MatrixCare by ResMed

Common billing errors in home health and hospice

In home health and hospice, most billing errors occur during the intake process, including entering incorrect patient or payor information, adding invalid diagnosis codes or authorization, and ordering services not covered by the payor.

Three common errors:

Incorrect patient information

Misspellings or incorrect information on patients' insurance IDs or demographic information can cause major problems in medical billing. Common examples are the incorrect subscriber ID or the patient's date of birth. With multiple people having a part in this process, human error is more likely to occur and any mistake can stay on the record through the claim process.

Claim formatting errors

Medical billing regulations are changing regularly. Certain payors may require different billing codes and forms, you may be missing specific revenue or service codes and more. This requires consistent updating of software and EHR systems. Training staff and developing new procedures are also critical to staying on top of these dynamic changes.

Non-corresponding treatment and diagnosis codes

Billing and diagnosis codes must be supported by the medical records. Often claims are denied because the diagnosis code does not correspond with the treatment code or something in the required medical documentation doesn't support the billing information. It's important that the clinical information is documented accurately and thoroughly – compliance is key for medical billing. And since specific diagnosis codes are deleted each year, it's important that your coding team is current on changes to diagnosis coding.

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Top claim submission errors for home health and hospice

Due to claim submission errors (CSEs), your billing will either be rejected or moved to your Return to Provider (RTP) file for correction — adding unnecessary costs to the Medicare program. Failure to submit accurate and compliant claims on an ongoing basis can lead to a referral to the Office of Inspector General for Medicare.

Here are the top CSEs by care setting:

Top CSEs for hospice:

37402 Hospice sequential billing error

38200 Duplicate claim

U5106 NOE falls within current hospice election

U5181 Occurrence code 27 required when certification date falls within dates of service

34952 Service facility NPI not included

U523A The dates of service on this claim are during both a Hospice election period and Medicare Advantage Plan

39929 The hospice claim was rejected due to an untimely NOE

U5194 Hospice claim received for untimely NOE & occurrence span code 77 is missing or invalid

31605 The dates of services on the claim cannot be within the span code 77 dates unless the charges are non-covered

31503 The total units on the level of care lines (0651, 0652, 0655, 0656) do not equal the number of days in the billing period.

Top CSEs for home health:

38157 Duplicate RAP

38107 FISS can't match claim billed to processed RAP

37253 No OASIS assessment found

U538I Overlapping episode of another HHA

38200 Duplicate Claim

U5391 No matching request for anticipated payment (RAP)

31018 Episode "TO" date not 60 days greater than "FROM" date

U5387 The patient status code is "30" and the through date does not equal the episode end date on file.

U538F RAP or final claim overlaps an existing period of care with the same provider number

C7010 No condition code 07 to indicate services unrelated to hospice election

While these billing errors are common, your organization can prevent them through focus, diligence and communication — helping to ensure accurate information, coding and orders.

Request a consultation to learn how outsourcing revenue management to MatrixCare can help reduce errors and grow your business.

Visit **matrixcare.com** to learn more.