# Your home health billing readiness checklist

Home health billing has a lot of moving parts. Eligibility requirements, documentation, coding, and payor-specific rules all play an important role in supporting timely reimbursement and revenue integrity.

**This checklist is designed to give home health agencies a clear, organized way to review key billing steps across the full revenue cycle.**

## Front-end intake and eligibility (before the first visit)

- Eligibility and authorization verified within 24–48 hours prior to SOC (payor, plan, effective dates)
- Correct payor and payor sequence identified (Original Medicare vs. Medicare Advantage vs. Commercial)
- Payor-specific home health requirements reviewed (authorization rules, visit limits, homebound status, and skill need)
- Physician NPI and address validated (PECOS-enrolled for Medicare)

## Payor-specific intelligence

- Medicare vs. Medicare Advantage rules clearly distinguished
- Medicare Advantage plan billing nuances documented
- Authorization, visit limit, and notification rules tracked by plan
- Provider representative or portal access confirmed for all payors

## Clinical documentation quality (point of care)

- SOC/OASIS completed within required timeframe
- Visit notes demonstrate medical necessity at every visit
- Interventions tie directly to physician orders and plan of care
- Discharge summaries completed timely and fully

## OASIS accuracy and PDGM/case-mix integrity

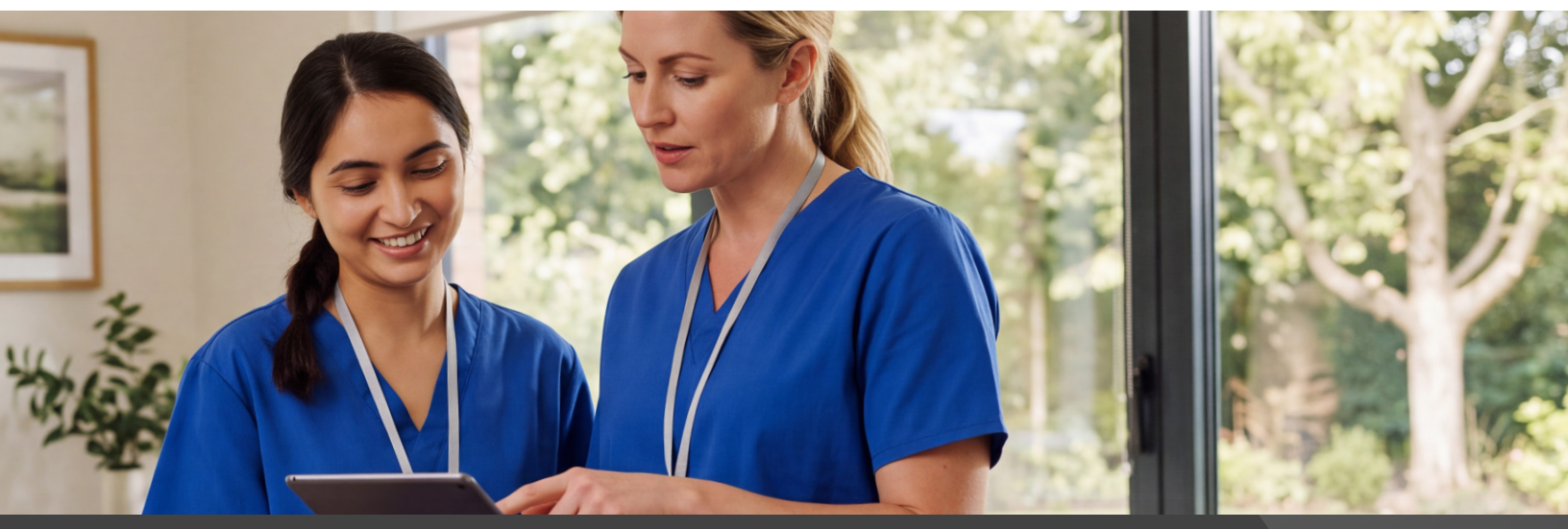
- OASIS completed by trained, up-to-date clinicians
- Functional scores supported by narrative detail
- Primary diagnosis sequencing reviewed pre-bill
- Comorbidity selections clinically supported

## Coding and billing readiness (pre-claim scrub)

- ICD-10 codes validated against documentation
- Revenue codes and discipline visits reconciled
- Units/Visit counts match clinical records
- Correct type of bill used (e.g. 329 for Medicare, 323 for other payors)

## Timely billing and submission

- NOA/Final claims submitted within payor timelines
- Clean claims submitted on first pass
- Electronic billing confirmations monitored daily
- Clearinghouse rejections reviewed and revised within 24–48 hours



## Keep billing moving with more clarity and confidence

A more efficient home health billing process starts with accurate eligibility verification, strong clinical documentation, timely reviews, and a proactive approach to reimbursement workflows. A process that's organized from intake through claim submission, can help strengthen compliance efforts, reduce billing disruptions, and improve reimbursement consistency.

To learn more about what's possible for your organization, contact our experts at **866-469-3766** or visit **www.matrixcare.com/rcm-billing**.