Avoiding Billing Errors Caused by Overlapping Home Health Episodes

HHAs are strongly encouraged to check eligibility prior to admitting the patient to your HHA AND before submitting the RAP/claim to Medicare for each episode:

- Log on to beneficiary eligibility system. To review provider eligibility inquiry options, see the CGS Web page, "Checking Beneficiary Eligibility" at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html. This page also contains links to educational materials to access and use the different options to inquire about a beneficiary's Medicare eligibility.

- You will want to ensure that you print a copy of the beneficiary's home health episode history and file it with the patient's record. Apply a time/date stamp if not shown on the screen print to document when you checked the patient's home health eligibility information.

Appropriate Billing Action Based on Review of Beneficiary's Home Health Episode History Posted to Common Working File (CWF)

1. If your dates of service fall between the episode dates listed **AND** the billing provider's National Provider Identifier (NPI) or Provider Transaction Access Number (PTAN) listed **IS NOT** yours, complete the following steps:

   - If an NPI is displayed for the home health agency providing care to the beneficiary, use the NPI Registry - https://npiregistry.cms.hhs.gov/ - housed on the National Plan & Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov/NPPES/Welcome.do. You will need to click on the link to "Search for an Organizational Provider" to determine the billing HHA's contact information.

   - If a PTAN is displayed, log on to http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html on the CMS website. Click on Home Health Agency on the left side of the screen. Scroll down and click on HHA Reports Zip File to open a zip file containing the "HHA_PROVIDER_ID_INFO" spreadsheet with home health agency provider contact information.

   - Follow the steps given for appropriately completing beneficiary elected transfers as outlined on the "Beneficiary Elected Home Health Transfer" Web page (http://www.cgsmedicare.com/hhh/education/materials/hh_transfer.html). Please note the documentation requirements found in this reference.

   - If this is a beneficiary elected transfer situation, and your agency is the receiving home health agency, enter a condition code 47 in FL 18-28. See Medicare Learning Network (MLN) Matters article, MM7338 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7338.pdf), for additional information on home health transfers.

2. If your dates of service fall between the episode dates listed **AND** the billing providers NPI or PTAN listed **IS** yours, ensure that you have billed the discharge claim for the beneficiary if the discharge is due to the patient meeting the goals of the plan of care. When discharging and readmitting a patient to your home health agency due to meeting the plan of care goals, no additional coding is required to indicate a second admission to the same HHA during the same 60 day episode. This situation will automatically result in a Partial Episode Payment (PEP). See the "Discharge and Readmit for Home Health Services" Web page (http://www.cgsmedicare.com/hhh/education/materials/discharge_and_remit.html) for additional information.

3. If your dates of service **DO NOT** fall within the episode dates listed, you may be able to bill the RAP and final claim as usual. If your episode dates are within 60 days of the prior episode billed by another HHA, CGS recommends following the steps under #1 of this sheet to avoid overlapping home health billing errors.

PLEASE NOTE: IF YOU HAVE COMPLETED THE ABOVE STEPS AND OVERLAPPING ISSUES PERSIST, PLEASE CALL THE CGS PROVIDER CONTACT CENTER AT 1.877.299.4500.