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Orientation to Medicare Session One

July 13, 2022

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

Mike Davis
POE Manager

Erin Musumeci RN; POE HHH Consultant

Jan Wood; POE HHH Consultant

Shelly Dailey MSN, BSN, RN, CPHM; POE HHH Consultant

Christa Shipman; POE HHH Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

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  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Define the role of the Medicare Administrative Contractor (MAC)
- Identify the HHH Medicare contractors
- Provide a basic description of other federal Medicare contractors
- Explain the role of the provider in safeguarding the Medicare trust fund against fraud, waste & abuse

Agenda

- Medicare Contractors
  - Medicare Administrative Contractors (MACs)
  - Other Medicare Contractors
- Safeguarding the Medicare Program
  - Fraud, Waste & Abuse
- References & Resources
- Question & Answer Period

The Centers for Medicare & Medicaid Services

- CMS relies on a network of contracted companies to serve as the primary operational contact between the Medicare fee-for-service program and health care providers enrolled in the program

Medicare Administrative Contractor

MAC

UPIC

RA

CERT

SMRC

BCRC

Medicare Administrative Contractor (MAC)

- Private Health Care Insurer
- Awarded Geographic Jurisdiction
- Process Medicare Claims
- Medicare Fee-for-Service (FFS) Beneficiaries

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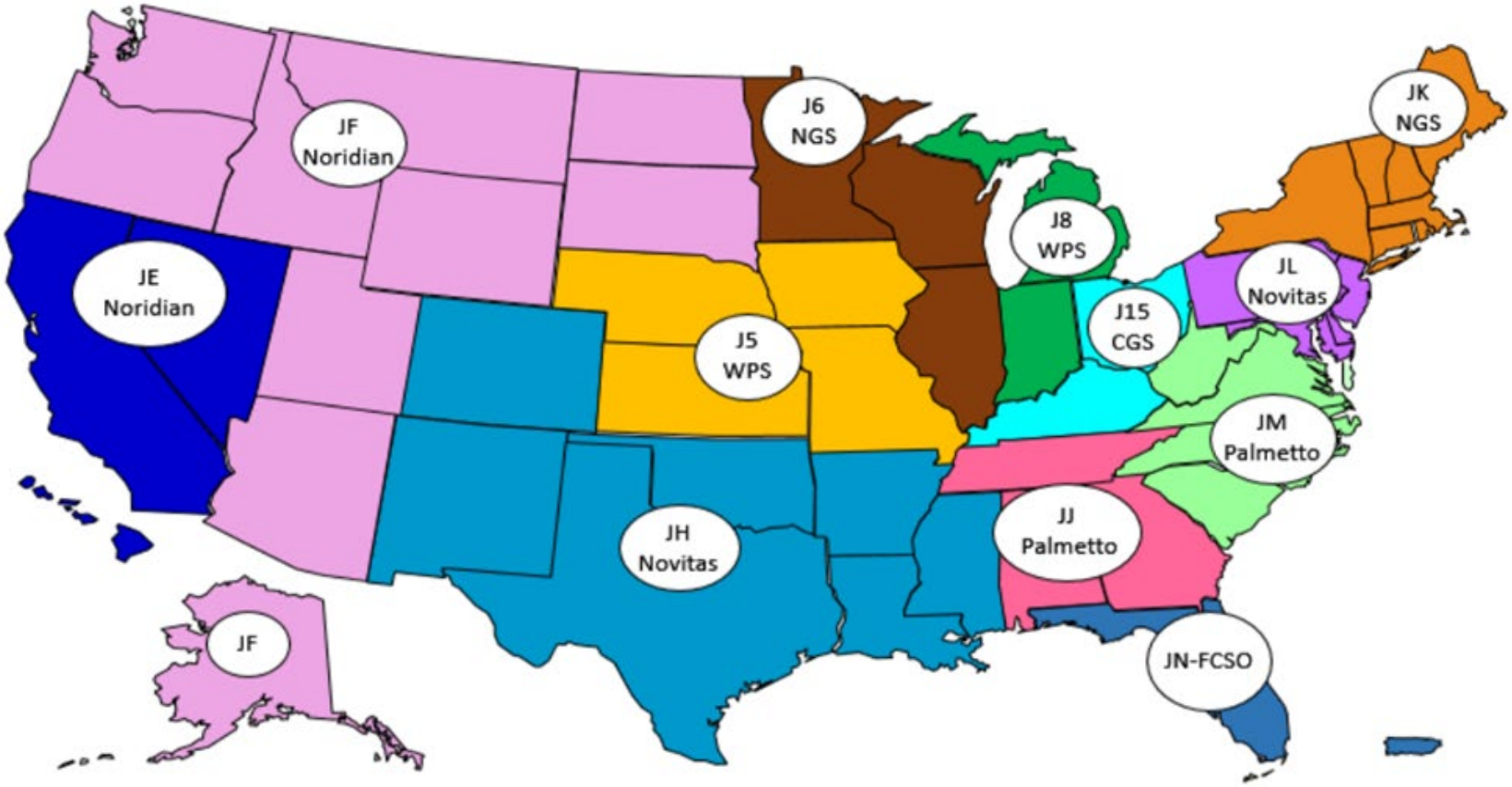
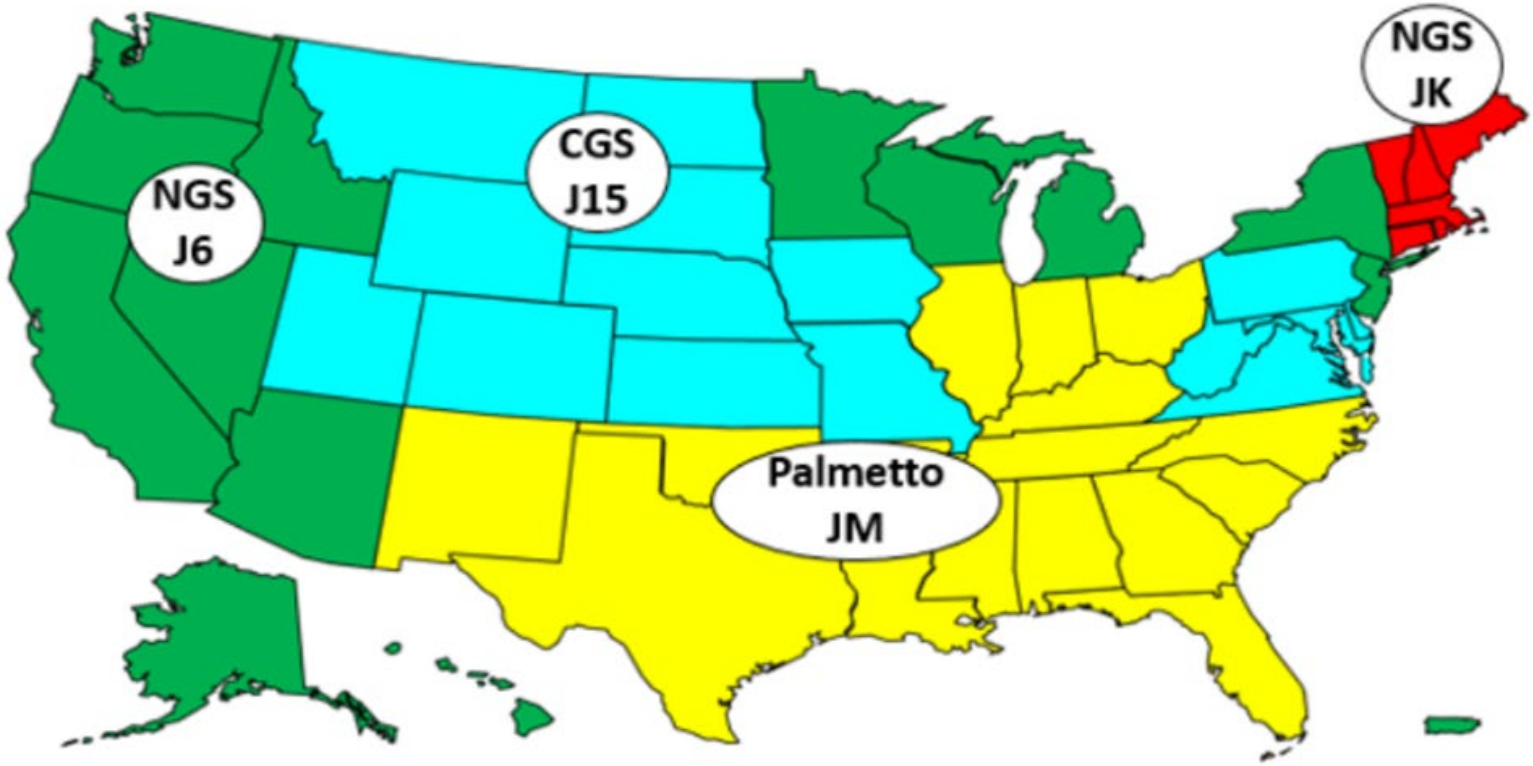
Medicare Administrative Contractor (MAC) Duties

- Provider Enrollment
- Claims Processing
- Claims Payment
- Medical Record Review
- Provider Audit & Reimbursement
- Provider Inquiry Response
- Provider Education
- First Level Appeals: Redeterminations

Medicare Parts A/B
Medicare Administrative Contractors



Home Health & Hospice
Medicare Administrative Contractors



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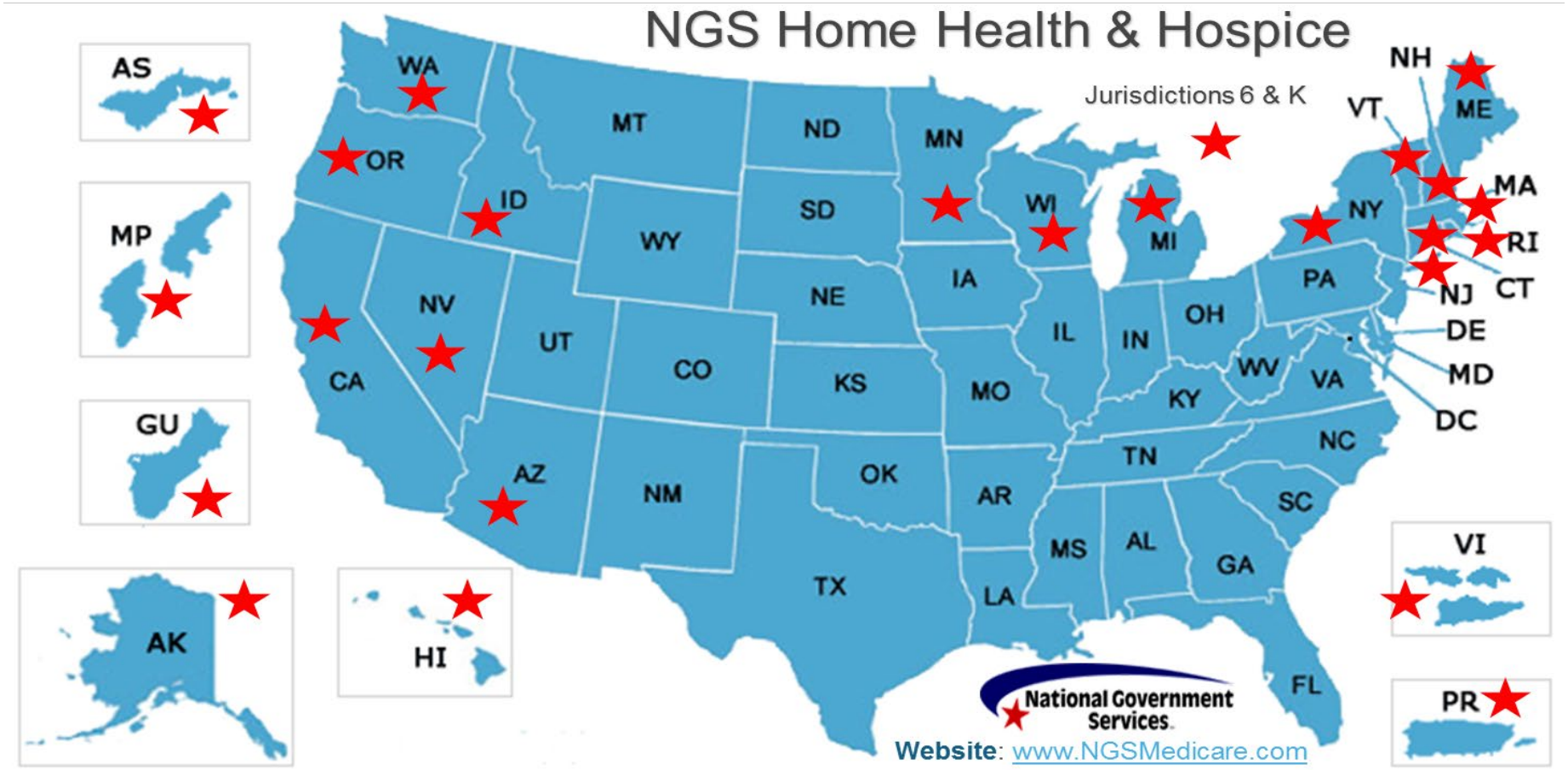
National Government Services
Home Health & Hospice Jurisdictions K & 6



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NGS Demographics

J6 Part A	J6 HHH	JK Part A & B	JK HHH
WI, MN, IL	AK, Samoa, AZ, CA, Guam, HI, ID, NV, NJ, NY, Mariana Islands, MI, MN, OR, PR, US VI, WI	CT, ME, MA, NH, NY, RI, VT	MA, RI, CT, NH, VT, ME
2.5+ Million Beneficiaries	12+ Million Beneficiaries	4+ Million Beneficiaries	2+ Million Beneficiaries
75,000 Physicians	**Approx 3K+ Home Health Agencies**	100,000 Physicians	**450+ Home Health Agencies**
450+ Hospitals	**1500+ Hospice Agencies**		**150+ Hospice Agencies**

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NGS Demographics

Serves over 27 million people with Medicare in 20 states & five US territories

Serves 240 members of Congress

14,000 Part A providers in 10 states

5,000 home health and hospice providers in 20 states & five US territories

4,500 FQHCs in 44 states, DC & five US territories

Over 416,000 Part B physicians and providers of service in 10 states

Over 228 million Medicare claims processed annually

Administered more than $84 billion from the Medicare trust fund in 2019

Responded to 2.4 million phone & interactive voice response calls

Responded to 59,000 written inquiries

Responded to 250 Congressional inquiries

Provider Outreach & Education

Provider Outreach & Education

MAC Collaboration
State HHH Associations
Medicare University
National HHH Associations
Social Media Venues
Annual Conferences & Virtual Education Events
Collaborative Education, Articles & Job Aids
Webinars, Computer Based Trainings & YouTube Videos

Unified Program Integrity Contractor

MAC

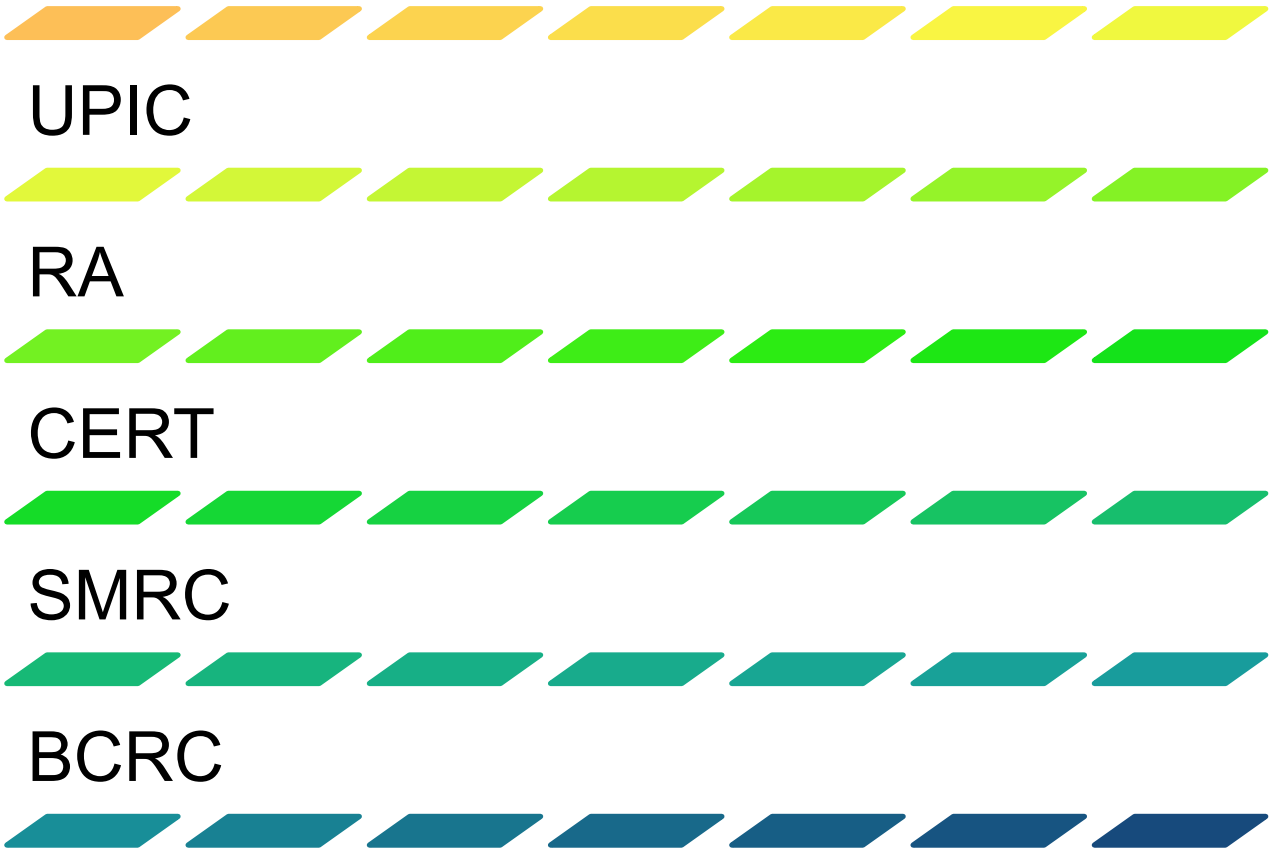
UPIC

RA

CERT

SMRC

BCRC



Unified Program Integrity Contractors (UPIC)

- Combine previously performed functions of the Zone Program Integrity Contractor (ZPIC) and the Program Safeguard Contractor (PSC)

Unified Program Integrity Contractors (UPIC)

- Detect, prevent and proactively deter fraud, waste and abuse within the Medicare Program

Unified Program Integrity Contractors (UPIC)

- Identify vulnerabilities
- Investigate fraud allegations
- Initiate the appropriate administrative actions to support evidence of fraudulent activity
- Refer any identified improper payments for recoupments to NGS

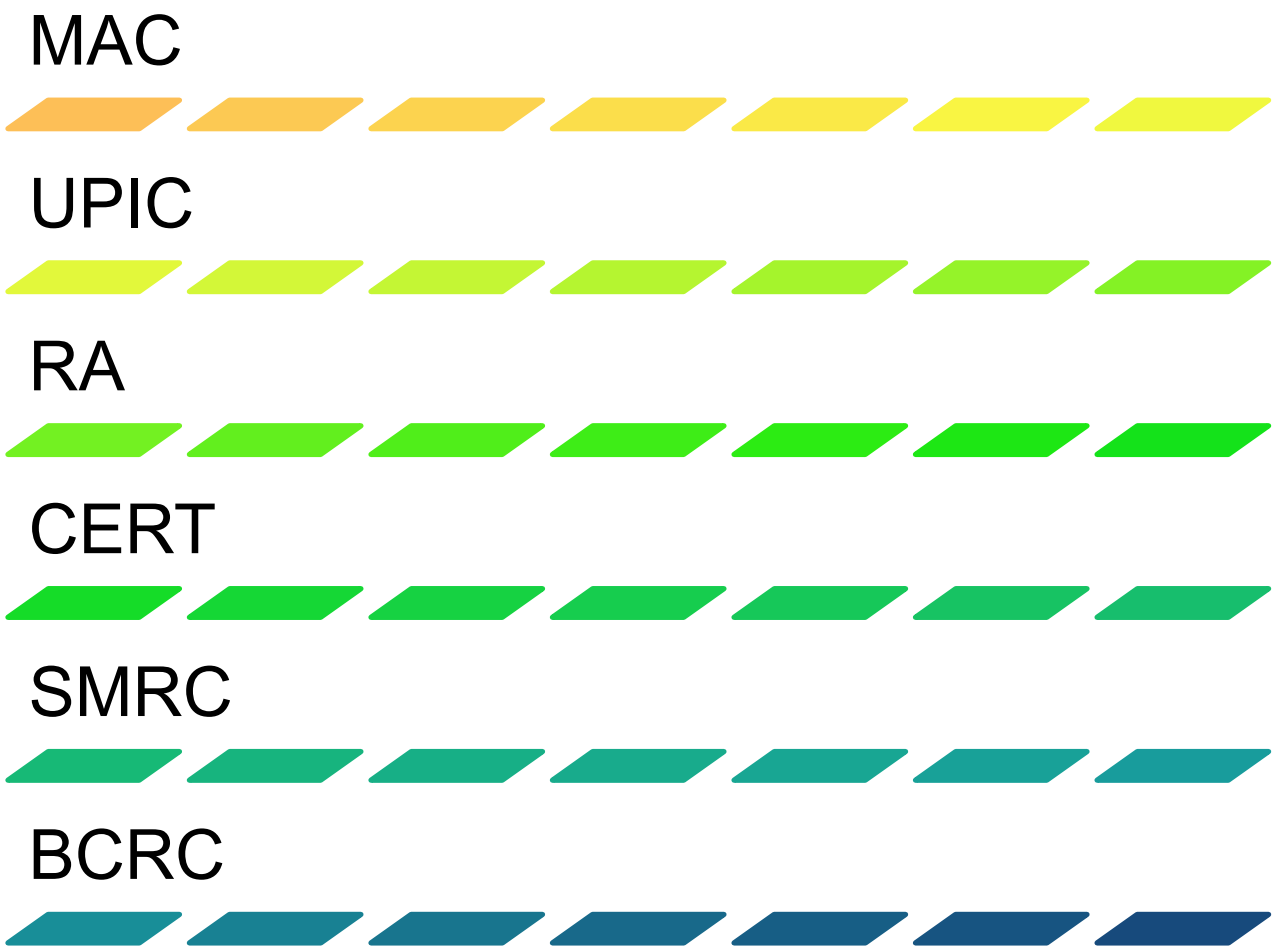
Unified Program Integrity Contractors (UPIC)

- NGS refers suspected fraud to the UPIC
  - Medical Review
  - Beneficiary Complaints
  - Data Analysis

Unified Program Integrity Contractors (UPIC)

UPIC North East	UPIC Mid West	UPIC South West	UPIC South East	UPIC West
Safeguard Services	CoventBridge Group	Qlarant Integrity Solutions	Safeguard Services	Qlarant Integrity Solutions
Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas	Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee, Virgin Islands, Virginia, West Virginia	Alaska, Arizona, American Samoa, **California**, Guam, Hawaii, Idaho, Montana, Nevada, North Dakota, Northern Marianas Islands, Oregon, South Dakota, Utah, Washington, Wyoming

Recovery Auditor



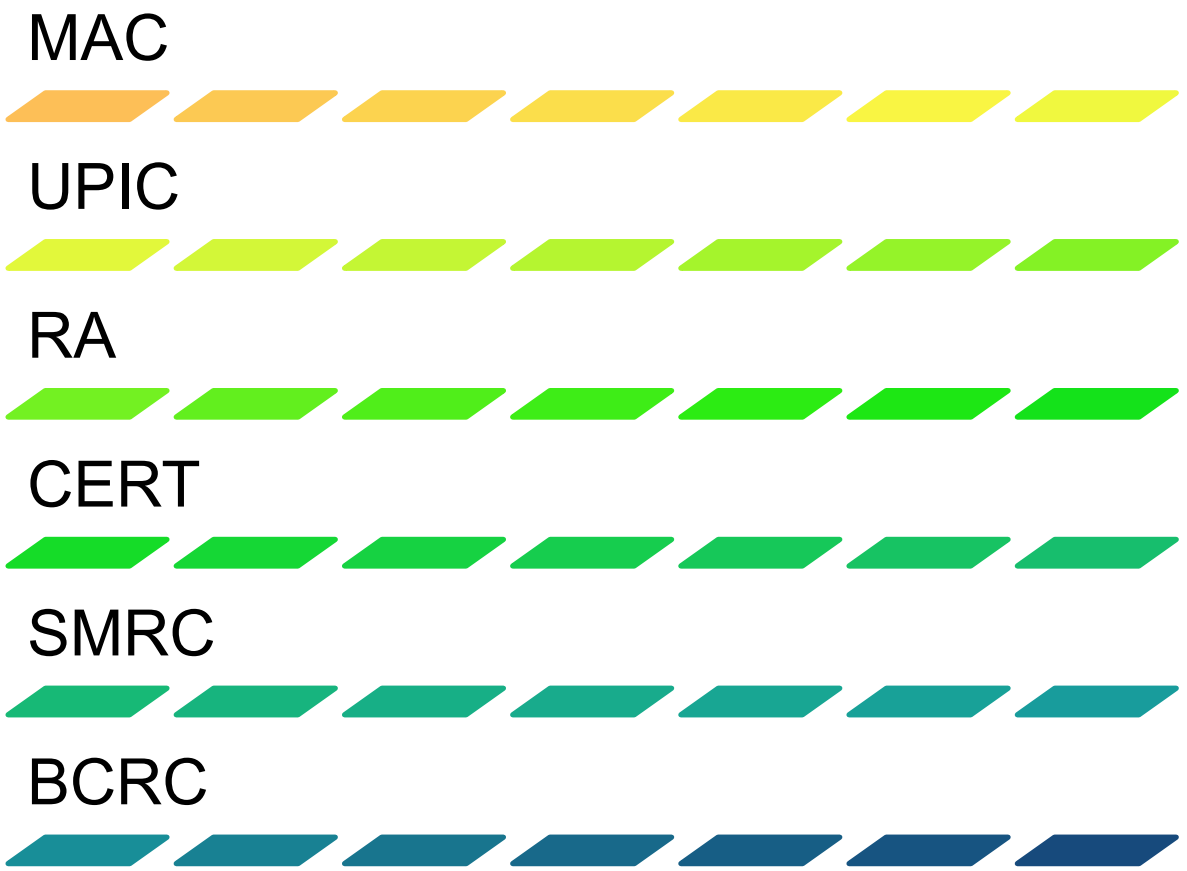
Recovery Auditor (RA)

- Goals:
  - Identify and recover Medicare overpayments and underpayments
- Functions:
  - Detect and correct improper payments
  - Implement actions that will prevent future improper payments

Recovery Auditor (RA)

- Nationwide
- Performant Recovery
  2751 Southwest Blvd.
  San Angelo, TX 76904
  Toll Free: 866-201-0580
- Email: info@performantrac.com
- Website: www.performantrac.com
- Medicare Fee for Service Recovery Audit Program

Comprehensive Error Rate Testing (CERT)



Comprehensive Error Rate Testing (CERT)

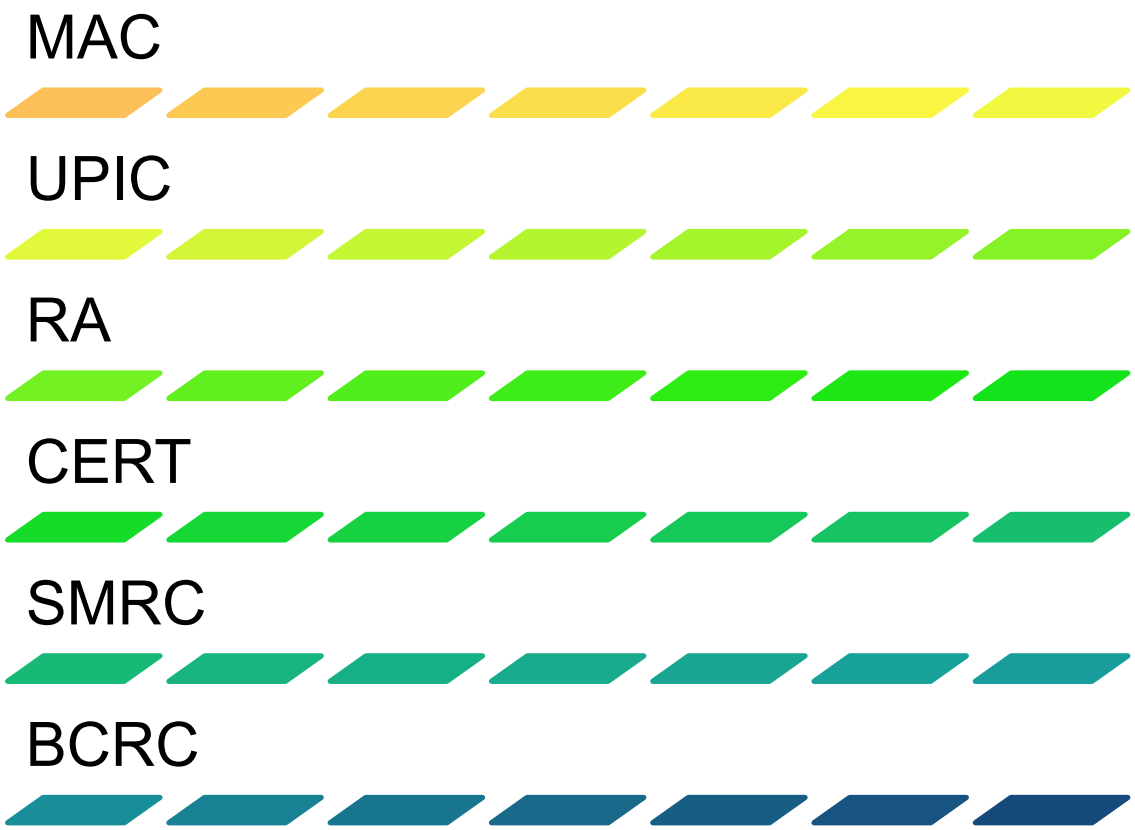
CERT Review Contractor:
NCI Information Systems, Inc.

Medical Record Submissions: CERTmail@nciinc.com

Comprehensive Error Rate Testing (CERT)

- CERT Documentation Center
  1510 East Parham Road
  Henrico, Virginia 23228
- Fax: 804-261-8100
- Customer Service: 888-779-7477
- Email: CERTprovider@nciinc.com

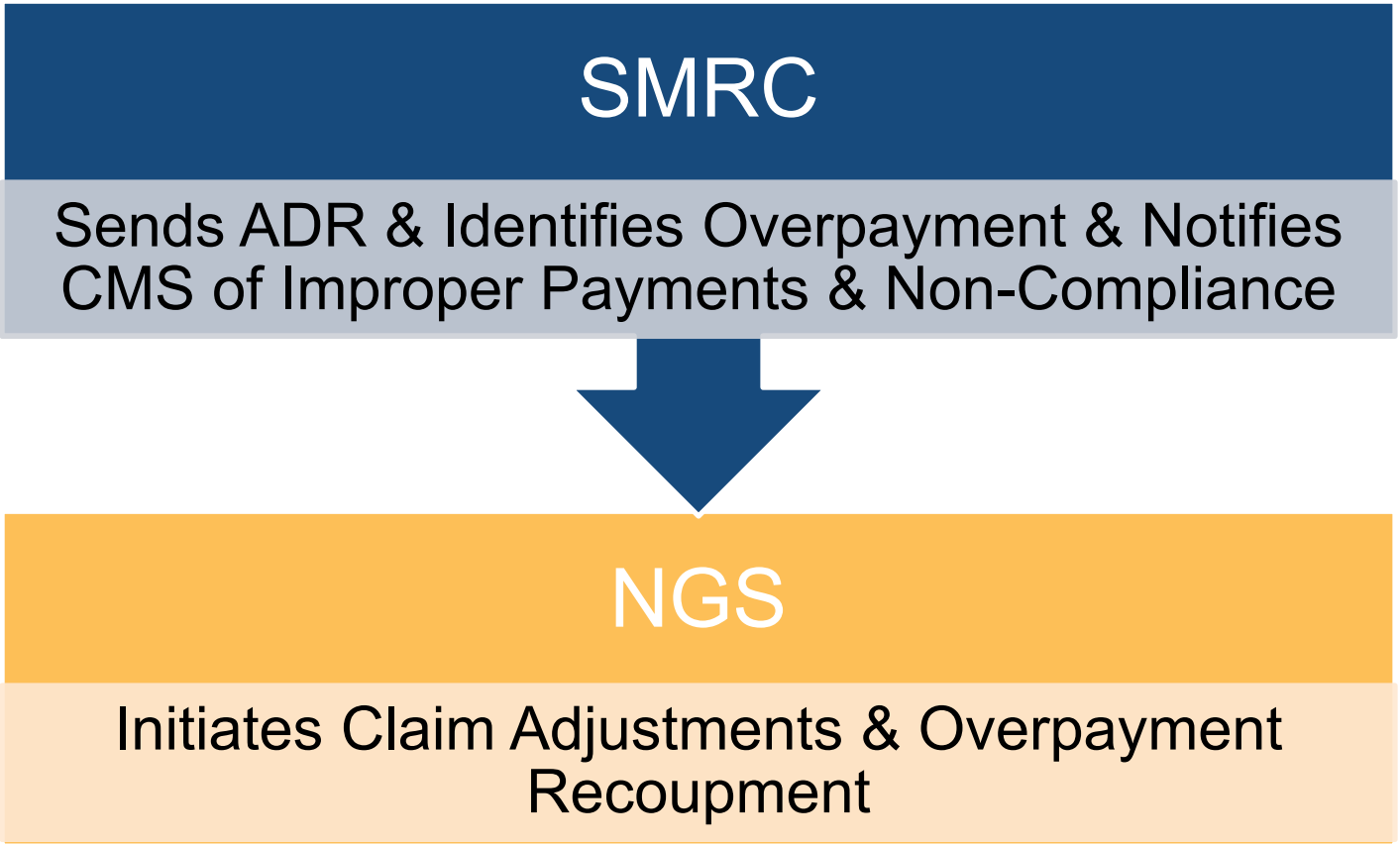
Supplemental Medical Review Contractor (SMRC)



Supplemental Medical Review Contractor (SMRC)

- Lower the improper payment rates and increasing efficiency of medical review functions of the Medicare and Medicaid programs
- Conducts medical review of Part A and B Medicare claims to ensure claims were billed in compliance
- Focus of review includes: vulnerabilities identified by CMS data analysis, CERT or other professional federal oversight agencies

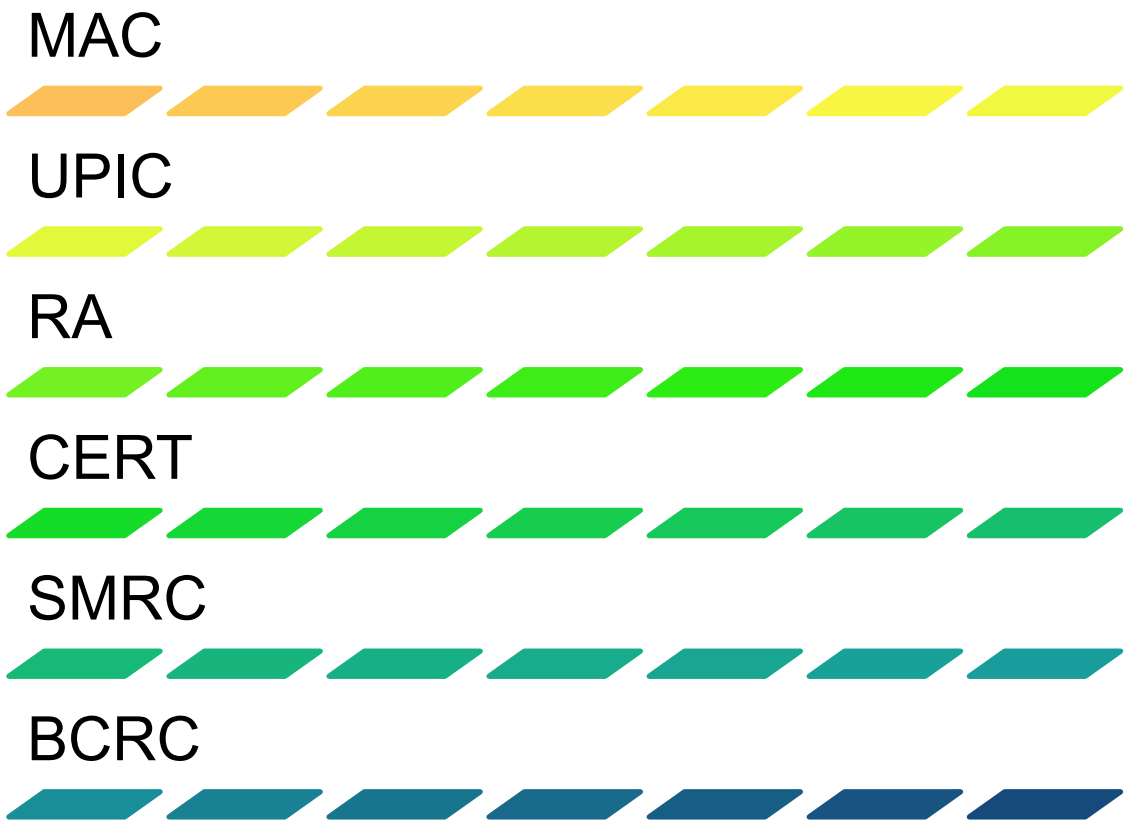
Supplemental Medical Review Contractor (SMRC)



Supplemental Medical Review Contractor (SMRC)

- SMRC
  Noridian Healthcare Solutions, LLC
  Noridian SMRC
  P.O. Box 6711
  Fargo, ND 58108-6711
- Accepts esMD Transactions
- Customer Service: 833-860-4133 (M-F 7:30 a.m.-5:00 p.m. CT)
- Email: SMRCMail@Noridian.com
- Website: https://www.noridiansmrc.com/

Benefits Coordination & Recovery Center (BCRC)



Benefits Coordination & Recovery Center (BCRC)

- The Medicare Secondary Payer (MSP) program is in place to ensure that Medicare is aware of situations where it should not be the primary, or first, payer of claims
- If a beneficiary has Medicare and other health insurance, Coordination of Benefits (COB) rules decide which entity pays first
- Activities related to the collection, management, and reporting of other insurance coverage for beneficiaries
- Responsible for creation, updates & termination of all MSP

Benefits Coordination & Recovery Center (BCRC)

- Customer Service
  M-F 8:00 a.m.-8:00 p.m. ET
- Telephone: 855-798-2627
- Fax:405-869-3307
- Written Inquiries
  Medicare – Data Collections
  P.O. Box 138897
  Oklahoma City, OK 73113-8897

Safeguarding the Medicare Program

Safeguarding the Medicare Program

Fraud

Waste

Abuse

Safeguarding the Medicare Program

FRAUD: The intentional deception or misrepresentation of facts that an individual or organization knows to be false or does not believe to be true and could result in some unauthorized benefit to himself/herself or some other person, or the organization.

Safeguarding the Medicare Program

WASTE: Over-utilization of services, or other practices that result in unnecessary costs, taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act, or omission by players with control over or access to government resources.

Safeguarding the Medicare Program

ABUSE: Actions that are inconsistent with accepted, sound medical, business or fiscal practices. Abuse can be identified when individuals unintentionally follow practices that result in unnecessary Medicare Program costs. Abusive practices may develop into fraud and be prosecuted as such. Abuse directly or indirectly results in unnecessary costs to the program through improper payments.

Safeguarding the Medicare Program

https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/downloads/2017-medicare-101.pptx

Safeguarding the Medicare Program

Helpful Hints

- Staff Education
- Responsibility
- Medical Necessity
- Comprehension Of the Anti-Kickback Statute & Stark Laws
- Report Fraud

Safeguarding the Medicare Program

Report Fraud, Waste & Abuse

By Phone

Health & Human Services Office of the Inspector General

1-800-HHS-TIPS
(1-800-447-8477)
TTY: 1-800-377-4950

Online

Health & Human Services Office of the Inspector General Website

By Fax

Maximum of 10 pages

1-800-223-8164

By Mail

Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

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CMS and NGS Home Health & Hospice References and Resources

CMS References & Resources

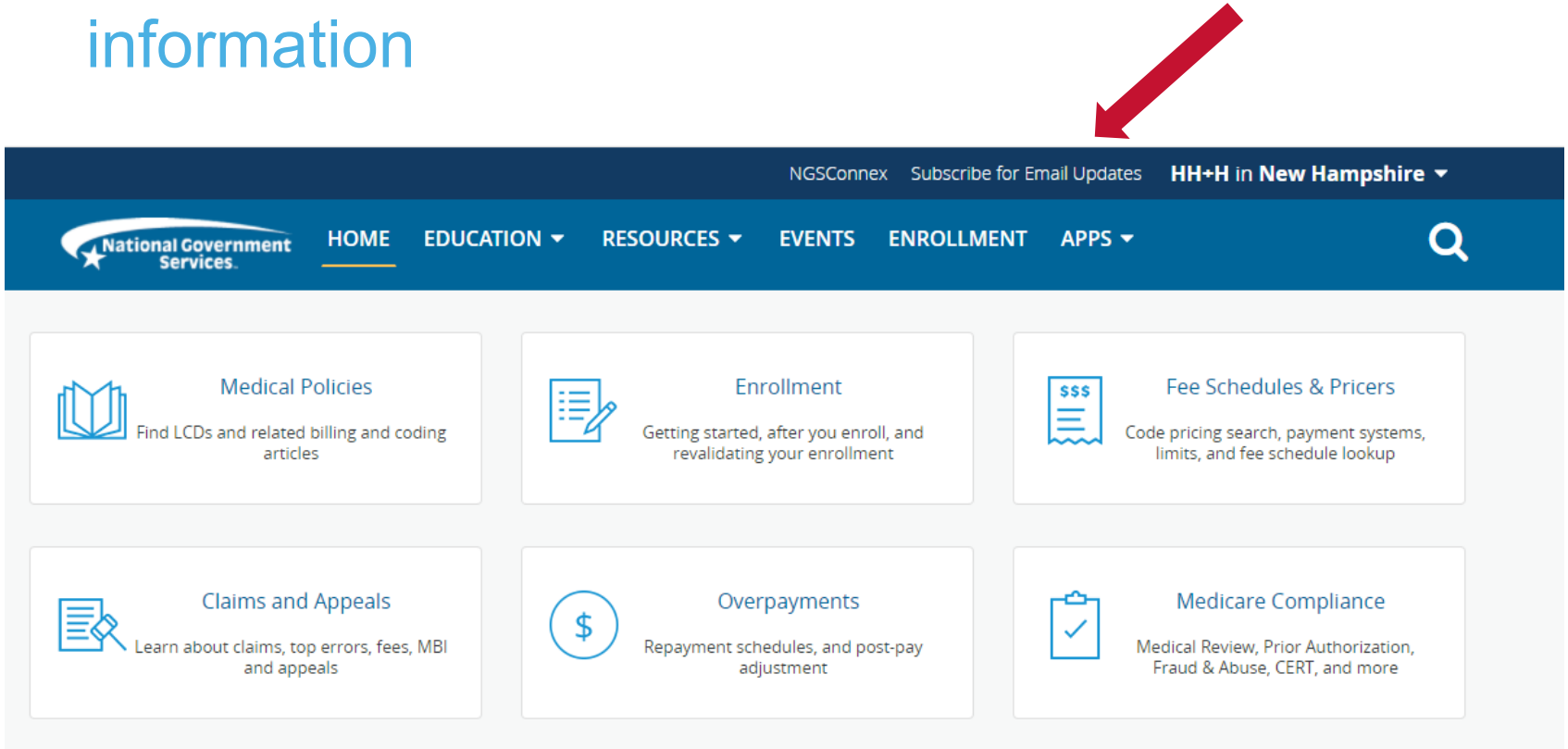
- CMS Original Fee-for-Service Appeals Portal
- Supplemental Medical Review Contractor (SMRC)
- Benefits Coordination & Recovery Center (BCRC)
- Medicare Fee-for-Service Recovery Auditor (RA)
- Comprehensive Error Rate Testing (CERT)
- Review Contractor Directory

NGS References & Resources

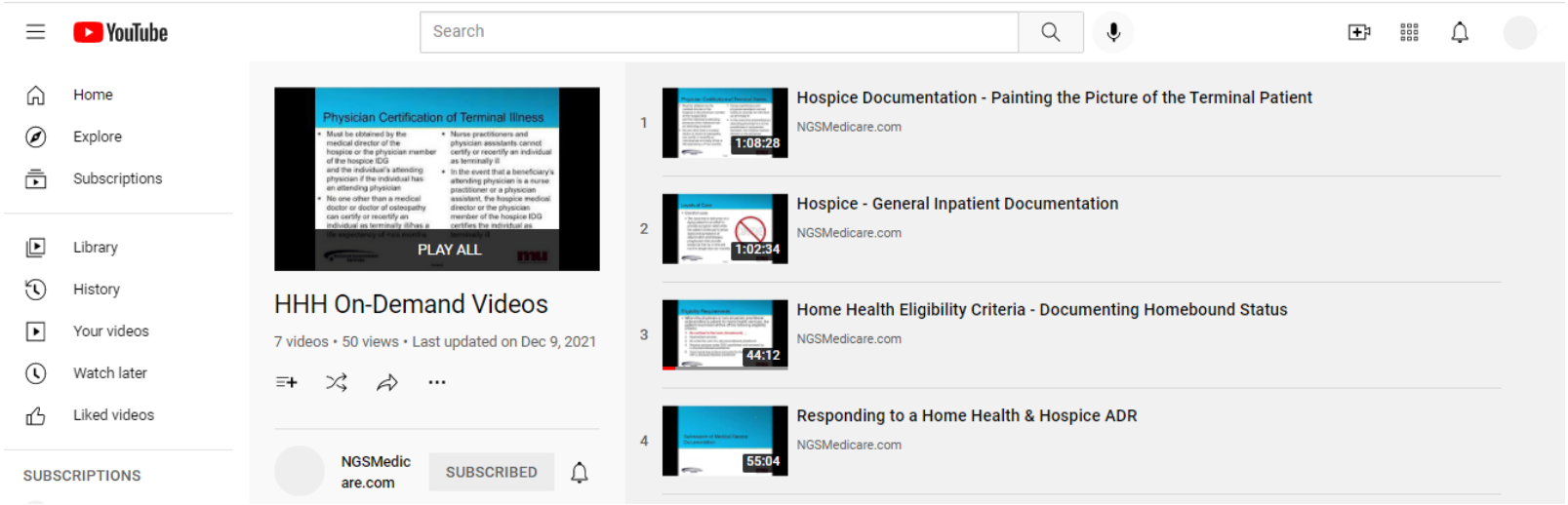
- NGS Website
  - Resources
  - Medicare Compliance
  - Fraud and Abuse

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS HHH On-Demand Videos



Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs

Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

2022 MAC Collaborative Home Health & Hospice Medicare Summit

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Thank You!

- Questions?

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Targeted Probe & Educate (TPE)
Session Two

July 13, 2022

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Responding to a Home Health & Hospice Additional Documentation Request (ADR) Session Three

July 13, 2022

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Objectives

- Provide direction regarding how to respond to an ADR to support your Medicare claim
- Review helpful tools to find ADRs and submit medical record documentation
- Decrease denials for nonsubmission of medical record documentation (56900)
- Improve provider collaboration of medical record documentation
- Increase utilization of electronic medical record documentation submission (NGSConnex)
- Offer an increased understanding of FISS

Agenda

- Additional Documentation Request (ADR)
- Submission of Medical Record Documentation
- NGSConnex
- Navigating FISS
- Helpful Hints
- References and Resources
- Question and Answer

Additional Documentation Request (ADR)

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ADR

- An ADR is a request for documentation to support a Medicare claim
  - It is imperative that providers maintain a process or policy that ensures requested medical record documentation is collected efficiently and appropriately for review
  - Methods or techniques often utilized to ensure proper documentation is collected include
    - Mock Chart
    - Check List
    - Staff Members Assigned to Collect Documentation
    - Staff Members Assigned to Review Documentation Prior to Submission

ADR

System Issues ADR	• Claim suspends to status/location SB 6001 • ADR is sent to provider • Provider has 45 days to return records to the MAC
Records are NOT received by day 45	• On day 46 the system will deny the claim and move it to S/L DB 9997 • Claim assigned reason code 56900
Wait one week and recheck status/location	• If the records were received the claim will move to S/L SM 5REC • If denial code appears, recheck, call the PCC for assistance, if necessary

ADR

- Incorporating the methods and techniques mentioned into policies/procedures will assist in ensuring
  - Appropriate documentation is obtained from outside entities
  - Records are reviewed for accuracy by multiple people prior to submission
  - All eligibility criteria have been met
  - All proper documentation is included in the medical record prior to submission
  - Proper claims payment

ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS VIA PAPER, FAX, CD/DVD AND ESMD OMB #0938-0969

PLEASE NOTE:

MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 45 CALENDAR DAYS.

NON-MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 14 CALENDAR DAYS.

ADR

- The ADR provides helpful hints to help appropriate claims payment

MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED.

MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN SIGNATURES, HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD.

ADR

PATIENT IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER SIGNATURE IS NOT CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE, AND THE INITIALS FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT AN ATTESTATION STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE THAT THE MEDICAL NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

PLEASE SUBMIT THE SUPPORTING DOCUMENTATION WITHIN 45 DAYS FROM THE DATE OF THIS NOTICE. THIS DOCUMENTATION MUST BE CLEAR AND LEGIBLE.

Date

Signature

Legibility

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ADR

- The ADR does not provide an all-inclusive list of what should/should not be included for medical record submission
- **Reminder:** It is important to review the records prior to submission to ensure documentation supports eligibility criteria

Submission of Medical Record Documentation

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Submission of Medical Record Documentation

- Documentation Collaboration
- Sources of documentation that may assist in supporting eligibility criteria include
  - Discharge summary
  - Progress notes
  - History and physical
  - Plan of care
  - Case Management records
  - Discharge Planning documentation
  - Therapy records
  - Face-to-face encounter documentation

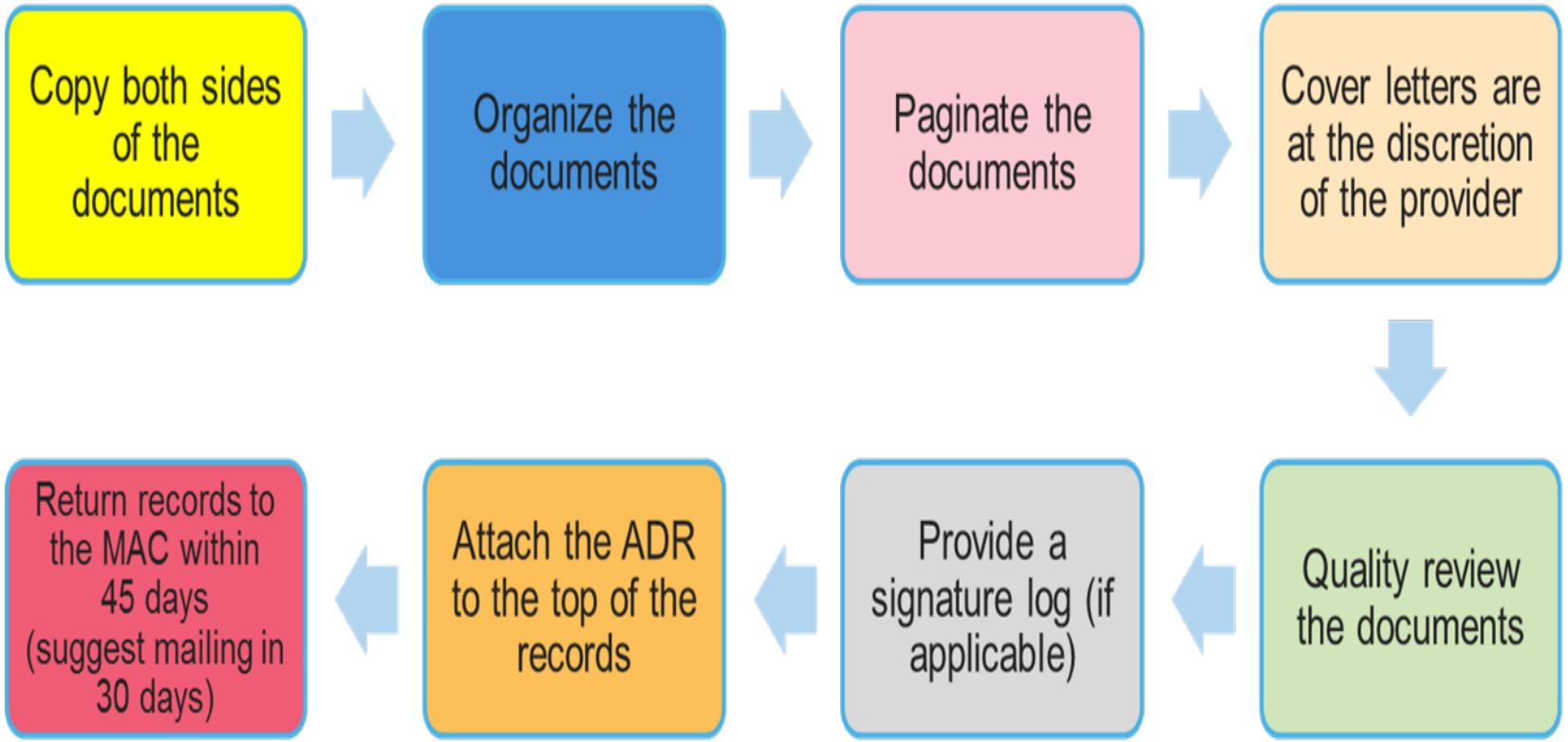
Submission of Medical Record Documentation

- Documentation Preparation
- Prior to submission of documentation, it is imperative that all medical record documentation is completely reviewed to ensure
  - All pages are for the appropriate patient
  - PECOS – Validation for all physicians involved in the patient's care for all DOS in the period of care
  - Appropriate OASIS submission
  - Any and all therapy evaluations and reevaluations are included
  - The patient's name is on each page (front and back where appropriate)
  - The correct dates of service for the claimed period of care
  - Dates and signatures are clear and appropriate
  - Legibility of all handwritten documentation

Submission of Medical Record Documentation

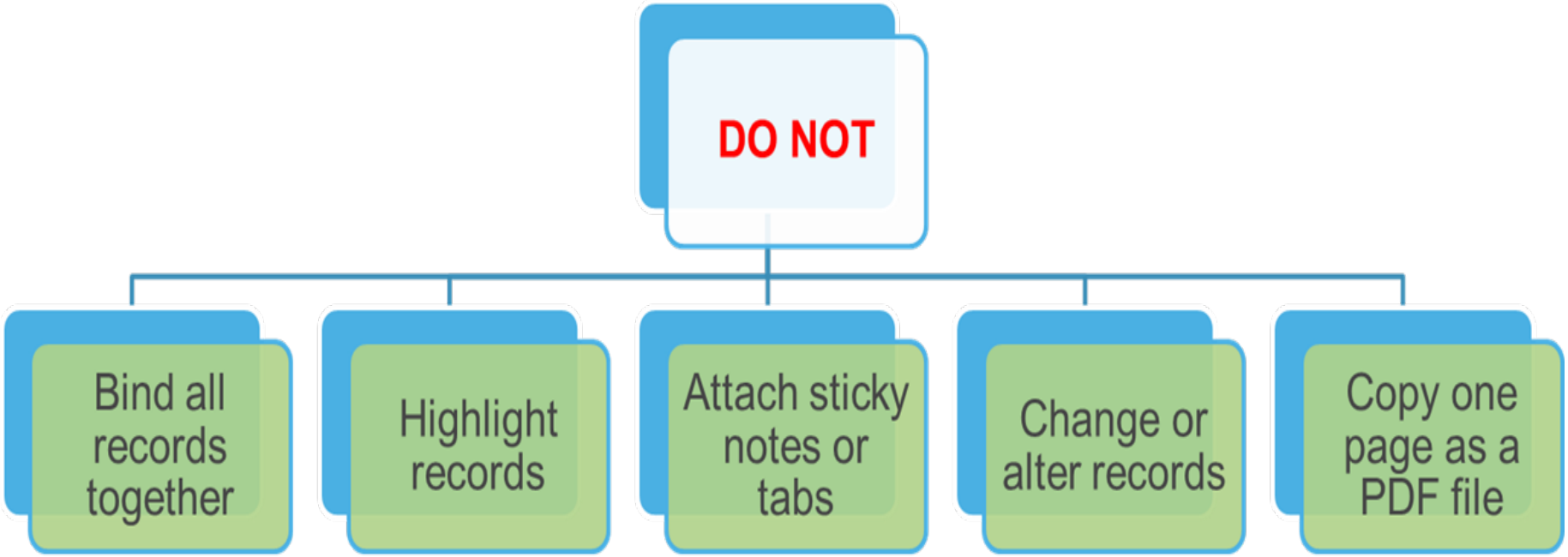
- Documentation Preparation
- Prior to submission of documentation, review all records to ensure
  - Identifiable credentials for each clinician signature
    - Signature sheets as appropriate from agency and referring facility/office
  - Accuracy of documentation
  - All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
  - Pages are not folded over, cut off or crinkled during copying/printing/faxing
  - Highlighter is not utilized
  - ADR is placed on the top of the medical record
  - Reminder: Black ink copies best
  - Provider contact name and telephone number

Submission of Medical Record Documentation

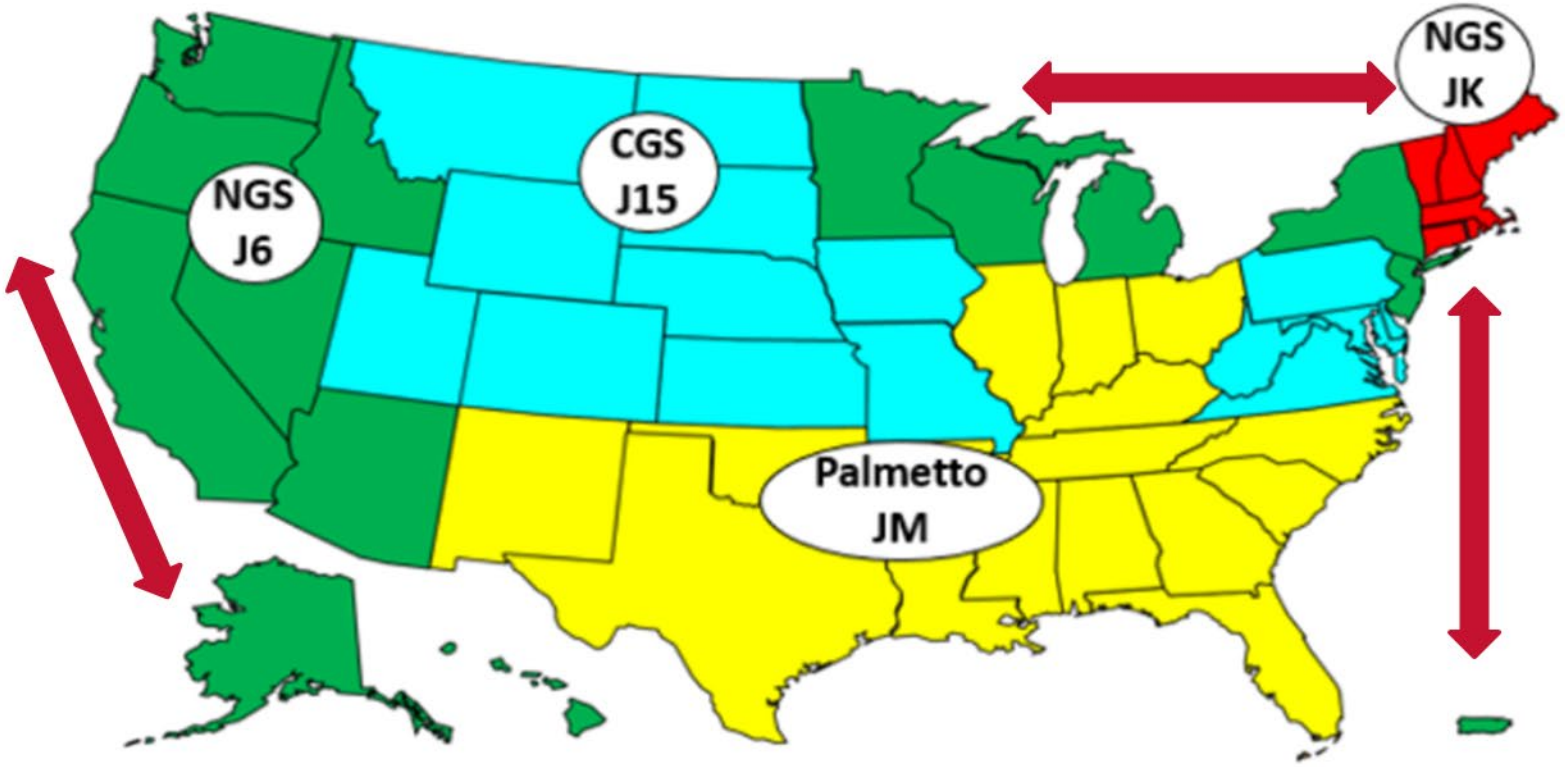


Submission of Medical Record Documentation

Documentation Preparation



Submission of Medical Record Documentation
Home Health & Hospice Jurisdictions



Submission of Medical Record Documentation **J6**

NGSConnex
esMD

FedEx

National Government Services Inc.
8115 Knue Rd
Indianapolis, IN 46250
Attn: Mail & Distribution

National Government Services Inc.
PO Box 7108
Indianapolis, IN 46206-6474

FAX: 315.442.4154

Always check www.NGSMedicare.com for the most current information

Records Not Received

NGSConnex

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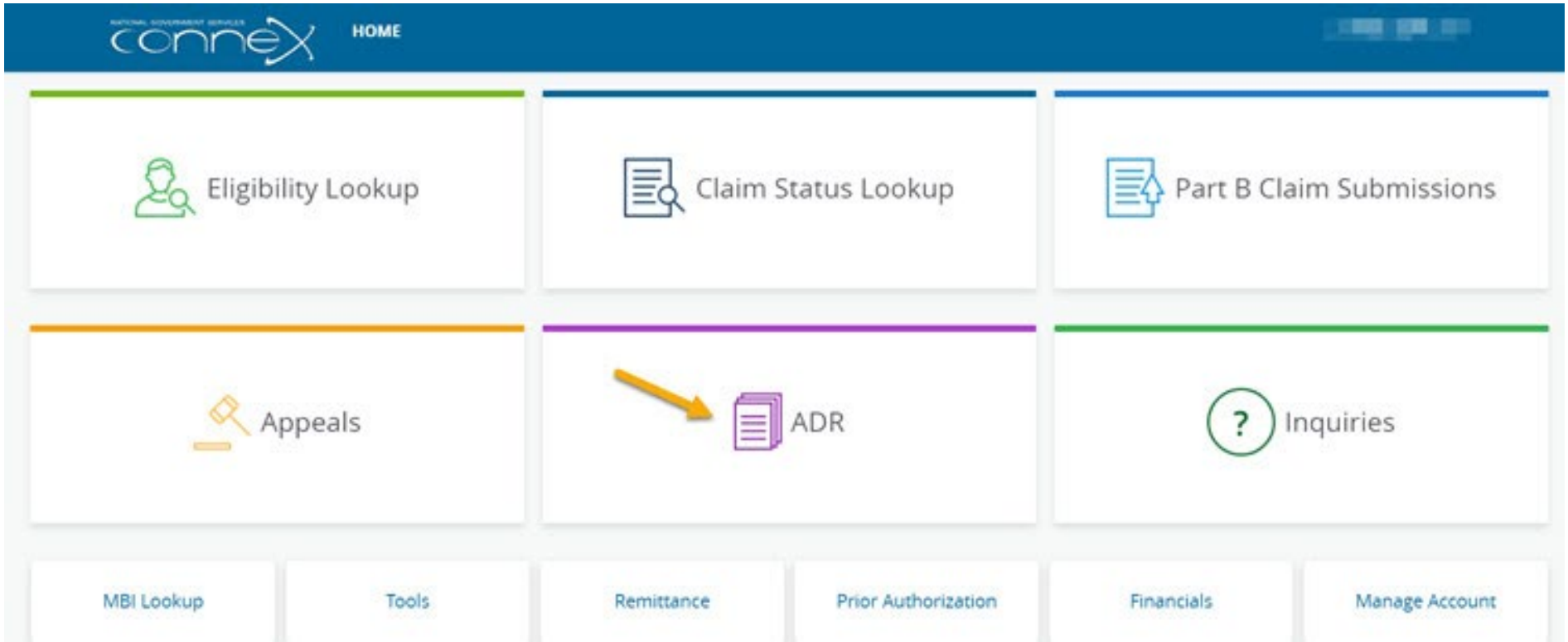
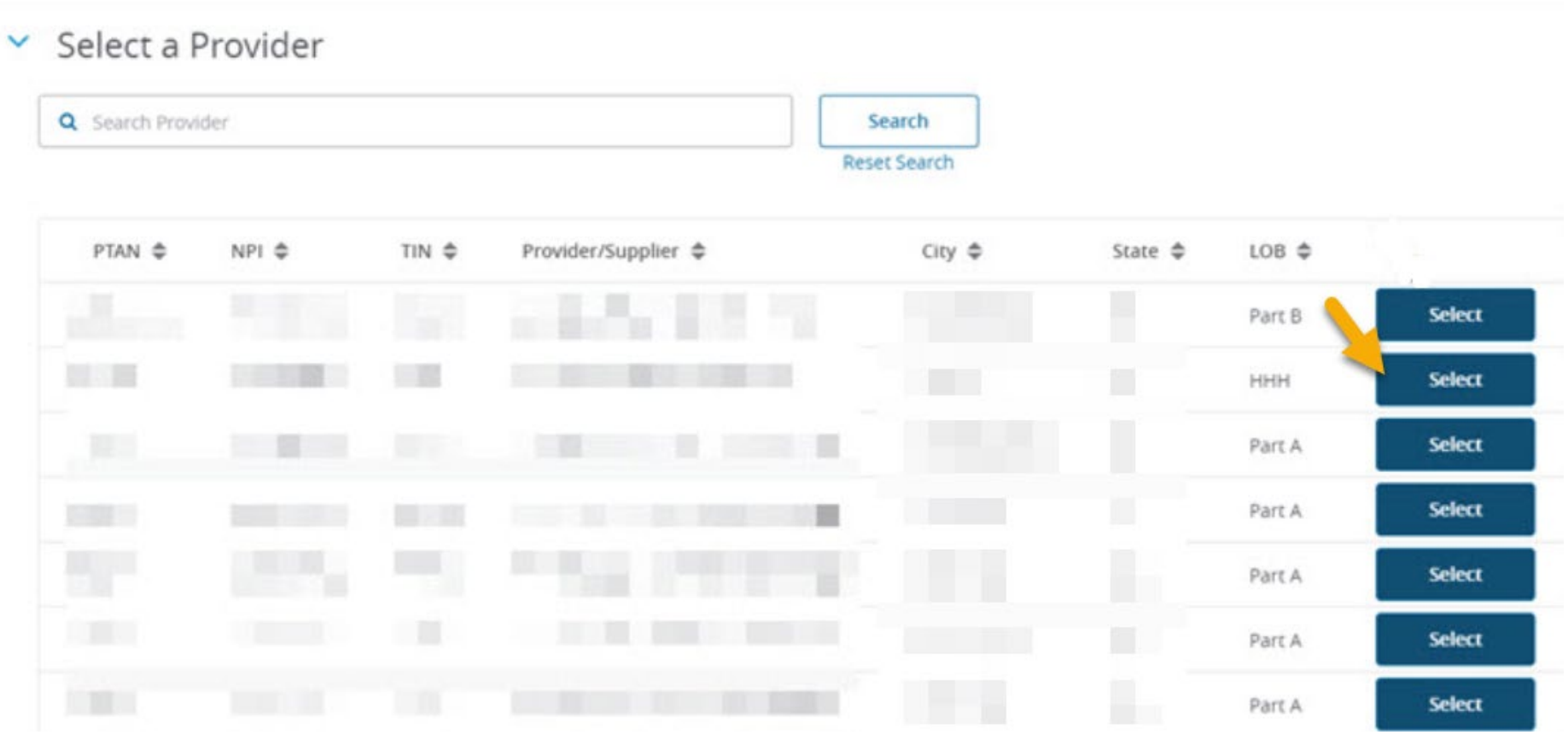
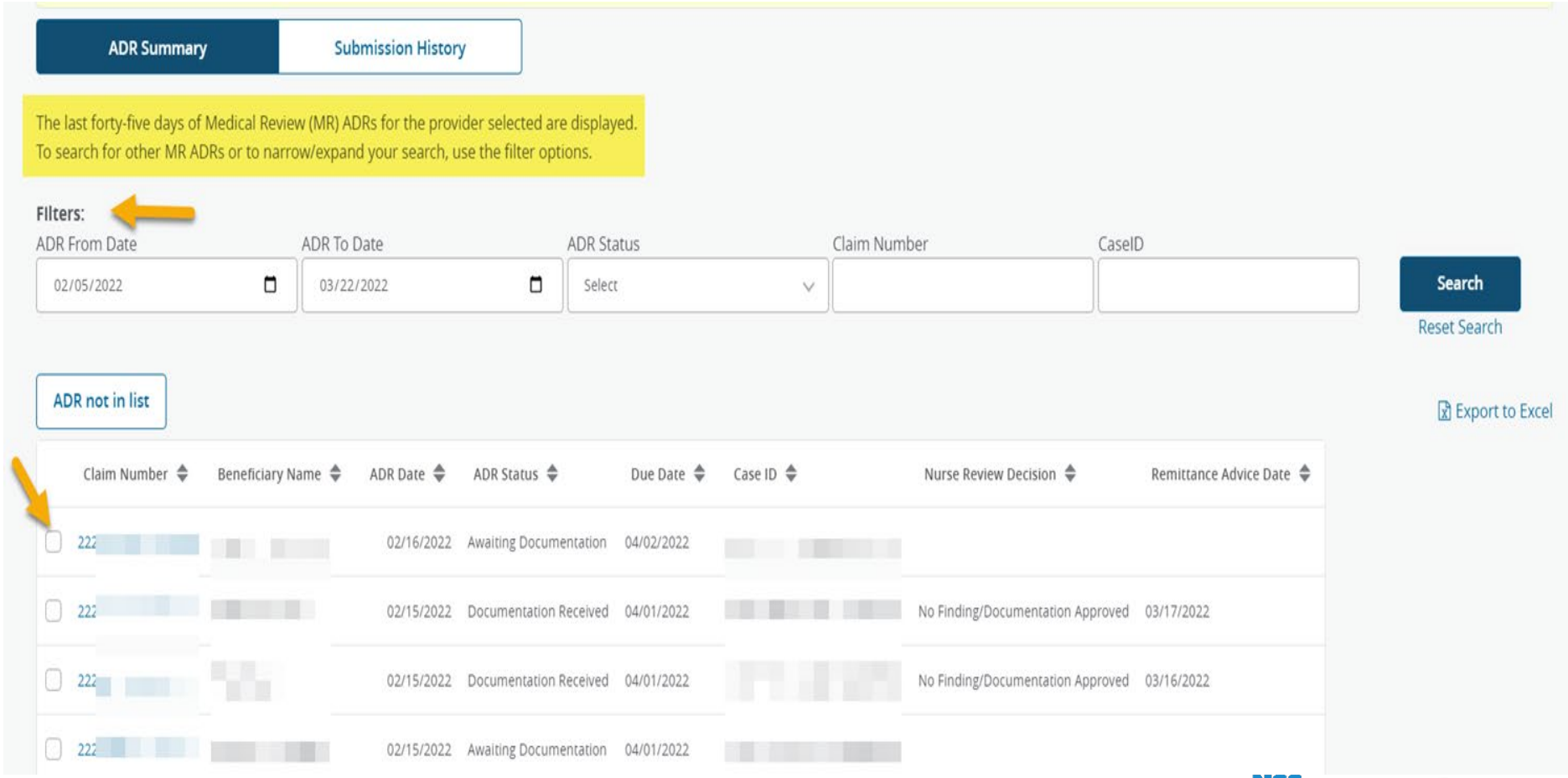
NGSConnex: Homepage



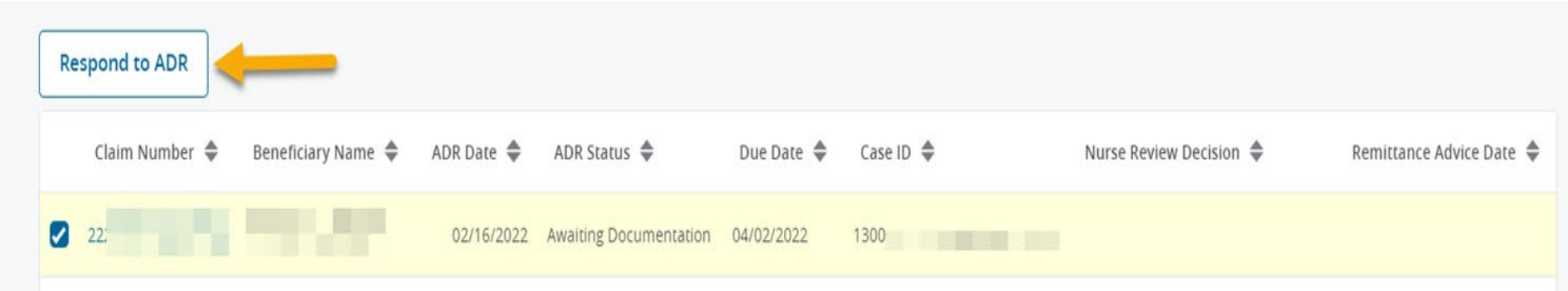
NGSConnex: Select a Provider



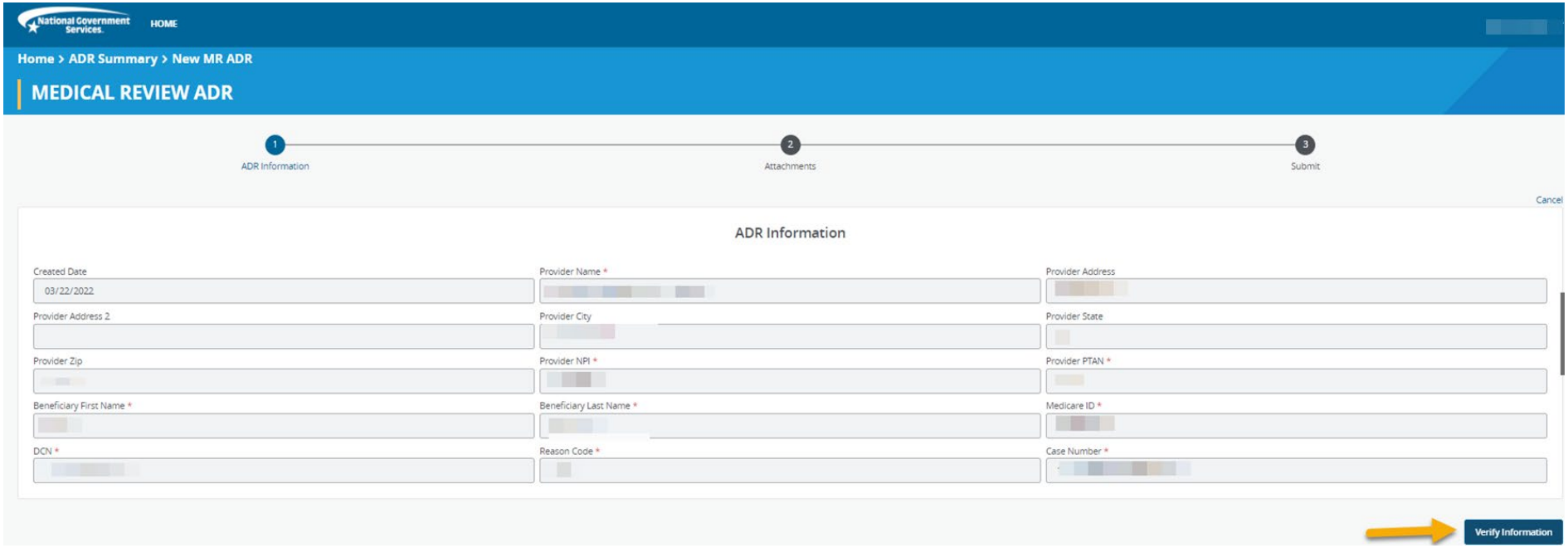
NGSConnex: ADR Summary Panel



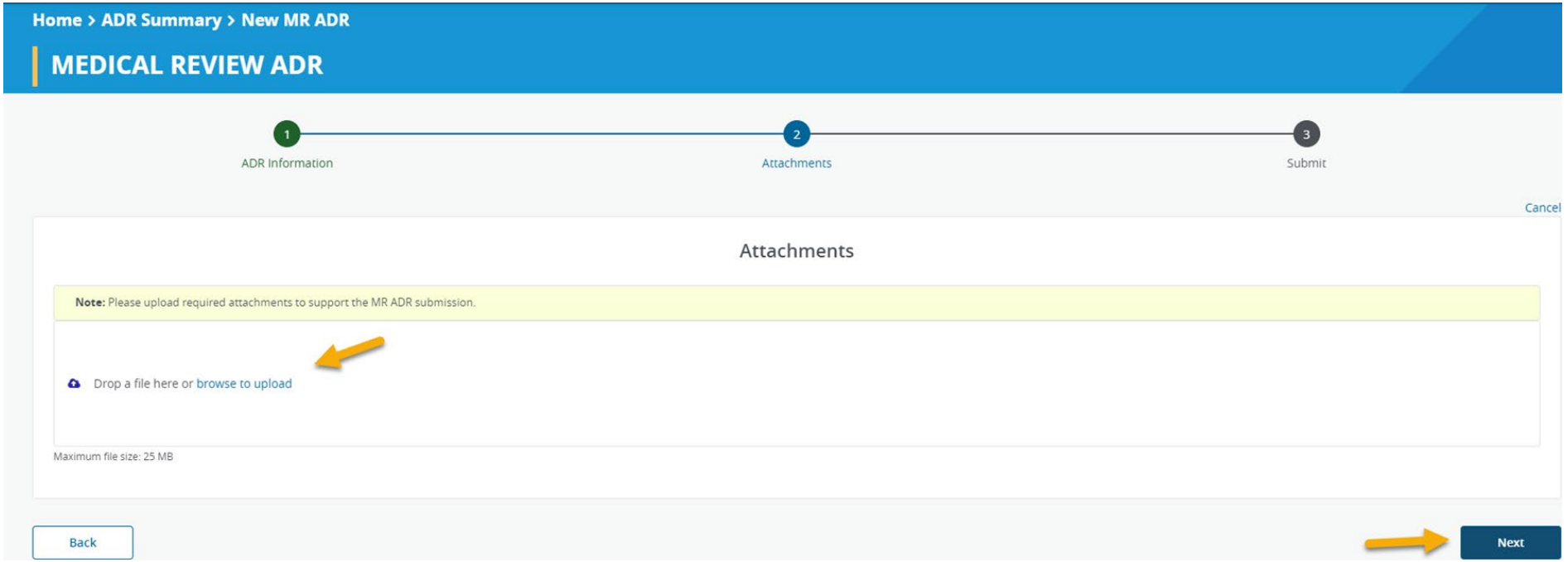
NGSConnex: Respond to an ADR



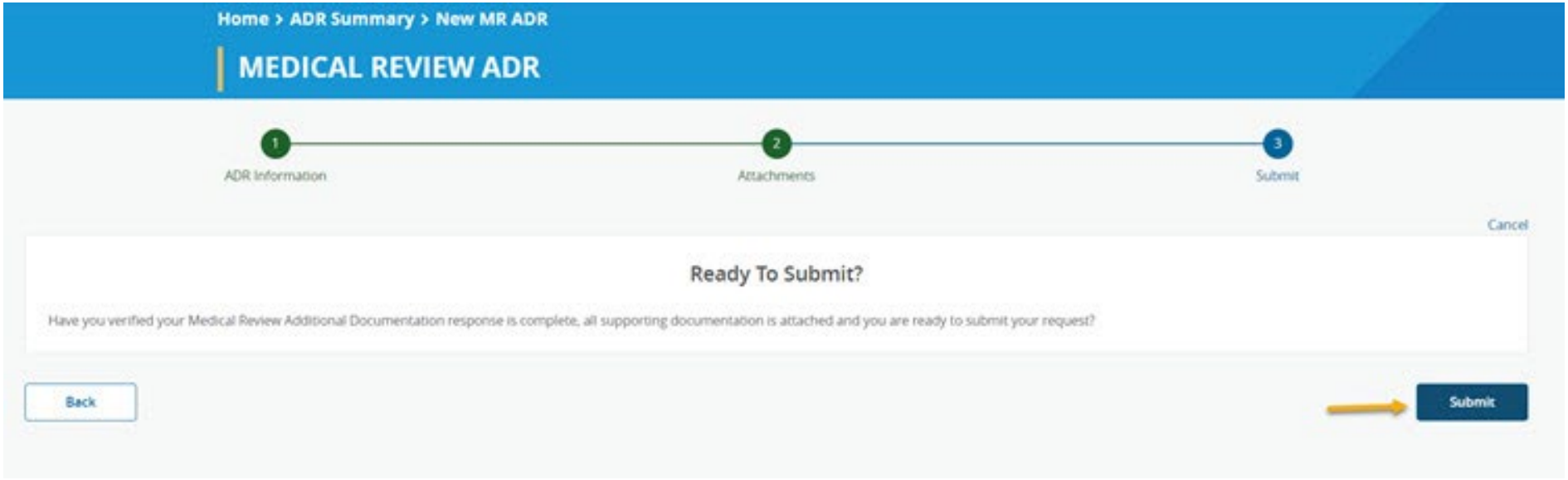
NGSConnex: ADR Information – Step 1



NGSConnex: ADR Information – Step 2



NGSConnex: ADR Information – Step 3



Navigating FISS

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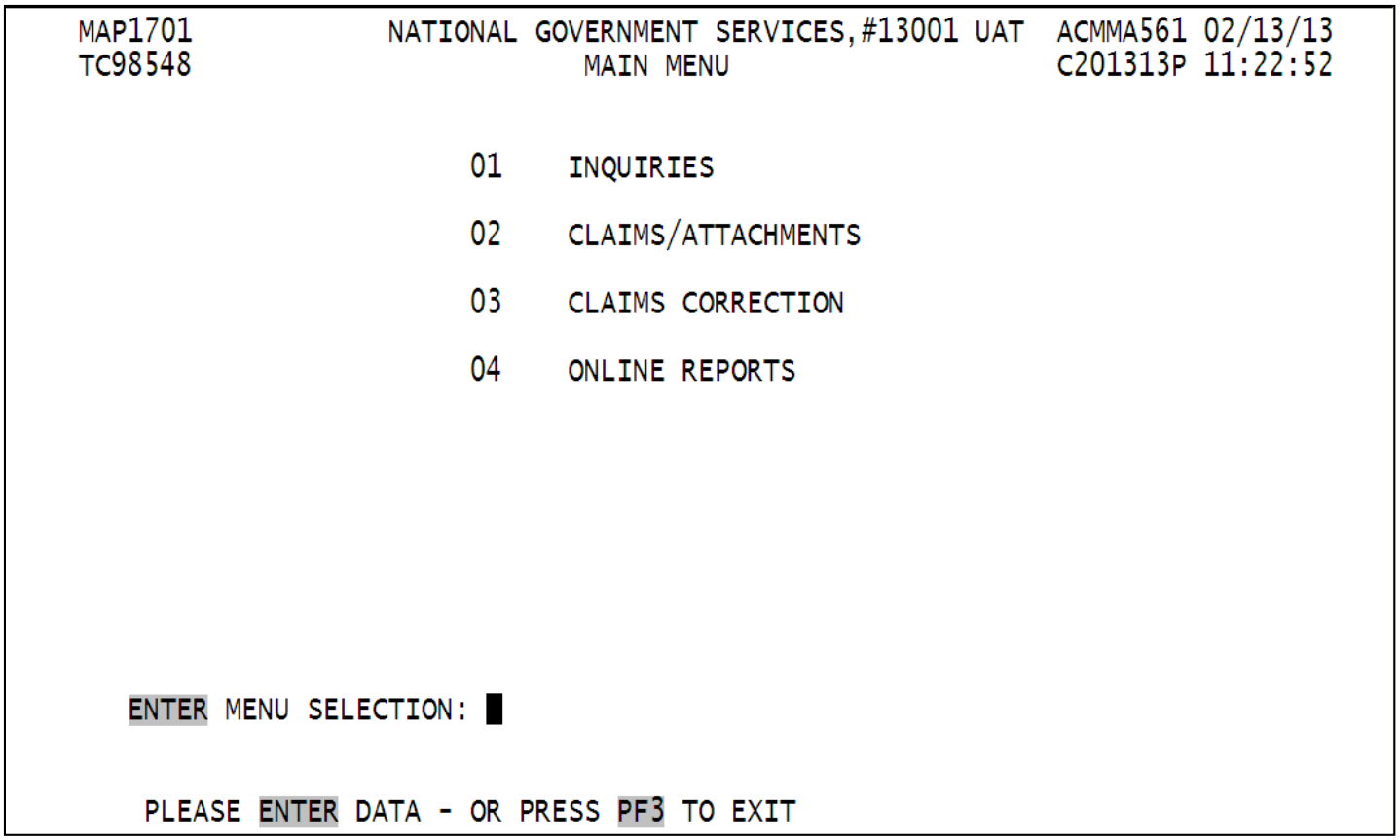
Accessing ADRs in the Claim Summary Option

- ADRs can be accessed by filtering the claims by status/location
  - ADRs are housed in S/LOC S B6001
- At the **Claims Inquiry** screen, type **SB6001** in the **S/LOC field** and press **<Enter>** - all claims in the SB6001 status and location will be displayed
  - (SB6001 status indicates that an ADR has been generated for a claim)
- At the desired claim, type **S** to the left of the claim under the **SEL field** and press **<Enter>**
- The ADR letter follows page 06 of the claim
- Please be sure to **not** press the **<P9>/<PF9>** key while viewing a claim in the SB6001 status—this will cause the claim to recycle and generate a second ADR letter
- **Note:** requested records are due to NGS 30 days from the date the claim went to **S/LOC SB6001** in FISS

FISS DDE Main Menu



Inquiries Sub-menu

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MAP1702          NATIONAL GOVERNMENT SERVICES,#13001 UAT  ACMFA561 03/11/20
MXG9282                      INQUIRY MENU                 A2020200 13:18:11


      BENEFICIARY/CWF          10    ZIP CODE FILE           19
      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY  1A
      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY     56
      REVENUE CODES            13    HOME HEALTH PYMT TOTALS 67
      HCPC CODES               14    ANSI REASON CODES       68
      DX/PROC CODES ICD-9      15    CHECK HISTORY           FI
      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10    1B
      REASON CODES             17    CMHC PAYMENT TOTALS     1C
      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER 1D
                                     NEW HCPC SCREEN         1E




   ENTER MENU SELECTION:
```

Claim Summary Option 01/12

```
MAP1741              NATIONAL GOVERNMENT SERVICES, #13001 UAT      ACMFA561 04/01/21

 KXT2938   SC              CLAIM SUMMARY INQUIRY              A20212CF 05:29:13

                              NPI

      MID                PROVIDER          S/LOC S B6001       TOB

  OPERATOR ID KXT2938    FROM DATE             TO DATE           DDE SORT

  MEDICAL REVIEW SELECT           DCN

      MID             PROV/MRN    S/LOC       TOB    ADM DT    FRM DT THRU DT    REC DT

SEL   LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT   CAN DT REAS NPC #DAYS

      XXXXXXXXXX    XXX100       S B6001          131            022221 022221     013121

      ABCDEFG         H          3502.90                              39700



                                        PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE

               PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
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Reason Code File (17) or PF1 (page 1)

```
MAP1881                          NATIONAL GOVERNMENT SERVICES,#13001          UAT   ACMFA561 04/01/21
  KXT2938    SC                     REASON CODES INQUIRY                              A20212CF
06:07:17

                                                                    MNT: CIE3820  082720
 PLAN REAS  NARR   EFF      MSN      EFF      TERM    EMC     HC/PRO  PP     CC
 IND  CODE  TYPE   DATE     REAS     DATE     DATE    ST/LOC  ST/LOC    LOC  IND
  1   5FGFP   E    060120                              S B6000 S B6000       E
  TPTP A    B    NPCD A     B     HD CPY A 2  B 2  NB ADR 1   CAL DY 45  C/L L
   ------------------------------NARRATIVE-------------------------------------
 MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED. MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN
SIGNATURES,
 HANDWRITTEN NITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD. PATIENT
IDENTIFICATION, DATE OF
 SERVICE AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER
SIGNATURE IS NOT
 CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE AND
THE INITIALS
 FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT
AN ATTESTATION
 STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW
 WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE
THAT THE MEDICAL
 NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

                                  PROCESS COMPLETED  ---   PLEASE CONTINUE
                                  PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

Page 2 of Reason Code

```
MAP1881                          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 04/01/21
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                                                                        MNT: CIE3820  082720
 PLAN REAS    NARR     EFF        MSN       EFF       TERM       EMC        HC/PRO      PP        CC
 IND  CODE    TYPE     DATE       REAS      DATE      DATE       ST/LOC     ST/LOC        LOC   IND
  1   5FGFP    E    060120                                       S B6000    S B6000          E
  TPTP A     B     NPCD A      B      HD CPY A 2   B 2   NB ADR 1    CAL DY 45   C/L L
       ------------------------------NARRATIVE-------------------------------------
 THIS ADDITIONAL DEVELOPMENT REQUEST (ADR) IS PART OF A SERVICE SPECIFIC POST-PAYMENT REVIEW.
  ******** WOUND DEBRIDEMENT SERVICES; HCPCS 11042*******
  LOCAL COVERAGE DETERMINATION (LCD): DEBRIDEMENT SERVICES (L33614)
  LOCAL COVERAGE ARTICLE: BILLING AND CODING: DEBRIDEMENT SERVICES (A56617)
  1. HISTORY AND PHYSICAL
  2. PROGRESS NOTES DOCUMENTING PHYSICAL FINDINGS AND EFFECTIVENESS OF
     TREATMENT
  3. AN OPERATIVE NOTE OR PROCEDURE NOTE FOR THE DEBRIDEMENT SERVICE. THIS
     NOTE SHOULD DESCRIBE THE ANATOMICAL LOCATION TREATED, THE INSTRUMENTS
     USED, ANESTHESIA USED IF REQUIRED, THE TYPE OF TISSUE REMOVED FROM THE
     WOUND, THE DEPTH AND AREA OF THE WOUND AND THE IMMEDIATE POST PROCEDURE
     CARE AND FOLLOW-UP INSTRUCTIONS.
  4. IDENTIFICATION OF THE WOUND LOCATION, SIZE, DEPTH AND STAGE EITHER
                              PROCESS COMPLETED  ---   PLEASE CONTINUE
                           PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

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Helpful Hints

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Helpful Hints

Timely Submission of Medical Record Documentation

- Staff Education
- Responsibility
- Medical Necessity
- Comprehension Of the Anti-Kickback Statute & Stark Laws
- Report Fraud

Home Health & Hospice References and Resources

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Home Health Resources

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 30
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- HH PPS web page

CMS Hospice Resources

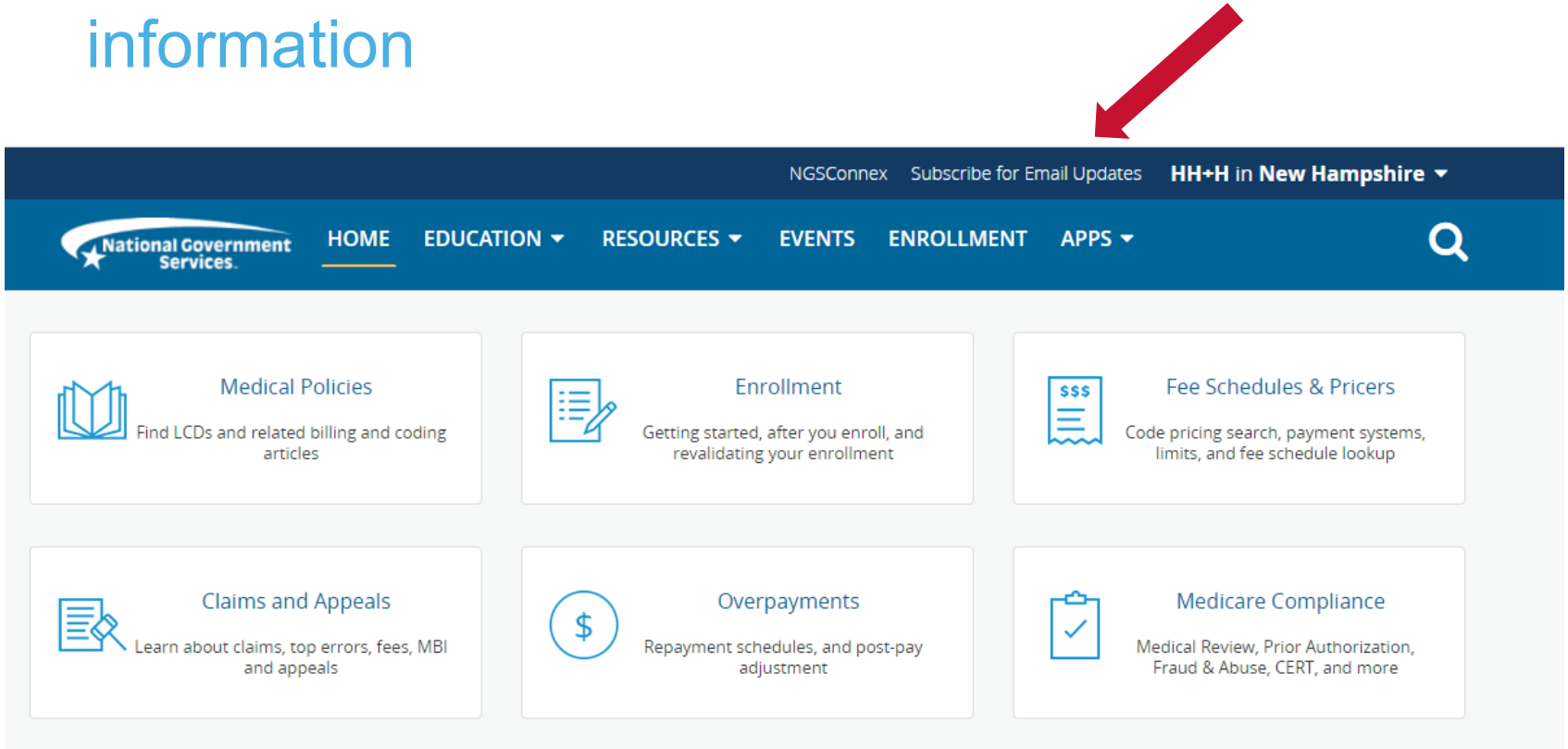
- Hospice Center Webpage
- Hospice Code of Federal Regulations
- Medicare Contractor Beneficiary and Provider Communications Manual
- Medicare Benefit Policy Manual-Hospice
- Medicare Claims Processing Manual-Hospice

NGS References & Resources

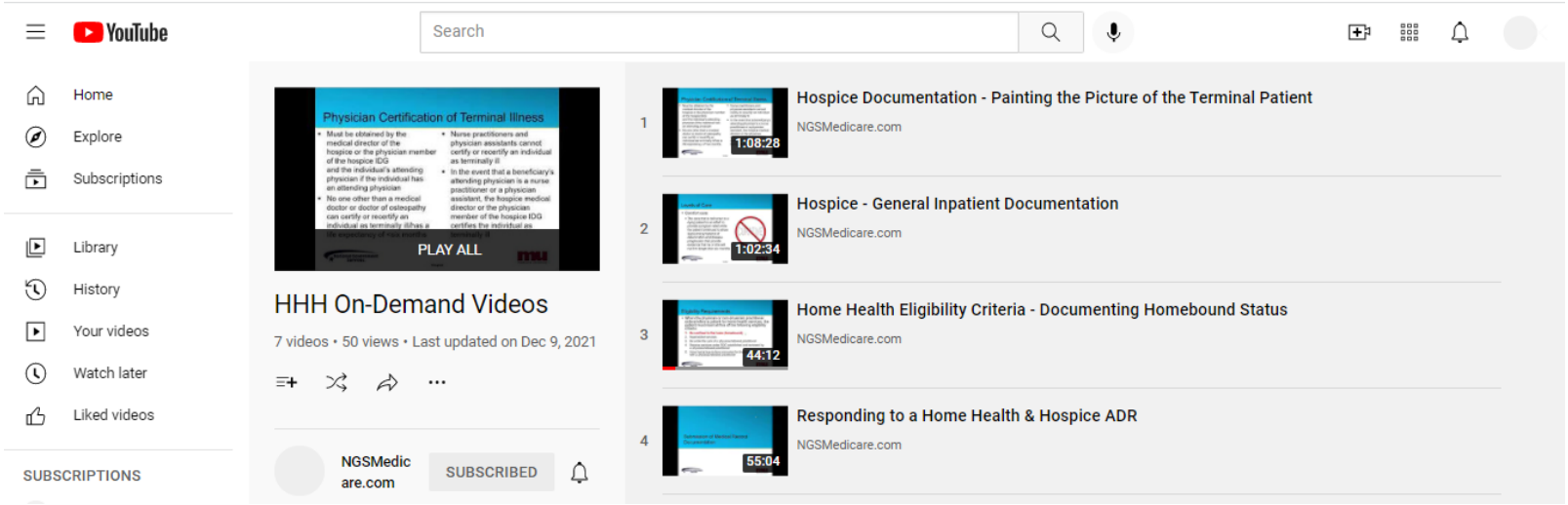
- NGSMedicare.com
- NGS YouTube Channel
- NGSConnex

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS HHH On-Demand Videos



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- Self-report attendance
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  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

Thank You!

- Questions?

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Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

Mike Davis
POE Manager

Erin Musumeci RN; POE HHH Consultant

Jan Wood; POE HHH Consultant

Shelly Dailey MSN, BSN, RN, CPHM; POE HHH Consultant

Christa Shipman; POE HHH Consultant

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Objectives

- Provide an understanding of the Targeted Probe & Educate Process

Agenda

- Targeted Probe & Educate
- References and Resources
- Question and Answer

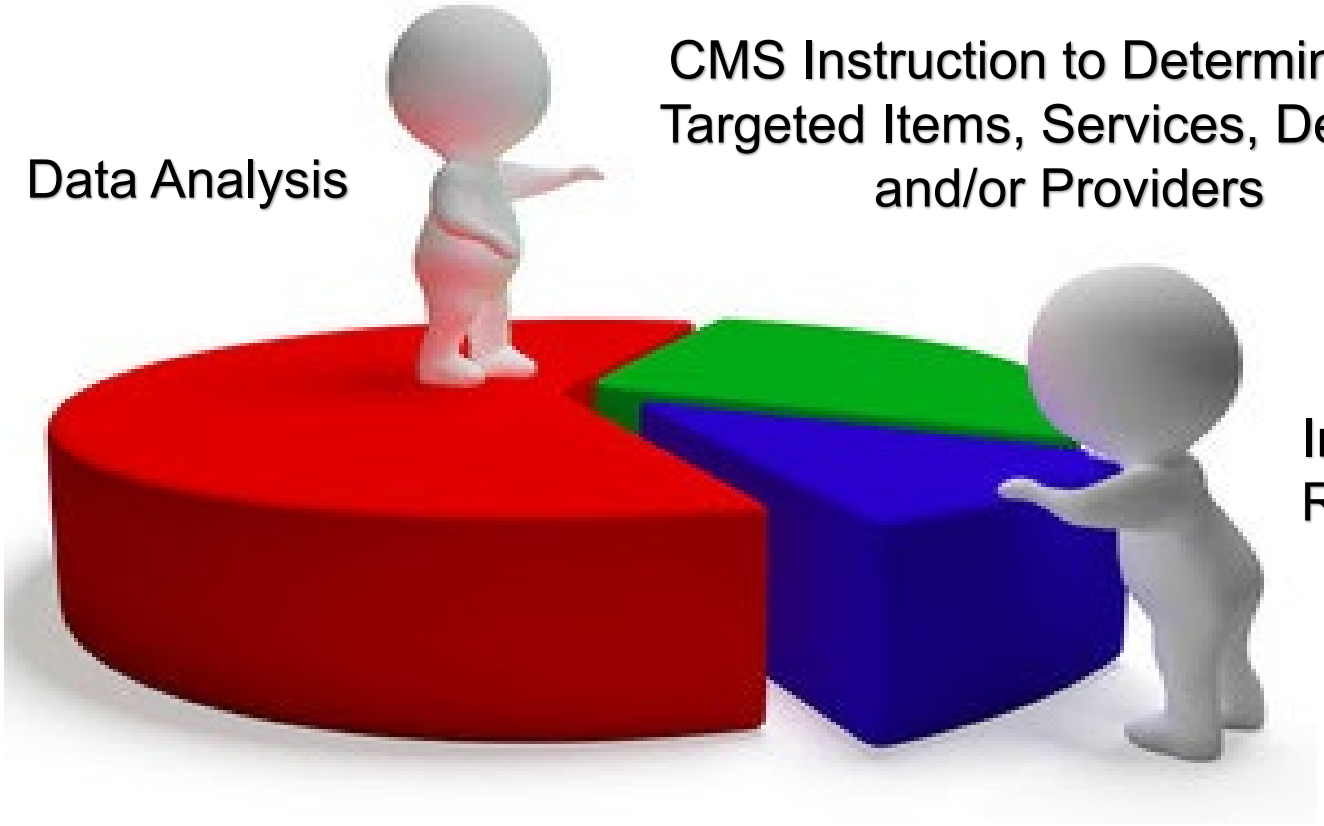
TPE

- CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals
- The goal is to help providers quickly identify and improve errors

TPE

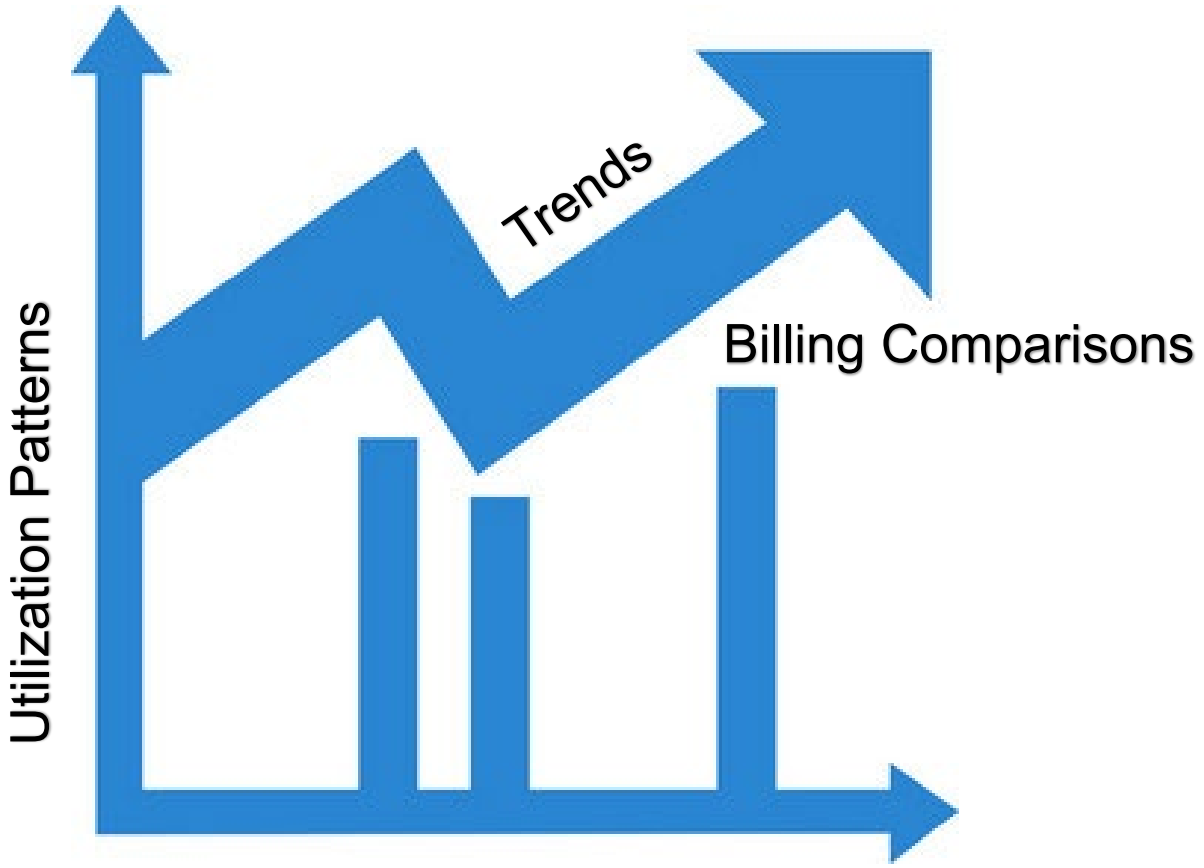
Data Analysis

CMS Instruction to Determine the Targeted Items, Services, Devices and/or Providers



Improper Payment Reduction Strategy

TPE



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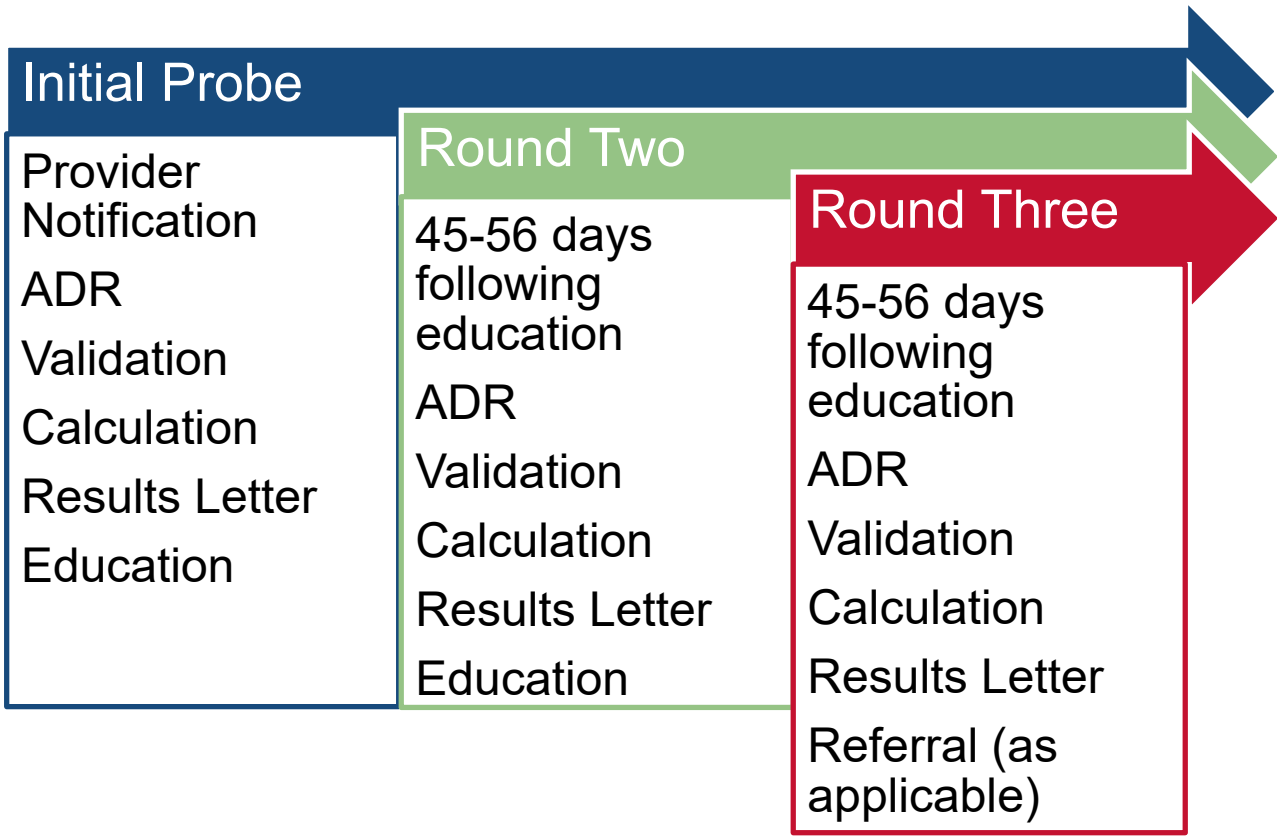
TPE



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Corrective Action
Extrapolation
Referral to UPIC
Referral to RA
100% Pre-Pay Review

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TPE

- Notice of review includes reason for review
- Request 20 – 40 claims
- Do not send documentation until ADR received for each claim
- ADRs generated via the usual process
- 45 days to respond
- Non-responders could be referred to the RA or UPIC
- Records Reviewed within 30 days of receipt
- Results letter offers 1:1 education

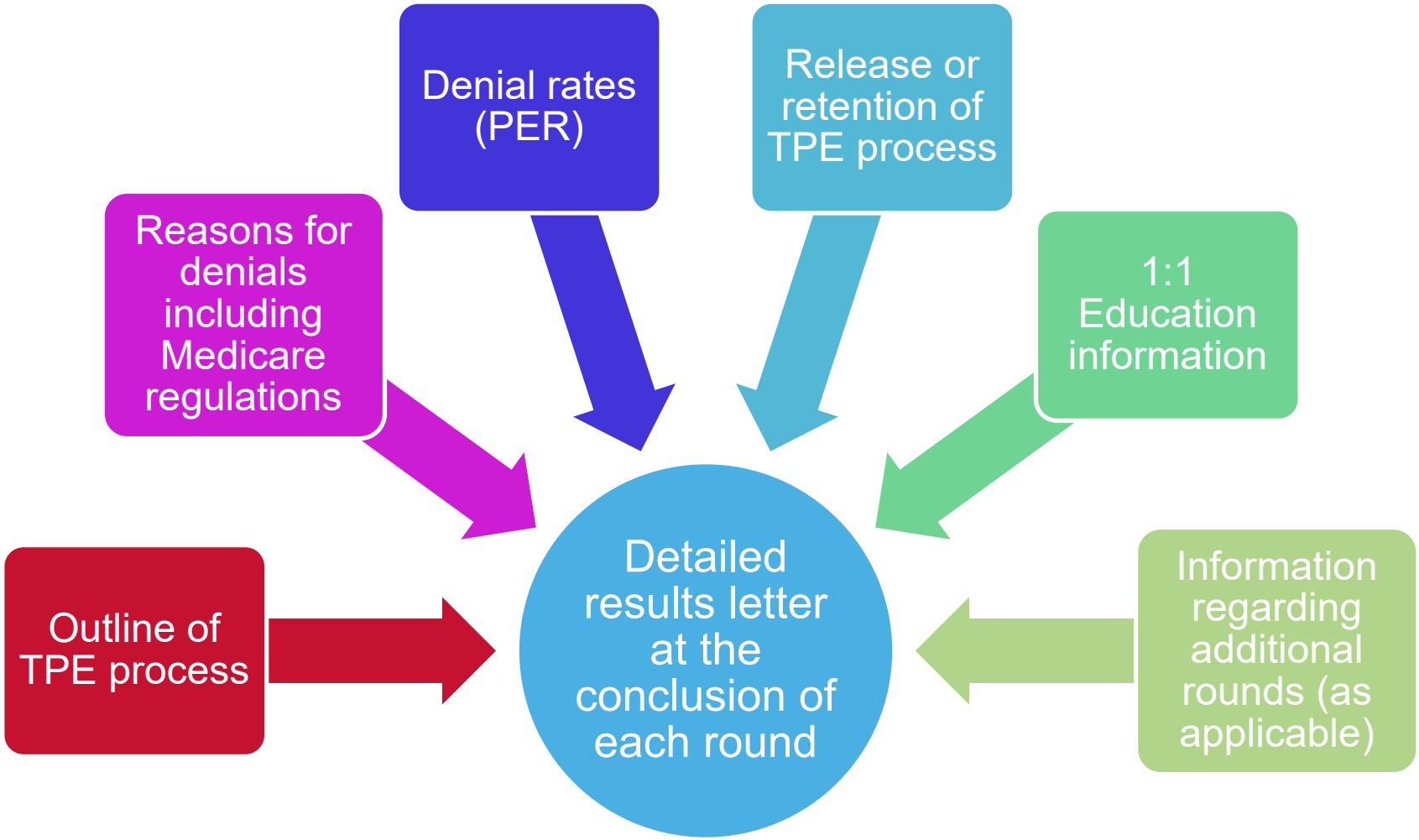
TPE

- Additional Rounds of Review
  - Payment error >15%
  - Additional rounds include education with Medical Review staff following each round of review
  - Payment Error Rate
    - Payment/Payment Denied
    - 1,000/500 = 50% PER
  - Claims Error Rate
    - # of Claims/Claim in Error
    - 10 Claims/5 Claims Denied = 50% CER

TPE

- Medical Review of Records for:
- Technical Components
  - Physician certification
  - Physician orders
  - Beneficiary election statement
- Eligibility Requirements
  - Medicare coverage guidelines
  - Medical necessity
  - Documentation to support services billed

TPE


Denial rates (PER)
Release or retention of TPE process
Reasons for denials including Medicare regulations
1:1 Education information
Outline of TPE process
Detailed results letter at the conclusion of each round
Information regarding additional rounds (as applicable)

Home Health & Hospice References and Resources

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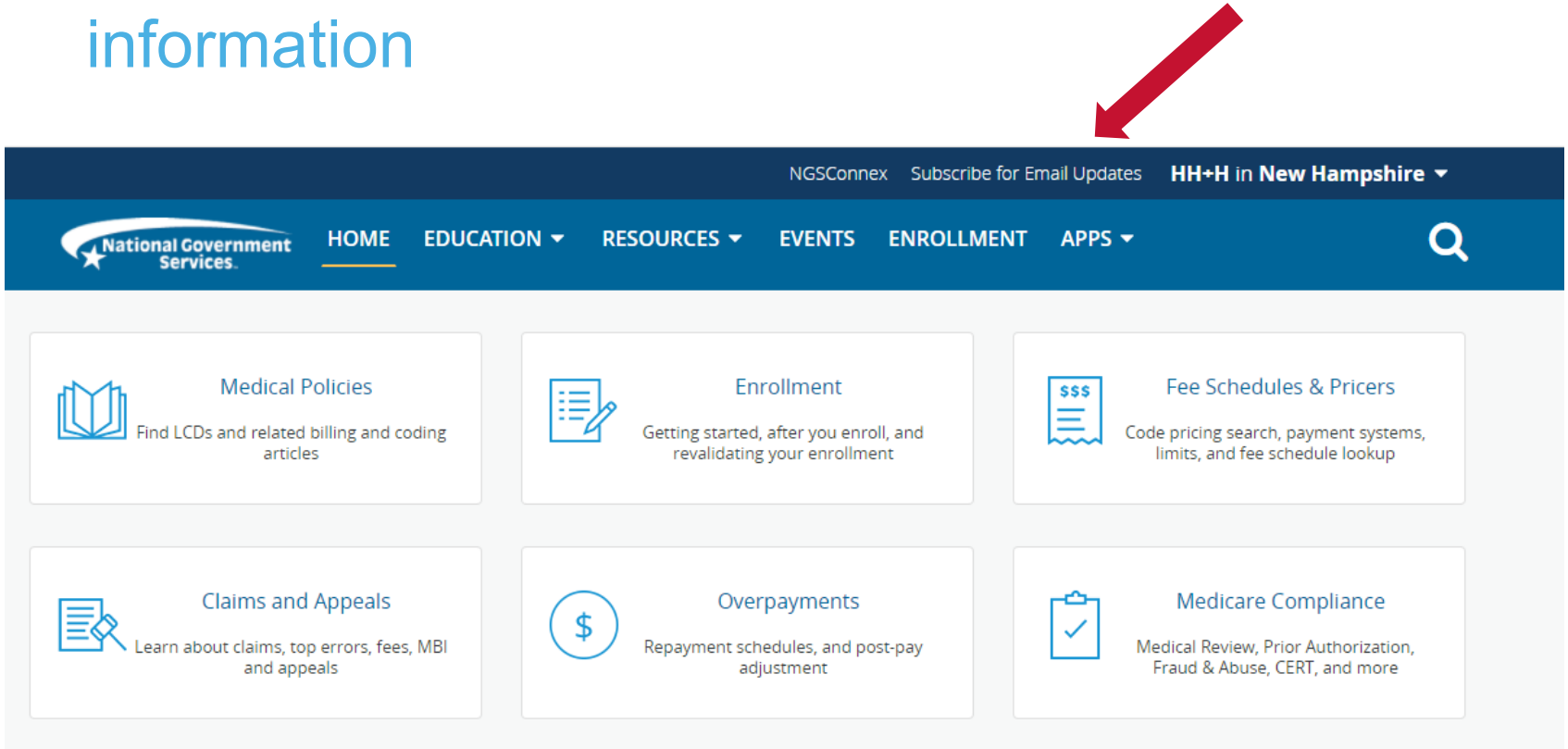

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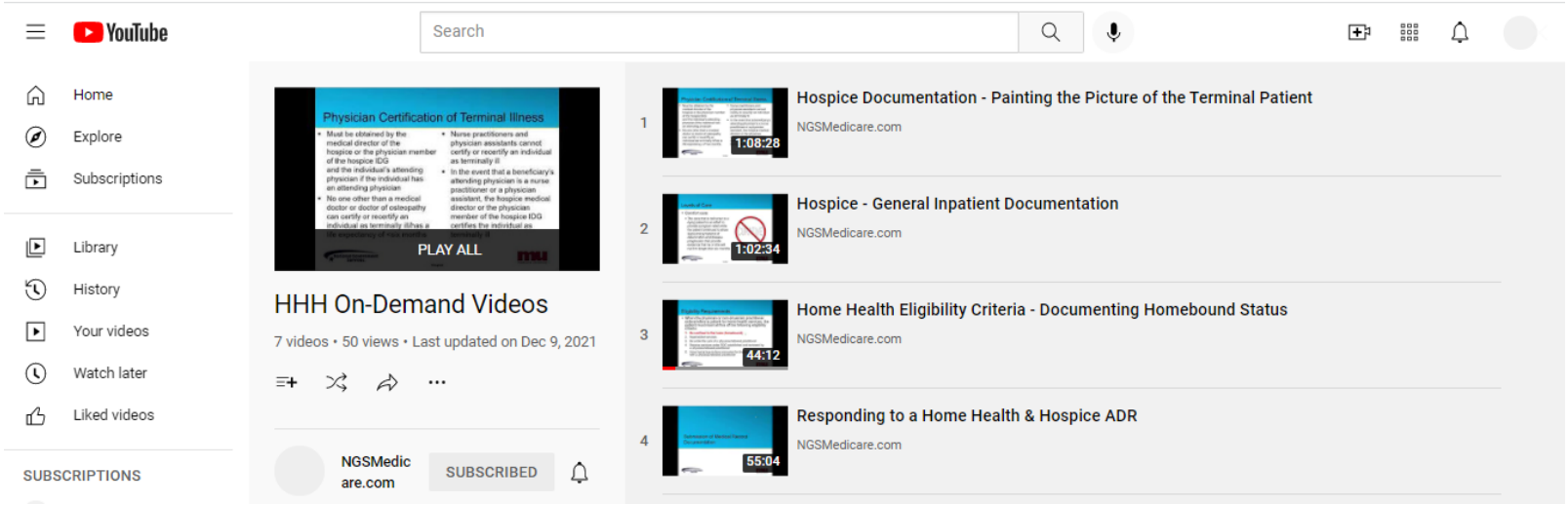

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Thank You!

- Questions?

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Appealing the Medicare Denial

Session Four

July 13, 2022

DATASOFTLOGIC
Create. Innovate. Transform.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

Mike Davis
POE Manager

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Objectives

- Clarify different levels of appeal
- Deliver clear instruction regarding how to properly appeal a denied claim
- Offer information regarding timely filing regulations
- Provide references and resources for all levels of appeal

Agenda

- Reopenings
- Appeals
  - Redetermination
  - Reconsideration
  - Administrative Law Judge
  - Medicare Appeals Council Department Appeals Board
  - US District Court
- Hints and Reminders
- References and Resources
- Question and Answer Period

Reopenings

Reopenings

- Also known as: Pre-redetermination
- Not an appeal
- Not processed through the appeals department
  - Minor human or mechanical errors
  - Occur at the discretion of MAC
  - Decision to "not" reopen a claim for a minor error cannot be appealed
  - Must occur within one year of claim finalized dates

Reopenings

- Mathematical Errors
- Transposed Codes
- Inaccurate Data Entry
- Computer Errors
- Incorrect Data Items

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Reopenings

- **Clerical Errors:** do not include omissions or failure to bill items
- **Third Party Payer Errors**: do not constitute clerical errors
- National Government Services accepts provider initiated electronic adjustments to correct claims partially denied by automated LCD and NCD denials

Reopenings

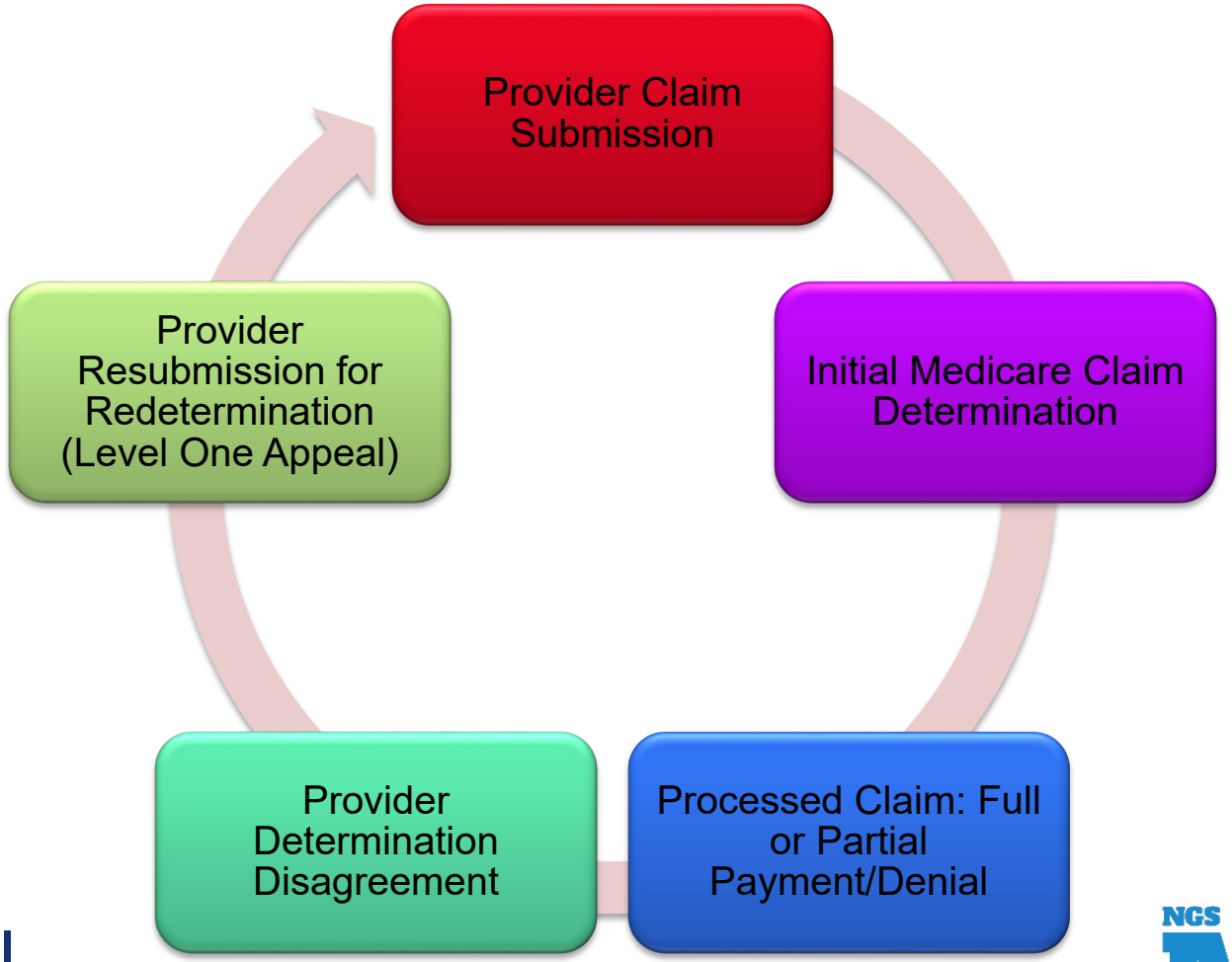
- Part A - Reopening Request Form

Jurisdiction K Part A, HHH	Jurisdiction 6 Part A, HHH, FQHC
National Government Services Appeals Department PO Box 7111 Indianapolis, IN 46207-7111	National Government Services Appeals Department PO Box 6474 Indianapolis, IN 46206-6474

- Submission in writing or via NGSConnex

Appeals

What is an Appeal?



Purpose of an Appeal

- All appeals activities are governed by CMS
  - Ensure correct adjudication of claims
- Providers and beneficiaries have the right to appeal any claim determination made by the MAC

Five Levels of Appeal

Level One Redetermination Medicare Administrative Contractor (MAC)

Level Two Reconsideration Qualified Independent Contractor (QIC)

Level Three Administrative Law Judge (ALJ)

Level Four Medicare Appeals Council Department Appeals Board (DAB)

Level Five US Federal District Court

Level One Appeals

Level One Appeals

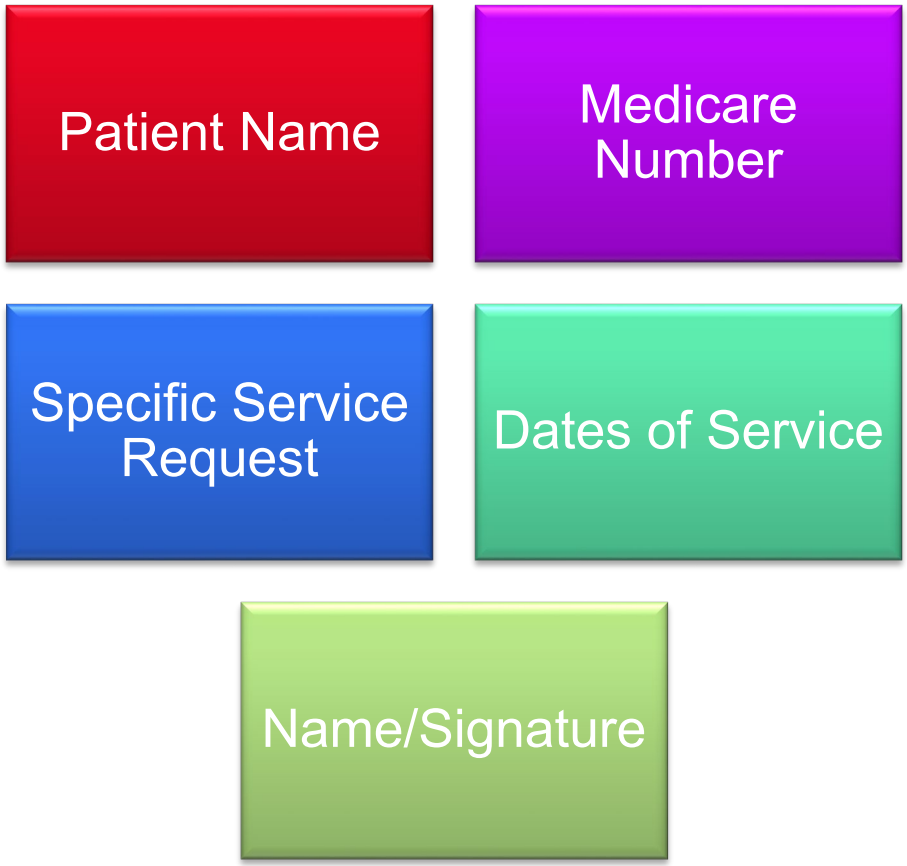
Redetermination – MAC			
Time limit to initiate = 120 days from date of initial determination	Time limit to complete the review = 60 days	Amount in controversy = no minimum amount	How to File: Electronically via NGSConnex or esMD or in writing via Redetermination Form

Level One Appeals

Redetermination – MAC	
Jurisdiction 6	Jurisdiction K
National Government Services Appeals Department P.O. Box 6474 Indianapolis, IN 46206-6474	National Government Services Appeals Department P.O. Box 7111 Indianapolis, IN 46207-7111
Mailing Address for states AK, AZ, CA, HI, ID, MI, MN, NJ, NV, NY, OR, WA, WI, & U.S. Territories	Mailing Address for states CT, MA, ME, NH, RI, VT:

Level One Appeals

- Must include all pertinent information to avoid dismissal of the case
- Previously sent records will automatically be incorporated



Timely Filing

- Federal regulations mandate timely filing of claims within one year of services rendered
- Appeals staff may extend time limit in certain situations called "Conditions that Establish Good Cause"

Timely Filing

- Conditions that Establish Good Cause
  - Unavoidable Circumstances
    - Provider is not excused from the timely filing rules for the next level of appeal

Timely Filing

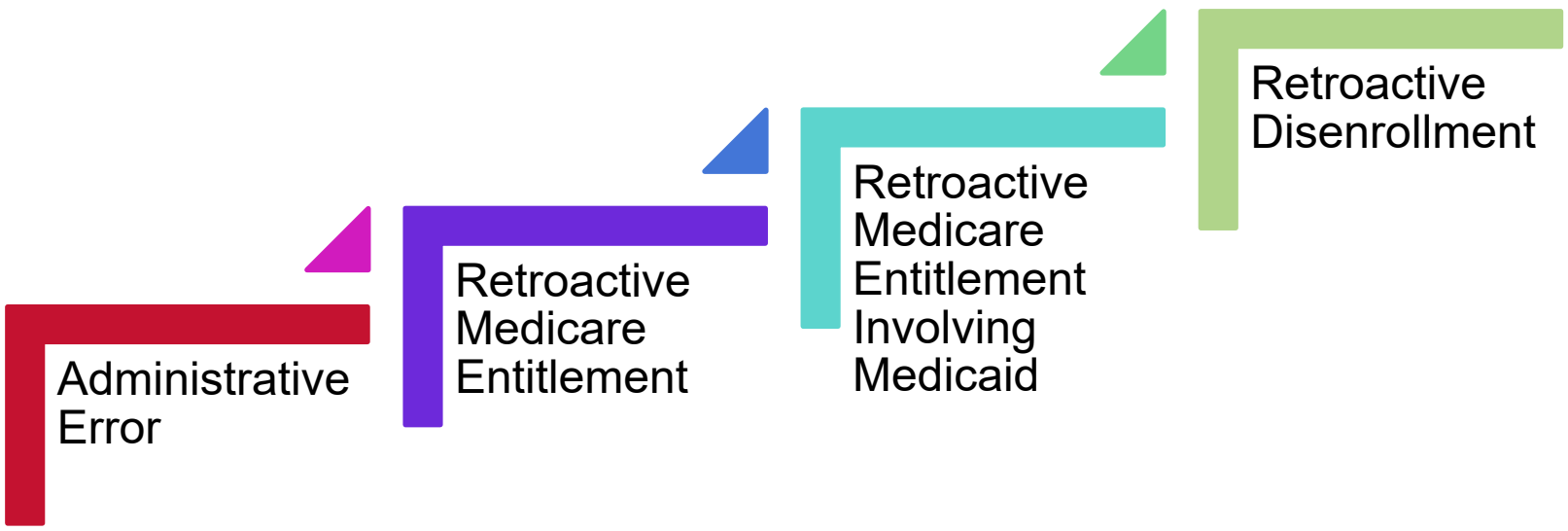
- Conditions that **do not** establish good cause

Timely Filing

- Timely filing for claims is not an appealable determination
  - Once a claim is processed, submitting an adjustment is the only mechanism to bypass timely filing

Timely Filing

Allowable Exceptions



Level Two Appeals

Level Two Appeals

Reconsideration – QIC			
Time limit to initiate = 180 days from date of redetermination denial	Time limit to complete the review = 60 days	Amount in controversy = no minimum amount	How to file: Reconsideration CMS Form 20033

Level Two Appeals

Reconsideration – QIC

Jurisdiction 6	Jurisdiction K
MAXIMUS Federal Services QIC Medicare Part A West 3750 Monroe Ave. Suite 706 Pittsford, NY 14534	**C2C Innovative Solutions, Inc.** QIC Part A East Appeals P.O. Box 45305 Jacksonville, FL 32232-5305

**Request must be made in writing only

Level Three Appeals

Level Three Appeals

Administrative Law Judge Hearing (ALJ)			
Time limit to initiate = 60 days from date of QIC denial	Time limit to complete the review = 90 days	Amount in controversy = minimum $180	How to File: ALJ Form: OMHA-100 Office of Medicare Hearings & Appeals

Level Three Appeals

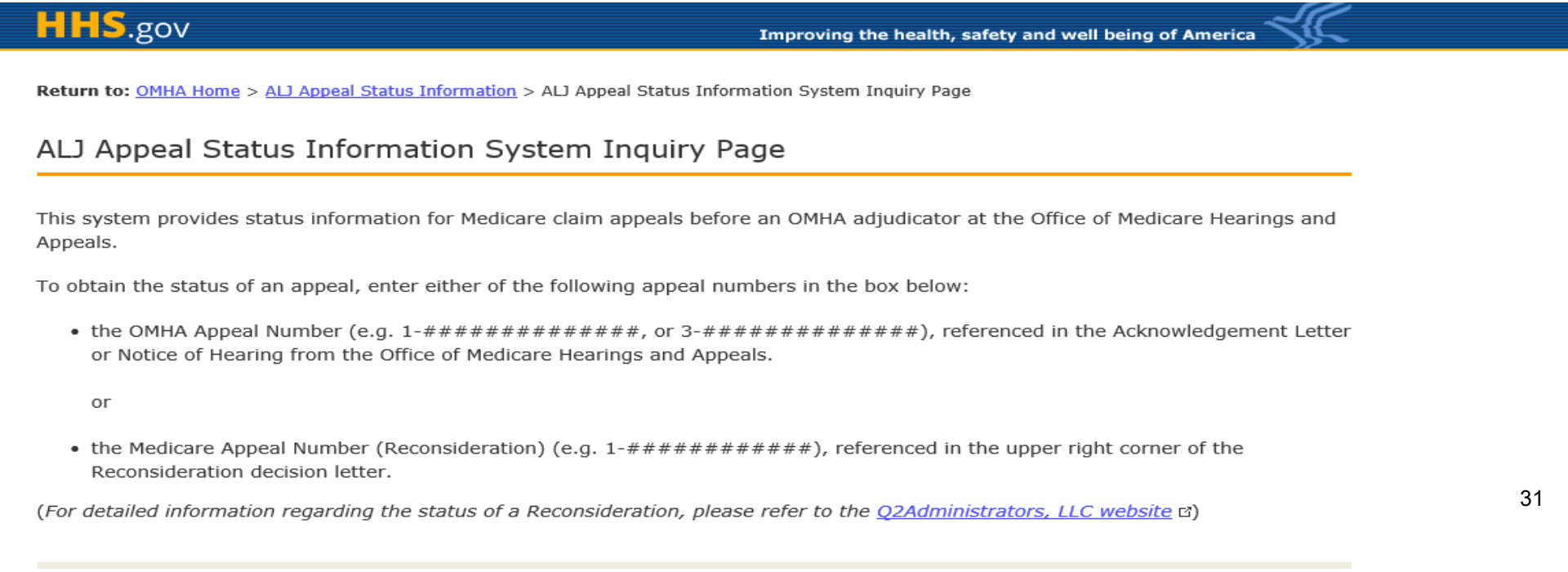
ALJ

OMHA **Central Operations**
1001 Lakeside Avenue, Suite 930
Cleveland, OH 44114-1158
For further assistance call
855-556-8475

OMHA e-Appeal Portal

ALJ Appeal Status Information System: AASIS

- US Department of Health & Human Services Office of Medicare Hearings and Appeals OMHA
  - Check the status of Medicare claim appeals before the ALJ
  - ALJ Appeal Status Information System (AASIS)



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Return to: OMHA Home > ALJ Appeal Status Information > ALJ Appeal Status Information System Inquiry Page

ALJ Appeal Status Information System Inquiry Page

This system provides status information for Medicare claim appeals before an OMHA adjudicator at the Office of Medicare Hearings and Appeals.

To obtain the status of an appeal, enter either of the following appeal numbers in the box below:

- the OMHA Appeal Number (e.g. 1-##############, or 3-##############), referenced in the Acknowledgement Letter or Notice of Hearing from the Office of Medicare Hearings and Appeals.

  or

- the Medicare Appeal Number (Reconsideration) (e.g. 1-############), referenced in the upper right corner of the Reconsideration decision letter.

(*For detailed information regarding the status of a Reconsideration, please refer to the Q2Administrators, LLC website*)

Level Four Appeals

Level Four Appeals

Medicare Appeals Council Department Appeals Board (DAB)			
Time limit to initiate = 60 days from date of ALJ denial	Time limit to complete the review = 90 days	Amount in controversy = no minimum amount	How to File: Form DAB 101

Level Four Appeals

Medicare Appeals Council
Department Appeals Board (DAB)

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

Fax: 202-565-0227

For further assistance call:
202-565-0100
**Requests must be made in writing or via fax

Level Five Appeals

Level Five Appeal

Federal U.S. District Court

Time limit to initiate = 60 days from date of receipt of DAB denial	Time limit to complete the review:	Amount in controversy = $1760	How to file: In writing, no form necessary. Suggest submission of all other forms for appeals level one through four

Level Five Appeal

U.S. Federal District Court

Department of Health and Human Services
General Counsel
200 Independence Avenue, SW
Washington, DC 20201

**Requests must be made in writing only

Appeal
Hints and Reminders

Appeals Overview Chart

Appeal Level	Time Limit For Filing	Monetary Threshold
Redetermination	120 days from date of receipt of RA	None
QIC Reconsideration	180 days from redetermination notice	None
ALJ Hearing	60 days from reconsideration notice	$180
DAB Review	60 days from the ALJ decision	None
Judicial Review	60 days from DAB decision	$1760

NGS Appeals Calculator

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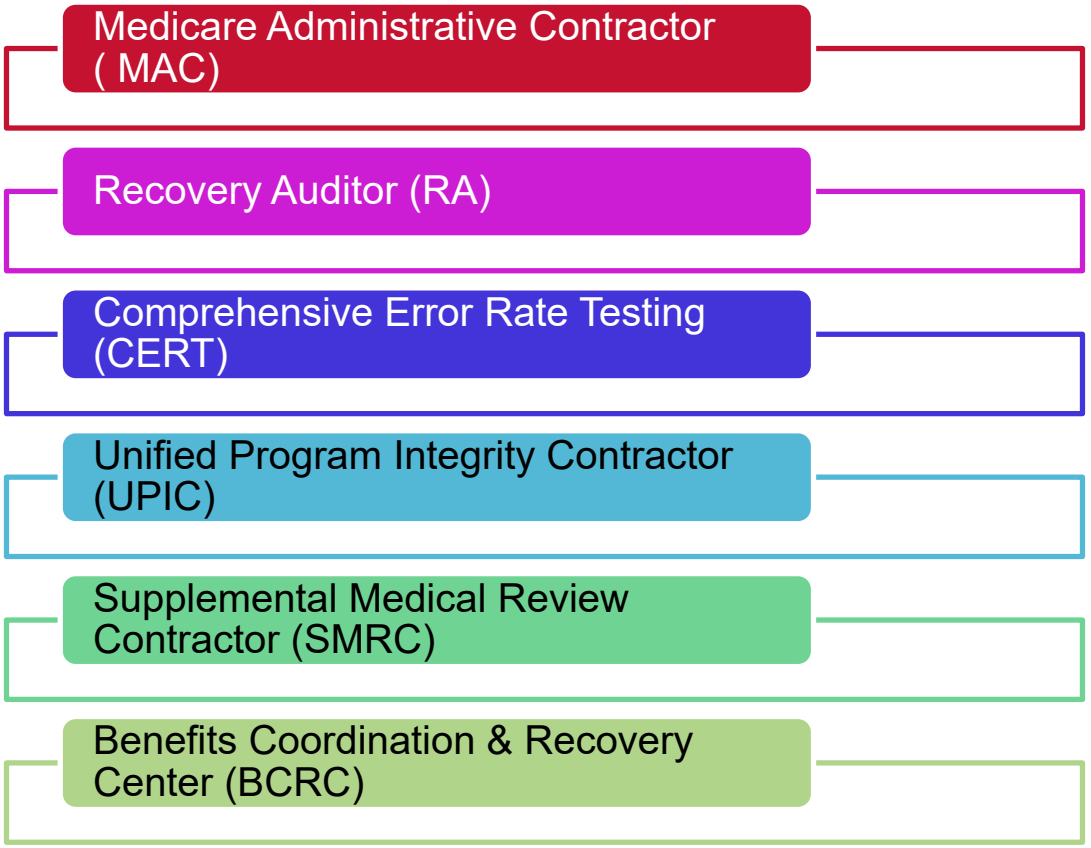
Helpful Hints

- Review reasons for denial
- "Remarks" section of FISS
- Claims determination letter



Helpful Hints

- Be sure to include the following with your appeal
  - Beneficiary name
  - Medicare number
  - Date of service
  - Requestor name and signature
  - Attachments for additional information
  - All pertinent supporting medical record documentation (signed by a physician)
  - Explanations for delayed requests

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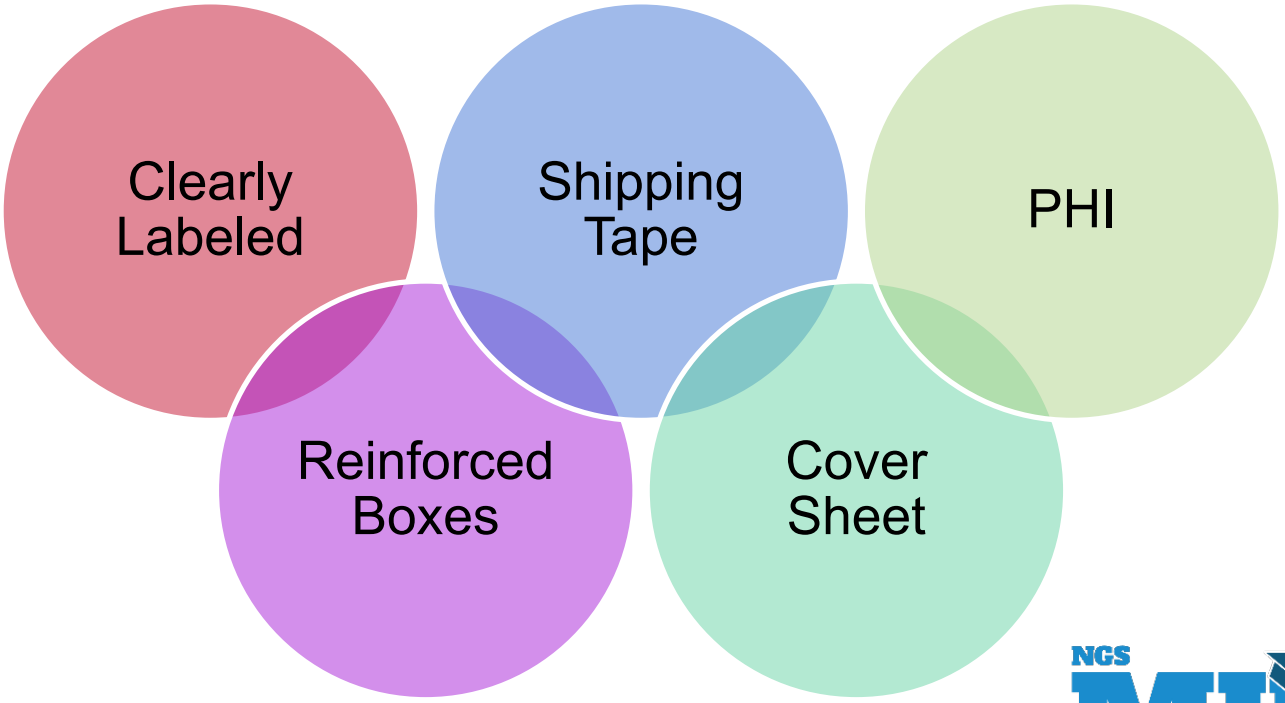
Helpful Hints

- Reminders when utilizing the following
  - USPS
  - Fed Ex
  - UPS



Compliance

HIPAA

Health Insurance Portability and Accountability Act

NGSConnex

esMD for Providers and Suppliers

Appeals
References and Resources

Appeals References & Resources

- The Centers for Medicare & Medicaid Services Original Medicare Appeals Portal
- Medicare Claims Processing Manual Chapter 29 – Appeals of Claims Decisions
- Office of Medicare Hearings & Appeals
- National Government Services Appeals Portal
- NGS Appeals Forms Portal

Appeals Forms

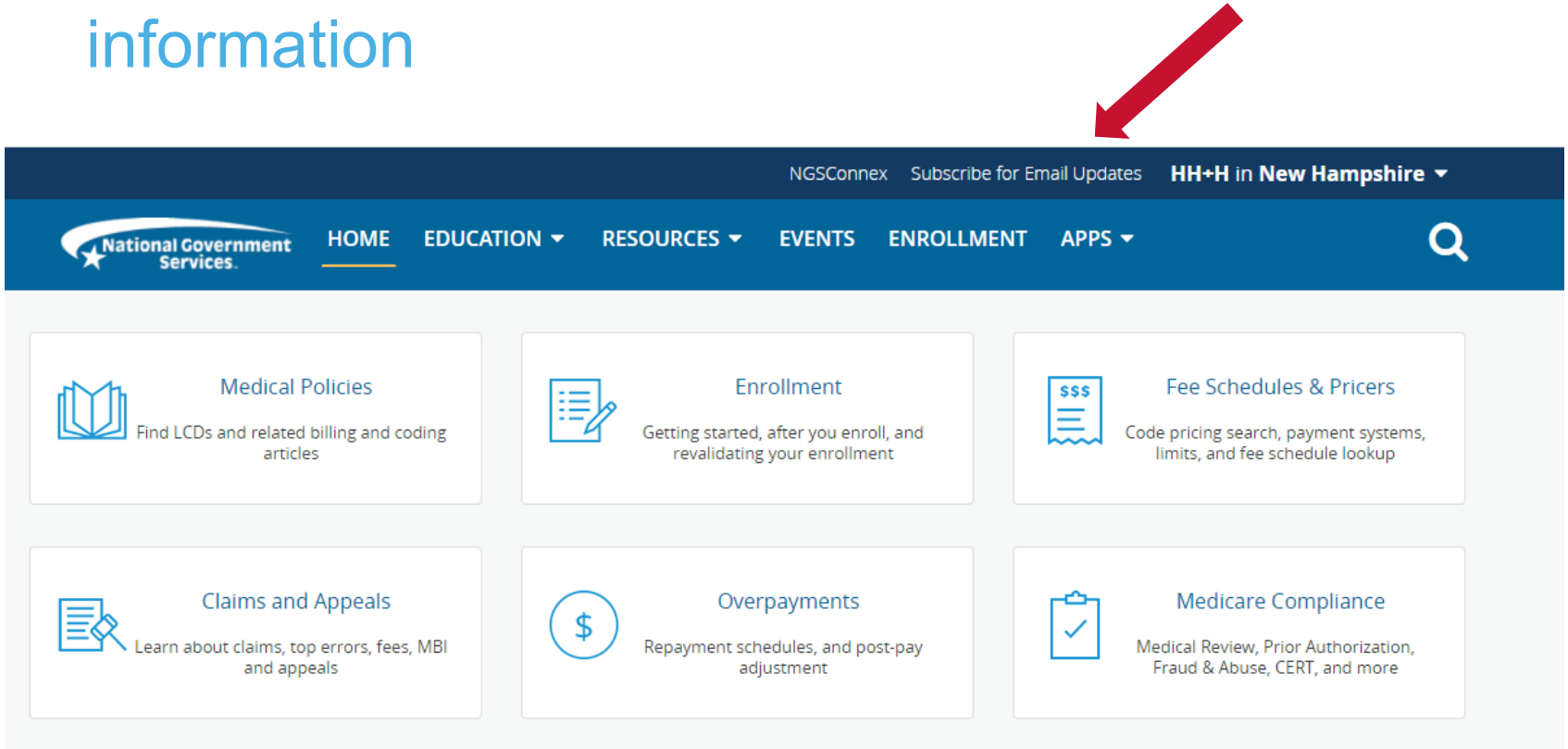
- Part A - Reopening Request Form
- Level One Appeal Redetermination
- Level Two Appeal CMS Form 20033
- Level Three Appeal ALJ Form OMHA-100
- Level Four Appeal Form DAB

NGS References & Resources

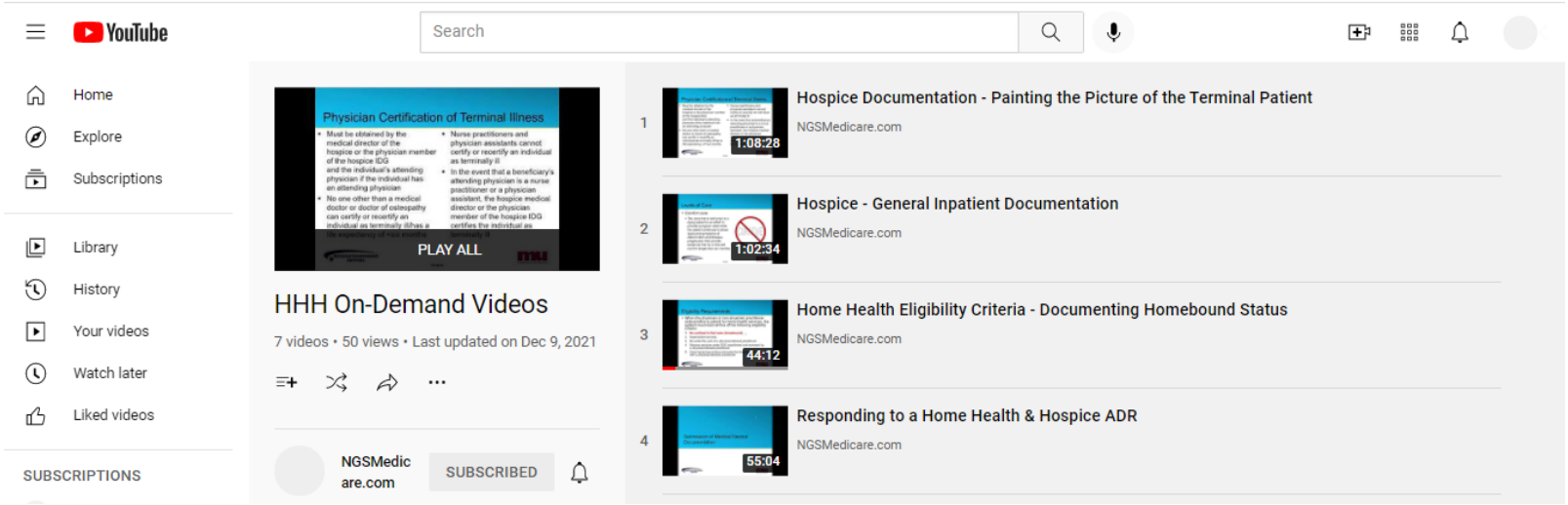
- NGSMedicare.com
- NGS YouTube Channel
- NGSConnex

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS HHH On-Demand Videos



Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs

Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

Thank You!

- Questions?

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Home Health Basic Billing Reminders
Session Five
July 14, 2022

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Documenting Home Health Eligibility Criteria

Session Seven

July 14, 2022

DATASOFTLOGIC
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

Mike Davis
POE Manager

Erin Musumeci RN; POE HHH Consultant

Jan Wood; POE HHH Consultant

Shelly Dailey MSN, BSN, RN, CPHM; POE HHH Consultant

Christa Shipman; POE HHH Consultant

Disclaimer

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To offer federal Medicare regulatory direction to home health agencies (*as well as any/all provider types ordering/referring home health services*) in an effort to provide assistance in the comprehension of documentation requirements required to support homebound status, need for skilled services, the home health plan of care, physician and allowed practitioner oversight of services and the face-to-face encounter. Certification and recertification of all home health eligibility criteria will be discussed, as well as documentation collaboration with other agencies, offices and facilities in an effort to ensure appropriate documentation within the medical record.

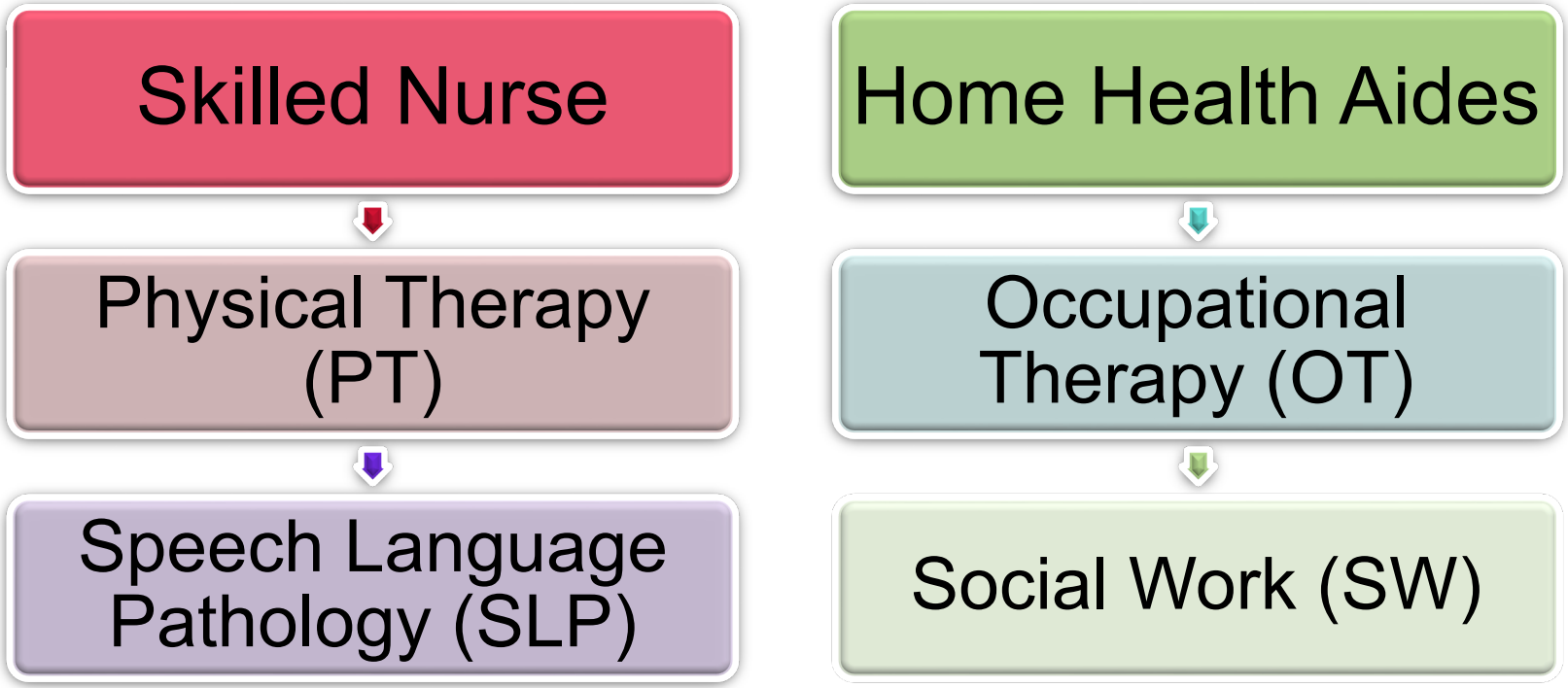
Agenda

- The Medicare Home Health Benefit
- Home Health Eligibility Criteria
  - Homebound Status
  - The Need for Skilled Service
  - The Plan of Care
  - Under the Care of a Physician or Allowed Practitioner
  - The Face-to-Face Encounter
- Certification & Recertification of Eligibility Criteria
- Documentation Collaboration
- Discharge from Home Health Services
- Reason Code 37253
- References & Resources
- Question & Answer Period

The Medicare Home Health Benefit

The Medicare Home Health Benefit

- Services that the Medicare beneficiary/patient may receive at home i



Home Health Eligibility Requirements

Eligibility Requirements

- Homebound
- Need for Skilled Service
- Under the Care of a Physician or Allowed Practitioner
- Plan of Care
- Face-to-Face Encounter

Homebound Status

Homebound Status

Criteria One

(One Standard Must Be Met)

- Because of Illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person to leave their place of residence;
- **or**
- Have a condition such that leaving his or her is medically contraindicated

Criteria Two

(Both Standards Must Be Met)

- There must exist a normal inability to leave home;
- **and**
- Leaving home must require a considerable and taxing effort

Homebound

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Homebound Status

- Criteria One
  - Verify the **type of support** and/or supportive device or **assistance** required to assist the patient in leaving home

  or

  - Verify the reason wh[illegible]edically **contraindicated**

Homebound Status

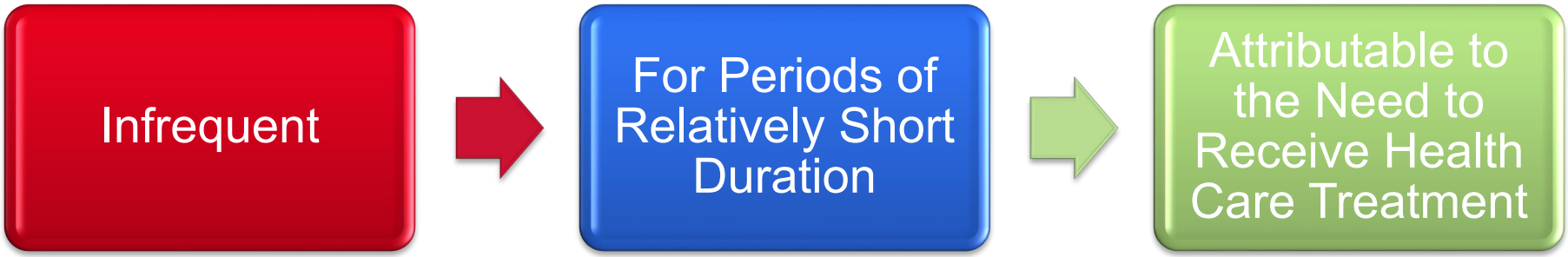
- Criteria Two
  - Clinical information about the patient's health status including their:
    - **Normal inability** to leave the home
    - Leaving home requires a **considerable and taxing effort**
      - Prior level of function
      - Current diagnosis
      - Duration of condition
      - Clinical course (worsening or improvement)
      - Prognosis
      - Nature and extent of functional limitations
      - Therapeutic interventions and results

Homebound Status

- Explain the patient's normal inability to leave home
- Define the taxing effort
- Ensure the information is patient specific
- For example:
  - Pain medications
  - Rest periods
  - Oxygen
  - Incontinence
  - Confusion
  - Safety concerns
  - Alternative accommodations

Homebound Status

- If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are:



  - For medical appointments/treatments
  - For religious services
  - To attend adult daycare centers for medical care
  - For other unique or infrequent events
    - Funeral, graduation, hair care

Homebound Status

- Documentation must:
  - **Include** information about the injury/illness and the type of support and/or supportive device/assistance required for illness/injury to assist the patient in leaving home **or**
  - **Explain** in detail how the patient's current condition makes leaving home medically contraindicated
  - **Clarify** exactly the distinct difference in the patient's normal ability versus their normal inability
  - **Describe** exactly what effects are causing the considerable and taxing effort for this patient when leaving home

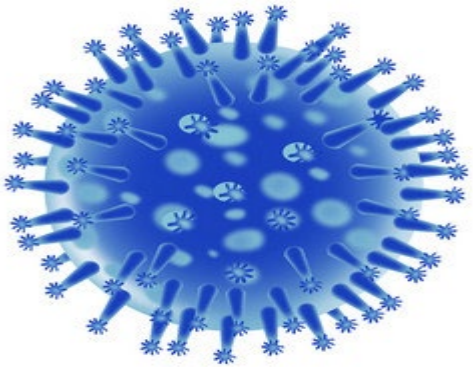
Homebound Status

- Declaring any portion of the regulation as a blanket statement copied from the CMS manual is vague

"It's a taxing effort for the patient to leave home."
"The patient leaves home for periods of short duration."
"The patient leaves home infrequently."
"The patient leaves home for religious services."
"The patient has a normal inability to leave their home."

Public Health Emergency

- Homebound Definition
  - A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19
  - As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide those services under the Medicare home health benefit



The Need for Skilled Services

Need for Skilled Services

- Home health agencies must continue to document the need for skilled services throughout the patient's medical record.
- The medical record documentation must include the reasons WHY the patient continues to require a skilled professional in their home.

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Need for Skilled Services

- Distinguish exactly what services are going to be provided by the skilled professional in the patient's h

Registered Nurse for Daily Sacral Wound Dressing Changes x3 weeks

Need for Skilled Services

- Explain why a "skilled professional" is required to provide the home health services requested

Need for Skilled Services

- **Disclose** clinical information (beyond a list of recent diagnoses, injury or procedure) that is individual and specific to the patient

Need for Skilled Services

- **Include** the findings from the face-to-face encounter to support the primary reason for the skilled services being provided

Need for Skilled Services

- **Skilled nursing services** are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a registered nurse are necessary

Need for Skilled Services

- To be considered a "skilled service," the service must be so inherently complex that it can only be safely and effectively performed by or under the supervision of a skilled professional

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Need for Skilled Services

- A skilled professional must document the services specific to the care provided as it pertains to the current diagnosis relative to the reason for home health services during every visit

Need for Skilled Services

- When the patient no longer meets eligibility criteria and skilled services are no longer required, the reason for discharge from home health services should be documented within the medical record and the provider monitoring patient care should be notified

The Plan of Care

The Plan of Care

- All care provided by the home health agency must be in accordance with the plan of care

The Plan of Care

- The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency and duration of the services

The Plan of Care

- The patient must be under the care of a physician or non-physician practitioner who is qualified to sign the physician certification and plan of care

The Plan of Care

- It is expected that in most instances, the physician or non-physician practitioner who certifies the patient's eligibility for Medicare home health services will be the same physician or non-physician practitioner who establishes and signs the plan of care

The Plan of Care

- The home health agency staff will further develop and evolve the plan of care in collaboration with the community physician or non-physician practitioner that is monitoring the home health services

The Plan of Care

- There are no federally mandated forms for the plan of care

The Plan of Care

Order Number:

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth | 9. Sex M F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-10	Principal Diagnosis	Date
12. ICD-10	Surgical Procedure	Date
13. ICD-10	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 Amputation 2 Bowel/Bladder (Incontinence) 3 Contracture 4 Hearing 5 Paralysis 6 Endurance 7 Ambulation 8 Speech 9 Legally Blind A Dyspnea With Minimal Exertion B Other (Specify)

18.B. Activities Permitted

1 Complete Bedrest 2 Bedrest BRP 3 Up As Tolerated 4 Transfer Bed/Chair 5 Exercises Prescribed 6 Partial Weight Bearing 7 Independent At Home 8 Crutches 9 Cane A Wheelchair B Walker C No Restrictions D Other (Specify)

19. Mental Status: 1 Oriented 2 Comatose 3 Forgetful 4 Depressed 5 Disoriented 6 Lethargic 7 Agitated 8 Other

20. Prognosis: 1 Poor 2 Guarded 3 Fair 4 Good 5 Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received Signed POT

24. Physician's Name and Address

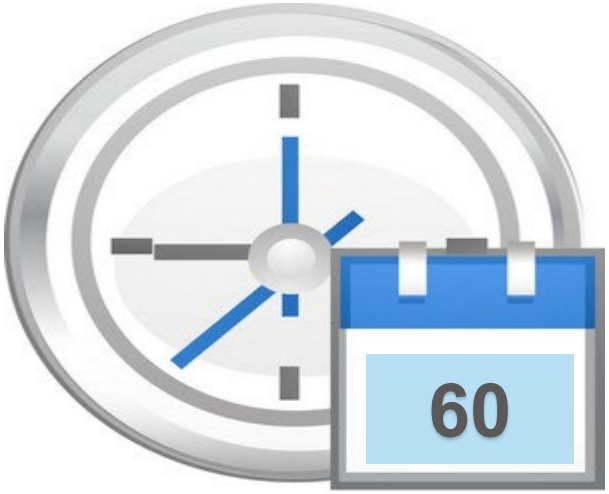
26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

The Plan of Care

- The plan of care must be reviewed and signed by the physician or non-physician practitioner who established the plan of care, in consultation with home health agency professional personnel, as frequently as the patient's condition requires, but no less frequently than every 60 days



The Plan of Care

- Each review of a patient's plan of care must be signed by the physician or non-physician practitioner who established the plan of care in consultation with the home health agency staff

The Plan of Care

- Home health agencies that maintain patient records via computer may utilize appropriately authenticated and dated electronic signatures

The Plan of Care

- The plan of care is considered terminated if the patient does not receive at least one covered skilled service within a 60-day certification period unless a physician or non-physician practitioner documents that the interval without care is appropriate to the treatment of the patient's illness/injury

Under the Care of a Physician or Allowed Practitioner

Under the Care of a Physician or Allowed Practitioner

- **Plans of Care and Certifying/Recertifying Patient Eligibility**: In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. These physicians/practitioners can:
  1. order home health services;
  2. establish and periodically review a plan of care for home health services (e.g., sign the plan of care),
  3. certify and re-certify that the patient is eligible for Medicare home health services
- This is a permanent change
  - These changes are effective for Medicare claims with a "claim through date" on or after 3/1/2020

Under the Care of a Physician or Allowed Practitioner

- Physician
  - A doctor of medicine, osteopathy, or podiatric medicine

- Non-Physician Practitioner
  - Nurse Practitioner (NP)
  - Physician Assistant (PA)
  - Clinical Nurse Specialist (CNS)

Under the Care of a Physician or Allowed Practitioner

- The patient must remain under the care of a physician/NPP who is qualified to sign the certification and plan of care

Under the Care of a Physician or Allowed Practitioner

- If the referring physician names a physician/NPP other than him/herself to monitor home health services, that information must be documented within the patient's medical record and shared with the home health agency

Dr. Joseph Lister

has agreed to monitor the patient's

home health services

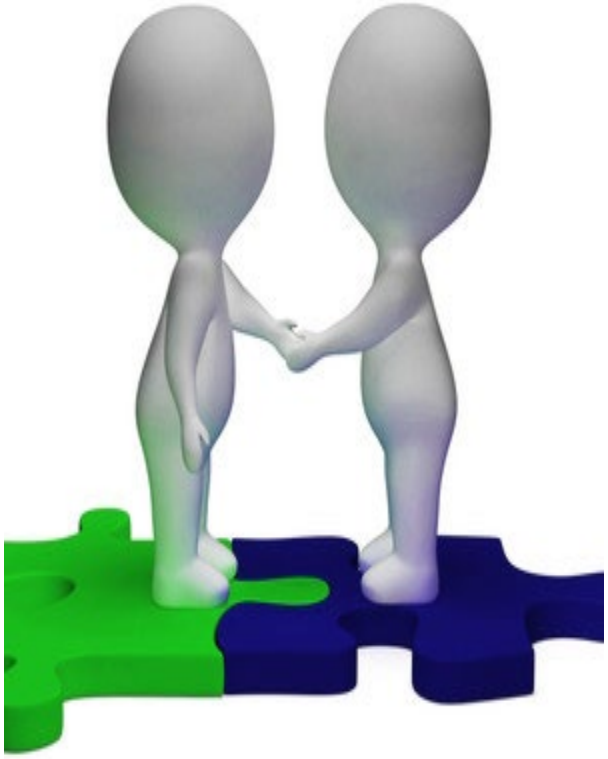
Under the Care of a Physician or Allowed Practitioner

- It is expected that in most instances, the physician/NPP who certifies the patient's eligibility for Medicare home health services will be the same physician/NPP who establishes and signs the plan of care

Under the Care of a Physician or Allowed Practitioner

Physician or Non-Physician Practitioner

- Order and/or refer a patient to home health services
- Monitor patient's home health plan of care and services in the home
- Ensure that a face-to-face encounter has been completed
- Certify & re-certify eligibility



Under the Care of a Physician or Allowed Practitioner

When the physician or non-physician practitioner is referring, certifying and monitoring home health services

- Is the beneficiary eligible for home health services?
- Is the patient homebound as per the CMS definition?
- Is there a need for skilled services in the home?
- Is a plan of care in place or will one be developed with the home health agency?
- Has a face-to-face encounter been completed?
  - Was all of this documentation from the face-to-face visit that prompted the referral to home health subsequently shared with the home health agency upon referral?
- Is the certification statement complete, signed & dated?

Medicare Home Health Benefit & Eligibility Criteria

When the physician or non-physician practitioner is referring a patient for home health services but NOT certifying eligibility or monitoring home health care

- Is the beneficiary eligible for home health services?
- Is the patient homebound as per the CMS definition?
- Is there a need for skilled services in the home?
- Has a physician/NPP that will be monitoring the home health plan of care and services been identified within the patient's medical record?
- Has a face-to-face encounter been completed?
  - Was all of this documentation from the face-to-face visit that prompted the referral to home health subsequently shared with the home health agency upon referral?
- Is the certification statement complete, signed & dated?

The Face-to-Face Encounter

The Face-to-Face Encounter

- Documentation of a 1:1 patient visit with a physician or allowed non-physician practitioner
  - Provider Office
  - Acute Care Facility (Hospital, Urgent Care Center)
  - Post Acute Care Facility (Skilled Nursing Facility, Rehabilitation Center)

The Face-to-Face Encounter

- Examples of face-to-face encounter documentation include:
  - The Admitting History & Physica
  - The Discharge Summary
  - The Progress Notes

The Face-to-Face Encounter

- Non-physician practitioners allowed to perform the encounter ir
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Nurse Midwife
  - Physician Assistant

The Face-to-Face Encounter

90 Days Prior to the Home Health Start of Care

Related to the Primary Reason the Patient Requires Home Health Services

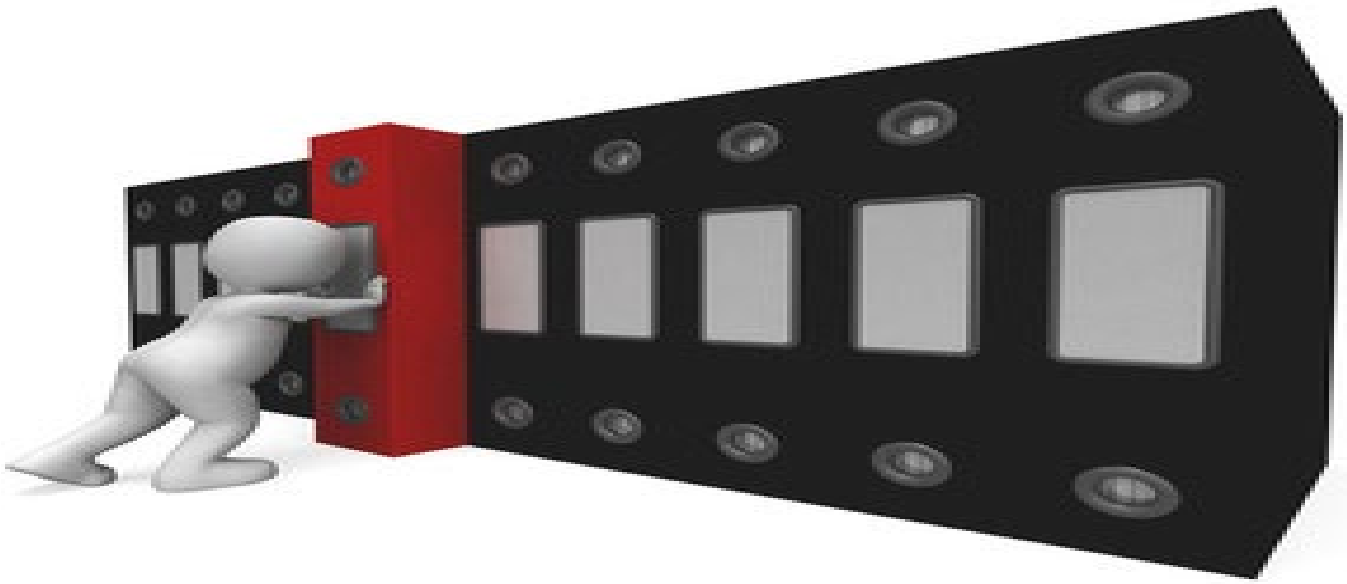
Performed by an Allowed Provider Type

The Face-to-Face Encounter

- Skilled oversight of unskilled care requires a written narrative

The Face-to-Face Encounter

- Documentation to support that an encounter occurred by an allowed provider type should be provided to the home health agency



The Face-to-Face Encounter

- The provider performing the encounter **must not** be employed by, or have a financial relationship with the home health agency

The Face-to-Face Encounter

- Telehealth

The Face-to-Face Encounter

- Telehealth & the Public Health Emergency

Discharge from Home Health Services

Discharge from Home Health Services

- When the patient no longer meets (just one) eligibility criteria and skilled services are no longer required, the reason for discharge from home health services should be documented within the medical record and the provider monitoring patient care should be notified

Discharge from Home Health Services

- Face-to-Face Encounter
- Initial Certification and Recertification
- Narrative if Skilled Oversight is Required
- All Signed Physician or Allowed Practitioner Orders
- Home Health Generated Documentation and Discipline Notes for all Services Billed
- Initial Therapy Evaluation & Documentation
- Plan of Care
- Documentation to Support Homebound Status & the Need for Skilled Services
- ABN (if generated)

Reason Code: 37253

Reason Code: 37253

- Claim has no matching OASIS assessment found in iQIES
- If there is no matching assessment found in iQIES when a claim is submitted, the HHA's claim will be returned with reason code 37253.
- There are several areas that need to be verified to help correct/avoid this error.
- If a claim gets returned for this reason code, please use the link below as checklist to ensure all areas have been verified and corrected:

Correcting Reason Code 37253

References and Resources

References & Resources

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 30
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- HH PPS web page
- Correcting Reason Code 37253

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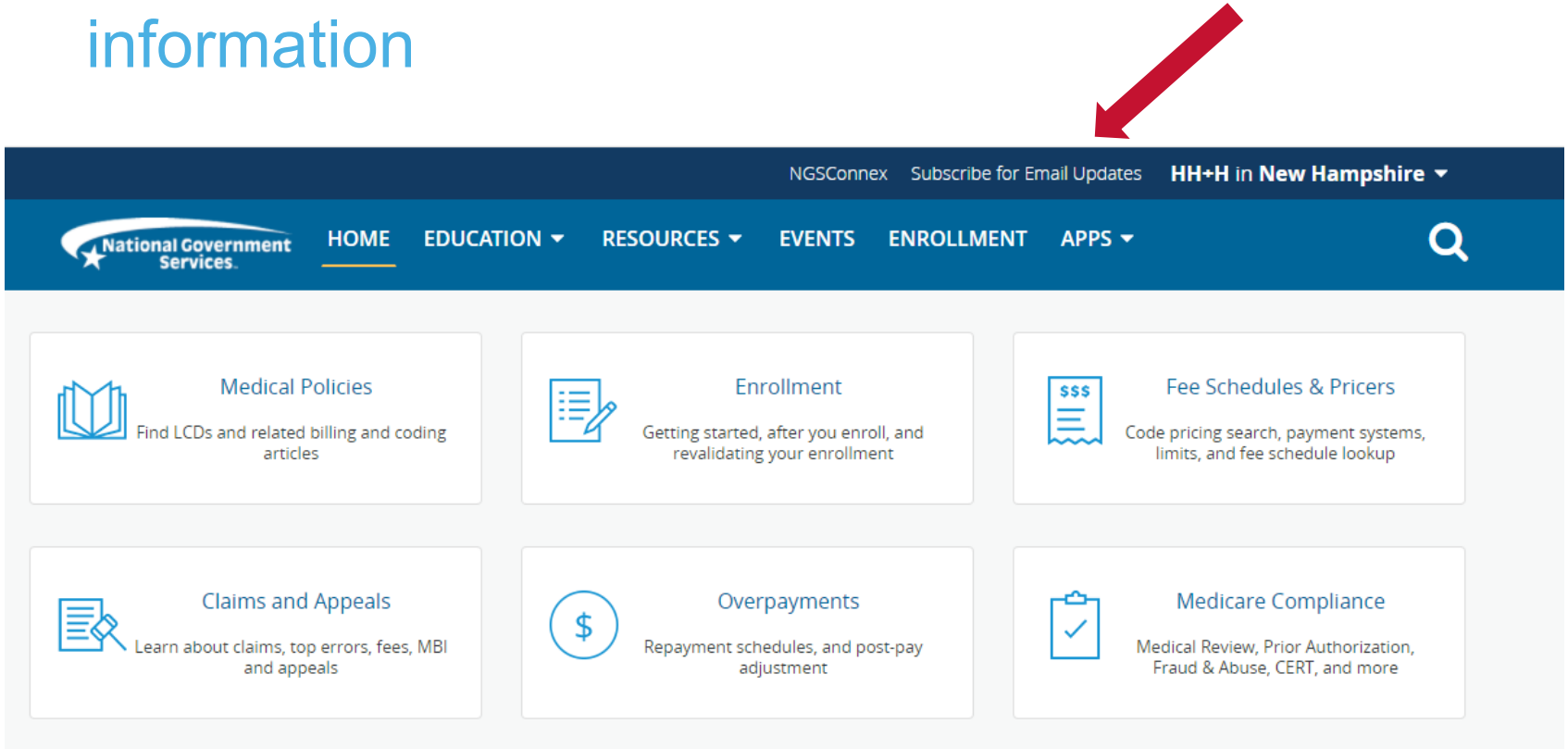
NGS References & Resources

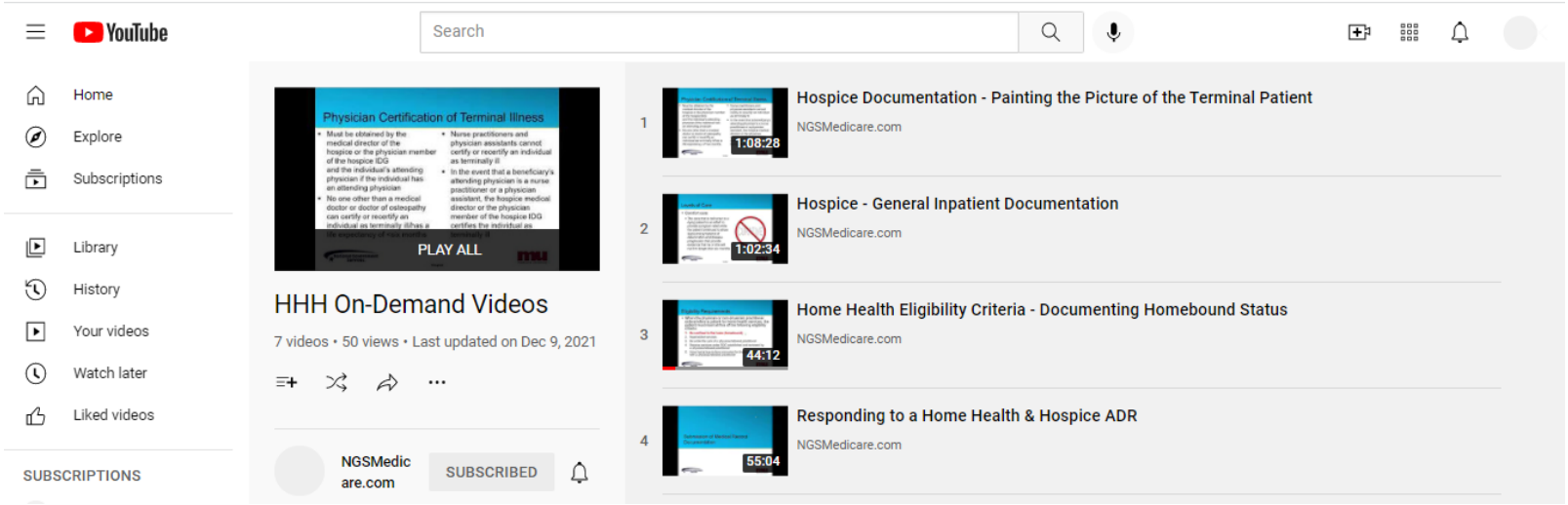
- NGSMedicare.com
- NGS YouTube Channel
- NGSConnex

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS HHH On-Demand Videos



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State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

Thank You!

- Questions?

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NGS MU

Today's Presenters

National Government Services
Provider Outreach & Education
Home Health & Hospice Team

Mike Davis
POE Manager

Erin Musumeci RN; POE HHH Consultant

Jan Wood; POE HHH Consultant

Shelly Dailey MSN, BSN, RN, CPHM; POE HHH Consultant

Christa Shipman; POE HHH Consultant

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Objectives

- Review payment structure under the Patient-Driven Groupings Model (PDGM)
- Go over basic billing reminders for the NOA and period of care claim
- Look at common questions and answers about billing the NOA

Agenda

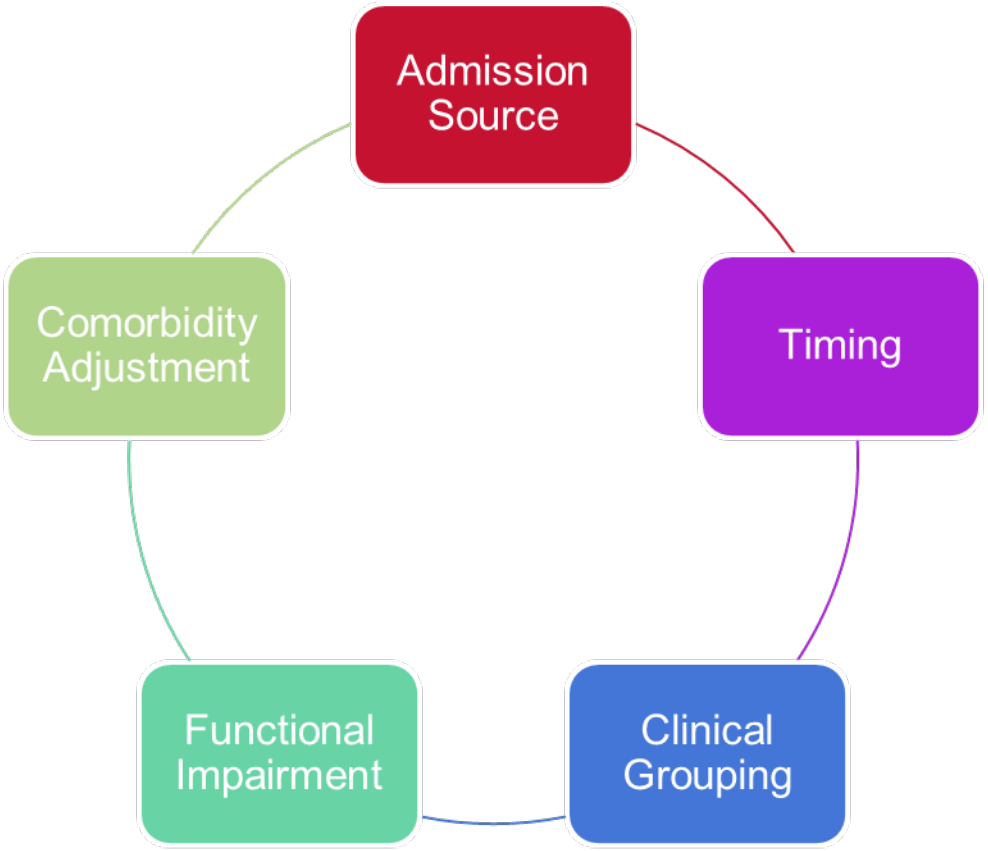
- Billing Basics
  - NOA
  - PDGM period of care claim
- NOA QAs
- Resources
- Questions

Patient-Driven Groupings Model (PDGM)

Patient-Driven Groupings Model (PDGM)

- PDGM effective 1/1/2020
- Payment model for HH PPS
  - 60-day certification/plan of care
  - Billed in two 30-day periods

PDGM Payment Groupings



Admission Source

Institutional

- Acute or post-acute admission within 14 days of “From” date

Community

- No acute or post-acute admission within 14 days of “From” date

Timing

Early Period

- First 30-day period

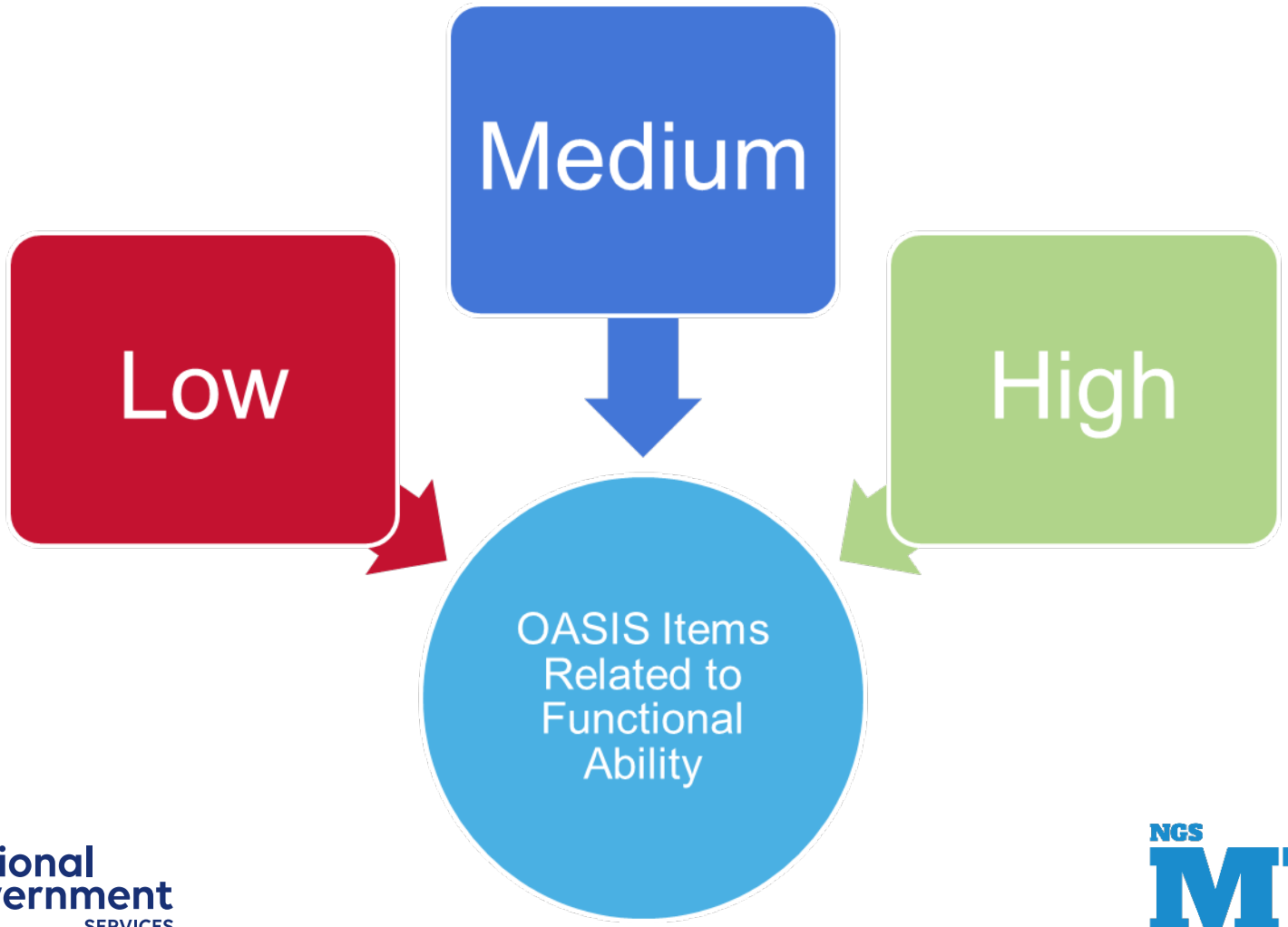
Late Period

- Second and later 30-day periods

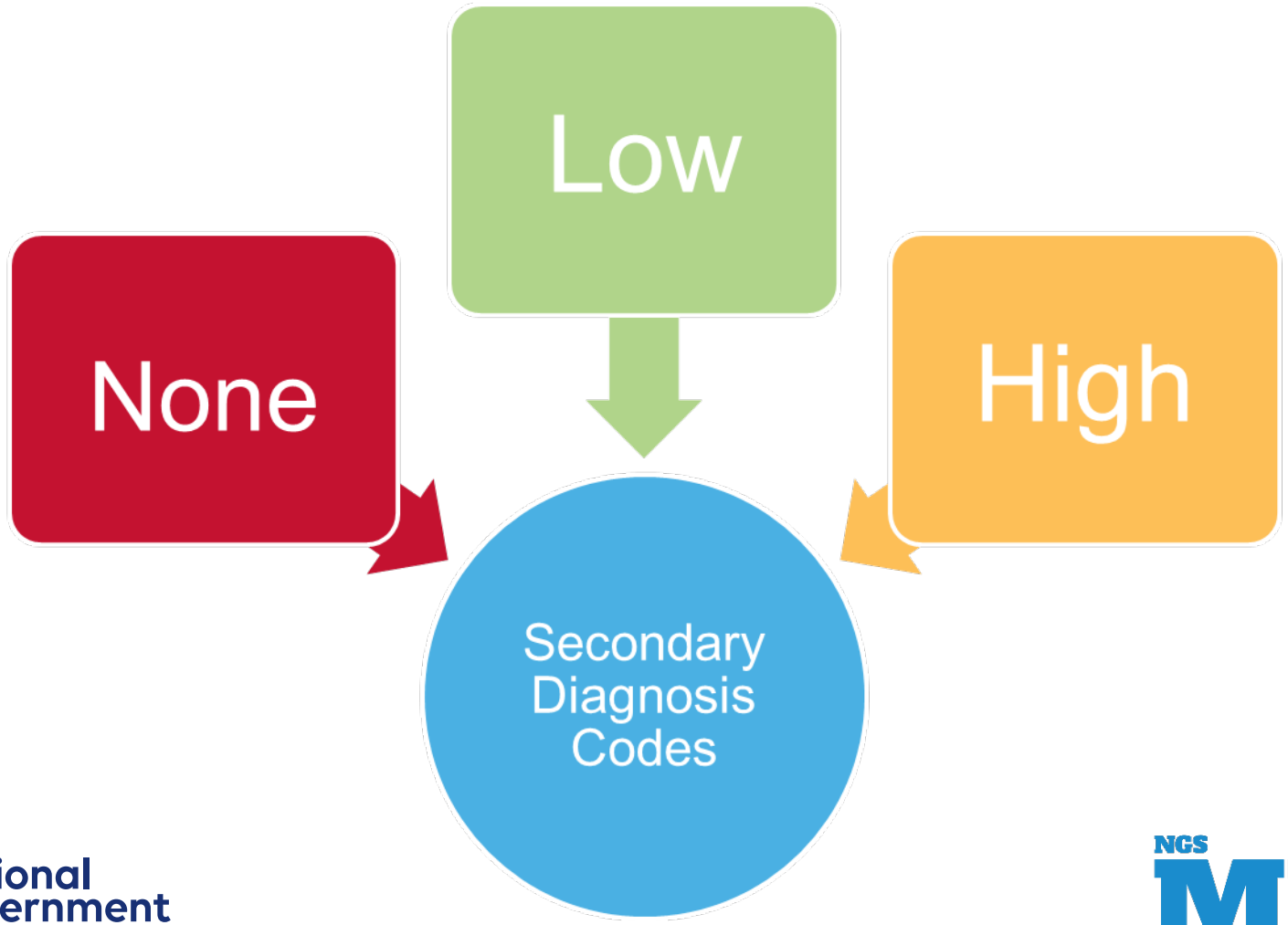
Clinical Groups

- Primary Reason for Home Health Care
- Based on Principal Diagnosis Code
- 12 Total Clinical Groups in PDGM Case-mix

Functional Impairment Levels



Comorbidity Adjustment



Case-mix HIPPS Coding

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1- Community Early	A- MMTA Other	A- Low	1- None	1
2- Institutional Early	B- Neuro Rehab	B- Medium	2- Low	
3- Community Late	C- Wounds	C- High	3- High	
4- Institutional Late	D- Nursing Complex Interv.			
	E- MS Rehab			
	F- Behavioral Health			
	G- MMTA Surgical Aftercare			
	H- MMTA Cardiac & Circulatory			
	I- MMTA Endocrine			
	J- MMTA GI/GU			
	K- MMTA Infectious Disease			
	L- MMTA Respiratory			

PDGM 30-day Periods

- Payment made for each 30-day period
  - Based on information submitted on period of care claim and certain OASIS data
  - NOA required at start of care to open home health admission period

Remember: OASIS, certification/recertification and plan of care based on 60 days

Consolidated Billing

- HHA must bill for all home health services which include:

Part-time or intermittent skilled nursing services

Skilled therapy services (PT, OT, SLP)

Routine and nonroutine medical supplies

Part-time or intermittent home health aide services

Medical social services

NPWT furnished using a disposable device

Covered osteoporosis drugs as defined in Section 1861(kk) of the Act

Notice of Admission (NOA)

NOA

- Must be submitted for any period of care that starts on or after 1/1/2022
- Purpose: open a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission

Requirements Prior to Billing the NOA

HHA has received appropriate physician's written or verbal order containing services required for an initial visit

HHA has conducted the initial visit at the start of care and admitted patient to HH care

Must submit within five calendar days from the start of care

Non-Timely Submission Reduction

- Payment reduction applies if HHA does not submit NOA within five calendar days from the start of care date

Note: The "From" date is day zero. Count five calendar days starting the day after the "From" date to determine timely NOA submission.

Exception to Late NOA Penalty

Fires, floods, earthquakes

CMS or MAC system issue

Late certification

Circumstances determined by CMS or MAC

Exception to Late NOA Penalty

- HHA may submit an exception request on the claim by:
  - Reporting the KX modifier with the HIPPS code on the revenue code 0023 line of Type of Bill 032x (other than 0322 and 0320) to indicate the HHA requests an exception to the late NOA penalty
  - Providing sufficient information in the remarks section of the claim to allow the MAC to research the exception request

Billing the NOA

- 32A – Notice of Admission billing
- 32D – Notice of Admission cancellation

Billing the NOA via DDE

Billing the NOA Electronically

(837I format)

HH Period of Care Claim

Billing the Period of Care Claim

329 TOB

- Home health final HH PPS period claim

327 TOB

- Adjustment to final HH PPS claim

328 TOB

- Cancellation of final HH PPS claim

Claim Submission

- At the end of a 30-day period of care
- Patient is discharged for meeting goals under plan of care (if before 30-day period end date)
- Patient transfers from one HHA to another

Requirements Prior to Claim Billing

All services have been provided to patient for 30-day period

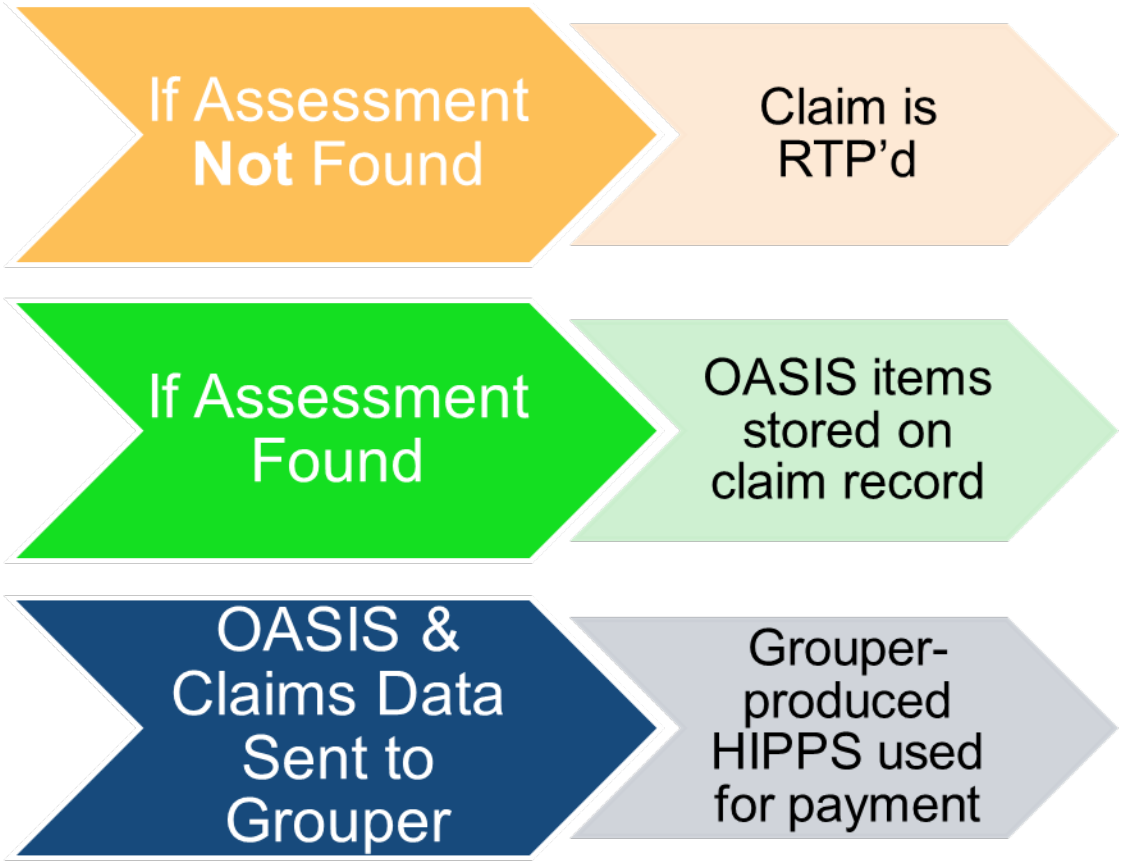
Physician has signed plan of care and all orders

OASIS submitted and accepted in iQIES

- Any warnings, regardless of accepted OASIS should be investigated and corrected

Face-to-face encounter completed

Claim Match with OASIS



Some Reminders…

- ✓ From date on initial claim must match the NOA date
- ✓ Admit date must ***always*** match the NOA date until the patient is discharged
- ✓ Occurrence code 50 must be billed with the matching OASIS completion date (M0090)
- ✓ 0023 Revenue line must contain valid HIPPS code under PDGM or a Grouper-produced HIPPS code
- ✓ Use occurrence code 61 for hospital discharge within 14 days of admission
- ✓ Use occurrence code 62 for other institutional discharge within 14 days of admission

Some Reminders…

- ✓ HHA must report revenue lines for all services provided during the period of care – covered and non-covered
- ✓ Site of service code required on all claims
- ✓ If certifying/recertifying physician is different than the one who signed the plan of care, both physicians' information must be reported
- ✓ Claims processing system assigns HIPPS code for payment using information from OASIS and claim data

NOA Questions and Answers

Q1 – Late NOA Exception

- Question: Since some NOAs were not processing due to a system error, can we request a late exception penalty on the affected claims?
- Answer: Yes. NGS is aware there was an issue with reason code U537F assigning incorrectly on some NOAs. Once the incorrectly RTP'd NOA is resubmitted and processed, the claims associated with the late NOA should be submitted with the KX modifier and add Remarks, e.g., "RAP was late due to System Problem – CWF CR 35441"

Q2 – How often to submit NOA

- Question: Does the NOA only need to be submitted once at the time of admission or should it be submitted for every 30-day period?
- Answer: The NOA only needs to be submitted when there is a new HH admission. It does not need to be submitted for every 30-day period of care. Medicare only requires one NOA for any series of HH periods of care beginning with admission to home care and ending with discharge. HHAs shall not submit an NOA for subsequent 30-day periods of care.

Q3 – Use of Condition Code 47

- Question: When is it appropriate to use condition code 47? Can we enter our NOA if the previous HHA has not processed their final claim or would this result in a late NOA?
- Answer: A transfer occurs when a home health patient transfers from one HHA to another HHA within a 30-day period. In transfers from one agency to another, the receiving agency submits the NOA with condition code 47. This will close the prior admission period from the previous agency.
- CC 47 may also be used when the beneficiary has been discharged from another HHA, but the period of care claim has not been submitted or processed at the time of the new admission to discharge the beneficiary.

Q4 – NOAs and Discharges

- Question: Is a Notice of Discharge required when billing home health?
- Answer: A home health discharge is determined by the period of care claim billed with a discharge patient status code. There is no separate billing requirement for a home health discharge.

Q5: Cancels to Correct the NOA

- Question: If the NOA is originally submitted timely, but needs to be canceled to correct an error, can the HHA file an exception on the initial claim?
- Answer: Yes. If the NOA was originally received timely, but was canceled (TOB 032D) and resubmitted to correct an error, enter Remarks to indicate this is the case, e.g., "Timely NOA, cancel and rebill." Append modifier KX to the HIPPS code on the 0023 revenue line of the period of care claim. HHAs should resubmit the corrected NOA promptly – generally within two business days of canceling the incorrect NOA.
  - Examples of errors that would require the NOA to be cancelled and resubmitted:
    - Incorrect "Admission", "From," or "Through" date
    - Incorrect beneficiary

Q6: Late NOA due to MA Plan Rejection

- Question: Is there any guidance about billing for an exception to the late NOA penalty when we find out the patient had switched from an MA plan to Original Medicare after the fact?
- Answer: Yes. Since Original Medicare begins as of the first visit after the MA enrollment period ends, the NOA must be billed with the date of the first visit under Original Medicare, and all visits from that point are billed to Original Medicare.
- In cases where the HHA did not find out the patient had disenrolled from their MA plan until well after the fact, or until the HHA gets a denial from the MA plan, the NOA should be submitted as soon as possible. The corresponding period of care claim is then billed with the KX modifier and the following statement in Remarks: "CR12256 disenroll MA XX/XX/XXXX." The XX/XX/XXXX date should be the day the MA coverage ended, e.g., "CR12256 disenroll MA 1/31/2022."

Q7: Discharges and Readmissions

- Question: When a patient is discharged from a home health period and is readmitted, does the original final claim with discharge information need to be submitted prior to the NOA for the new admission?
- Answer: HHAs are not required to submit the discharge claim from the previous period when readmitting to the same home health agency. When the HHA submitting a new NOA is the same provider that has the open admission period, the system will recognize that and not RTP or reject the new NOA. The HHA can submit the NOA before the prior claim.

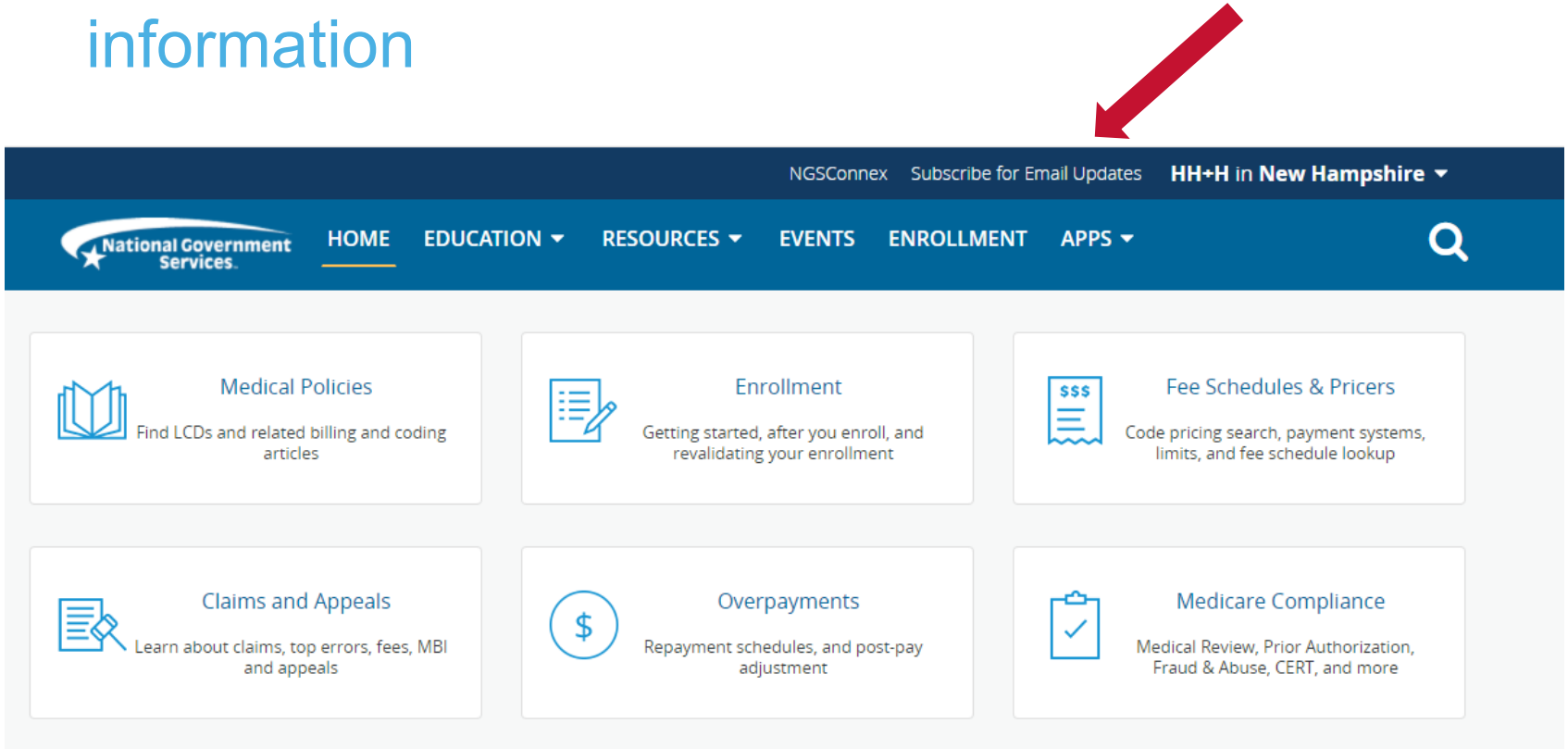
Home Health & Hospice References and Resources

NGS Website

- NGS Website
  - Articles and Job Aids
  - Resources
  - Medicare Compliance
  - Fraud and Abuse

NGS Email Updates

- Subscribe to receive the latest Medicare information



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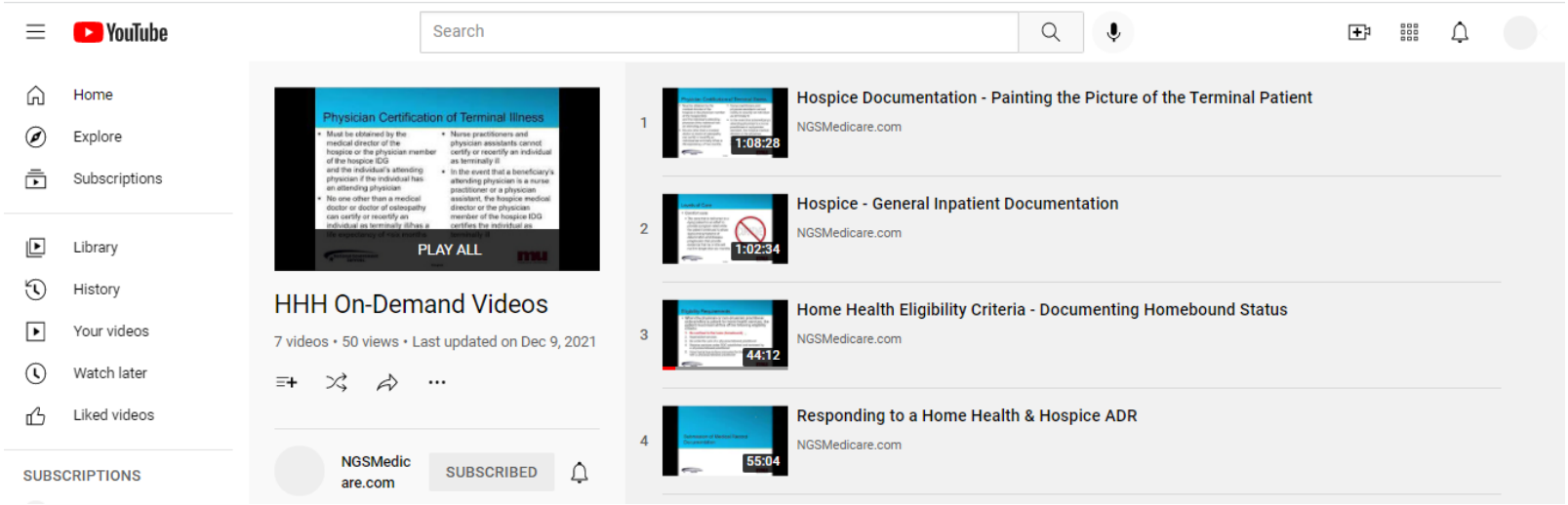

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Avoiding Top Home Health Billing Errors
Session Nine
July 14, 2022

DATASOFTLOGIC
Create. Innovate. Transform.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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POE Manager

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Objectives

- Review the top rejection and return to provider (RTP) reason codes assigned to home health claims
- Educate on correcting the reason code errors and the billing guidelines behind the NOA and claim

Agenda

- Billing Reminders
- Top Rejection Reason Codes
  - How to correct and background billing guidelines
- Top RTP Reason Codes
  - How to correct and background billing guidelines
- Resources
- QA

Some Basic Reminders

Notice of Admission

Purpose: Opens a home health admission period in CWF which allows other HHAs and providers of care to see an open home health admission

When to Submit the NOA

HHA has received the appropriate physician's written or verbal order that contains the services required for an initial visit

HHA has conducted the initial visit at the start of care and admitted the patient to HH care

Must be submitted within five calendar days from the start of care

Requirements Prior to Billing Claim

- Submitted after all services for the period have been provided
- Physician has signed plan of care and all orders
- Face-to-face encounter has been completed
- OASIS has been submitted and accepted by iQIES
  - Any warnings, regardless of the OASIS being accepted, should be investigated and corrected
- Claim submission:
  - At the end of a 30-day period of care, or
  - When patient is discharged for meeting goals under plan of care (if before 30-day period end date), or
  - When patient transfers from one HHA to another

Claim Billing Reminders

- 329 type of bill
- 0023 revenue line must be billed with a Grouper-produced HIPPS or any valid HIPPS under PDGM
- Must report revenue lines for all services (covered and noncovered) provided to the beneficiary during the period of care
  - Includes services provided directly and/or under arrangements
- Must contain a revenue line with a site of service code

Claim Billing Timeliness

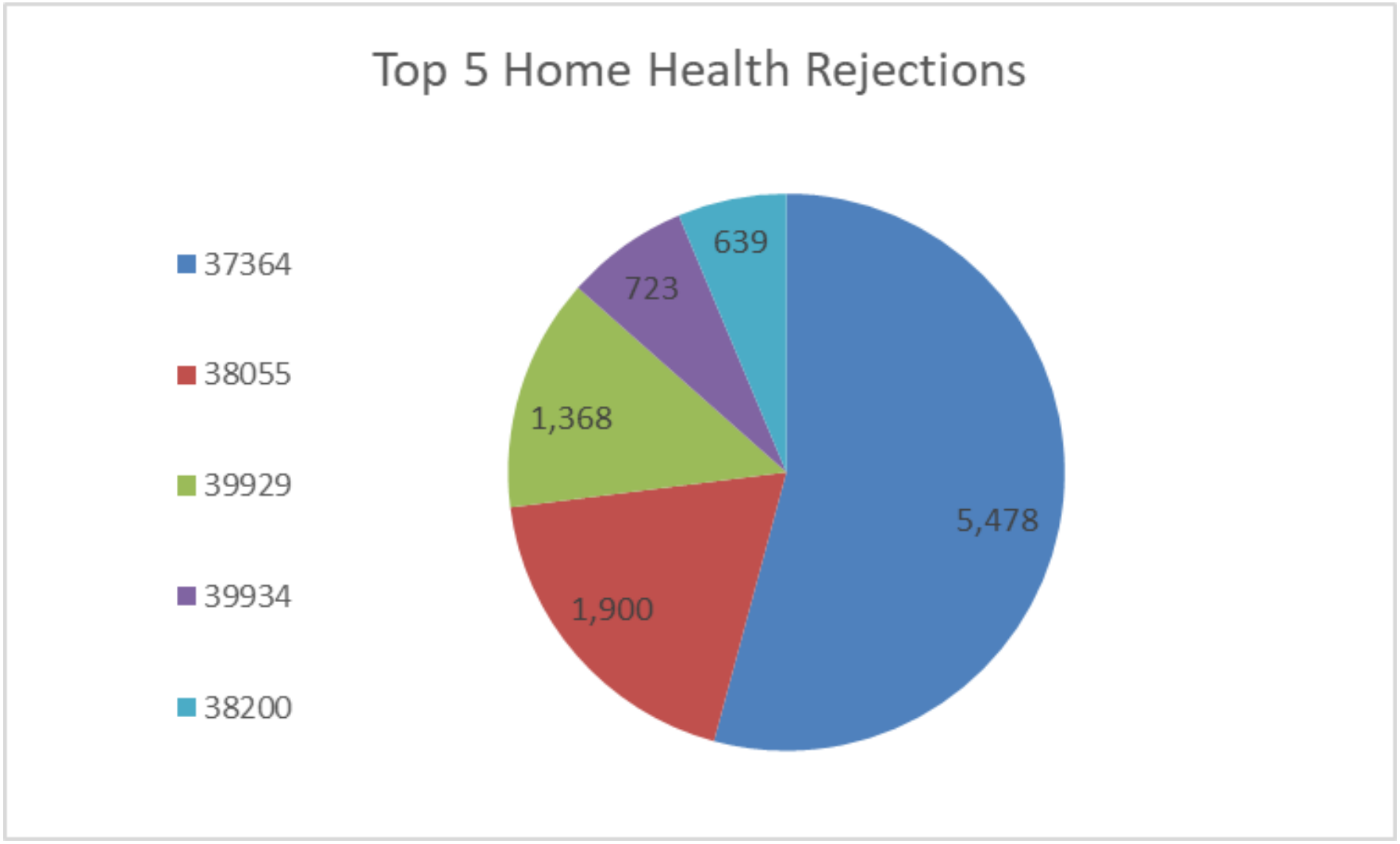
- Period of care claims must be received in the FISS claims processing system within one (1) calendar year of the period end date

Claim Status/Locations

- Rejections (R B9997)
  - Claims are resubmitted (in very limited situations, claims are adjusted)
- Returned to Provider (T B9997)
  - Claims are corrected and resubmitted

Top Billing Errors - Rejections

Rejected Claims



Rejection Reason Code 37364

- The dates of service fall within the span of days between the NOA receipt date and the claim From date on TOB 32X with Statement From Date on or after 01/01/2022, the NOA receipt date is 30 or more days from the claim From date, the payment amount returned from HH Pricer is equal to zero and the PROVIDER REIM field on MAP103A is blank.

Background/Correcting Reason Code 37364

There was an issue with NOAs incorrectly editing for U537F – once the system was fixed, NOAs could be resubmitted and subsequently processed

NOAs submitted late due to this issue may have affected more than one period of care claim

All claims affected should be submitted with modifier KX appended to the HIPPS code on the 0023 revenue line and Remarks specifying the request for exception to the late NOA penalty

Background/Correcting Reason Code 37364

Adjust the rejected claim to add the KX modifier and Remarks

Enter condition code ‘D9’	Use ‘OT’ adjustment reason code	Delete and re-key HIPPS code line to add ‘KX’ modifier	Add appropriate Remarks requesting late exception penalty

Rejection Reason Code 38055

- This home health claim was submitted as a Medicare primary claim and contains exact service dates corresponding to a previously submitted claim for the same provider with at least one matching revenue code

Provider Action for Reason Code 38055

Verify the claim history to determine claim causing overlap

- FISS/DDE
- NGSConnex
- Remittance advice

Correcting Reason Code 38055

Submit adjustment bill (3X7 TOB) to add any services not included on the original claim

- All services provided to a beneficiary within the home health period of care must be submitted on one claim

Always verify previously billed information prior to submitting any new billing to Medicare

- Avoid overlap edits for your own claims

Rejection Reason Code 39929/39934

- 39929: Each line of charges on this claim has been rejected and/or rejected and denied
- 39934: All revenue lines on the claim denied as noncovered and one or more of the lines denote beneficiary liability

Provider Action for Reason Codes 39929/39934

- Verify line level rejection information to determine the rejection for each line of the claim
- Access MAP171D for line item detail information
  - Hit F2 once or F11 twice from page two of the claim to access MAP171D
  - Since it is possible for each line item to have a different line item reason code, review the additional lines by using F6 to forward to the next claim line and F5 to go back through previous claim lines

Rejection Reason Code 38200

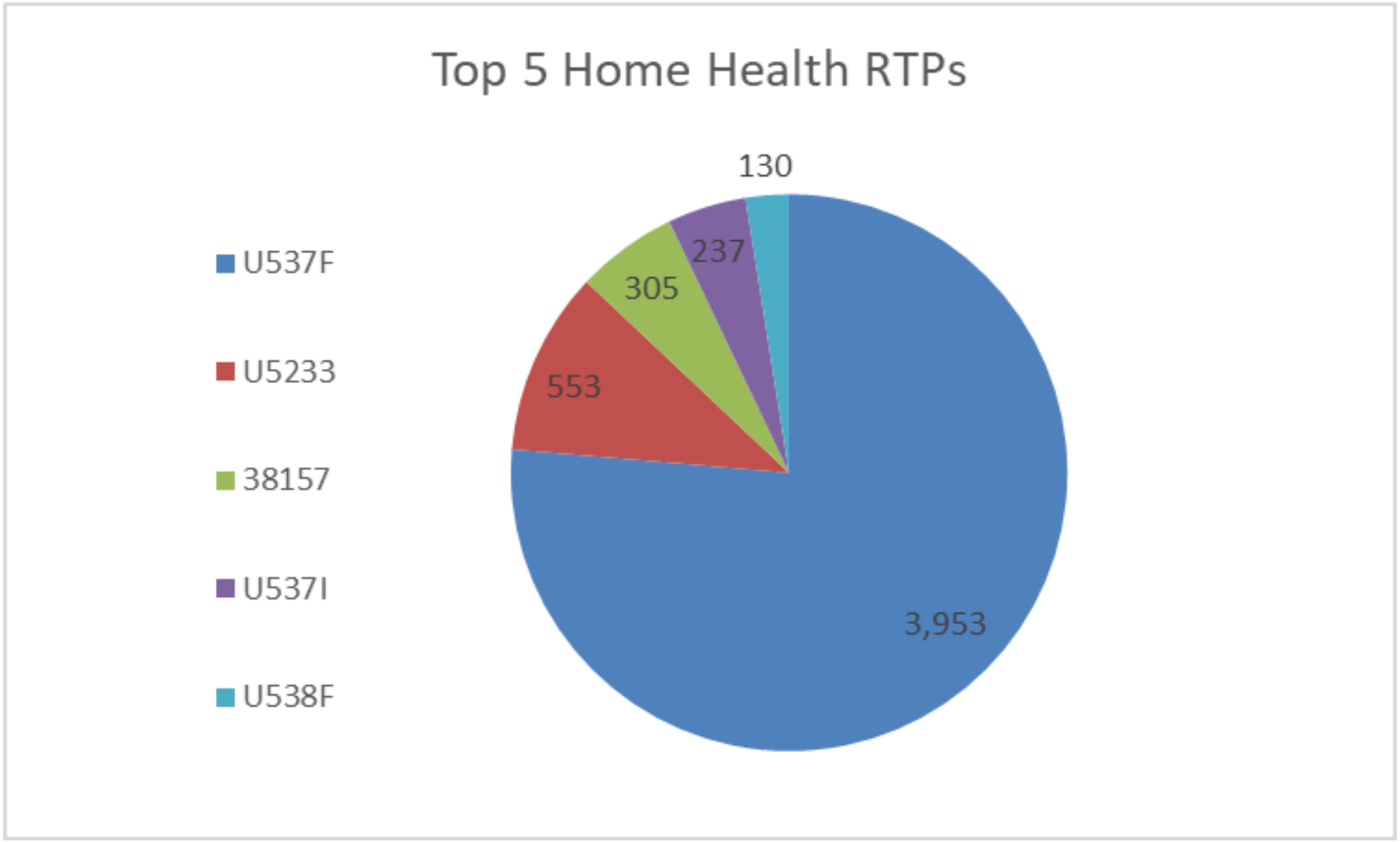
- This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same:
  - HIC Number
  - TOB (all three positions of any TOB)
  - Provider number
  - Statement from date of service
  - Statement through date of service
  - Total charges (0001 revenue line)
  - Revenue code
  - HCPCS and modifiers (if required by revenue code file)

Background/Correcting Reason Code 38200

- FISS will only accept one original billing (329) for each period of care
- A processed claim is in the FISS history file – any claim billed with the same information will reject as a duplicate
- Verify billing already submitted: check remit, NGSConnex, or FISS/DDE

Top Billing Errors - RTPs

Return to Provider Claims



RTP Reason Code U537F

- The From date on the HH NOA falls within an existing home health admission period

Correcting Reason Code U537F

Assigned Incorrectly

- Some NOAs edited in error due to CWF not recognizing discharges (patient status other than 30)

Assigned correctly on duplicate NOAs for the same admission period

- NOA should not already be in the system pending processing or finalized prior to submitting a new NOA for a beneficiary
- HHAs should not submit multiple NOAs for same admission

Assigned correctly on NOAs if the provider CCN does not match the CCN on the prior HH episode posted at CWF

- When opening a new admission for a transferred patient, the NOA should be billed with condition code 47

Provider Action for Reason Code U537F

- Always verify billing before submitting a new NOA for a beneficiary admission
- Effective 4/4/2022, providers can resubmit any HH NOAs (32A) that RTP'd incorrectly
  - Submit the KX modifier on the affected final HH claim(s)
  - Add Remarks to request an exception to the late-filing penalty, e.g., "Late NOA due to U537F System Problem"

RTP Reason Code U5233

- No Medicare payment can be made because the services on this claim fall within or overlap a Medicare Advantage Organization (MAO) enrollment period

Background/Correcting Reason Code U5233

Services can only be paid by traditional Medicare or an MA plan for the period a beneficiary is entitled/enrolled in either plan

Patient starts period of care under MA plan then switches to Original Medicare	Complete new OASIS	Submit NOA to open admission period under Original Medicare
Patient starts period of care under Original Medicare then switches to MA plan	Bill Medicare up to the MAO enrollment date	Submit claim with patient status code 06

Background/Correcting Reason Code U5233

- HHAs should submit a claim prior to the MAO enrollment date with patient status code '06' when the HHA is aware the patient will become enrolled in an MAO
- Always verify MA plan information prior to rendering services/billing the period of care
- Billing guidelines: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10, Sections 10.1.5.2 and 40.2

MA Complaints

- HHAs can call 1-800-MEDICARE to file a complaint about a Medicare Advantage Plan
- Press '0' or say, 'Agent' to speak to a live customer service agent 24/7
- Be very specific and clear and advise 1-800-MEDICARE you have been working with the MA Plan either through their provider contact center or through the appeals process but no resolution could be settled
- Request the complaint be elevated to the appropriate CMS Regional office's account representative over the MA Plan to mediate
- If the 1-800-MEDICARE customer service agent does not understand the complaint intake process, ask to be transferred to a supervisor

RTP Reason Code 38157

- This RAP is a duplicate to a paid RAP or to a paid, suspended, or denied home health claim for the same provider, same Medicare number, and same statement 'From' date and does not contain a cancel date
  - This edit may fire due to the RAP and final claim being submitted at the same time and are editing against each other

Background/Correcting Reason Code 38157

RAPs must be submitted and processed prior to submitting the matching period claim	• Always submit the RAP and wait for it to complete processing before submitting the final claim
Always verify prior records	• Look at FISS/DDE, NGSConnex, or remittance advice before submitting any new billing
Final claim has processed and needs to be corrected	• RAP should not be resubmitted; send adjustment to finalized paid claim
Final claim has been denied	• Use the appeals process, if appropriate

RTP Reason Code U537I

- The From and Through dates on HH claim fall outside a Home Health admission period

Background/Correcting Reason Code U537I

The NOA opens an admission period for a beneficiary – all claim dates of service must follow the date of admission until the patient is discharged

There cannot be any dates billed prior to the admission date

Verify the from and through dates billed and correct as appropriate

RTP Reason Code U538F

- A RAP or home health claim overlaps an existing episode with the same provider number and the "From" date equals the episode's start date

Background/Correcting Reason Code U538F

- When billing subsequent period of care claims, the ‘From’ date needs to reflect the first day of the new billing period
- Only the initial period of care billing should reflect the same date in the ‘Admit Date’ (i.e., period start date) and ‘From’ date fields

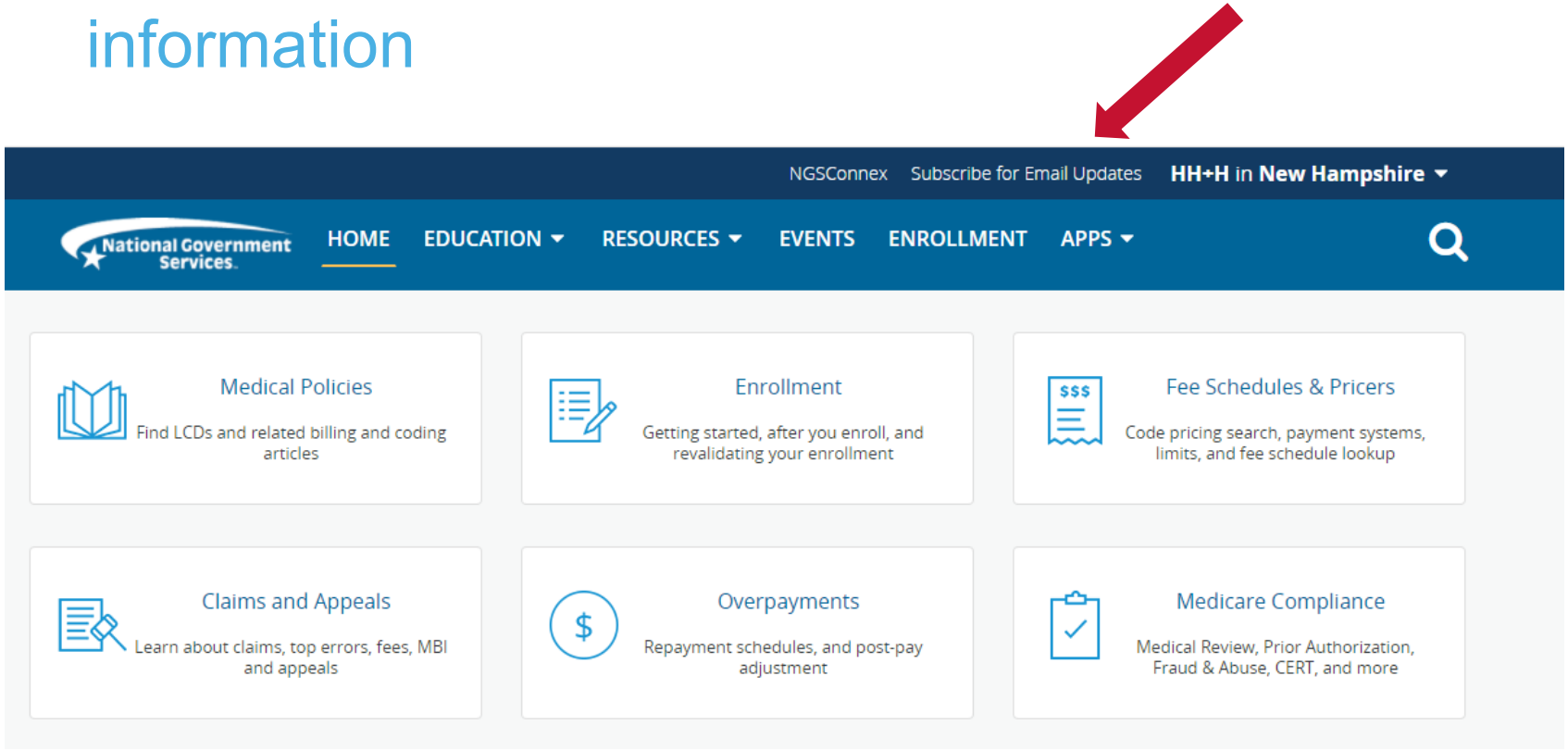
Home Health & Hospice References and Resources

NGS Website

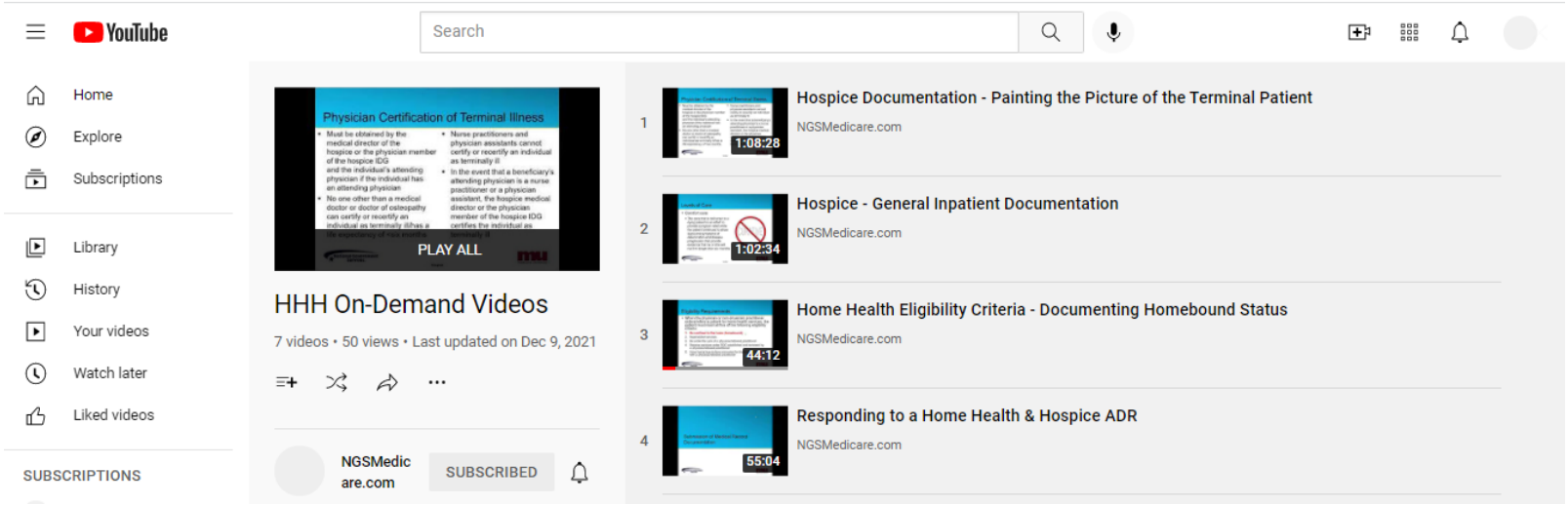
- NGS Website
  - Articles and Job Aids
  - Resources
  - Medicare Compliance
  - Fraud and Abuse

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS HHH On-Demand Videos



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Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

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Thank You!

- Questions?

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Certification, Recertification, Documentation Collaboration & Current Home Health Denials

Session Eleven

July 14, 2022

DATASOFTLOGIC
Create. Innovate. Transform.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team

Mike Davis
POE Manager

Erin Musumeci RN; POE HHH Consultant

Jan Wood; POE HHH Consultant

Shelly Dailey MSN, BSN, RN, CPHM; POE HHH Consultant

Christa Shipman; POE HHH Consultant

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Ensure a comprehensive understanding of the documentation requirements for home health certification and recertification of eligibility criteria
- Discuss the importance of documentation collaboration for home health services
- Review the top home health denialsand how to avoid them

Agenda

- Home Health Certification and Recertification
- Home Health Documentation Collaboration
- Home Health Medical Review Updates
- Home Health References & Resources
- Question & Answer Period

Certification and Recertification of Eligibility Criteria

Certification of Eligibility Criteria

- Is the patient eligible to utilize their home health benefit?

- Does the patient meet all of the eligibility criteria?

Certification of Eligibility Criteria

The certifying/re-certifying physician or allowed practitioner is attesting to the fact that all five eligibility criteria have been met:

1. The patient is confined to the home (homebound)
2. Has a need for skilled services in the home
3. A plan of care has been established and will be periodically reviewed by a physician or allowed practitioner
4. Services will be furnished while the patient is under the care of a physician or allowed practitioner
5. A face-to-face encounter occurred by a physician or allowed practitioner for the current diagnosis

Certification of Eligibility Criteria

- **Certifying physician** must be enrolled in the Medicare Program and be a Doctor of Medicine, a Doctor of Osteopathy; or a Doctor of Podiatric Medicine
- **Certifying allowed practitioner** must be a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law
  - **Certifying physician/allowed practitioner** must be enrolled in PECOS
  - **Certifying physician/allowed practitioner** cannot have financial relationship with the home health agency unless it meets one of exceptions within the Code of Federal Regulations: 42 CFR 411.355-42 and CFR 411.357

Certification of Eligibility Criteria

- The certification statement can be signed at the time of referral by the ordering/referring physician or by the community physician/allowed practitioner that has agreed to oversee the patients home health services

Certification of Eligibility Criteria

- If the certifying or allowed practitioner is an acute/post-acute care provider **and will not be following the patient** while they are receiving home health services, the medical record documentation must identify the name of community physician who will be monitoring the home health services and signing the plan of care

Certification of Eligibility Criteria

- The certification must be complete prior to when the home health agency bills Medicare for reimbursement
- Certification should be completed when the plan of care is established, or as soon as possible thereafter
- It is not acceptable for the home health agency to wait until the end of a 60-day certification period to obtain a completed certification or recertification

Certification of Eligibility Criteria

- **Certification Statement Example**
  - The ordering/referring physician or allowed practitioner is certifying eligibility for home health services, **but is not monitoring** the patients home health care
    - *I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy.* ***I have authorized the services on the initial plan of care which will be further developed by Dr. XXX who has agreed to monitor home health services.*** *I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.*

Certification of Eligibility Criteria

Certification Statement Example

- The ordering physician or allowed practitioner is certifying eligibility and **will be monitoring** the patients home health care
  - *I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy.* ***This patient is under my care.*** *I have authorized the services on this plan of care and will continue to monitor home health services. I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.*

Recertification of Eligibility Criteria

- Recertification is required at least every 60 days
- Medicare does not limit the number of continuous episode re-certifications for patients who continue to be eligible for the HH benefit
- The physician or allowed practitioner recertifying the patient's eligibility is the same provider that has been continually monitoring the plan of care and providing oversight of home health services

Recertification of Eligibility Criteria

Recertification Statement Example

- *I recertify this patient continues to be confined to the home and has a continued need for skilled services. This patient remains under my care; I have authorized the services on the plan of care and will continue to monitor home health services. I also re-certify that this patient had a face-to-face encounter performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that continues to be related to the primary reason the patient requires home health services.*

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

What is Missing from this Certification Statement?

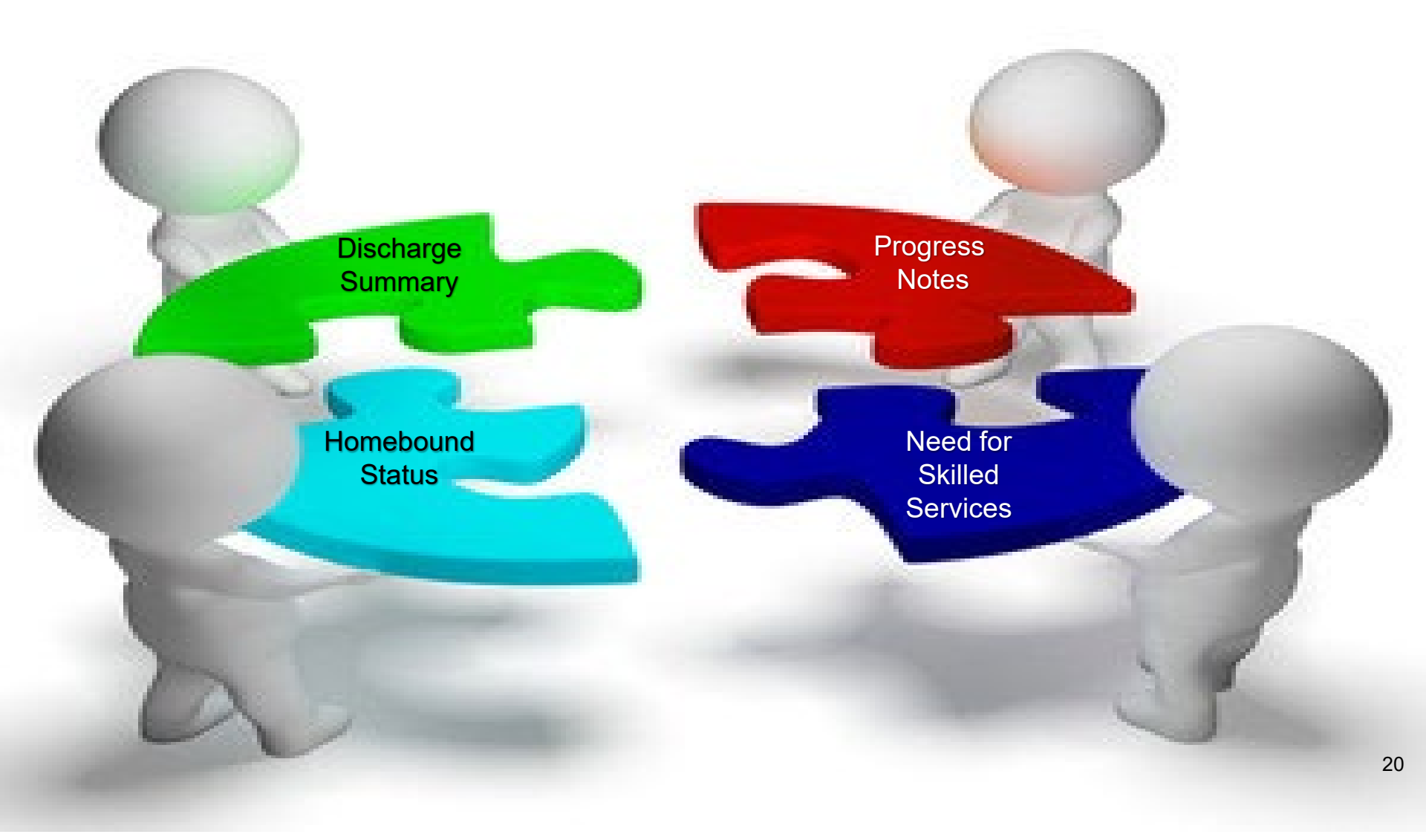
Certification of Eligibility Criteria

26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

CMS POC/Certification

Documentation Collaboration

Documentation Collaboration



Documentation Collaboration

Acute Care Facility	• Must forward any & all supporting documentation
Post-Acute Care Facility	• Must forward any & all supporting documentation
Physician's Office	• Must forward any & all supporting documentation
Other Services (including Ambulance, Oxygen, Intravenous therapy, etc.)	• Must forward any & all supporting documentation

Home Health Agency

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Documentation Collaboration

Documentation Collaboration

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Documentation Collaboration

- Home health agencies require as much documentation from the certifying physician/allowed practitioner medical records and/or the acute/post-acute care facility's medical records as necessary to assure that the patient eligibility criteria have been met
- The home health agency must be able to provide all documentation to CMS and its review entities upon request

Documentation Collaboration

- Documentation within the certifying physician/allowed practitioner medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined

Documentation Collaboration

- Examples of documentation to share **at the point of referral**
  - Referral and orders for home health services
  - Documentation (from anywhere in the medical record) supporting homebound status and the need for skilled services
  - The face-to-face encounter documentation which would Include a discharge summary or interoffice progress notes documenting the one-on-one physician/allowed practitioner visit

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Documentation Collaboration

- The home health agency generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services
- It is the patient's medical record held by the certifying physician/allowed practitioner and/or the acute/post-acute care facility that must support the patient's eligibility for home health services

Documentation Collaboration

- Incorporating home health agency documentation into the physician/allowed practitioner record
  - Information from the home health can be incorporated into the certifying physician/allowed practitioner medical record for the patient
  - The certifying physician/allowed practitioner must review and sign any documentation used to support the certification of eligibility criteria
  - If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim

Home Health Medical Review Updates

Home Health Medical Review Updates

- **Targeted Probe & Educate (TPE)**
  - *Resumed September 2021*
  - Current J6 Edits:
    - **5CAM1/5WAM**: Increase in Reimbursement 2019 – 2021
    - **5CHP/5WHP:** Claims just at/over LUPA threshold

Questions regarding TPE or ADRs:

j6probeandeducate@anthem.com

Home Health Medical Review Updates

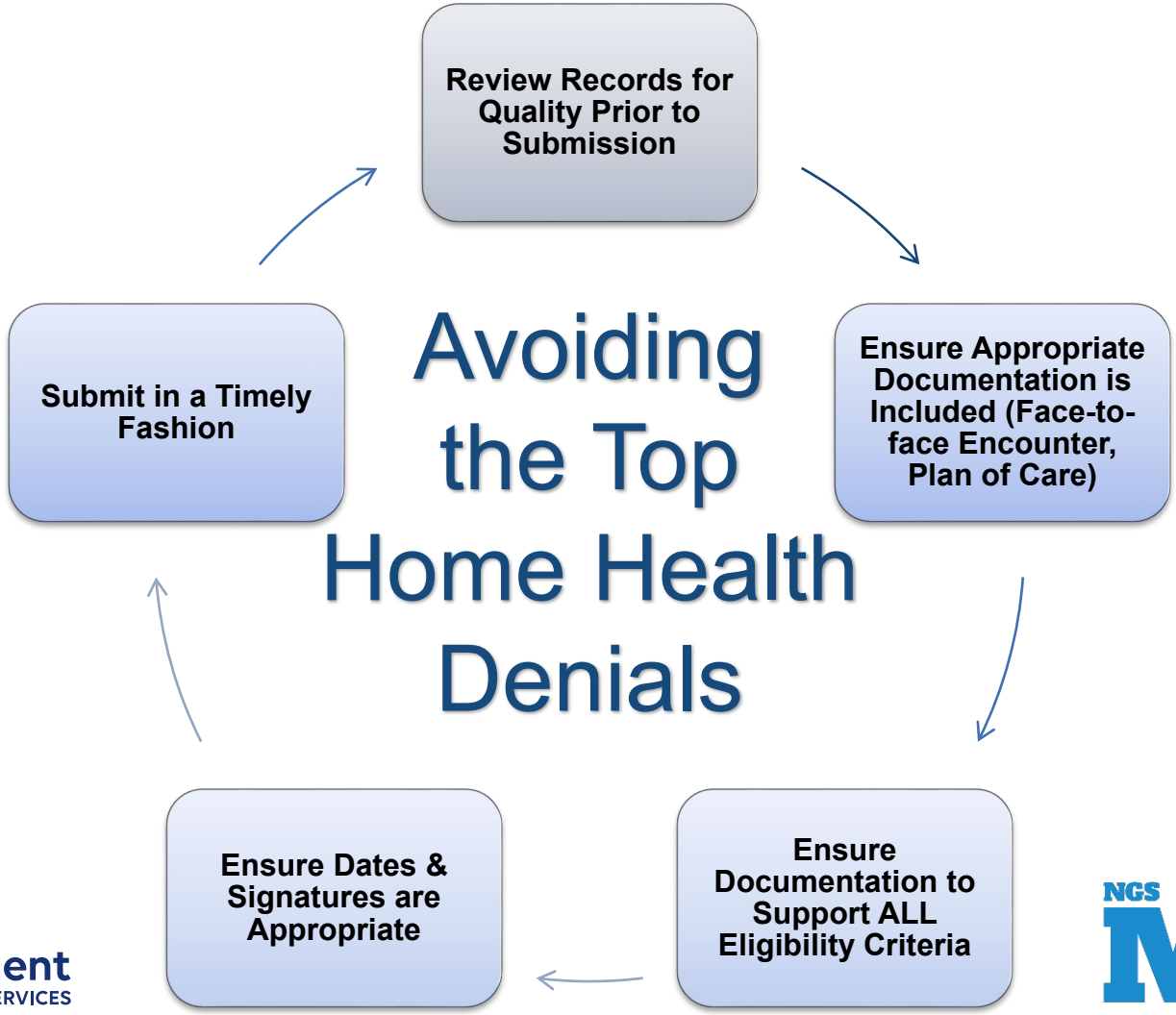
- Homebound Status Documentation
- The Need for Skilled Services Documentation
- Certification & Recertification
- Interdisciplinary Group Notes
- The Plan of Care
- Documentation from the Referring Provider Regarding the Provider who Agreed to Monitor Home Health Services
- Nurses Notes & Initial Assessment
- Progress Notes & Orders
- All Other Caregiver and Contracted Agency Notes
- Face-to-Face Encounter Documentation
- ABN, Signed & Dated (as applicable)

Home Health Medical Review Updates

Top Home Health Claim Denials

55HTP	• The initial certification was missing, incomplete, or invalid; therefore, the recertification episode is denied
55H3V	• Skilled nursing services were not medically necessary
55H2B	• Documentation does not support homebound status

Home Health Medical Review Updates



Home Health References & Resources

References & Resources

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 30
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- HH PPS web page

NGS References & Resources

- NGSMedicare.com
- NGS YouTube Channel
- NGSConnex

NGS Email Updates

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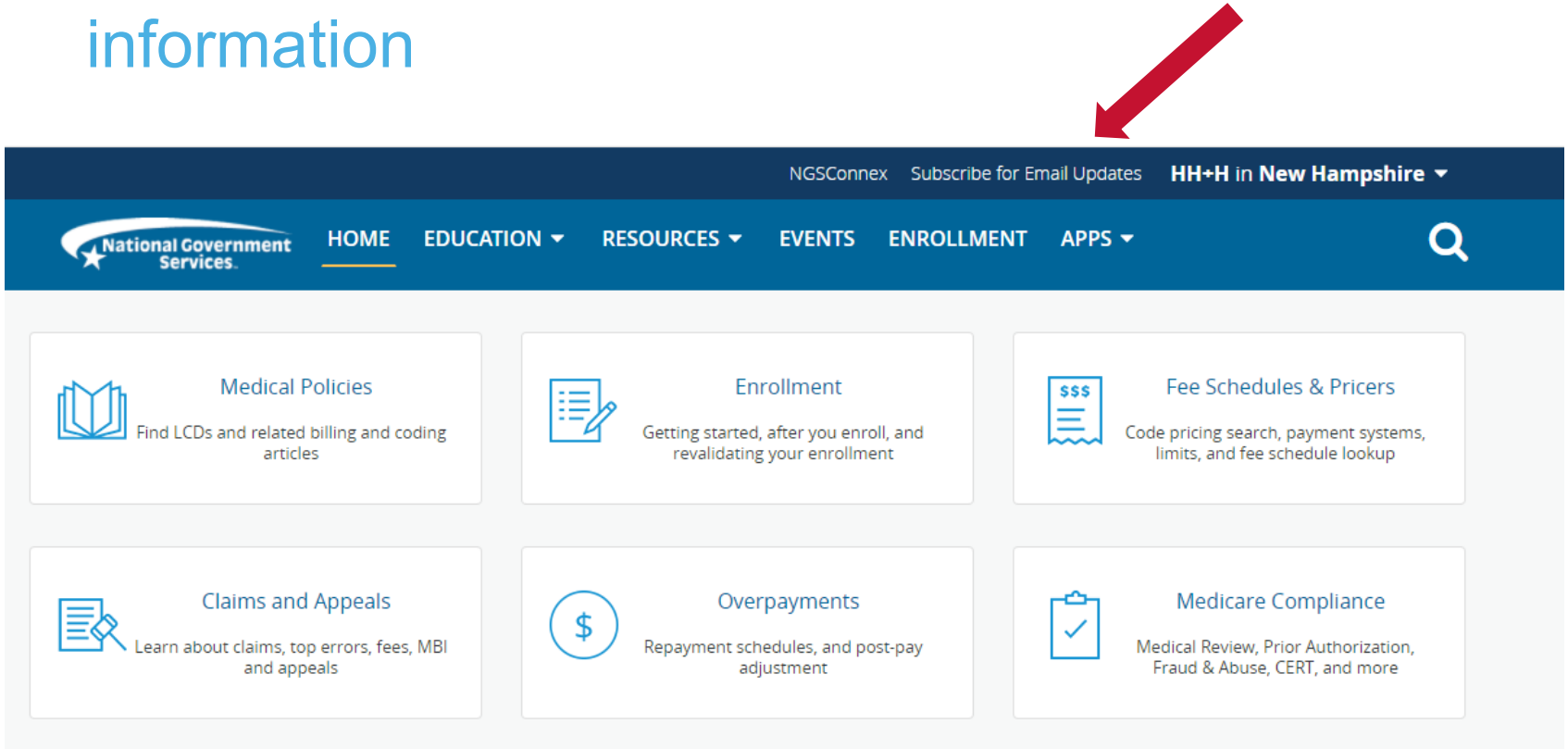

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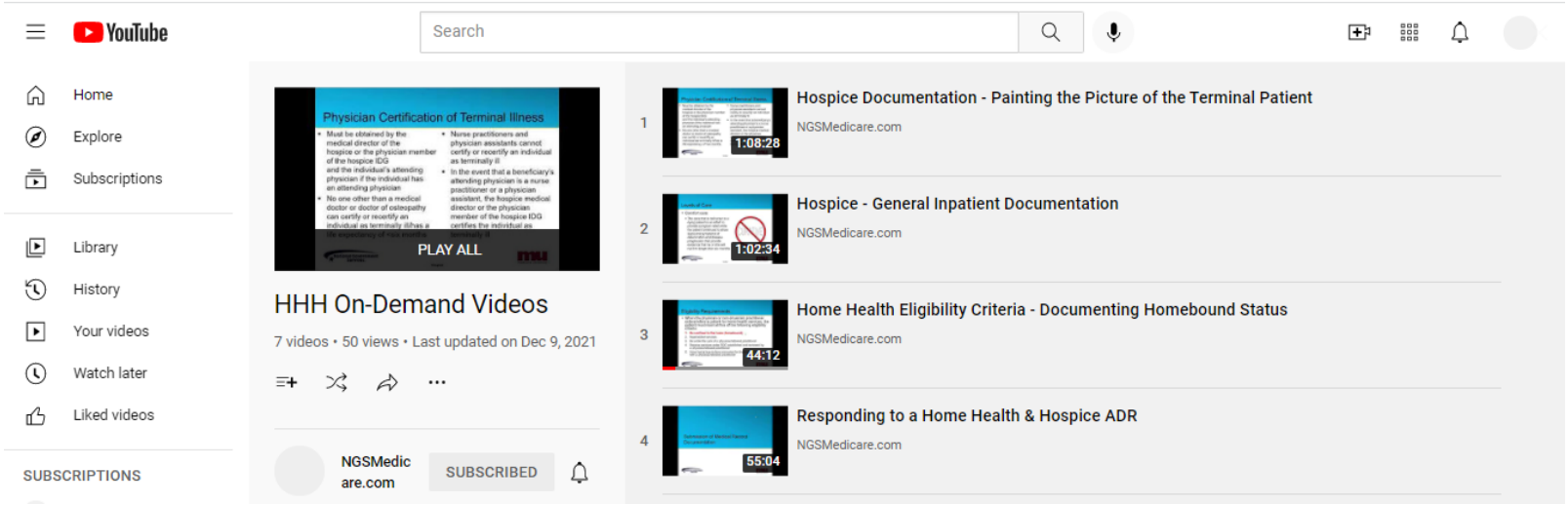

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Billing the Home Health Notice of Admission (NOA) Electronically

Any codes within this job aid indicate common codes for required fields on Home Health NOAs. The National Uniform Billing Committee (NUBC) maintains the coding information for Medicare billing, including the UB-04 data elements. For an all-inclusive listing of codes appropriate for all claim fields used for Medicare billing, visit www.nubc.org to subscribe to the Official UB-04 Data Specifications Manual.

The bolded fields on the claim screen shots provided are the fields required when billing the Home Health NOA via the 837I format (electronically). The tables below the screen shots include field title descriptions and the associated valid values.

NOA Claim Page 1

```
MAP1711        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
  SC                          INST CLAIM ENTRY                        SV:
  MID              TOB        S/LOC            OSCAR                 UB-FORM
 NPI             TRANS HOSP PROV                  PROCESS NEW HIC
 PAT.CNTL#:                          TAX#/SUB:                  TAXO.CD:
  STMT DATES FROM          TO          DAYS COV      N-C        CO      LTR
  LAST                               FIRST                 MI    DOB
  ADDR 1                                    2
       3                                    4
       5                                    6
 ZIP            SEX    MS    ADMIT DATE         HR    TYPE   SRC     HM     STAT
    COND CODES 01     02     03     04     05     06     07     08     09     10
  OCC CDS/DATE 01            02             03             04             05
               06            07             08             09             10
    SPAN CODES/DATES 01                     02                     03
 04                  05                     06                     07
 08                  09                     10                     FAC.ZIP
   DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
 01                       02                        03
 04                       05                        06
 07                       08                        09
      PLEASE ENTER DATA
        PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-EXIT
```

Field	Description/Notes
MID Medicare ID Number	Enter the Medicare Beneficiary Identifier.
TOB	32A – Notice of Admission

Field	Description/Notes
Type of Bill	32D – Cancellation of Admission
NPI National Provider Identifier Number	Enter your home health agency's NPI number.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Report the date of the first visit provided in the admission as the From date. The "To" or "Through" date on the NOA must always match the "From" date.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F).
ADMIT DATE	Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date (MMDDYY). The Admission date on the NOA must always match the From date.
SRC Source of Admission	Submit a default value of "1."
STAT Patient Status	Submit default value of "30."
COND CODES Condition Codes	Enter condition code 47 for a patient transferred from another HHA. HHAs can also use cc 47 when the patient has been discharged from another HHA, but the discharge claim has not been submitted or processed at the time of the new admission.
FAC. ZIP	Facility ZIP Code of the provider or subpart (9 digit code).

NOA Claim Page 2

```
MAP1712        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
  SC                          INST CLAIM ENTRY                REV CD PAGE 01

  MID                TOB      S/LOC          PROVIDER

                                    TOT     COV
  CL  REV  HCPC MODIFS       RATE UNIT    UNIT  TOT CHARGE NCOV CHARGE SERV DT









        PROCESS COMPLETED  ---  PLEASE CONTINUE
   PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

Field	Description/Notes
REV Revenue Codes	Enter Revenue Code 0023, which indicates billing under HH PPS.
HCPC Healthcare Common Procedure Code	Submit HIPPS code 1AA11 as a placeholder value, since differing HIPPS codes may apply over the course of an HH admission.
TOT UNITS Total Services Units	Enter 1 unit
TOT CHARGE Total Charge	The total charge for the 0023 revenue line must be zero.
SERV DT Service Date	Must not be a future date. The admission date may be duplicated to satisfy this requirement.

NOA Claim Page 3

```
MAP1713        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 03
  SC                          INST CLAIM ENTRY
  MID               TOB       S/LOC          PROVIDER
                                                      OFFSITE ZIPCD:
   CD  ID    PAYER                    OSCAR      RI AB  PRIOR PAY  EST AMT DUE
  A
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                    COST RPT DAYS      NON COST RPT DAYS
  DIAGNOSIS CODES  1          2          3          4          5
                   6          7          8          9
  ADMITTING DIAGNOSIS           E CODE          HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES  1                 2
   3                 4                 5                 6

  ESRD HOURS 00  ADJUSTMENT REASON CODE FC  REJECT CODE        NONPAY CODE
  ATT PHYS        NPI               L                        F           M     SC
  OPR PHYS        NPI               L                        F           M     SC
  OTH PHYS        NPI               L                        F           M     SC
  REN PHYS        NPI               L                        F           M     SC
  REF PHYS        NPI               L                        F           M     SC

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
PAYER Payer Identification	Enter "Medicare" on line A with payer code "Z."
RI Release of Information	Enter "Y", "R" or ''N." "Y" – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims "R" – Indicates the release is limited or restricted "N" – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code or submit any valid diagnosis code.
ATT PHYS Attending Physician	Enter the NPI and name (last name, first name, middle initial) of the attending physician who established the plan of care

Field	Description/Notes
	with verbal orders — this must be the individual physician's NPI, not a group NPI.

NOA Claim Page 4

```
MAP1714        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 04
  SC                          INST CLAIM ENTRY        REMARK PAGE 01

  MID               TOB       S/LOC          PROVIDER


REMARKS

   47  PACEMAKER    48  AMBULANCE    40  THERAPY    41  HOME HEALTH
   58  HBP CLAIMS (MED B)            E1  ESRD ATTACH
   ANSI CODES - GROUP:     ADJ REASONS:     APPEALS:

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
REMARKS	Remarks are not required on the NOA; however, remarks are recommended when canceling the NOA to indicate the reason for cancellation.

NOA Claim Page 5

```
MAP1715        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 05
  SC                          INST CLAIM ENTRY
  MID                TOB      S/LOC          PROVIDER
INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB   INS GROUP NUMBER
  A

  B

  C

  TREAT. AUTH. CODE



  TREAT. AUTH. CODE



  TREAT. AUTH. CODE


          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card.
CERT/SSN/HIC	Enter the beneficiary's Medicare number as it appears on the Medicare card if it does not automatically populate.

NOTES:

- Required for any period of care that starts on or after 1/1/2022
- HHAs with periods of care that continue into 2022 from 2021 need to submit an NOA with a one-time artificial admission date that corresponds with the 'From' of the new period of care in 2022
- HHAs are to submit the NOA when they have received the appropriate physician's written or verbal order that contains the services required for an initial visit, and the HHA has conducted the initial visit at the start of care
- NOA must be submitted within five calendar days from the start of care. A payment reduction applies if an HHA does not submit the NOA within this timeframe.

- Reduction in payment amount would be equal to a 1/30th reduction to the wage-adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submitted the NOA
  - The reduction would include any outlier payment
  - The reduction amount will be displayed with value code QF on the claim

Patients Continuing Care in 2022

HHAs with periods of care that continue from 2021 into 2022 must submit a NOA with a one-time artificial admission date that corresponds with the "From" on the new period of care in 2022.

For example, if the start of care is 12/13/21, the first 30-day period of care runs from 12/13/21 – 01/11/22. The NOA date needs to be 1/12/22 for the new period beginning in CY2022.

- Start of Care: 12/13/21
- 30-day period of care: 12/13/21 – 1/11/22
- Submit an NOA with an admission date of 1/12/22 for the next 30-day period of care, and any subsequent period(s) of care until the patient is discharged

Resources

- There are chapters that include billing instructions for specific disciplines. These are within certain publications in the CMS Internet Only Manuals (IOMs). Information on home health billing can be found in chapter 10 of the Medicare Claims Processing manual.
- Replacing Home Health Requests for Anticipated Payment (RAPs) With a Notice of Admission (NOA) – Manual Instructions (MLN Matters® Number: MM12256)
- Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission – Implementation: Change Request 12227
- CMS 837I NOA Companion Guide

Disclaimer: This job aid is not a legal document. It has been developed as an instructional tool.

Billing the Home Health Period of Care Claim – PDGM

Any codes within this job aid indicate common codes for required fields on Home Health claims. The NUBC maintains the coding information for all medical billing including the UB-04 data elements. For an all-inclusive listing of codes appropriate for all claim fields used for Medicare billing, visit the NUBC website for subscription to the UB-04: http://www.nubc.org.

The bolded fields on the claim screen shots provided are the fields required in billing the Home Health period of care claim. The tables below the screen shots include field title descriptions and the associated valid values.

HHAs must submit an NOA at the beginning of an admission period and submit a claim for each 30-day period of care. Claims submitted before an NOA has been received for the beginning of an admission period will be returned to the provider.

Claim Page 1:

```
MAP1711        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
  SC                          INST CLAIM ENTRY                        SV:
  MID              TOB        S/LOC            OSCAR                UB-FORM
 NPI             TRANS HOSP PROV                  PROCESS NEW HIC
 PAT.CNTL#:                          TAX#/SUB:                  TAXO.CD:
  STMT DATES FROM          TO           DAYS COV      N-C        CO      LTR
  LAST                               FIRST                 MI    DOB
  ADDR 1                                      2
       3                                      4
       5                                      6
 ZIP            SEX    MS    ADMIT DATE          HR    TYPE    SRC      HM     STAT
    COND CODES 01     02     03     04     05     06     07     08     09     10
  OCC CDS/DATE 01             02             03             04             05
               06             07             08             09             10
    SPAN CODES/DATES 01                      02                      03
 04                  05                      06                      07
 08                  09                      10                      FAC.ZIP
   DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
 01                        02                        03
 04                        05                        06
 07                        08                        09
      PLEASE ENTER DATA
        PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-EXIT
```

Field	Description/Notes
MID	Medicare ID Number – Enter the Medicare Beneficiary Identifier

Field	Description/Notes
TOB	Type of Bill 329: Final Claim for an HH PPS Period – This code indicates an HH original bill to be processed following the submission of an HH PPS Notice of Admission (TOB 032A) 327: Replacement of Prior Claim – HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim. 328: Void/Cancel of a Prior Claim – HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement claim must be submitted for the period of care to be paid.
NPI	National Provider Identifier Number
PAT. CNTL#	Patient Control Number – enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Enter the beginning and ending date of the period covered by the claim. The "From" date must be the first day of the period. MMDDYY format. The "From" date on an initial period must match the NOA date. The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)
ADMIT DATE	The HHA enters the same date of admission that was submitted on the NOA for all periods until the patient is discharged (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC	Source of Admission – Enter the appropriate NUBC code for the source of admission.
STAT	Patient Status – Enter the code that most accurately describes the patient's status as of the "To" date of the billing period. Any applicable NUBC approved code may be used.

Field	Description/Notes
COND CODES (Optional field)	Some period claims may be billed with condition code 54 if there are no skilled services being billed, but there is a policy exception that allows billing covered services (e.g., home health aide services, medical social worker visits).
OCC CDS/DATE	Occurrence Codes and corresponding date (MMDDYY format): Enter Occurrence Code 50 with OASIS completion date (OASIS item M00900) Enter Occurrence Code 61 if there is a hospital discharge date within 14 days of HHA admission Enter Occurrence Code 62 if there is an other institutional discharge date (SNF, IRF, LTCH, or IPF) within 14 days of HHA admission
FAC. ZIP	Facility Zip Code of the provider or subpart (9 digit code).
VALUE CODES	Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes. Enter Value Code 85 with the appropriate Federal Information Processing Standards (FIPS) code. The five-digit FIPS code must also be entered with two trailing zeroes. Note: CBSA codes can be found in the wage index file attached to the final rule. Each year, the Home Health Final Rule is linked to the Home Health Agency (HHA) Center page on the Centers for Medicare & Medicaid Services (CMS) website.

Claim Page 2:

```
MAP1712        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
  SC                          INST CLAIM ENTRY                REV CD PAGE 01

  MID                TOB      S/LOC          PROVIDER

                                    TOT     COV
  CL  REV   HCPC MODIFS        RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT

        PROCESS COMPLETED  ---  PLEASE CONTINUE
   PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

Field	Description/Notes
REV	Revenue Codes – Claims must report a Revenue Code line 0023 to indicate billing under HH PPS. HHAs must also report revenue lines for all services provided to the patient within the period.
HCPC	The HIPPS code reported on the 0023 revenue line can be the HIPPS code the HHA expects will be used for payment if choosing to run grouping software for internal accounting purposes. If not, the HHA may submit any valid HIPPS code in order to meet this requirement. For all other revenue lines, report HCPCS codes as appropriate for each revenue code.
MODIFS	Modifiers – If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty, append modifier KX to the HIPPS code reported on the 0023 revenue code line.

Field	Description/Notes
SERV DT	Service Date – For initial periods of care, report the date of the first covered visit provided during the period on the 0023 revenue line. For subsequent periods, report the date of the first service provided under the HIPPS code reported on the 0023 revenue line, regardless of whether the visit was covered or noncovered. Report all other service dates for additional revenue codes as appropriate. MMDDYY format.
TOT UNITS	Total service units – No units of service are required on the 0023 revenue line. Units of service for other revenue codes are reported as appropriate.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line must be zero. Total charges for other revenue codes are reported as appropriate.
NCOV CHARGE (Optional Field)	Noncovered Charges – Report total noncovered charges related to the revenue line. Examples of noncovered charges on HH PPS claims may include: • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments

Claim Page 3

```
MAP1713        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 03
  SC                          INST CLAIM ENTRY
  MID               TOB       S/LOC          PROVIDER
                                                      OFFSITE ZIPCD:
   CD  ID    PAYER                    OSCAR      RI AB  PRIOR PAY  EST AMT DUE
  A
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                    COST RPT DAYS      NON COST RPT DAYS
  DIAGNOSIS CODES  1          2          3          4          5
                   6          7          8          9
  ADMITTING DIAGNOSIS           E CODE          HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES  1                 2
   3                 4                 5                 6

  ESRD HOURS 00  ADJUSTMENT REASON CODE FC  REJECT CODE        NONPAY CODE
  ATT PHYS         NPI               L                       F           M     SC
  OPR PHYS         NPI               L                       F           M     SC
  OTH PHYS         NPI               L                       F           M     SC
  REN PHYS         NPI               L                       F           M     SC
  REF PHYS         NPI               L                       F           M     SC

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
PAYER	Payer Identification – If Medicare is the primary payer, enter "Medicare" on line A with payer code 'Z'. Enter appropriate payer information for MSP situations.
RI	Release of Information – Entering "Y", "R" or ''N" "Y" – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims "R" – Indicates the release is limited or restricted "N" – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code and any other diagnosis codes (up to 24 additional codes) to accurately

Field	Description/Notes
	record what is driving patient care. The diagnosis codes on the period claim may not always match the OASIS.
ATT PHYS	Attending Physician – Enter the NPI and name (last name, first name, middle initial) of the attending physician who signed the plan of care – this must be the individual physician's NPI, not a group NPI. The physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.
OTH PHYS	Name and NPI of the physician who certifies/recertifies the patient's eligibility for home health care (this field only needs to be completed if the physician who certifies/recertifies is different than the physician who signs the plan of care). The individual physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.

Claim Page 4

```
MAP1714        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 04
  SC                          INST CLAIM ENTRY        REMARK PAGE 01

  MID                TOB      S/LOC          PROVIDER


REMARKS




   47  PACEMAKER    48  AMBULANCE    40  THERAPY    41  HOME HEALTH
   58  HBP CLAIMS (MED B)           E1  ESRD ATTACH
   ANSI CODES - GROUP:     ADJ REASONS:     APPEALS:

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
REMARKS	Remarks are not required on the claim; however, remarks are recommended when canceling/adjusting a claim to indicate the reason for cancellation/adjustment.

Field	Description/Notes
	If the NOA that corresponds to the claim was filed late, and the HHA is requesting an exception to the late-filing penalty, enter information supporting the exception category that applied to the NOA.

Claim Page 5

```
MAP1715        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 05
  SC                          INST CLAIM ENTRY
  MID                TOB      S/LOC          PROVIDER
INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB    INS GROUP NUMBER
  A

  B

  C

  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card (or the information for the primary insurer in MSP situations).
CERT/SSN/HIC	Enter the Beneficiary's Medicare number (or insured information for MSP claims) as it appears on the Medicare card if it does not automatically populate.

Resources

There are chapters that include billing instructions for specific disciplines. These can be found within certain Publications in the CMS Internet Only Manuals (IOM):

- Information on billing as it specifically relates to Home Health can be found in CMS IOM Pub. 100-04, Chapter 10.
- Information on billing Medicare Secondary Payer can be found in the CMS IOM, Pub. 100-05.
- MSP information can also be found here on our website.

Billing the Home Health Period of Care Claim – PDGM

Any codes within this job aid indicate common codes for required fields on Home Health claims. The NUBC maintains the coding information for all medical billing including the UB-04 data elements. For an all-inclusive listing of codes appropriate for all claim fields used for Medicare billing, visit the NUBC website for subscription to the UB-04: http://www.nubc.org.

The bolded fields on the claim screen shots provided are the fields required in billing the Home Health period of care claim. The tables below the screen shots include field title descriptions and the associated valid values.

HHAs must submit an NOA at the beginning of an admission period and submit a claim for each 30-day period of care. Claims submitted before an NOA has been received for the beginning of an admission period will be returned to the provider.

Claim Page 1:

```
MAP1711        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
  SC                          INST CLAIM ENTRY                        SV:
  MID              TOB        S/LOC            OSCAR                UB-FORM
 NPI             TRANS HOSP PROV                  PROCESS NEW HIC
 PAT.CNTL#:                          TAX#/SUB:                  TAXO.CD:
  STMT DATES FROM          TO           DAYS COV      N-C        CO      LTR
  LAST                               FIRST                 MI    DOB
  ADDR 1                                      2
       3                                      4
       5                                      6
 ZIP            SEX    MS    ADMIT DATE          HR    TYPE    SRC      HM     STAT
    COND CODES 01     02     03     04     05     06     07     08     09     10
  OCC CDS/DATE 01             02             03             04             05
               06             07             08             09             10
    SPAN CODES/DATES 01                      02                      03
 04                  05                      06                      07
 08                  09                      10                      FAC.ZIP
   DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
 01                        02                        03
 04                        05                        06
 07                        08                        09
      PLEASE ENTER DATA
        PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-EXIT
```

Field	Description/Notes
MID	Medicare ID Number – Enter the Medicare Beneficiary Identifier

Field	Description/Notes
TOB	Type of Bill 329: Final Claim for an HH PPS Period – This code indicates an HH original bill to be processed following the submission of an HH PPS Notice of Admission (TOB 032A) 327: Replacement of Prior Claim – HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim. 328: Void/Cancel of a Prior Claim – HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement claim must be submitted for the period of care to be paid.
NPI	National Provider Identifier Number
PAT. CNTL#	Patient Control Number – enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Enter the beginning and ending date of the period covered by the claim. The "From" date must be the first day of the period. MMDDYY format. The "From" date on an initial period must match the NOA date. The "To" date is either the date of discharge, transfer, or (for continuous care periods) 29 days after the "From" date. MMDDYY format.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)
ADMIT DATE	The HHA enters the same date of admission that was submitted on the NOA for all periods until the patient is discharged (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC	Source of Admission – Enter the appropriate NUBC code for the source of admission.
STAT	Patient Status – Enter the code that most accurately describes the patient's status as of the "To" date of the billing period. Any applicable NUBC approved code may be used.

Field	Description/Notes
COND CODES (Optional field)	Some period claims may be billed with condition code 54 if there are no skilled services being billed, but there is a policy exception that allows billing covered services (e.g., home health aide services, medical social worker visits).
OCC CDS/DATE	Occurrence Codes and corresponding date (MMDDYY format): Enter Occurrence Code 50 with OASIS completion date (OASIS item M00900) Enter Occurrence Code 61 if there is a hospital discharge date within 14 days of HHA admission Enter Occurrence Code 62 if there is an other institutional discharge date (SNF, IRF, LTCH, or IPF) within 14 days of HHA admission
FAC. ZIP	Facility Zip Code of the provider or subpart (9 digit code).
VALUE CODES	Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes. Enter Value Code 85 with the appropriate Federal Information Processing Standards (FIPS) code. The five-digit FIPS code must also be entered with two trailing zeroes. Note: CBSA codes can be found in the wage index file attached to the final rule. Each year, the Home Health Final Rule is linked to the Home Health Agency (HHA) Center page on the Centers for Medicare & Medicaid Services (CMS) website.

Claim Page 2:

```
MAP1712        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
  SC                          INST CLAIM ENTRY                REV CD PAGE 01

  MID                TOB      S/LOC          PROVIDER

                                    TOT     COV
  CL  REV   HCPC MODIFS        RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT

        PROCESS COMPLETED  ---  PLEASE CONTINUE
   PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

Field	Description/Notes
REV	Revenue Codes – Claims must report a Revenue Code line 0023 to indicate billing under HH PPS. HHAs must also report revenue lines for all services provided to the patient within the period.
HCPC	The HIPPS code reported on the 0023 revenue line can be the HIPPS code the HHA expects will be used for payment if choosing to run grouping software for internal accounting purposes. If not, the HHA may submit any valid HIPPS code in order to meet this requirement. For all other revenue lines, report HCPCS codes as appropriate for each revenue code.
MODIFS	Modifiers – If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty, append modifier KX to the HIPPS code reported on the 0023 revenue code line.

Field	Description/Notes
SERV DT	Service Date – For initial periods of care, report the date of the first covered visit provided during the period on the 0023 revenue line. For subsequent periods, report the date of the first service provided under the HIPPS code reported on the 0023 revenue line, regardless of whether the visit was covered or noncovered. Report all other service dates for additional revenue codes as appropriate. MMDDYY format.
TOT UNITS	Total service units – No units of service are required on the 0023 revenue line. Units of service for other revenue codes are reported as appropriate.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line must be zero. Total charges for other revenue codes are reported as appropriate.
NCOV CHARGE (Optional Field)	Noncovered Charges – Report total noncovered charges related to the revenue line. Examples of noncovered charges on HH PPS claims may include: • Visits provided exclusively to perform OASIS assessments • Visits provided exclusively for supervisory or administrative purposes • Therapy visits provided prior to the required re-assessments

Claim Page 3

```
MAP1713        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 03
  SC                          INST CLAIM ENTRY
  MID               TOB       S/LOC          PROVIDER
                                                      OFFSITE ZIPCD:
   CD  ID    PAYER                    OSCAR      RI AB  PRIOR PAY  EST AMT DUE
  A
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                    COST RPT DAYS      NON COST RPT DAYS
  DIAGNOSIS CODES  1          2          3          4          5
                   6          7          8          9
  ADMITTING DIAGNOSIS           E CODE          HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES  1                 2
   3                 4                 5                 6

  ESRD HOURS 00  ADJUSTMENT REASON CODE FC  REJECT CODE        NONPAY CODE
  ATT PHYS         NPI               L                       F           M     SC
  OPR PHYS         NPI               L                       F           M     SC
  OTH PHYS         NPI               L                       F           M     SC
  REN PHYS         NPI               L                       F           M     SC
  REF PHYS         NPI               L                       F           M     SC

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
PAYER	Payer Identification – If Medicare is the primary payer, enter "Medicare" on line A with payer code 'Z'. Enter appropriate payer information for MSP situations.
RI	Release of Information – Entering "Y", "R" or ''N" "Y" – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims "R" – Indicates the release is limited or restricted "N" – Indicates no release is on file
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code and any other diagnosis codes (up to 24 additional codes) to accurately

Field	Description/Notes
	record what is driving patient care. The diagnosis codes on the period claim may not always match the OASIS.
ATT PHYS	Attending Physician – Enter the NPI and name (last name, first name, middle initial) of the attending physician who signed the plan of care – this must be the individual physician's NPI, not a group NPI. The physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.
OTH PHYS	Name and NPI of the physician who certifies/recertifies the patient's eligibility for home health care (this field only needs to be completed if the physician who certifies/recertifies is different than the physician who signs the plan of care). The individual physician NPI in this field must be in PECOS as an eligible specialty to order and refer services under the home health benefit.

Claim Page 4

```
MAP1714        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 04
  SC                          INST CLAIM ENTRY        REMARK PAGE 01

  MID                TOB      S/LOC          PROVIDER


REMARKS




   47  PACEMAKER    48  AMBULANCE    40  THERAPY    41  HOME HEALTH
   58  HBP CLAIMS (MED B)           E1  ESRD ATTACH
   ANSI CODES - GROUP:     ADJ REASONS:     APPEALS:

          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
REMARKS	Remarks are not required on the claim; however, remarks are recommended when canceling/adjusting a claim to indicate the reason for cancellation/adjustment.

Field	Description/Notes
	If the NOA that corresponds to the claim was filed late, and the HHA is requesting an exception to the late-filing penalty, enter information supporting the exception category that applied to the NOA.

Claim Page 5

```
MAP1715        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 05
  SC                          INST CLAIM ENTRY
  MID                TOB      S/LOC          PROVIDER
INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB    INS GROUP NUMBER
  A

  B

  C

  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


          PROCESS COMPLETED  ---  PLEASE CONTINUE
               PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Field	Description/Notes
INSURED NAME	Enter the patient's name as shown on the Medicare card (or the information for the primary insurer in MSP situations).
CERT/SSN/HIC	Enter the Beneficiary's Medicare number (or insured information for MSP claims) as it appears on the Medicare card if it does not automatically populate.

Resources

There are chapters that include billing instructions for specific disciplines. These can be found within certain Publications in the CMS Internet Only Manuals (IOM):

- Information on billing as it specifically relates to Home Health can be found in CMS IOM Pub. 100-04, Chapter 10.
- Information on billing Medicare Secondary Payer can be found in the CMS IOM, Pub. 100-05.
- MSP information can also be found here on our website.

Order Number:

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐ M ☐ F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-10	Principal Diagnosis	Date
12. ICD-10	Surgical Procedure	Date
13. ICD-10	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures:

16. Nutritional Req.	17. Allergies:

18.A. Functional Limitations

- 1 ☐ Amputation
- 2 ☐ Bowel/Bladder (Incontinence)
- 3 ☐ Contracture
- 4 ☐ Hearing
- 5 ☐ Paralysis
- 6 ☐ Endurance
- 7 ☐ Ambulation
- 8 ☐ Speech
- 9 ☐ Legally Blind
- A ☐ Dyspnea With Minimal Exertion
- B ☐ Other (Specify)

18.B. Activities Permitted

- 1 ☐ Complete Bedrest
- 2 ☐ Bedrest BRP
- 3 ☐ Up As Tolerated
- 4 ☐ Transfer Bed/Chair
- 5 ☐ Exercises Prescribed
- 6 ☐ Partial Weight Bearing
- 7 ☐ Independent At Home
- 8 ☐ Crutches
- 9 ☐ Cane
- A ☐ Wheelchair
- B ☐ Walker
- C ☐ No Restrictions
- D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT

24. Physician's Name and Address	26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.