

Billing for Horizon Blue Cross Blue Shield of New Jersey Home Health Providers

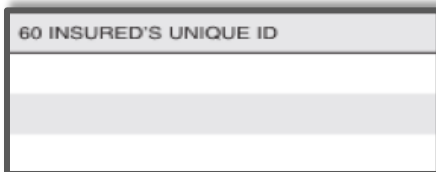
Overview

Use this quick reference guide when submitting claims for home health services.

General Billing Tips

Follow these requirements for submitting clean claims to CareCentrix for home health services.

- Use the correct claim form
 - For **traditional home health services**, bill using the **837/UB-04 claim form**.
 - For home medical equipment, home infusion, orthotics and prosthetics, bill using the 837P/CMS 1500 claim form.
- Include the complete and correct subscriber ID number as it appears on the patient's subscriber ID card on the claim.

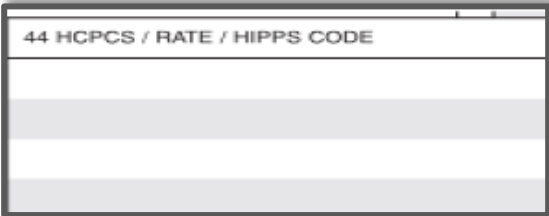


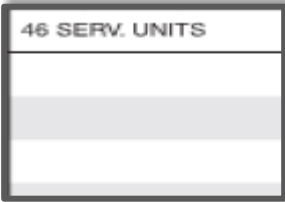
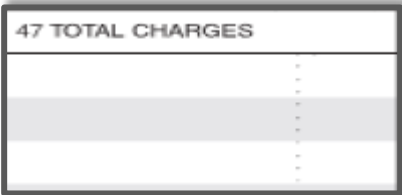
- Include the complete and correct patient name (including prefix and suffix when applicable), address, gender and date of birth on the claim.
 - Enter Patient Last Name, First Name and Middle Name/Initial (in that specific order.)
 - Enter the Patient's Date of Birth. MMDDYYYY, e.g. 09211965
 - Enter the Patient's Gender. M and F are acceptable.
- Ensure the HCPCS/modifier combination on the claim matches the HCPCS/modifier combination on the Service Authorization Form (SAF).
- Include a taxonomy code and the appropriate qualifier with all claim submissions.
 - All claims submitted to CareCentrix, regardless of claim type format must include the provider taxonomy in the appropriate field. Taxonomy is a data element identified under HIPAA for electronic claims submissions under the 5010 format.
 - The recommended taxonomy numbers for Home Health line of business is 251E0000X.

- Follow all ICD coding rules. **Do not use V codes as the primary diagnosis code**

If	Then
Services rendered on or after 10/1/2015	Submit with ICD-10
Services rendered before 10/1/2015	Submit with ICD-9

- Bill using the correct place of service codes based on the location where the services were provided.
- Ensure the billed units and date spans on the claim match.
- For all institutional claims, bill using the correct Revenue Code, HCPCS, and Modifiers.

Claim Field	Requirement																												
42 – REV CD	<p>Enter the 4-digit revenue code that applies to this service line.</p> <ul style="list-style-type: none"> ➤ Examples of appropriate revenue codes to HCPCS <table border="1"> <thead> <tr> <th>HCPCS Code</th> <th>Modifier 1</th> <th>Description Of Service</th> <th>Revenue Code</th> </tr> </thead> <tbody> <tr> <td>S9122</td> <td>SQ</td> <td>Home Health Aide Hourly</td> <td>0572</td> </tr> <tr> <td>T1021</td> <td>SC</td> <td>Home Health Aide Visit</td> <td>0571</td> </tr> <tr> <td>S9123</td> <td>TD</td> <td>RN Hour</td> <td>0580</td> </tr> <tr> <td>T1030</td> <td>TD</td> <td>RN Visit</td> <td>0551</td> </tr> <tr> <td>S9124</td> <td>TE</td> <td>LPN Hourly</td> <td>0550</td> </tr> <tr> <td>T1031</td> <td>TE</td> <td>LPN Visit</td> <td>0589</td> </tr> </tbody> </table>	HCPCS Code	Modifier 1	Description Of Service	Revenue Code	S9122	SQ	Home Health Aide Hourly	0572	T1021	SC	Home Health Aide Visit	0571	S9123	TD	RN Hour	0580	T1030	TD	RN Visit	0551	S9124	TE	LPN Hourly	0550	T1031	TE	LPN Visit	0589
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44 – HCPC/RATES/HIPPS CODE	<p>Enter the applicable HCPCS code and up to 4 modifiers (as needed) or a HIPPS code with NO modifiers. The code submitted needs to be appropriate for the state revenue code entered in field 42. CareCentrix does not accept Q-codes.</p>  <p><i>Note: Home Health claims for patients covered under Medicare Advantage plans are required to contain a HIPPS code.</i></p>																												

46 – SERV UNITS	<p>Enter the quantity (number of units) for this service line.</p>  <p><i>Note: For a HIPPS code line, this should always be 1.</i></p>
47 – TOTAL CHARGES	<p>Lines 1-22: Enter the billed amount for this service line.</p>  <p><i>Note: For a HIPPS code line, this should always be a Zero.</i></p>

- Do not submit claims with future dates of services (for example, if the current date is 9/10, you cannot submit a claim for a date range of 9/1 - 9/30).
- Include all services performed on the same day on the same claim.
- Include a HIPPS code on all home health claims submitted for Medicare patients.
 - Providers must submit the appropriate HIPPS code with the corresponding revenue code based on the service rendered. HCPCS codes must not be billed with revenue codes '0022', '0023' or '0024' and a HIPPS code must not be billed with any other revenue code.
 - Providers must submit the appropriate HIPPS code when billing for initial assessment services for Medicare Advantage patients. At least one HIPPS code should be on these claims.
 - Providers must submit the appropriate HIPPS code with a unit value = 1 and a billed amount = \$0.00. This code should be listed on line one. Do not bill the HIPPS code with 0 or a value greater than 1.
 - Providers must submit the appropriate HIPPS code on the last line of the claim.
 - Treatment authorization code (TAC) should be in field #63 of UB-04 for all BlueCard claims.
- When applicable, include both the referring and attending physician information on the claim.

Private Duty Nursing

CareCentrix includes the required claim form needed on the Service Authorization Form for each PDN patient. Providers will follow the direction provided for Horizon Care@Home (HCAH) program.

- For ISE HCR groups: Submit your claim on an **Institutional** form.
- For all other groups: Submit your claim on a **Professional** form.

Down Billing

Billing for a lower skilled service, even when authorization may be on file for a higher skilled service must be submitted appropriately.

- Only bill services that were rendered to the patient. Billing any services other than what was rendered to the patient is **fraud**.
 - Example: If LPN services are substituted for RN services, then LPN services must be billed.

Higher Skilled Service	Lower Skilled Service LPN/LVN
RN	<p>NOTE: If down billing, it is imperative that you reflect the appropriate revenue code with the downgraded HCPCs.</p>

Voiding a Claim

When an original submission was sent on the wrong claim form type, you must void the original submission, and then submit a new original claim on the correct claim form.

Steps	Action				
1.	Acknowledgment of claim acceptance received from CareCentrix. <table border="1" style="margin-top: 10px; width: 100%;"> <thead> <tr style="background-color: #800080; color: white;"> <th>If</th> <th>Then</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">A void claim is submitted prior to CareCentrix receiving the 835 for the original claim from the Payor</td> <td style="padding: 5px;">The void claim will pend with CareCentrix and hold for Payor response <i>Note: The 837 void will be processed upon receipt of the 835 Payor responses.</i></td> </tr> </tbody> </table>	If	Then	A void claim is submitted prior to CareCentrix receiving the 835 for the original claim from the Payor	The void claim will pend with CareCentrix and hold for Payor response <i>Note: The 837 void will be processed upon receipt of the 835 Payor responses.</i>
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2.	Submit a Void transaction (Frequency code 8) on the original claim.				

3.	Submit a new claim on the correct claim form.
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