Billing Enhancement Overview

Step by Step Instructions

Overview

HEALTHCARE*first* is changing Network Service Vendors and is now partnered with ABILITY Network. The transition is already underway and will require **prompt attention** from your organization in order to ensure no delays in cash flow or with your billing process. Your agency must take action in *first*HOMECARE and/or *first*HOSPICE to continue:

- Creating and submitting electronic claims
- Downloading claims for submission
- Receiving response files

We have outlined a step by step process to guide you through everything that needs to occur in order for you to make this transition smoothly. Step one is **required** by all agencies regardless of whether you wish to enroll in *first*REV.

NOTE: If HEALTHCAREfirst provides billing services to your agency, you do not need to do anything. We will manage this setup for you.

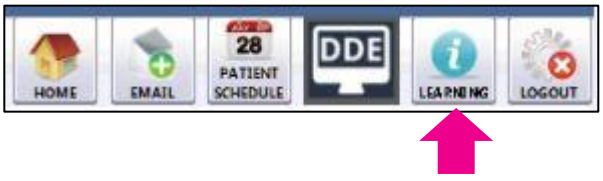
Step by Step at a Glance

1. Setup Receiver IDs for all Receivers and associate them to offices **BEFORE** your transition date. *first*HOMECARE and *first*HOSPICE clients will be migrated based on the MAC jurisdiction you reside in. Login the day after migration to ensure your receiver IDs are properly associated with your payors. *This step is required in order to submit claims going forward.*
2. Determine if you wish to transition to *first*REV. We are including these services to you at no additional charge for being a valued customer. There are many benefits of switching as outlined on page 6.
3. Start *first*REV enrollment process. *Steps 3-5 are optional.*
4. Enroll with payors that require additional enrollment.
5. Register for training on *first*REV.

Read on to find detailed instructions for each step!

For answers to your most pressing questions, reference the FAQ found in iLearning.

Access iLearning by clicking on the iLearning icon at the top right of your home screen.



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Step 1: Receiver ID Setup, Office and Payor Association (REQUIRED)

Receiver IDs must be set up in *first*HOMECARE/*first*HOSPICE prior to your transition date, in order to create claims, send claims, and receive responses going forward.

Before your transition date, set up Receiver IDs and associate them to offices:

1. Go to Master Files > Receivers
2. Click ***New***
3. Enter your Receiver and Submitter data. Reference the MAC Jurisdictions and Receiver IDs on page 3 and the commonly used Commercial/Medicaid Receiver IDs found on page 5
4. Click ***Save***
5. Repeat steps 1-4 for each Receiver you use for electronic submission. If you have more than one submitter ID per Receiver, create one Receiver record for each. Example: ABC HH&H electronically submits to CGS for Medicare, Iowa for Medicaid and Zirmed for commercial

Receiver Name	Receiver ID	Submitter ID	Submitter Name
CGS	**15004**	**IA00999**	**ABC Home Health and Hospice**
CGS	15004	IA00988	ABC Home Health and Hospice
Iowa MD	18049	I2345A	ABC Home Health and Hospice
Iowa MD	18049	I2345B	ABC Home Health and Hospice
Zirmed	ZIRMEDCOM	Z123	ABC Home Health and Hospice

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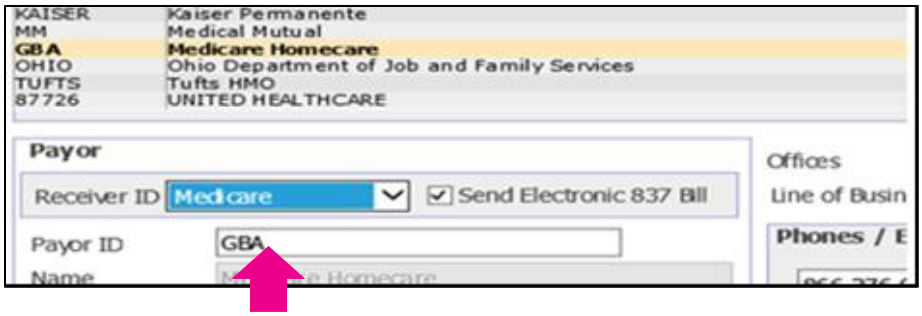
After your transition date, verify Payors and offices are associated to your Receiver IDs:

1. Go to Master Files > Payor/Plans
2. Select a Payor that is submitted electronically. "Send Electronic 837 Bill" checked
3. Verify the Receiver ID selected in the dropdown is correct. If no Receiver ID is selected or the wrong one is selected, select the Receiver ID the Payor is associated to and Click ***Save***
4. Repeat steps 1-3 for all Payors submitted electronically



If your non-Medicare Receiver ID records are only associated to one submitter number/location each, there is no further action to take. HEALTHCARE*first* will associate them and any Medicare Receiver ID records to your offices upon transition.

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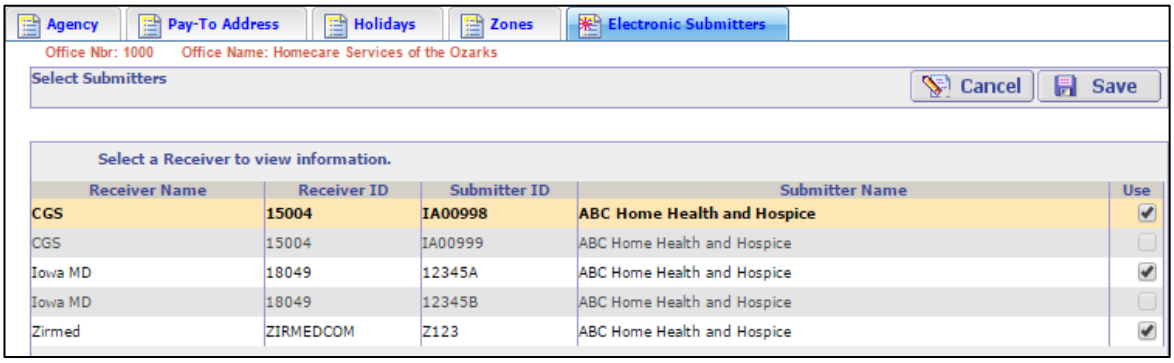
Step 1: Continued…

If any of your non-Medicare Receiver ID records are associated to multiple submitter numbers/locations, please go to Master files > Agency > Electronic Submitters and associate your offices to the correct submitter number/Receiver ID record.

1. Go to Master Files > Agency
2. Select your first office record
3. Click on the ***Electronic Submitter*** tab
4. Click "Use" checkbox for applicable receiver record
5. Click ***Save***
6. Repeat steps 1-4 for each office that has its own Receiver ID/Submitter number record



Agencies will be transitioned using the schedule and dates below.

April 11

Jurisdiction K Clients – NGS – ID 14011
(States: CT, ME, MA, NH, RI, VT)

April 18

Jurisdiction 6 Clients – NGS – ID 06001
(States: MI, MN, NJ, NY, Puerto Rico, VI, WI)

Jurisdiction 6 Clients – NGS – ID 06014
(States: AK, AS, AZ, CA, GU, HI, ID, NV, Northern Mariana Islands, OR, WA)

April 20

Jurisdiction 15 Clients – CGS – ID 15004
(States: CO, DE, DC, IA, KS, MD, MO, MT, NE, MD, PA, SD, UT, VA, WV, WY)

April 24

Jurisdiction M Clients – Palmetto GBA – ID 11001
(States: AR, AL, FL, GA, IL, IN, KY, LA, MS, NM, NC, OH, OK, SC, TN, TX)

2 Step 2: Determine Whether to Use *first*REV

*first*REV is an optional feature offered at **no additional cost** that allows you to manage your entire revenue cycle for *all* payors. There are many benefits of using *first*REV as outlined on page 6. You will gain greater visibility to claims and you will have more utility at your fingertips. Additionally, you may be able to eliminate the cost of your current clearinghouse, saving money for your agency. All you have to do to get started is enroll!

Please note that it is not necessarily for your agency to use *first*REV, as you will still be able to send Medicare claims and receive responses within the system without it. For other payors, you will still be able to generate the 837 claim file, download it to your computer and upload it to your payor. However, the ability to edit claims directly on the UB04 will be moving to *first*REV.

3 Step 3: Start Enrollment Process (OPTIONAL)

To get started with *first*REV, agencies will need to complete an onboarding process. The first step is to complete the enrollment form/report. To make this easy, HEALTHCARE*first* has created a report in the software that contains almost all of the information needed. Note that this report will not be available to you until after your transition date outlined on page 3.

1. Go to Reports > Master Listing
2. Click ***firstREV Enrollment Report***
3. Review all of the information in this report to confirm its accuracy, add in any missing information and save this file to your computer
4. Email your approved *first*REV Enrollment Report to firstrevsupport@healthcarefirst.com

4 Step 4: Additional Payor Specific Enrollment

Some payors require additional enrollment forms to be completed. HEALTHCARE*first* will determine if your payors have additional enrollment requirements and send you any additional enrollment forms that need to be completed. It is important to complete them fully not leaving anything blank as this may result in a denial of enrollment. Please send additional payor-specific enrollment forms to firstrevsupport@healthcarefirst.com. Your prompt response will expedite account setup.

HEALTHCARE*first* will respond back to you as soon as we have more information regarding your set up. Payor responsiveness varies so please be patient during this time. Note that you can continue to submit claims to these payors just as you always have in the past by generating the 837 claim file from the HEALTHCARE*first* system and uploading directly to your payor or send by your normal process. By enrolling with the payor through *first*REV, you will no longer be uploading to them through another clearinghouse, so you may want to cancel any contractual relationships once you are live in *first*REV.

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Step 5: Training

HEALTHCARE*first* will be offering the following webinars to get you up to speed quickly and answer your questions. Webinars will be recorded so if you miss it, don't worry! We'll send you a link to the recorded webinar. This is a full featured system with a lot of utility enabling you to effectively manage your revenue cycle like never before. We know you're going to love it!

Upcoming Webinars:

***first*REV Basics**
Tuesday, April 18 | 1:00pm-2:00pm CT | Register Here
Wednesday, April 26 | 10:00am-11:00am CT | Register Here
Tuesday, May 9 | 10:00am-11:00am CT | Register Here

Commonly Used Commercial and Medicaid Receiver IDs

HEW = 810525733
Availity = 030240928
WebMD/Emdeon= 133052274
Highmark = 54771
Highmark Senior = 15460
MDOnline = MCC
Zirmed = ZIRMEDCOM
Office Ally = 330897513
UHIN Medicaid FFS = HT000004-001
UHIN Medicaid MCO = HT000004-002
UHIN Medicaid DVP = HT000004-00)
UHIN Medicaid Crossovers = HT000004-005
UHIN Medicaid Atypical = HT000004-801

Aetna = 042064683
Relay Health = CLAIMSCH
Louisiana Medicaid = LA-DHH-
Texas Medicaid =617591011CMSP
Ohio Medicaid = MMISODJFS
Connecticut Medicaid = 061274678
Medi-Cal (CA Medicaid) = 610442
Iowa Medicaid = 18049
NC Medicaid = DNC00
Mass Health = DMA7384

Benefits of Using *first*REV

*first*REV is a smarter way for home health and hospice providers to manage their entire revenue cycle. From submitting all payor claims electronically, checking eligibility, managing appeals and the remittance process, agencies will have total visibility to every aspect of the claim lifecycle with 100% acknowledgement on all transactions making it easier than ever to pinpoint billing issues and resolve problems quickly. With superior claim scrubbing and more complete documentation, *first*REV helps eliminate administrative burdens and improve the bottom line.

HEALTHCARE*first* partners with ABILITY Network to link directly to source data to bring you faster transaction processing, higher first-pass acceptance rates and superior denials management in an easy to use interface. Everything you need to seamlessly bill for all payors is fully integrated so you never have to leave the software!

Significantly decrease payor rejections – Get first-pass payor acceptance rates of 98% or better.

Gain greater visibility into claims status - Users receive *all* messages from the payer, always tied to the original claim and for the life of the claim until reimbursed.

Receive fast, clear correction guidance - Any claim rejected by a payer is instantly placed back in the work queue with a clear message about the correction needed - no more waiting and wondering!

Reduce A/R days – Speed up the payment cycle by validating claims against the most current rules available.

Work more efficiently – Work with individual transactions or in batches based on user preference, easily edit UB04 forms directly, attach notes, create your own user defined dashboard and more.

Quickly pinpoint issues – Extensive audit trail shows every detailed change made to a claim throughout its lifecycle allowing you to identify any breakdowns in the process and prevent future occurrences.

End manual, time-consuming follow-up - Fast, up-to-date correction messages stop the need for users to hunt down rejection causes, contact payers, submit appeals, and monitor “unique” payer rules.

Eliminate eligibility issues upfront – Verify eligibility at the time a claim is uploaded to flag any issues and correct them, avoiding adjudication issues.

Efficiently manage denials and appeals – Easily track and work claim appeals through final determination without leaving the software.

Customize business rules with robust rules engine – Easily customize business rules to tailor the system to your needs and stay current with even the most complicated rule sets from commercial payors and CMS.

Monitor financial performance - Robust analytics paint the entire picture of financial performance with details for addressing common issues.