

When patient changes from Medicare (traditional) to Medicare HMO or vice-versa

The following is an excerpt from the PalmettoGBA Billing Manual. The full manual ([link](#)) is included as a related article to this post:

10.1.5.2 - Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes on HH PPS Episodes (Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11) If a Medicare beneficiary is covered under an MA organization during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the Medicare payment source changes. With that assessment, a RAP may be sent to Medicare to open an HH PPS episode. If a beneficiary under fee-for-service receiving home care elects an MA organization during an HH PPS episode, the episode will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The MA organization becomes the primary payer upon the MA organization enrollment date. Other changes in eligibility affecting fee-for-service status should be handled in a similar manner. For additional information about MA eligibility changes, see section 80.

Knowledgebase

<http://kb.barnestorm.biz/KnowledgebaseArticle51476.aspx>