Hospice Billing

User Guide

Prepared for

myUnity Essentials Financial

Netsmart

www.ntst.com
11100 Nall Avenue
Overland Park, KS 66211
800.842.1973

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Overview

This guide provides instructions for the Hospice Billing process in myUnity Essentials Financial.

Insurance Setup

Insurances are added in the Insurance library from the Clinical home page. Additional billing setup is completed in the Billing Module when a new hospice payer is added.

Go to **File > File Maintenance > Entity,** press **Change Type** and set the radio button to Insurance. Press **Find** to search for and select the insurance and then click on the **Insurance** tab. The following fields must be set:

Insurance Type: payers are grouped by type if they use the same Revenue/HCPCS/Modifiers on claim output. If the payer uses the same codes as Medicare, select Medicare Hospice Rev type.

Financial Class: groups payers for purposes of running the billing process, claim generation and reports. Select either Medicare Hospice, Commercial Hospice, etc.

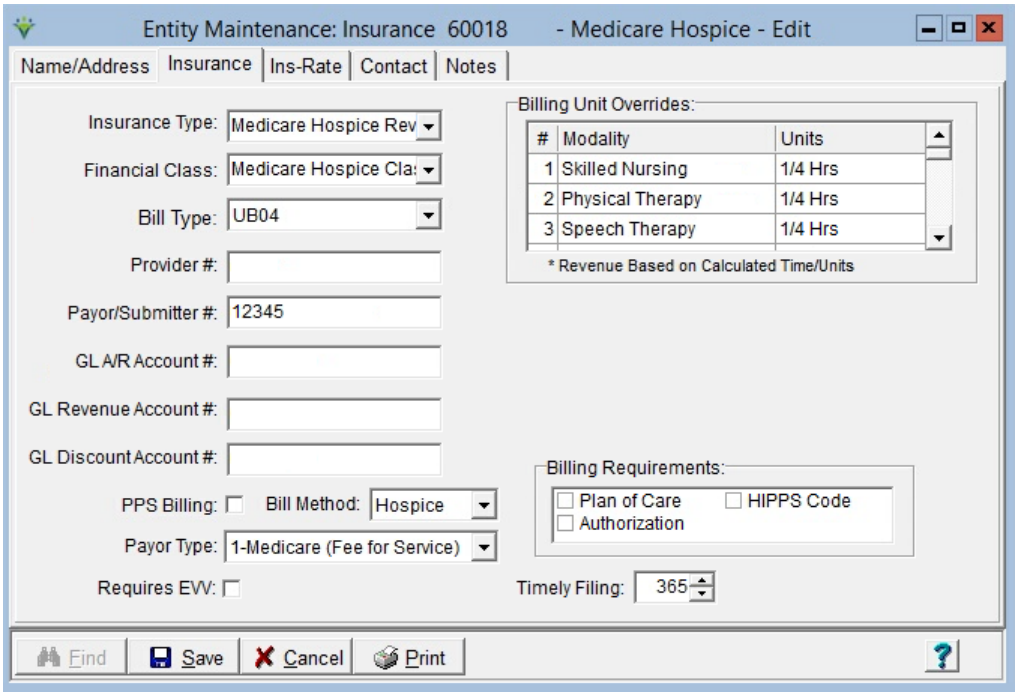
Bill Type: Select the claim format to be used for claim generation.

Payor/Submitter#: 5-digit electronic claim Payor ID (obtained from clearinghouse or payer) or setup the Clearing House Info if contracted with Netsmart for RevConnect or Waystar.

Bill Method: select Hospice (if payer reimburses a calculated amount like Medicare) or Normal (if they pay flat rate for each Level of Care).

Payor Type: Determines the value for element SBR09 Claim Filing indicator in electronic claim files. (i.e. MA for Medicare, MC for Medicaid, CI for Private Insurance or VA for Other Gov't). Also used to determine if insurance is Medicare to allow for Real-Time Eligibility functions.

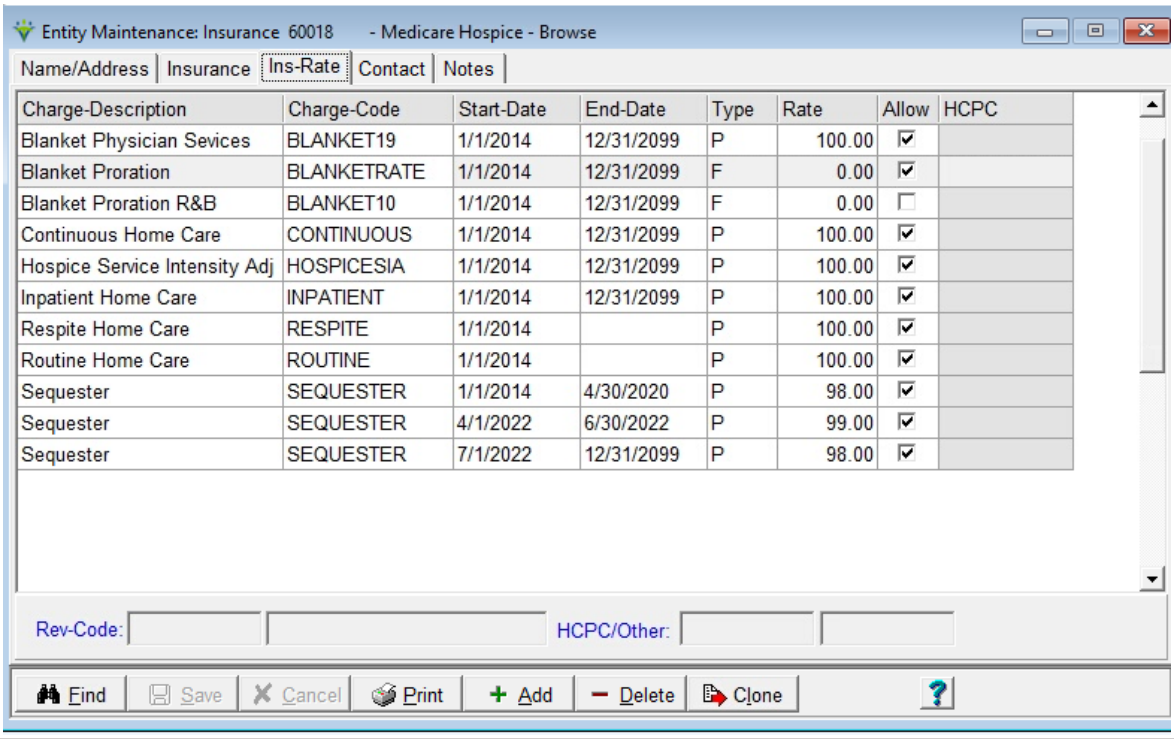
Billing Unit Overrides: For Medicare Hospice, units should be 1/4 Hours for Visits Modalities & Continuous, Units for other Per Diems. For other payers, follow your payers billing guidelines.



On the **Ins-Rate** tab, add a rate for each Per Diem Charge & SIA for 100% (Type = P) and enter the Sequester rate(s) with the Allow box checked. For other payers, enter rate amounts based on the payer's published reimbursement instructions.

Enter the **BLANKETRATE** charge code for 0% and check the Allow box to indicate all other visits are not reimbursed by Medicare for the Medicare Hospice insurance. Do the same for non-Medicare payers if applicable.

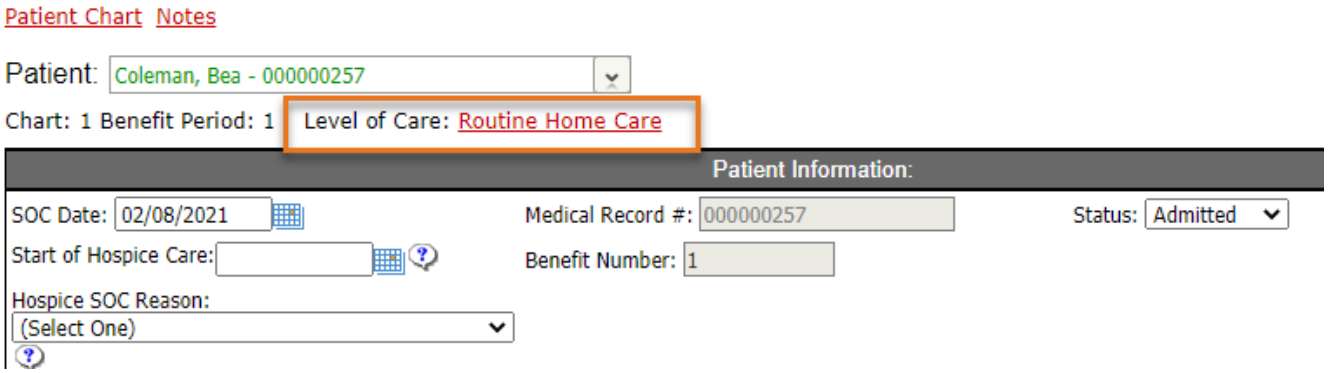
If the agency bills **Room & Board**, follow the R&B Billing FAQ for additional instruction.



Patient Information

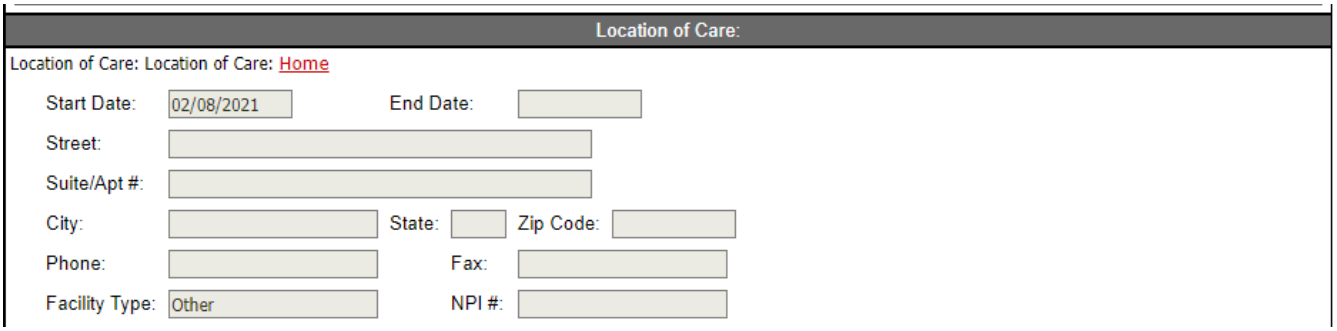
Level of Care

Patients are admitted in Clinical and their Level of Care (LOC) is added and updated in the **Clinical Patient Profile** and can be viewed in the Billing Module Patient file Other tab. It must be present to begin the billing process.



Location of Care

Patient Location of Care information is entered in the **Clinical Patient Profile** and posts to the Billing Module **Patient** file **Assign** tab. If no Institute is present, the Location of Care is considered 'Home.'



Benefit Periods and Diagnosis Codes

The Benefit period is created in the Billing Module when a (re)Certification of Terminal Illness, Hospice Item Set (HIS) Admission record or other form your agency has configured is posted from the **Clinical Patient Chart**.

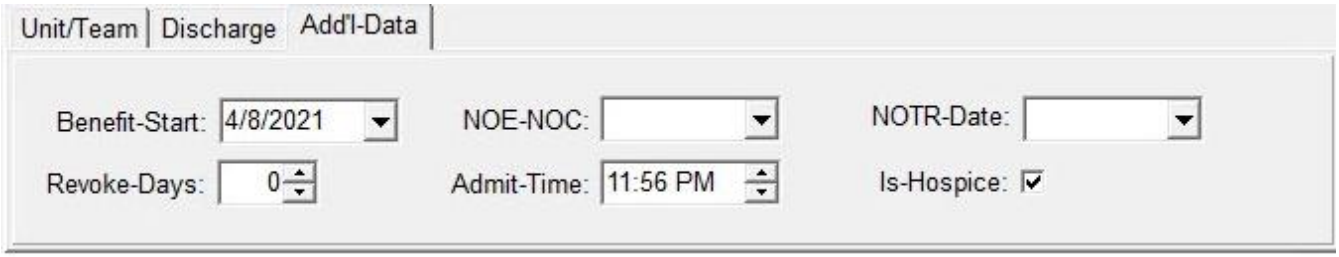
The Diagnosis Export (DE mark) on the form creates a 485 record in the Billing Module which stores the diagnosis codes used in billing for that period. To view Diagnosis Codes in the Billing Module:

- Go to **Patient > Admit/Maintain,** select the patient and on the **Certify** tab select the benefit period on the top half of the window.
- Select the **485** record on the lower half of the window. Press **Print,** then **Preview** to view the diagnosis codes.

Diagnosis Code corrections are made to the form in Clinical and reposted to the Billing Module.

Revocation Days

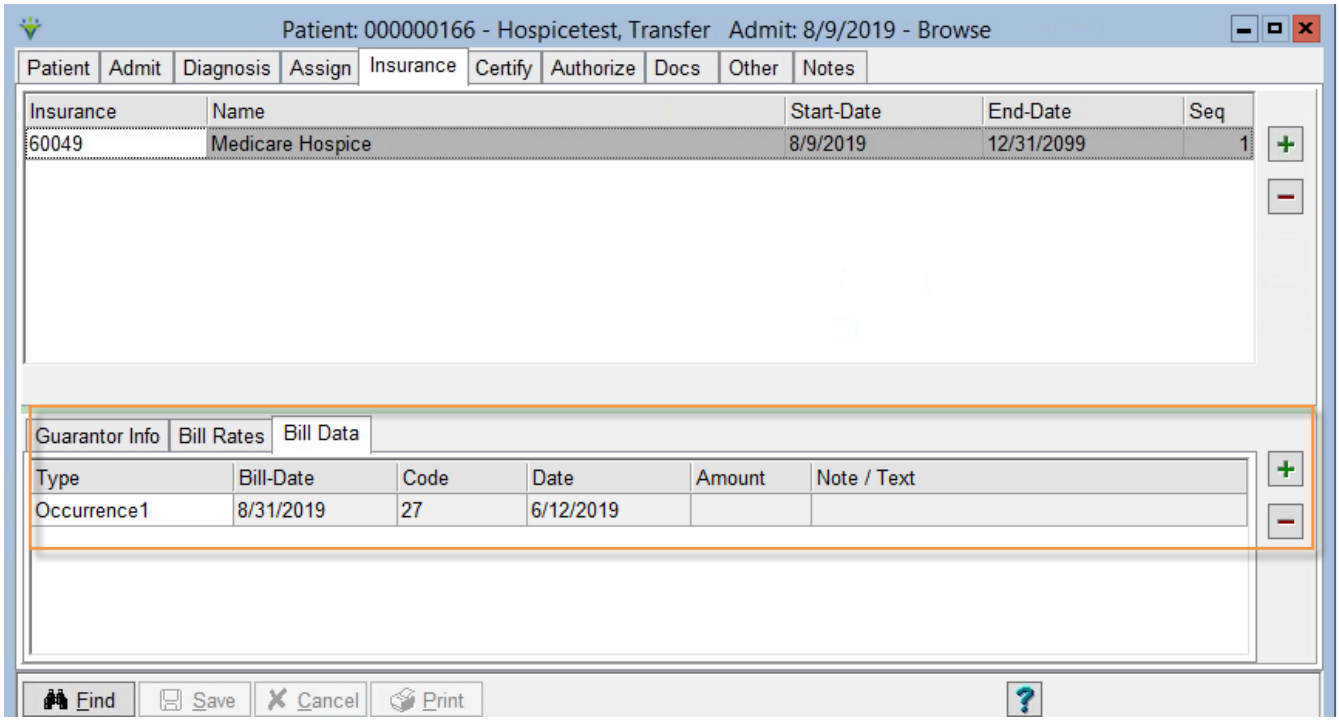
For patients who revoked and reelected the hospice benefit within 60 days, enter their number of benefit days used. This information should be entered in the **Billing Module Patient** file **Admit** tab in the **Revoke-Days** field and determines when the patient's Late Routine day begins (day 61).



Transfers from another Hospice

For patients who transferred from another hospice agency, confirm the Hospice SOC Reason and Benefit (Start of Hospice Care) Date are correct in the Clinical module to ensure the NOC can be generated in the Electronic Claims menu.

If an Occurrence Code 27 is required on a claim for a certification period that started with the other agency, use the Bill Data tab in Billing to enter this data (this code will populate automatically for all certification periods that are present in billing).



Facility Information

Add institutes in the Clinical Facility library with a Facility Type assigned. This is needed for claim Q-code designation. The following Facility Types need their NPI and 9-digit zip code present: Q5003(LTC/NSNF), Q5004(SNF), Q5005(I/P Hospital), Q5007(LTC Hospital), Q5008(IP Psych).

After a new Facility has posted from Clinical, assign the County in the **Billing Module.**

- Go to **File > File Maintenance>Entity**, press **Change Type** and set the radio button to **Institute**.
- Search for and select the facility and assign the **County** from the dropdown.
- If billing Room & Board, assign a **Bill-To** charge on the **Other-Info** tab. Review the Room & Board FAQ for detailed billing instructions.

Medication Import

Go to **Report Groups** (or **File > Import/Export**) to import the pharmacy charges to be included on Medicare claims. Refer to the Medication Import Process Only FAQ for detailed steps on importing.

NOE/NOC

Notices of Election and Notices of Change are created in the Electronic Claims menu.

Refer to the Hospice NOE FAQ for detailed information.

Hospice LOC Report

The Hospice LOC Report is the first step in the billing process. It identifies patients missing their Level of Care information, performs billing edit checks, and generates Per Diem and Service Intensity Add-On (SIA) amounts. For Commercial payers reimbursing a flat daily rate instead of a calculated amount, the report generates Per Diem charges if **Warn if Insurance not set for Hospice Bill Method** is un-checked on the 'More Options' tab.

Go to **Report Groups** or **Charge > Hospice LOC Report.**

Specify the current **Billing Period** month and year.

Missing LOC

Run the report choosing **Only Patients with Missing LOC** on the **More Options** tab for a list of patients who need their Level of Care information added in the Clinical Patient Profile. Uncheck the option when done.

Create/Fix LOC Charges

Run the report with Report Type set to **All Records** and **Create/Fix LOC Charges** checked. Press **Preview** and go to the last page of the report to generate LOC charges for all patients. Close the Preview window.

Exceptions Found

Run the report with Report Type set to **Exceptions Found**. Review and correct any exceptions using the Hospice LOC Report Guide. After making corrections, run the report again choosing **Create/Fix LOC Charges**.

Ready to Bill

Once the exceptions have been corrected and pharmacy meds have been imported, run the Hospice LOC Report with Report Type set to **Ready to Bill**. *Jump to the last page of the report* to populate the list of Ready to Bill patients, then close the Preview window.

Press the **Bill Audit** button at the bottom of the report window.

Billing Audit

Enter the **Bill Date.** The bill date specified will depend on agency billing practices. This is the date used to age the receivables and for claim creation.

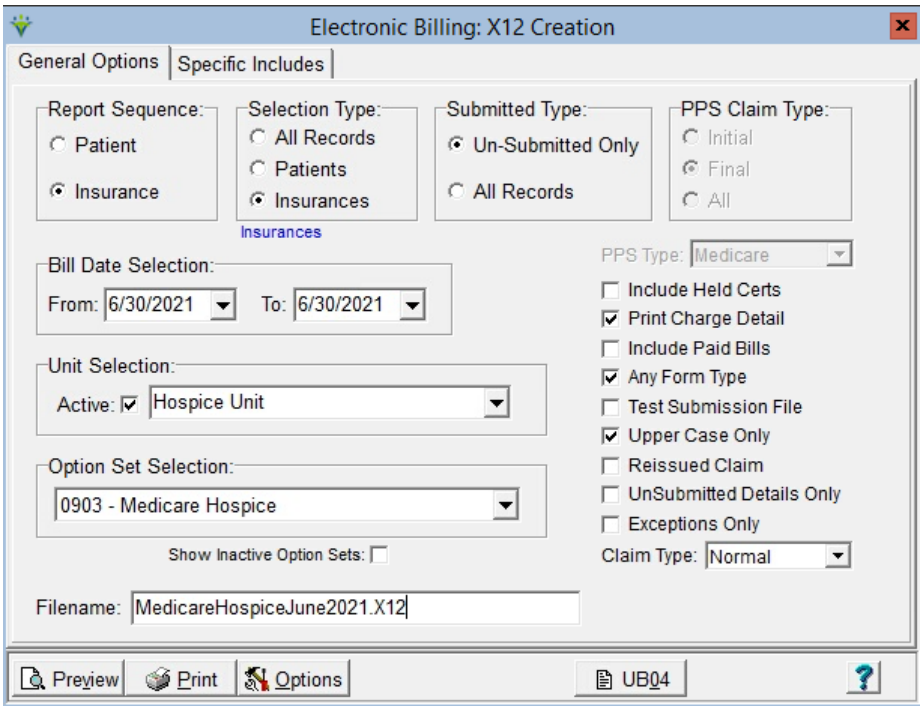
Press **Preview** and review the audits to ensure rate amounts are correct and charges are flowing to the proper insurance for each patient. Audits can be printed or saved to PDF if desired.

Once satisfied that the information is correct, close the Preview window and press **Post**. Check with your agency System Administrator for the posting password if unknown.

Electronic Claims

Electronic Claims is where 837 claim files can be created for submission to a payer or clearinghouse. Batch claims can be created in ANSI X12 professional or institutional formats based on the Option Set selected in the drop-down. If your agency has contracted with Netsmart for one of the clearinghouses, review the Zirmed Interface Guide, Ability Interface Guide or RevConnect Interface Guide.

Go to **Billing > Electronic Claims** and select the Medicare Hospice Option Set or alternative hospice option set from the dropdown, depending on the payer(s) being billed.



Report Sequence: Select Patient or Insurance

Selection Type: Select All Records or individual Patients/Insurances (use Specific Includes tab to specify individual patients or insurances).

Specific Includes tab: This tab appears if selected Patients or Insurances is chosen. For specific insurance selection, the 'Store' button can be used to save the insurance selection for future use for the selected option set. The 'Clear' button will clear the insurance selection for the current run only. To permanently detach an insurance from an option set, highlight the insurance, press Remove and then Store.

Submitted Type: Set to 'Un-Submitted Only,' unless claims are being re-submitted in which case 'All Records' should be chosen.

Bill Date Selection: Enter the Bill Date from the Billing Audit for this claim period.

Unit Selection: For agencies with multiple Units, check the 'Active' box under Unit Selection and select the Unit for which the claim file is being created. Otherwise leave un-checked.

Print Charge Detail: Select this option to see charge detail on the Electronic Claim Submission report.

Exceptions Only: Select this option to see only claims that have errors needing correction.

Claim Type: Defaults to "Normal". If choose "Replacement" or "Cancel" the Bill Frequency code will be generated accordingly and the original claim DCN will pull to claim.

Option Set Selection: Use the drop-down arrow to select the Option Set to be used for electronic claim file creation. Option sets give you the ability to customize the claim based on the payor requirements.

Filename: Enter a unique file name with a .X12 extension. Special characters are not allowed in file names. Check if your payor has a required naming convention.

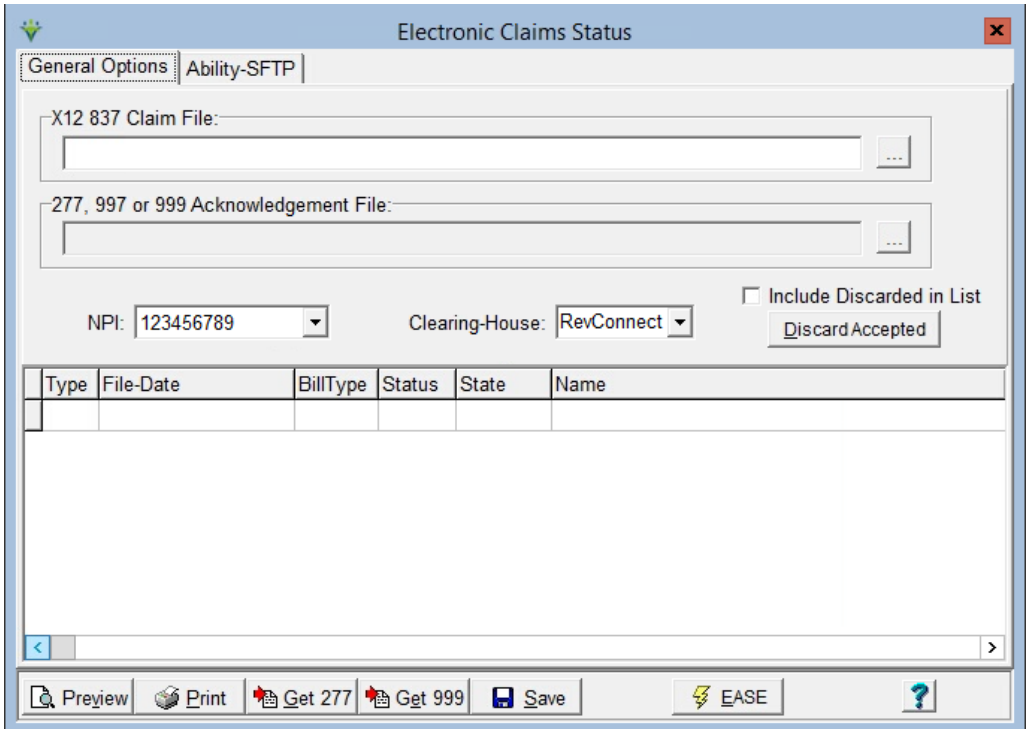
UB04/1500 Button: Click on the **UB04** or **1500** buttons to preview Institutional files as a UB04 form or Professional claim files as a 1500 form. Note: This is for informational purposes only, if sending the hard copy claim to the payer, use the Printed Claims menu to generate claims.

Press **Preview** after your selections have been made. Review the Electronic Submission Exceptions Guide for help making corrections.

After the exceptions have been corrected and the preview window is closed, the electronic claim file will be ready for transmission to the payer. If the file is ready to be sent, press "Mark as Submitted". If you are not ready to send the file, choose "Do NOT Mark as Submitted." Upload the .x12 file to the payer or clearinghouse website.

Claim Status

Go to **Billing > Claims Status** to view the 999 and 277 claim response files. If your agency has contracted with Netsmart for one of the clearinghouses, review the Zirmed Interface Guide, Ability Interface Guide or RevConnect Interface Guide.

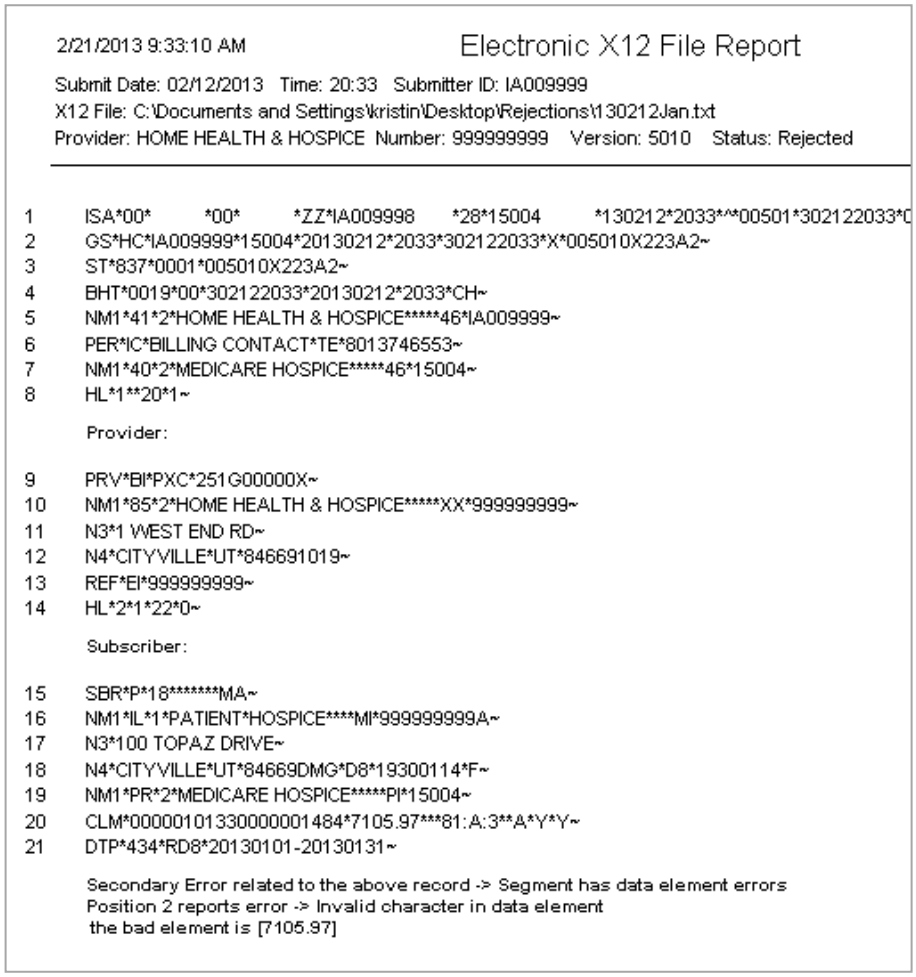


X12 837 Claim File: Specify the path where the electronic claim file was created or click the ellipsis button to browse to the file location (can leave this blank to view only the 999 or 277)

277 or 999 Acknowledgement File: Specify the path to where the 999 was downloaded or click the ellipsis button to browse to the file location.

Click **Preview** to view the Electronic X12 Report.

Sample Electronic X12 File Report:



2/21/2013 9:33:10 AM Electronic X12 File Report

Submit Date: 02/12/2013 Time: 20:33 Submitter ID: IA009999
X12 File: C:\Documents and Settings\kristin\Desktop\Rejections\130212Jan.txt
Provider: HOME HEALTH & HOSPICE Number: 999999999 Version: 5010 Status: Rejected

```
1   ISA*00*       *00*       *ZZ*IA009998     *28*15004        *130212*2033*^*00501*302122033*0
2   GS*HC*IA009999*15004*20130212*2033*302122033*X*005010X223A2~
3   ST*837*0001*005010X223A2~
4   BHT*0019*00*302122033*20130212*2033*CH~
5   NM1*41*2*HOME HEALTH & HOSPICE*****46*IA009999~
6   PER*IC*BILLING CONTACT*TE*8013746553~
7   NM1*40*2*MEDICARE HOSPICE*****46*15004~
8   HL*1**20*1~

    Provider:

9   PRV*BI*PXC*251G00000X~
10  NM1*85*2*HOME HEALTH & HOSPICE*****XX*999999999~
11  N3*1 WEST END RD~
12  N4*CITYVILLE*UT*846691019~
13  REF*EI*999999999~
14  HL*2*1*22*0~

    Subscriber:

15  SBR*P*18*******MA~
16  NM1*IL*1*PATIENT*HOSPICE****MI*999999999A~
17  N3*100 TOPAZ DRIVE~
18  N4*CITYVILLE*UT*84669DMG*D8*19300114*F~
19  NM1*PR*2*MEDICARE HOSPICE*****PI*15004~
20  CLM*00000101330000001484*7105.97***81:A:3**A*Y*Y~
21  DTP*434*RD8*20130101-20130131~

    Secondary Error related to the above record -> Segment has data element errors
    Position 2 reports error -> Invalid character in data element
     the bad element is [7105.97]
```

Adjusting Prior Months

When done with the current month billing, run the Hospice LOC Report for the prior month for Exceptions Found to view patients whose information may have changed after they were billed so corrected claims can be submitted. This also generates SIA amounts for patients who expired in the current period with SIA-eligible services from the prior month.

HIS Export Files

HIS records can be entered in the **Patient > Certify** tab if not interfacing with Clinical Software. HIS export files are created in the **Clinical > Oasis/HIS Export** Menu.

Refer to the "How do I generate the HIS export file?" FAQ for further information.

CAHPS Export Files

Hospice CAHPS Export files are created in the **Clinical > CAHPS Export** menu.

Refer to the "How do I generate my Hospice CAHPS export file" FAQ for further information.