Submit claims using Bill Type 322 and 329
Bill claims as a 60 day episode
Providers can bill using one of the two following methods:
• Providers can elect to bill a RAP and a final claim
  – When providers choose to bill an initial RAP (Bill Type 322), the payment will be 50% of the anticipated payment and 50% for the final bill.
• Providers can elect to bill a single claim utilizing Bill Type 329 at the conclusion of the episode.
• When an episode is completed, submit a final RAP, representing the remaining 50% of reimbursement.
  – Please note: If the service is different than what was originally submitted, it will pay either more or less based on the services billed.

Providers must follow Medicare rule for submitting episodic care claims.

On both claims:
• Submit the HIPPS code as the first line in the charge information – REV code 023, and then a 5 digit alpha numeric code (This code gives information about what services are going to be rendered).
• Include the CBSA number; this is a location indicator (value code); (Note: this is commonly missing on the final RAP and can cause a delay in payment).

LUPA Payments:
• The proposed home health PPS has a low-utilization payment adjustment for beneficiaries whose episodes consist of four or fewer visits. These episodes will be paid the standardized, service-specific, per-visit, amount multiplied by the number of visits actually provided during the episode. If it is determined on the final claim that a LUPA Payment is warranted, there is a chance this will result in a recoupment if the RAP was reimbursed at a higher utilization.

Additional Information Required by Medicare:
• TAC (Treatment Authorization Code) 16 digit hexavigesimal code; this number provides the date span and other information on what services have been provided.
  – TAC code should be the only code in this field. Providers should not append or replace with the health plan authorization number.
• The Q code is needed on the final claim and should be based on the initial encounter date for episodic care.
  – Please note: In the past NH Healthy Families has required providers to submit the T1030 code to identify the service as an episodic care. Based on provider feedback, the T1030 is no longer needed on the authorization request.
• Although the assessment (the first visit) does not require an authorization, please include that assessment date in order to process the claim.
  – Please note: The NH Healthy Families authorization is not required on the claim; just the TAC number.

Additional information for Ambetter from NH Healthy Families claims:
• If a provider sends in the final claim only; the final claims will be paid at 100%.
• If the provider sends in the initial claim in thereafter; it will be denied.

Link to the Medicare Claims Processing Manual: