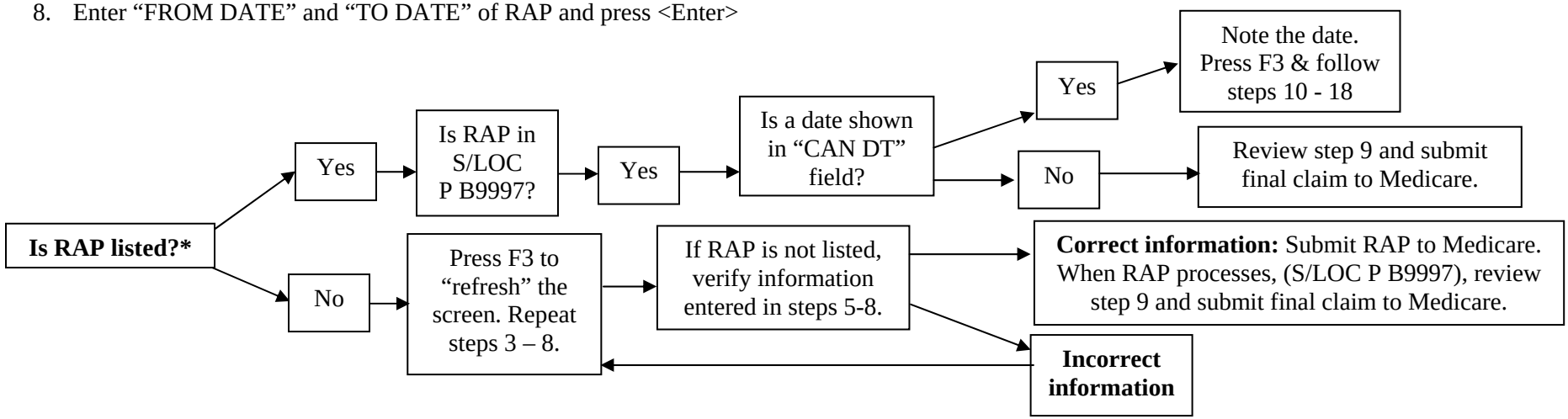
Note: Fields where information is keyed in MAP 1741 are bolded.



***REMINDER:** Under HH PPS, HHAs are not required to submit RAPs when 4 or fewer visits have been provided during the episode. If a RAP is required, it must be in S/LOC P B9997 prior to the claim's submission to Medicare to avoid receiving reason code 38107. Please also ensure when reviewing the RAPs listed for the episode in question on MAP 1741, you are looking at the RAP with the most recent date in the PD DT (paid date) field.

Matching RAP & Claim Information

9. Prior to submitting the final claim to Medicare, ensure the information in each of the following fields matches between the RAP and final claim:
   - Provider number
   - "FROM" date
   - "ADMIT" date
   - First four positions of the HIPPS code
   - Service date on 0023 revenue line (This must be the date of the first Medicare billable service.)

Checking for Auto-Canceled RAPs

10. Follow steps 1-6
11. Enter "P B9997" in S/LOC field
12. Enter "328" in TOB
13. Enter "FROM DATE" and "TO DATE" of RAP and press <Enter>
14. Review list of billing transactions. If no "328" appears, RAP not auto-canceled.
15. Select "328" TOB with "CAN DT" matching "CAN DT" on "322" TOB
16. View Claim Page 3 for "ADJUSTMENT REASON CODE" field
17. If "NF" in "ADJUSTMENT REASON CODE" field, RAP auto-canceled
18. Re-bill RAP. When processed (S/LOC PB9997), review step 9 and submit final claim to Medicare.

Avoiding Billing Errors Caused By Overlapping Home Health Episodes

It is recommended that prior to admitting the patient to your HHA **AND** submitting the RAP/claim to Medicare for each episode:

- Log on to ELGH.
- Enter the information required to access the beneficiary's eligibility information. In addition, enter the start of care date or first calendar day of the episode in the APP DATE field found on the *CWF Part A Eligibility System* screen.
- Review the information found on ELGH page 3, noting especially the information in the START DATE, END DATE, and PROV NUM fields.
- Print this page and file with the patient's record. Apply time/date stamp if not shown on screen print.

Appropriate Billing Action Based on Review of ELGH Page 3:

1. If your dates of service fall between the dates listed in the START DATE and END DATE fields on ELGH page 3 **AND** the provider number listed **IS NOT** your provider number, complete the following steps:
   - Log on to http://www.cms.hhs.gov/CostReports/. Click on "Home Health Agency" link. Scroll down to list of downloads. Click on "HHA ProviderID Information" to download a spreadsheet containing the contact information for HHAs. You can also log onto http://www.healthcarehiring.com/homecare_directory.html to obtain this information; however, this information is not maintained by CMS; therefore, we cannot guarantee its accuracy.
   - Follow the steps given for appropriately completing beneficiary-elected transfers as outlined in Section 60.5.20 of the "Claims Filing Section" of the *Medicare Reference Guide for Home Health Agencies* accessed at https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/hh_claims.pdf. Please note the documentation requirements found in this reference.
   - If this is a transfer situation, and your agency is the receiving home health agency in a beneficiary-elected transfer, your RAP and final claim for this episode will need to contain a source of admission code "B" in FL 15 on the UB-04 claim form. This field has the description, SRC, in the Fiscal Intermediary Standard System (FISS), and is found on claim page 01.

2. If your dates of service fall between the dates listed in the START DATE and END DATE fields on ELGH page 3 **AND** the provider number listed **IS** your provider number, ensure that you have billed the discharge claim for the beneficiary. When discharging and readmitting a patient to your home health agency during the same 60-day period, a source of admission code "C" in FL 15 should be used on the first RAP and final claim that is submitted for the second admission date.

3. If your dates of service **DO NOT** fall between the dates listed in the START DATE and END DATE fields on ELGH page 3, bill the RAP and final claim as usual.

PLEASE NOTE: IF YOU HAVE COMPLETED THE ABOVE STEPS AND OVERLAPPING ISSUES PERSIST, PLEASE CALL THE CAHABA GBA, LLC HOME HEALTH PROVIDER CONTACT CENTER AT 1 (877) 299-4500.

Special Billing Situations Under HH PPS

Low Utilization Payment Adjustment (LUPA)

- A LUPA occurs when 4 or fewer visits are provided in a 60-day episode. Instead of payment being based on the HIPPS code, payment is made based on a national average per-visit payment by discipline for visits provided during the episode.

- If the HHA determines at the beginning of the episode that ***4 or fewer visits*** will be provided to a patient during that 60-day episode, the HHA has the choice to submit a No-RAP-LUPA claim. This means that the HHA may submit the final claim for the episode to Medicare without first submitting a RAP.

- Like all final claims under HH PPS, physician's orders must be signed prior to submitting No-RAP-LUPA claims for payment.

- When billing No-RAP LUPA claims, the statement "to" date should reflect the 60th day of the episode OR the date the patient transfers to another HHA, is discharged or dies. Like all other RAPs and final claims, all fields should be completed as usual for No-RAP LUPA claims.

- For episodes beginning on or after January 1, 2008, HHAs will receive an "add-on" payment to the first covered billable visit when a LUPA claim is the first or only episode in a series of adjacent episodes.

Beneficiary Elected Transfers

- A patient may decide to transfer from one HHA to another. When this occurs within an established 60-day episode the ***HHA the patient is transferring from*** should discharge the patient from their care.

- The ***HHA that the patient is transferring to*** will need to establish a new start of care date and plan of care (POC). The original start of care date and POC established by the first HHA ***may not*** be used by the receiving agency.

- In addition, the receiving HHA ***must document*** that the patient has been informed they will no longer receive HH services from the first HHA after the transfer date **and** that the first HHA will no longer receive Medicare payment on their behalf. Cahaba GBA, LLC also advises HHAs to review the patient's status and open PPS episodes on ELGH & ELGA and print a copy showing this information **before** accepting the patient for care. Also contact the initial HHA to inform them that the patient is electing to transfer. Document the call with the name and phone number of the person at the initial HHA who received this information. More detailed information on documenting transfers can be found in CMS Pub. 100-02, Ch. 7, §10.8 **http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf** and Pub. 100-04, Ch. 10, § 10.1.15 **http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf**

- When a patient transfer situation occurs within a 60-day episode, the original HHA will receive a **Partial Episode Payment (PEP),** in which payment for HH services is based on a proportion of the 60-day episode (first billable visit through last billable visit).

- When billing the final claim in a transfer situation, the ***original*** HHA should record the last Medicare billable service date as the "through" date on the claim. The patient status code should be recorded as a "06" in FL 17 on the UB-04. This field in found on claim page 01 of FISS. Complete all other fields as usual.

- When billing a transfer situation **OR** if the patient was discharged and readmitted to another HHA within the same 60 day episode, the ***receiving*** HHA should record the first Medicare billable service date as the "from" date, "admit" date and the HIPPS code service date. The "source of admission" code should be recorded as a "B" in FL 15 on the UB-04. This field is also found on claim page 01 of FISS. Complete all other fields as usual.

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Special Billing Situations Under HH PPS

Patient Discharge/Readmission

- Patients may be discharged prior to the end of a 60-day episode if all treatment goals of the POC have been met.
- Cases may occur in which an HHA has discharged a patient prior to the end of a 60-day episode, but the patient is readmitted to the ***same*** HHA during the ***same*** 60-day episode. The readmission prior to the end of the episode will generate a new OASIS, POC, RAP, claim (or No-RAP LUPA instead of RAP and claim) and a new 60-day episode.
- The HHA will receive a PEP for the original episode (HH services provided prior to the patient's discharge).
- When billing for a discharge/readmission to the same HHA situation, the patient status code on the discharge claim should be recorded as a "06" (FL17 – UB-04; FISS claim page 01) if the HHA knows that it is a discharge/readmit situation; otherwise the HHA should record the appropriate discharge status code. Complete all other fields as usual.
- When billing for a discharge/readmission to the same HHA situation, ***the first Medicare billable service date after the readmission*** is recorded as the "from" date, "admit" date and the HIPPS code service date. The "source of admission" code should be recorded as a "C" (FL15 – UB-04; FISS claim page 01). Complete all other fields as usual.

Significant Changes in Condition (SCIC)

- SCICs may occur when the patient experiences a change in condition that places them in a different HIPPS code level. Patients may go through an unlimited number of SCICs during an episode.
- Please note that the 60-day episode ***does not end*** when a SCIC takes place.
- HHAs ***may*** complete a new OASIS assessment/evaluation and ***submit the final claim for the episode with both the original and the SCIC HIPPS code*** when a patient undergoes a SCIC during an existing episode. Verbal orders must be obtained for the change in care.
- In addition, a multiple-part calculation of payment occurs. Payment is prorated using the HIPPS code assigned before and after the SCIC occurred, as well as the span of days before and after the SCIC. The span of days is based on first billable service date and last billable service date before and after the SCIC.
- HHAs ***are not required*** to submit SCIC information during an existing episode ***if the patient's condition worsened and if reporting the SCIC would cause financial disadvantage*** for the agency. The ***only time*** HHAs ***must*** report a SCIC is in the event of the patient's unanticipated improvement that was not foreseen at the time of their admission.
- When billing SCICs, the ***first revenue line*** should contain revenue code "0023", ***the pre-SCIC HIPPS code*** and the date of the first billable service in the episode. The ***second revenue line*** should contain revenue code "0023", ***the post-SCIC HIPPS code*** and the date of the first billable service provided ***after the SCIC occurred***. The Treatment Authorization Code (aka the OASIS Matching Key) of the last assessment/evaluation should be used. Complete all other fields as usual.
- For episodes beginning on or after January 1, 2008, SCICs ***can no longer*** be submitted to Medicare.

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