PDGM Payment Doesn’t Match Billed Amount

Prepared for

myUnity Essentials Financial

Netsmart

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Table of Contents

Overview

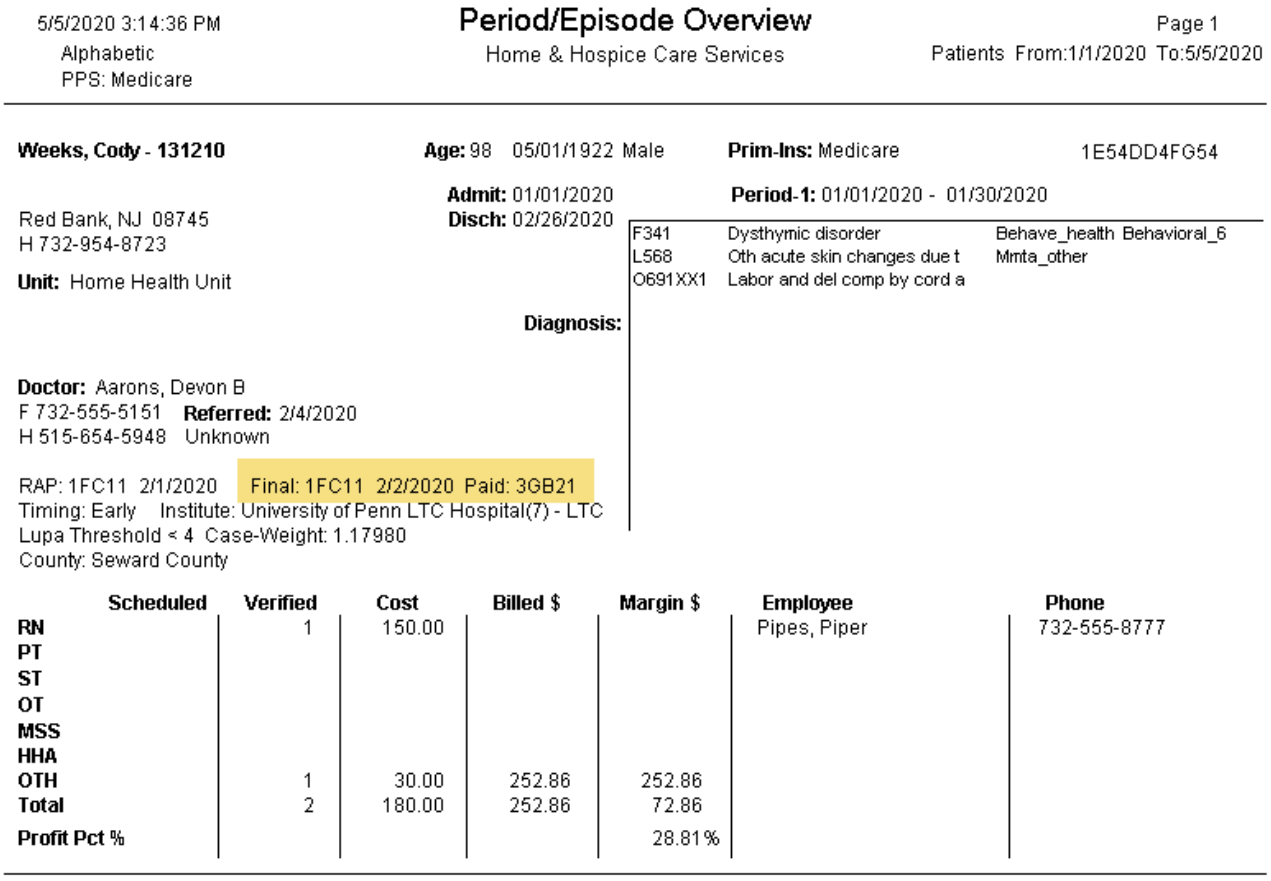
This document will help determine why you may have a remaining AR balance after the Final Medicare payment has been applied to a PDGM period and how to make corrections in each case.

Late RAP Submission

For periods starting 1/1/2021, a RAPs not submitted/accepted within 5 calendar days after the start of each 30-day period of care will incur a payment reduction equal to 1/30th of the payment amount for each day from the period start date until the date the RAP was accepted. This applies to MSP RAPs as well. Go to Payments and view the claim record to evaluate the Period Start date compared to the Initial Submit Date to determine if the RAP was submitted late. If needing to resubmit a RAP with an exception request, submit it with the KX modifier.

HIPPS Discrepancy

With the implementation of PDGM, Medicare pays on the recalculated HIPPS. If information in the billing software doesn't match the CWF at the time of Final claim processing, it's possible for the Billed and Paid HIPPS reimbursement amounts to not match. To determine if this is the case, run the **Stats > Period Overview** report for the patient/period in question. Review the Final HIPPS and Paid HIPPS. If they don't match, continue through this section. If they do match, skip to the next section.



5/5/2020 3:14:36 PM
Alphabetic
PPS: Medicare

Period/Episode Overview
Home & Hospice Care Services

Page 1
Patients From:1/1/2020 To:5/5/2020

Weeks, Cody - 131210 **Age:** 98 05/01/1922 Male **Prim-Ins:** Medicare 1E54DD4FG54

Admit: 01/01/2020
Disch: 02/26/2020

Period-1: 01/01/2020 - 01/30/2020

Red Bank, NJ 08745
H 732-954-8723

Unit: Home Health Unit

F341	Dysthymic disorder	Behave_health Behavioral_6
L568	Oth acute skin changes due t	Mmta_other
O691XX1	Labor and del comp by cord a	

Diagnosis:

Doctor: Aarons, Devon B
F 732-555-5151 **Referred:** 2/4/2020
H 515-654-5948 Unknown

RAP: 1FC11 2/1/2020 Final: 1FC11 2/2/2020 Paid: 3GB21
Timing: Early Institute: University of Penn LTC Hospital(7) - LTC
Lupa Threshold < 4 Case-Weight: 1.17980
County: Seward County

	Scheduled	Verified	Cost	Billed $	Margin $	Employee	Phone
RN		1	150.00			Pipes, Piper	732-555-8777
PT							
ST							
OT							
MSS							
HHA							
OTH		1	30.00	252.86	252.86		
Total		2	180.00	252.86	72.86		
Profit Pct %					28.81%		

Timing or Admission Source

If the first position of the billed vs. paid HIPPS is different, it indicates Medicare recoded due to Early/Late Timing or due to Community/Institute source of admission. These two variables make up the first position of the HIPPS:

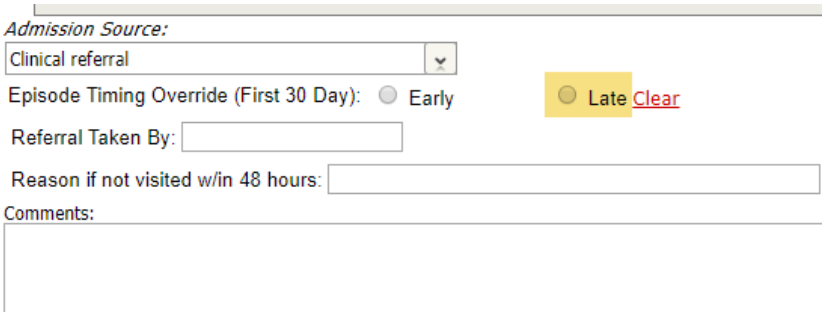
1 = Early Timing, Community Admission Source

2 = Early Timing, Institute Admission Source

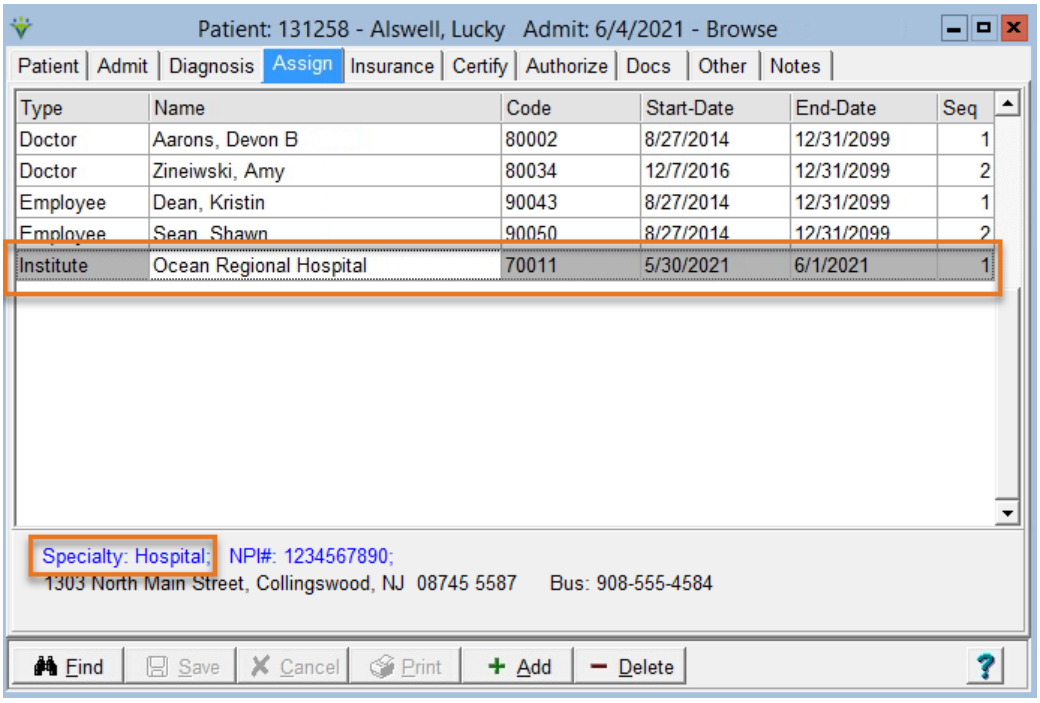
3 = Late Timing, Community Admission Source

4 = Late Timing, Institute Admission Source

- If the patient was billed as Early but paid as Late and an eligibility check confirms they should be billed as Late, mark them as **Late** in the **Clinical Patient Profile** (Referral information section), which posts to billing so the period will calculate as Late.
- Un-bill and rebill the Final claim or adjust the AR balance to zero in Payment entry using an adjustment code. If un-billing the Final, the rebilled claim does not need to be submitted to Medicare since they should have recoded and paid correctly.



If Community/Institute coding is wrong, check the **Patient** file **Assignment** tab in billing to confirm the Institute record is present. The End Date should be within 14 days of the period start date and the Specialty should be Hospital (used for admission and subsequent period claims), SNF, IP Rehab, LTC Hospital, or IP Psych (used for admission period claims only). If no Institute is found that meets the above criteria, the period will be scored as Community.



- If the information is missing, enter it in the **Clinical Patient Profile** under the **Location of Care** and post the information to billing.
- If the **Specialty** designation is wrong, correct it in the **Clinical Facility library**.
- Un-bill and rebill the Final claim or adjust the AR balance to zero in Payment entry using an adjustment code. If un-billing the Final, the rebilled claim does not need to be submitted to Medicare since they should have recoded and paid correctly.

Primary Diagnosis Code

If the second position of the HIPPS is different, it indicates a discrepancy in the primary diagnosis code grouping. Because Medicare uses the claim diagnosis codes for payment, you should not see a difference in this code between the billed and paid HIPPS. If you do, you can unbill/rebill the Final claim in myUnity Essentials. If that doesn't correct the HIPPS code, contact myUnity Essentials Financial support at https://netsmartconnect.com or check with your MAC for claim processing issues.

OASIS

If the third position of the HIPPS is different, confirm the Occurrence Code 50 date submitted on the claim matches the OASIS used for HIPPS scoring and that no responses were changed to the HIPPS-related questions after the OASIS was accepted by iQIES. M00 questions used in the scoring are:

M1033 - Risk for Hospitalization

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

- In Billing, go to the **Patient** file **Certify** tab. Select the certification period and click on the **OASIS/HIS** tab. Select the OASIS RFA 1, 3, 4 or 5 used for HIPPS scoring for the period in question. Press **Print** then **Preview** to view the answers to the above M00 questions. Compare to what is on file in iQIES.
- If a corrected OASIS needs to be submitted, view the OASIS Unlock FAQ for steps on making corrections.

Comorbidity Diagnosis Codes

If the fourth position of the HIPPS is different, it indicates a discrepancy in the secondary diagnosis code comorbidity grouping. Since Medicare uses the claim diagnosis codes for payment, you should not see a difference in this score between the billed and paid HIPPS. If you do, contact myUnity Essentials Financial support at https://netsmartconnect.com or check with your MAC for claim processing issues.

Agency Settings

VBP Adjustments

If the billed and paid amounts are off by the same percentage amount, confirm the VBP rate for your agency. As of 1/1/2022, all States are subject to the Home Health Value Based Purchasing model. Information on HHVBP can be found here: https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model

If needed, enter or update the VBP rate for your agency following the instructions in the online help under File > File Maintenance > Entity, Unit on the Misc-Rates tab.

The AR balance can be manually adjusted in Payment entry, or to reflect accurately in AR and on the PPS Revenue Report, the Final claim can be un-billed from Payments and a new Final billing audit posted.

Sequestration and Quality/Non-Quality Rate

If the payment amount is 2% higher or lower than the billed amount, make sure the sequestration amount is properly accounted for in the Medicare insurance setup. View the Sequestration Rates FAQ for detailed instructions on setting up rates and corresponding dates. The CARES Act temporarily suspended the sequestration, so be sure appropriate dates have been entered.

If your agency is setup as Quality instead of Non-Quality, or vice-versa, you can change the setting in **File > File Maintenance > Entity, Unit** file for each unit on the **Misc-Rates** tab. Non-quality agencies are subject to a 2% payment reduction.

Outlier adjustments

Outlier adjustments are generated during the Final Billing Audit posting if 'Include Outlier in AR Amount' is checked in **File>File Maintenance>System Settings** on the **Reporting** tab. If Medicare did not pay an outlier amount, confirm that the Outlier cap has not been exceeded by your agency. If your agency is having issues with Outlier adjustments, turn the **Billing Pre-Audit** setting on to **Fail** or **Warn** for **Visits Over 12 Hours** on the More Options tab. This will help ensure correct 15-minute increment units on the claim which are utilized in Outlier calculations.

PEP adjustments

Partial Episode Payments are not automatically accounted for in the software. If the remittance advice indicates a PEP, remaining balances can be adjusted to zero by applying a manual adjustment in Payment Entry. To reflect these as PEPs for Medicare Cost Reporting, check the PEP box in the Patient > Certify tab.

Rounding differences

Small balances due to rounding issues can be automatically adjusted at the time of electronic remittance posting. Review the Small balance adjustments FAQ for additional details.

Visit Set-Up

If not all visits on the claim were counted towards LUPA or Outlier adjustments, ensure the billed charges are setup under the correct modality in **File>File Maintenance> Charge Code.** Confirm all visits are pulling to the Final claim as expected.

Review Choice Demonstration

For agencies in States subject to the Review Choice Demonstration who have selected Choice #3 Minimal Review, claims are subject to a 25% payment reduction. For agencies who selected Choice #1 Pre-Claim Review and a PCR request was not submitted is also subject to a 25% payment reduction.

Third Party Issues

Pricer Software

The links below are not supported by Netsmart but are helpful in confirming RAP and Final reimbursement based on claim criteria. If the billed amounts match the calculated amounts using either tool, contact your MAC to discuss the payment discrepancy.

- Palmetto GBA's HHA PPS Claims Calculator is an online tool that can be used to determine RAP and Final amounts.

  http://www.palmettogba.com/palmetto/hhapps.nsf/main?Openform&lob=J11HHH&tname=HHA%20PPS%20Claims%20Calculator

- CMS provides PC Pricer software that can be run to calculate RAP and Final payments based on claim data. Their webpage includes a user manual for installing and using the software. Updated software is provided annually.

  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/HH.html

MAC Issues

Contact your MAC or visit their website to check for any known claim processing issues.

CGS Website: http://www.cgsmedicare.com/hhh/claims/FISS_Claims_Processing_Issues.html

Palmetto Website: http://www.palmettogba.com/Palmetto/Providers.nsf Claims Processing Issues

NGS Website: https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs Claims Processing Issues

If the payer is not Medicare but has instructed the agency to bill like Medicare, confirm with the payer that they are truly paying episodically and not per visit.