Well Spring Health (WSH)

Shirley Hanley

INSTRUCTION:

Shirley specializes in Geriatric Medicine. The majority of care is provided in a nursing homes and rest homes.

This client does not have a traditional office, nor any staff to assist us. We are her staff and will need to handle everything we can to receive reimbursement for services provided.

Charges get emailed to Carmen via App River. Shirley sends demographics but when she doesn't, we are to request them from the facility.

Hearthstone Medical Records: 541-779-8294
Regency Care (aka Fairview) Medical Records: 541-471-0611
Email Bridget Long at BLong@regency-pacific.com via App River for any demographics or medical records.
See list of contacts at end of instructions.

REGISTRATION:

- **Registration/Demographics** We do not ask the provider for demographics, unless there are issues receiving them. The provider is aware that we need to have demographics sent over for new patients. If we need to request any demographics needed, see the very last page on this document to find the contact information to obtain this information.

Self Pay: It is very rare for a Long Term Care patient to be Self Pay. If you get a Self Pay at registration - Question it. Check MMIS for any Medicaid coverage. If none, query biller so they can contact the patient. Do not bill the patient until query is responded to.

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CHARGES:

Provider:

SLH- Shirley L Hanley

Place of service-

See Charge Sheet provider will check mark where patients were seen

Everything you need to post charges will be provided: DOS, POS, Patient Name, Patient DOB, CPT and Diagnoses. Generally, there is one date of service per spreadsheet but could contain more than one date of service.

- The best places to go for information are:

The nursing home – to see if they have additional info on file that was not received at time of registration or Epic Health portal.

The patients should be registered with an emergency contact or family member. We try to have contact information due to the patient's age.

DX -R62.51 (failure to thrive child) is ok to change to R62.7 (failure to thrive adult) per Shirley.
DX- F17210 (invalid code for CPT 99406) we can change to F17210. (Same description)

MEDICAL RECORDS:

If a patient or a family member wants medical records, they have to request them directly from the nursing home as we do not have a signed authorization to release those records.

MAIL RETURNS:

We have a high percentage of mail returns on these patients. They are usually registered with "previous address". If mail is returned try to see if registration has alternate contact that is handling finances. If not verify if patient is still a resident, mail can be addressed to the patient in care of the nursing home. In addition, we can contact facility for updated information.

COMMON MEDICARE DENIALS:

- CO31 Unable to ID patient - Verify spelling of patient name.
- PR31 Unable to ID patient - Medicare Part A only. The balance falls to patient responsibility. unless they have other insurance.
- Patient is enrolled in a managed care plan – Check Endeavor for name of managed care and then follow-up with that payer for policy number. Policy number in Endeavor is not for billing use.
- Patient is enrolled in Hospice – See Hospice instruction

COLLECTION REVIEWS:

- Send collection review to provider via App River.
- When provider responds to a collections review with statement, *"No further action, please".* This means to write off balance.
- If approved for collections we send to General Credit

CARE OVERSIGHT PLAN:

Care Plan Oversight (CPO) is physician supervision of patients under either the home health or hospice benefit where the patient requires complex or multidisciplinary care requiring ongoing physician involvement. Medicare does not pay for care plan oversight services for nursing facility or skilled nursing facility patients. Medicare will not cover a certification or recertification of home health if a patient shall become deceased during the certification or re-certification period. This is a provider write off.

HCPCS Codes

- G0179: MD re-certification HHA PT
- G0180: MD certification HHA patient
- G0181: Home health care supervision
- G0182: Hospice care supervision

99378 get's replaced with G0182 when billing to Medicare & Medicare Advantage Plans.

HHA Initial Certification & Re-certification: Separate payment is allowed for the services involved in physician certification/re-certification and development of a plan of care for Medicare covered home health services.

- Submit HCPCS code G0179 for re-certification after a patient has received services for at least 60 days (or one certification period). HCPCS code G0179 may be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.
- Submit HCPCS code G0180 when the patient has not received Medicare covered home health services for at least 60 days. The initial certification (HCPCS code G0180) cannot be filed on the same date of service as the supervision service HCPCS codes (G0181 or G0182).
- **Dates of service: for HCPCS codes G0179 and G0180, submit the date physician signed the certification or re-certification.**

Home Health Care Supervision & Hospice Supervision:

- Do not submit the first and last calendar date of the month unless services were provided on those dates)
- Submit the claim after the end of the month in which the service is performed
- Report care planning only once per calendar month
- Report only one month's services per line item
- Dates of service: for HCPCS codes G0181 and G0182, submit the first and last date during which documented care planning services were actually provided during the calendar month.

The Oregon Health Plan does not cover the above services. When OHP is secondary, any balance is provider write-off (be sure to verify patient was eligible on DOS).

HOSPICE:

- If the service provided is not related to the hospice condition, modifier -GW would be appended to the CPT code.
- If services are related to the hospice condition, modifier -GV would be appended to the CPT code. You may need to contact the hospice organization to determine the patient's admitting diagnosis. This will assist you in selecting the correct modifier.

Hospice claim denials from Medicare advantage plans require that we submit claims directly to Original Medicare. Medicare Advantage plans must cover all of the services that Original Medicare covers except hospice care.

Create an account alert with the hospice diagnosis for future reference. This will assist with subsequent charge posting to ensure that the claim is submitted correctly with appropriate modifier.

Hospice Organizations:

- RVMC Hospice (541) 789-5005
- Providence Hospice (541) 732-6500
- ACH Home Health & Hospice (541) 552-9900

VA BILLING:

When there is no payer source for physician services, the SNF VA contract states that the facility is responsible to pay for physician services. In other words, if the patient has health insurance, we are to bill them not the facility.

For charges billed at Hearthstone only.
VA includes reimbursement for professional services in bundled payment made to facility. We bill Pinnacle Healthcare for these services. The insurance is posted as code IVA and HCFA is generated to paper and mailed to Pinnacle Health Care. The adjustment code tied to IVA is A1 (Medicare adjustment) If a patient calls stating charges were supposed to be covered by the VA we notify patient that we were told facility was covered by primary insurance (Medicare) and they need to call the VA and find out if authorization was obtained and get authorization number. Usually a rep from the VA will call and ask a few questions and let you know if services were auth'd. We do not question Pinnacle again as they have already confirmed who paid facility. Usually patient assumes VA is paying but they never authorized. If you see VA in patient profile, we always bill Pinnacle first. **We never bill VA directly.**

Linda Vista – Patients that have Medi-Cal Secondary:

Claims are submitted to Linda Vista for reimbursement. **Exception: If Oregon Medicaid allowable is less that Medicare payment, adjust balance off using adjustment A3.**

1. Check MMIS for OHP coverage before mailing claims to Linda Vista as patients will eventually transition from California Medicaid to Oregon Medicaid. This reduces unnecessary billing to Linda Vista.
2. Use the following information to fill in box 19 depending on what CPT was billed.
    1. $$ will change as allowed amounts change for DMAP we need to keep an eye on this and look at current EOB's in Ebridge.

CPT	$ in box 19
99334	$2.78
99335	$4.39
99336	$6.24
99326	$6.43

99305	$6.02
99308	$3.21
99309	$4.25
99310	$
99315	$

3. **Do not attach Medicare EOB per Melinda's request.**
4. Note line that you sent claim to Linda Vista Secondary for payment and the amount that was written in box 19.

EFT:

Shirley Hanley is enrolled for EFT for the following payers:

- **Medicare**

NURSING HOME CONTACT LIST:

Facility Name				
Arbor Place				
Fair View (now called) **Regency Care Rogue Valley**				
Farmington Square				
Fern Garden				
Hearthstone Billing				
Laurel Hills				
Linda Vista				
AVAMERE Medford Rehab				
The Bridge				
3FTNS Three Fountains				
Skylark Assisted Living				
Highland House				