

10

dos and don'ts
to help ensure timely
reimbursements

More coverage options are available, including the rapid rise of Medicare Advantage. With that growth comes additional complexities and updated requirements for eligibility and authorization. The home health and hospice providers who embrace this change? They're turning complexity into clarity and setting themselves up for more efficient care, faster reimbursement, and seamless operations.

The goal: Keep every patient moving without coverage gaps

From start of care to recertification and resumption of care, eligibility and authorizations can shape what happens next. So, what should teams stay focused on?



Dos:

Tips that can move you forward

1

Know your payors and plans

The Insight: Understand payor types and billing requirements

The tip: Identify the correct primary payor from the start to support timely Notice of Admission/Notice of Election submission and compliance

2

Master commercial, Medicaid, and Medicare Advantage vs. Traditional Medicare

The Insight: Payor rules can vary significantly—some pay per episode or on level of care (LOC), while others pay per visit, even when HIPPS codes are required similarities can end there

The tip: Configure payors correctly so revenue reflects what you've earned

3

Stay vigilant on authorizations

The Insight: The best time to request authorizations is at intake, but it doesn't stop there

The tip: Review new and recertification orders, monitor resumption of care, and track end dates by discipline to minimize coverage gaps

4

Reverify coverage and manage changes

The Insight: Coverage isn't set-it-and-forget-it; it changes as life does

The tip: Stay aware of coordination of benefits updates, payor changes, dual eligibility (Medicare + Medicaid), MSP situations, Medicare Part C rules, and discharge/readmission requirements

5

Do maintain accuracy and communication

The Insight: Verify demographics at every touchpoint

The tip: Monitor prior election or admission status, document authorization, and eligibility verification as well as educate clinicians on visit limits



Don'ts:

Tips to minimize the detours

1

Assume COB is static

The Insight: Coordination of benefits can change mid-episode

The tip: Build in a quick-check and always reverify on a pre-set schedule, with a frequency of at least once a month

2

Ignore timely filing limits

The Insight: Missing authorization or claim submission deadlines can result in non-payment

The tip: Timelines matter, especially when things move fast—keep deadlines visible

3

Overlook hospice overlap

The Insight: Providing hospice services to a patient under a prior hospice election will lead to an election being blocked and can cause sequential billing delays

The tip: Stay clear on prior hospice elections

4

Forget out-of-network rules

The Insight: Some payor plans require prior authorization for out-of-network providers, or may not cover them at all

The tip: Out-of-network doesn't mean out of luck—stay aware of the plan's specific rules

5

Rely on retroauthorizations

The Insight: Many payors will not issue retroauthorizations, especially after discharge

The tip: Stay proactive to make timely adjustments and support cleaner billing and fewer denials

Your eligibility and authorization strategy matters

Eligibility and authorization management is more than another to-do. It's an ongoing process that supports the full patient admission journey. When teams stay consistent, organized, and proactive, it can help maximize compliance and minimize billing disruption.

The MatrixCare Services team understands the rhythm of eligibility and authorization. We've seen what works and have helped providers like you refine their processes. Want to explore what's possible together? Contact our experts at [866-469-3766](tel:866-469-3766) or visit matrixcare.com to learn more.

