carecentrix

Provider Newsflash April 2018

Medicare Advantage
Home Health Billing Reminder

Purpose of this communication:

- To remind Home Health Providers of specific billing requirements for Medicare Advantage members. Claims that do not adhere to these requirements may be rejected or denied.

What do I need to know?

- All home health claims billed on an institutional format for services provided to Medicare Advantage members must include several data elements when billing with a Health Insurance Prospective Payment Systems (HIPPS) code.

What do I need to do?

For Medicare Advantage Members only:

  - Include the Treatment Authorization Code (TAC) in box 63 and remove all CareCentrix authorization numbers from this field when a TAC is present
  - The fourth digit of the Type of Bill on an institutional claim form represents the Frequency Code
    - Original Medicare Advantage PPO claim submissions should be billed with frequency code 9
    - Providers should follow CMS billing requirements for frequency code guidance regarding original claim submissions for all non-PPO Medicare Advantage plans
    - Providers should only bill frequency code 2 when billing with revenue code 023 (HIPPS line) with no additional charges

- Do NOT include a HIPPS code on claims for services provided to patients who are NOT covered by a Medicare Advantage plan.
- Additional information is available on the Provider Portal: HomeBridge℠ at: www.carecentrixportal.com > Education Center > Claims 2.0 training.

Thank you in advance for your cooperation and continued partnership. If you have any questions, please reach out to CareCentrix Network Services Team at 877-725-6525