Connecting with Medicare Billing Updates

2017 MAHC Annual Conference, Osage Beach, MO | Nykesha Scales | April 27, 2017

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Enrollment

Updates

Provider Enrollment Revalidation – Cycle 2

Revised, SE1605, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

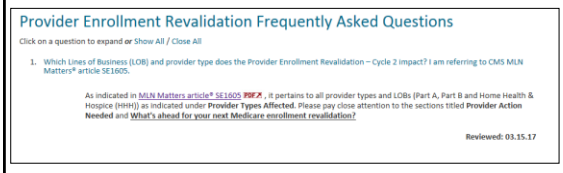
- Resumes regular revalidation cycles
- Implements several revalidation improvements
- Does not change other aspects of enrollment process
- Provides web link to check for revalidation due date & further instructions
- Updates table (pg.6) with useful information

SE1605 – Revised - March 15, 2017

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date		**September 30, 2017**
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	7

Provider Enrollment/Revalidation Frequently Asked Questions (FAQs)

- Provider Enrollment FAQs, http://www.cgsmedicare.com/hhh/education/faqs/PE_FAQs.html
- Revalidation FAQs, http://www.cgsmedicare.com/hhh/education/faqs/PER.html


Provider Enrollment Revalidation Frequently Asked Questions

Click on a question to expand or Show All / Close All

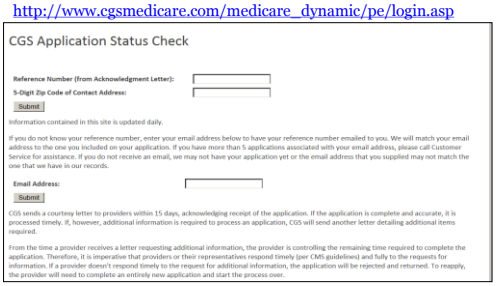
1. Which Lines of Business (LOB) and provider type does the Provider Enrollment Revalidation – Cycle 2 impact? I am referring to CMS MLN Matters® article SE1605.

As indicated in MLN Matters article® SE1605 PDF, it pertains to all provider types and LOBs (Part A, Part B and Home Health & Hospice (HHH)) as indicated under **Provider Types Affected.** Please pay close attention to the sections titled **Provider Action Needed** and **What's ahead for your next Medicare enrollment revalidation?**

Reviewed: 03.15.17

CGS Provider Enrollment Application Status

http://www.cgsmedicare.com/medicare_dynamic/pe/login.asp


CGS Application Status Check

Reference Number (from Acknowledgment Letter):

5-Digit Zip Code of Contact Address:

Submit

Information contained in this site is updated daily.

If you do not know your reference number, enter your email address below to have your reference number emailed to you. We will match your email address to the one you included on your application. If you have more than 5 applications associated with your email address, please call Customer Service for assistance. If you do not receive an email, we may not have your application yet or the email address that you supplied may not match the one that we have in our records.

Email Address:

Submit

CGS sends a courtesy letter to providers within 15 days, acknowledging receipt of the application. If the application is complete and accurate, it is processed timely. If, however, additional information is required to process an application, CGS will send another letter detailing additional items required.

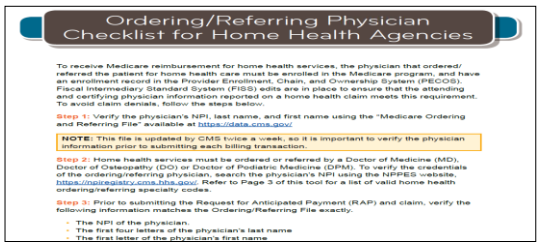
From the time a provider receives a letter requesting additional information, the provider is controlling the remaining time required to complete the application. Therefore, it is imperative that providers or their representatives respond timely (per CMS guidelines) and fully to the requests for information. If a provider doesn't respond timely to the request for additional information, the application will be rejected and returned. To reapply, the provider will need to complete an entirely new application and start the process over.

REMINDER: ORDERING/REFERRING EDITS

- **Reason Codes:** 37236, 37237 & 32072
  - If claim was denied (D B9997 status/location), must follow "Ordering/Referring denial Reopening" process
    - Cannot resubmit your claim
  - CGS "Ordering/Referring Denial Reopening" on 'Reopenings' Web page, http://www.cgsmedicare.com/hhh/appeals/Reopenings.html
    - Reopening Request Form, http://www.cgsmedicare.com/hhh/appeals/pdf/hhh_reopening_form.pdf, and
    - Adjustment claim on hardcopy UB-04

ORDERING/REFERRING CHECKLIST FOR HHAS QRT

http://www.cgsmedicare.com/hhh/education/materials/pdf/ord_ref_phys_checklist_hha.pdf



Ordering/Referring Physician Checklist for Home Health Agencies

To receive Medicare reimbursement for home health services, the physician that ordered/referred the patient for home health care must be enrolled in the Medicare program, and have an enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS). Fiscal Intermediary Standard System (FISS) edits are in place to ensure that the attending and certifying physician information reported on a home health claim meets this requirement. To avoid claim denials, follow the steps below.

Step 1: Verify the physician's NPI, last name, and first name using the "Medicare Ordering and Referring File" available at https://data.cms.gov/

NOTE: This file is updated by CMS twice a week, so it is important to verify the physician information prior to submitting each billing transaction.

Step 2: Home health services must be ordered or referred by a Doctor of Medicine (MD), Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM). To verify the credentials of the ordering/referring physician, search the physician's NPI using the NPPES website, https://npiregistry.cms.hhs.gov/. Refer to Page 3 of this tool for a list of valid home health ordering/referring specialty codes.

Step 3: Prior to submitting the Request for Anticipated Payment (RAP) and claim, verify the following information matches the Ordering/Referring File exactly.

- The NPI of the physician
- The first four letters of the physician's last name
- The first letter of the physician's first name

RECENT CHANGE REQUESTS (CRS) & PROCESS CHANGES

For Home Health Providers

CY 2017 HH PPS Rate Update

CR 9820, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2017

MM9820, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9820.pdf

- Implementation Date: **January 3, 2017**

Provider Action: Be informed of updates to 60-day national episode rates, national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, & non-routine medical supply payment amounts for CY 2017

Policy Changes for CY 2017 HH PPS

CR 9736, Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System (HH PPS)

- Informs Medicare contractors about implementation of separate payment for HHAs for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit.
- In addition, CR 9736 will do the following:
  - Implement changes to the methodology used to calculate outlier payments to HHAs and
  - Create new G codes associated with registered nurse (RN) and licensed practical nurse (LPN) visits in the home health setting.
    - Effective Date: **January 1, 2017**
- MM9736, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9736.pdf

Creation of New G Codes for RN & LPN in Home Health Episodes

Effective January 1, 2017, **G0163** and **G0164** are retired and replaced with four new G-codes:

1. **G0493** - Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

2. **G0494** - Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

3. **G0495** - Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

4. **G0496** - Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9736.pdf

Manual Updates to Clarify Payment Policy Changes for NPWT Using a Disposable Device & the Outlier Payment Methodology for Home Health Services

CR 9898 updates "Medicare Benefit Policy Manual" policies discussed in CY 2017 HH PPS Final Rule, published November 3, 2016

- Policies relate to payment for furnishing of NPWT using a disposable device, as well as changes to methodology used to calculate outlier payments to HHAs
- Changes relate to multiple revised sections of Chapter 7 in the "Medicare Benefit Policy Manual"

MM9898, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9898.pdf

- Implementation Date: **March 27, 2017**

2017 Annual Update to the Therapy Code List

MM9782, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf

- Implementation Date: **January 3, 2017**

CR 9782 updates the therapy code list for Calendar Year (CY) 2017 by:

- Adding eight "always therapy" codes (97161 – 97168) for physical therapy (PT) and occupational therapy (OT) evaluative procedures
- Deleting four codes currently used to report these services (97001 – 97004)

Implementation of New Influenza Virus Vaccine Code

CR 9793 informs MACs about changes to instructions for payment and edits for the Common Working File (CWF) to include influenza virus vaccine code **90674** (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after **January 3, 2017**.

MM9793, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9793.pdf

Denial of Home Health Payments When Required Patient Assessment Is Not Received

CR 9585 directs MACs to automate the denial of HH PPS claims when the condition of payment for submitting patient assessment data has not been met..

MM9585, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9585.pdf

- Implementation Date: **April 3, 2017**

Home Health Quality Initiatives

- Information available on the CMS website, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html
  - Goals
  - Measures
  - Process
  - Reporting Data
  - Manuals
  - Resources
  - Notifications of National Provider Calls/Training

Future Changes

Implementation of New Influenza Virus Vaccine Code

MM9876, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf

- Implementation Date: **July 3, 2017**

CR 9876 provides instructions for payment and edits for CWF to include influenza virus vaccine code **90682** (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after **July 1, 2017**.

Future Changes

Future changes communicated by CMS via Change Requests (CRs)

- Providers can monitor CMS Home Health Agency Center Web page, http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Sign up for CMS ListServs, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MailingLists_FactSheet.pdf

CGS will communicate any final instructions via usual channels

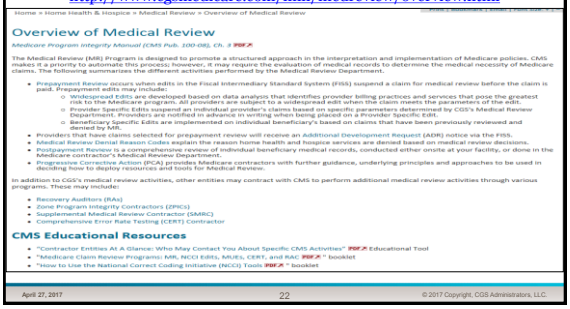
- Home Health & Hospice Medicare Bulletin, http://www.cgsmedicare.com/hhh/pubs/mb_hhh/index.html
- CGS Listserv
  - Join/update ListServ http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp
  - "Recent News" link, http://www.cgsmedicare.com/hhh/pubs/news/index.html
- Provider education events, posted to Calendar of Events Web page, http://www.cgsmedicare.com/hhh/education/webinars.html

Medicare Claim Review Programs

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf

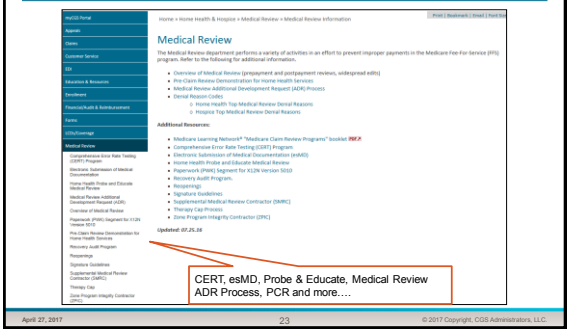
CGS Medical Review (MR)

http://www.cgsmedicare.com/hhh/medreview/overview.html



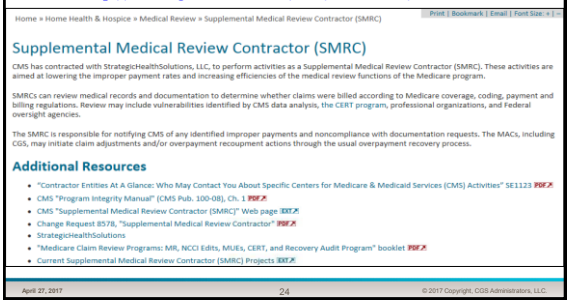
CGS Medical Review Web Page

http://www.cgsmedicare.com/hhh/medreview/index.html



Supplemental Medical Review Contractor (SMRC)

http://www.cgsmedicare.com/hhh/medreview/smrc.html



Comprehensive Error Rate Testing (CERT) Program

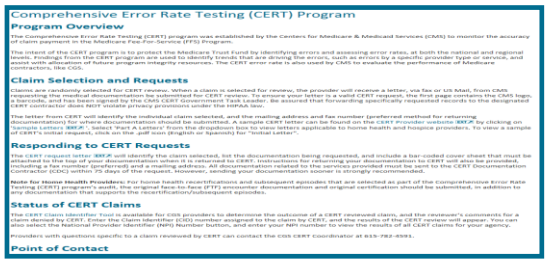
http://www.cgsmedicare.com/hhh/education/materials/cert.html

Dedicated CERT page with information such as:

- Program Overview
- Claim Selection Details
- How to Respond to CERT Requests
- Point of Contact Designation/Verification
- Resources & Education

HH&H CERT Web Page

http://www.cgsmedicare.com/hhh/education/materials/cert.html


Comprehensive Error Rate Testing (CERT) Program

Program Overview

The Comprehensive Error Rate Testing (CERT) program was established by the Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claim payment in the Medicare Fee-For-Service (FFS) Program.

The intent of the CERT program is to protect the Medicare Trust Fund by identifying errors and assessing error rates, at both the national and regional levels. Findings from the CERT program are used to identify trends that are driving the errors, such as errors by a specific provider type or service, and assist with allocation of future program integrity resources. The CERT error rate is also used by CMS to evaluate the performance of Medicare contractors, like CGS.

Claim Selection and Requests

Claims are randomly selected for CERT review. When a claim is selected for review, the provider will receive a letter, via fax or US Mail, from CMS requesting the medical documentation be submitted for CERT review. To ensure your letter is a valid CERT request, the first page contains the CMS logo, a barcode, and has been signed by the CMS CERT Government Task Leader. Be assured that forwarding specifically requested records to the designated CERT contractor does NOT violate privacy provisions under the HIPAA law.

The letter from CERT will identify the individual claim selected, and the mailing address and fax number (preferred method for returning documentation) for where documentation should be submitted. A sample CERT letter can be found on the CERT Provider website (.pdf) by clicking on 'Sample Letters (.pdf)' - select 'Part A Letters' from the dropdown box to view letters applicable to home health and hospice providers. To view a sample of CERT's initial request, click on the .pdf icon (English or Spanish) for "Initial Letter".

Responding to CERT Requests

The CERT request letter (.pdf) will identify the claim selected, list the documentation being requested, and include a bar-coded cover sheet that must be attached to the top of your documentation when it is returned to CERT. Instructions for returning your documentation to CERT will also be provided, including a fax number (preferred) and a mailing address. All documentation related to the service provided must be sent to the CERT Documentation Contractor (CDC) within 75 days of the request. However, sending your documentation sooner is strongly recommended.

Note for Home Health Providers: For home health recertifications and subsequent episodes that are selected as part of the comprehensive Error Rate Testing (CERT) program's audit, the original face-to-face (FTF) encounter documentation and original certification should be submitted, in addition to any documentation that supports the recertification/subsequent episodes.

Status of CERT Claims

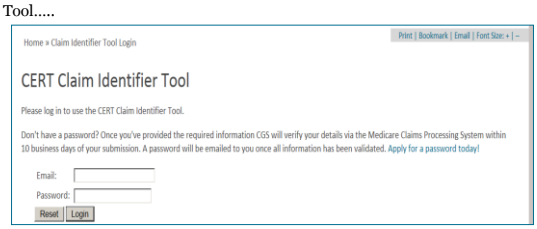
The CERT Claim Identifier Tool is available for CGS providers to determine the outcome of a CERT reviewed claim, and the reviewer's comments for a claim denied by CERT. Enter the Claim Identifier (CID) number assigned to the claim by CERT, and the results of the CERT review will appear. You can also select the National Provider Identifier (NPI) Number button, and enter your NPI number to view the results of all CERT claims for your agency.

Providers with questions specific to a claim reviewed by CERT can contact the CGS CERT Coordinator at 615-782-6591.

Point of Contact

CERT Claim Identifier Tool

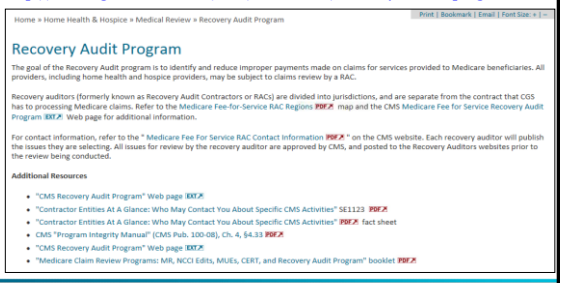
Need to check the status of a CERT claim? Use our CERT Claim Identifier Tool.....



http://www.cgsmedicare.com/medicare_dynamic/cid_tool/index.asp

Recovery Audit (RA) Contractor

http://www.cgsmedicare.com/hhh/medreview/recovery_audit_program.html


Home » Home Health & Hospice » Medical Review » Recovery Audit Program

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Recovery Audit Program

The goal of the Recovery Audit program is to identify and reduce improper payments made on claims for services provided to Medicare beneficiaries. All providers, including home health and hospice providers, may be subject to claims review by a RAC.

Recovery auditors (formerly known as Recovery Audit Contractors or RACs) are divided into jurisdictions, and are separate from the contract that CGS has to processing Medicare claims. Refer to the Medicare Fee-for-Service RAC Regions map and the CMS Medicare Fee for Service Recovery Audit Program Web page for additional information.

For contact information, refer to the " Medicare Fee For Service RAC Contact Information " on the CMS website. Each recovery auditor will publish the issues they are selecting. All issues for review by the recovery auditor are approved by CMS, and posted to the Recovery Auditors websites prior to the review being conducted.

Additional Resources

- "CMS Recovery Audit Program" Web page
- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" SE1123
- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" fact sheet
- CMS "Program Integrity Manual" (CMS Pub. 100-08), Ch. 4, §4.33
- "CMS Recovery Audit Program" Web page
- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" booklet

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Top Billing Errors & Reminders

Claim Submission Errors (CSEs)

Top Billing Errors

Defined: Any RAP or claim that cannot be processed as billed

- Returned to provider for correction (RTP, status/location T B9997)
- Rejected (R B9997)

Provider impact:

- Delayed payment
- Additional time and work for staff to identify and correct errors

Risks:

- No payment
- Appearance in data resulting in possible referral to OIG

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Reminder: Verify Beneficiary Eligibility

At minimum, verify eligibility information:

- Prior to admission to home health
- Prior to submitting **each** billing transaction
- Encourage monthly eligibility check by HHAs

Data updated at any time by multiple sources

- Social Security Administration
- Employers/Insurers
- Medicare Advantage plans
- Medicare contractors
- Providers

Top Billing Errors (September 2016 – February 2017)

Overview of HH Claim Submissions and CSEs	
# of HH "Claims" Submitted	1,336,552
# of HH CSEs	188,452
Percent of billing errors	14.10%

CGS Billing Errors – Home Health

September 1, 2016 – February 28, 2017		
Reason Code	**Billing Error**	**# of Errors**
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	54,789
38107	FISS can't find matching RAP	43,645
U538I	Overlap another HHA's episode	10,217
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	4,930
U5211	Svcs billed on claim provided after bene's DOD	2,744

MO Top HH Billing Errors

September 1, 2016 – February 28, 2017		
Reason Code	**Billing Error**	**# of Errors**
38107	FISS can't find matching RAP	3,387
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	1,849
32403	HCPCS billed is not valid for the dates of service on the claim. Please correct the HCPCS	831
U538I	Overlap another HHA's episode	819
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	426

RC 38107 – Claim Cannot Match to RAP

Defined: Final claim was submitted but cannot be matched to a processed RAP

Reason for error:

- RAP was not submitted
- RAP was not processed
- RAP was auto-cancelled because claim not submitted timely
- Information on final claim did not match information on RAP

RC 38107 – Claim Cannot Match to RAP

Reminders to avoid error:

- Ensure RAP is submitted and processed (P B9997) before submitting final claim
  - Use FISS Option 12 to verify status of RAP
- Submission of final claim must occur within greater of:
  - 60 days from when RAP processed
  - 60 days from end of HH episode
  - If final claim not submitted timely, RAP will auto-cancel, and RAP must be rebilled before submitting final claim

38157/38200 – Duplicate RAP/Claim

Defined: RAP or claim was submitted that contains the same information as a previously processed RAP/claim

- HICN
- Dates of service
- Provider number/NPI

Reason for error: Duplicate submission of identical billing transaction due to:

- Duplicate submission of claim batch
- Not tracking processed RAPs/claims
- Rejected claims requiring adjustment instead of resubmission

38157/38200 – Duplicate RAP/Claim

Good to know:

- Use FISS Option 12 or remittance advice to monitor processing of RAPs/claims
- If rejected claim posted to Common Working File (CWF), must adjust claim (XX7) instead of resubmitting

38157/38200 – Duplicate RAP/Claim

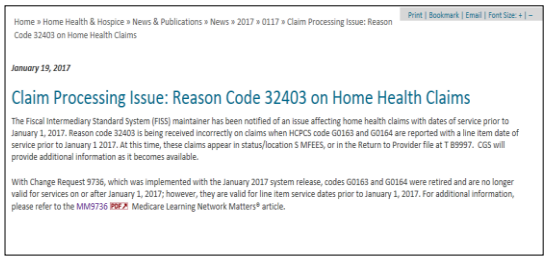
Good to know: To determine if rejected claim posted to CWF, review TPE-TO-TPE field on MAP171D

- Blank = Information posted to CWF
  - Examples: Overlap, Medicare secondary payer (MSP), inpatient dates of service
  - Note: No need to resubmit RAP
- X = Information not posted to CWF; must resubmit claim
  - Examples: Overlap hospice election, Medicare Advantage (MA) Plan

Refer to Chapter 3 of FISS Guide for more information, http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf

32403 – HCPCS Not Valid For DOS

http://www.cgsmedicare.com/hhh/pubs/news/2017/0117/cope1873.html


Home » Home Health & Hospice » News & Publications » News » 2017 » 0117 » Claim Processing Issue: Reason Code 32403 on Home Health Claims

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January 19, 2017

Claim Processing Issue: Reason Code 32403 on Home Health Claims

The Fiscal Intermediary Standard System (FISS) maintainer has been notified of an issue affecting home health claims with dates of service prior to January 1, 2017. Reason code 32403 is being received incorrectly on claims when HCPCS code G0163 and G0164 are reported with a line item date of service prior to January 1 2017. At this time, these claims appear in status/location S MFEES, or in the Return to Provider file at T B9997. CGS will provide additional information as it becomes available.

With Change Request 9736, which was implemented with the January 2017 system release, codes G0163 and G0164 were retired and are no longer valid for services on or after January 1, 2017; however, they are valid for line item service dates prior to January 1, 2017. For additional information, please refer to the MM9736 PDF Medicare Learning Network Matters® article.

U538I - RAP/Claim Overlaps Another HHA's Episode

Defined: RAP or claim overlaps an existing episode with a different provider number

Reason for error: Most commonly occurs when beneficiary elects to transfer from one HHA to another during a 60 day episode & the receiving HHA submits their initial episode RAP/claim without condition code 47 to indicate transfer between HHAs

U538I - RAP/Claim Overlaps Another HHA's Episode

Reminders to avoid error:

- Prior to admission or submitting RAPs/claims, check beneficiary's eligibility to review home health episodes, which may impact your dates of service
- If the beneficiary is transferring to your home health agency:
  - Follow the steps for appropriately completing beneficiary elected transfers as outlined on the:
    - CGS Beneficiary Elected Home Health Transfer Web page: http://www.cgsmedicare.com/hhh/education/materials/hh_transfer.html

U538I - RAP/Claim Overlaps Another HHA's Episode

Good to know:

- When other provider's National Provider Identifier (NPI) is listed, use the National Plan and Provider Enumeration System (NPPES) website to determine their contact information
  - https://nppes.cms.hhs.gov/NPPES/Welcome.do
- When Provider Transaction Access Number (PTAN) is displayed, log on to http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/HHA.html to access contact information
  - **To access home health information**, from the left side of the page, click on "Home Health Agency" and scroll down to locate and click on the HHA Reports Zip File link to open a ZIP file, and then select the "HHH_Provider_ID-Info" file to download a spreadsheet containing the contact information for HHAs

U538I - RAP/Claim Overlaps Another HHA's Episode

Good to know: To indicate a beneficiary has transferred to your HHA, enter a condition code "47" in the first available COND CODES field (FL 18-28) on FISS page 01

```
 MAP1711   PAGE 01        CGS J15 MAC - HHH REGION        ACPFA052 MM/DD/YY
 XXXXXXX   SC           INST CLAIM ENTRY               C201444F HH:MM:SS
 HIC XXXXXXXXXXA   TOB 322  S/LOC S B0100 OSCAR XXXXXX        SV:    UB-FORM
NPI XXXXXXXXXX  TRANS HOSP PROV                PROCESS NEW HIC
PAT.CNTL#:                TAX#/SUB:                TAXO.CD:
 STMT DATES FROM 1017YY  TO 1017YY   DAYS COV      N-C       CO       LTR
 LAST PATIENT                FIRST JOSEPHINE        MI    DOB 040119YY
 ADDR 1 1234 AT HOME STREET            2 DES MOINES IA
 3                          4                                  CARR:
 5                          6                                  LOC:
ZIP 503109999 SEX F  MS   ADMIT DATE 1017YY HR 00 TYPE 9 SRC 2 D HM      STAT 30
  COND CODES 01 47  02    03    04    05    06    07    08    09    10
```


U538I - RAP/Claim Overlaps Another HHA's Episode

Resources:

- CGS Avoiding Billing Errors Caused by Overlapping Home Health Episodes Quick Resource Tool (QRT): http://www.cgsmedicare.com/hhh/education/materials/pdf/avoid_overlap_errors.pdf
- CGS Special Billing Situations Under HH PPS QRT: http://www.cgsmedicare.com/hhh/education/materials/pdf/special_billing.pdf

31018 - Episode "TO" Date Not 60 Days

Reason for error: Home health claims are RTP'd for correction with this reason code for one of two reasons:

1. Span of more than 60 days between the "FROM" and "TO" date submitted on the claim
   - Example: "FROM" date billed is March 15 and the "TO" date billed is May 14, which equals 61 days

31018 - Episode "TO" Date Not 60 Days

2. Less than 60 days between the "FROM" and "TO" date submitted, and a patient status code "30" appears on the claim
   - Example: "FROM" date billed is March 15 and the "TO" date billed is May 11, which equals 58 days.
   - Patient status code "30" indicates the beneficiary remains a patient of the HHA at the end of the episode; therefore, the span between the "FROM" and "TO" dates cannot be less than 60 days.

31018 - Episode "TO" Date Not 60 Days

Good to know:

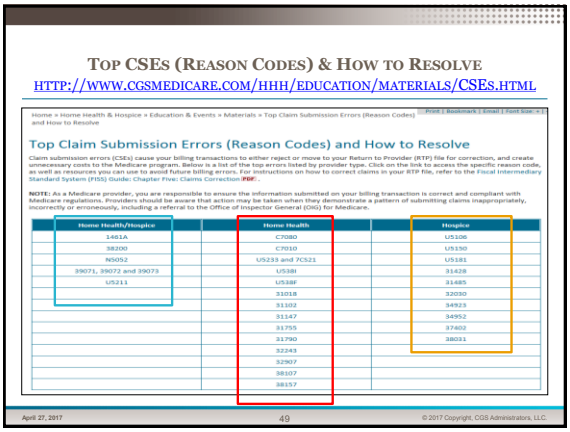
- Don't bill more than 60 days on a home health final claim – type of bill (TOB) 3X9
- One final claim per episode per agency
  - Unless beneficiary discharged (met POC goals) and re-admitted during same 60 day episode
- If billing less than 60 days, ensure patient status code is not "30"

Resources:

Home Health 60-Day Episode Calendar Schedule QRT:
http://www.cgsmedicare.com/hhh/education/materials/pdf/60-day_calendar.pdf

Top CSEs (Reason Codes) & How to Resolve

http://www.cgsmedicare.com/hhh/education/materials/cses.html



Home » Home Health & Hospice » Education & Events » Materials » Top Claim Submission Errors (Reason Codes) and How to Resolve

Print | Bookmark | Email | Font Size: + |

Top Claim Submission Errors (Reason Codes) and How to Resolve

Claim submission errors (CSEs) cause your billing transactions to either reject or move to your Return to Provider (RTP) file for correction, and create unnecessary costs to the Medicare program. Below is a list of the top errors listed by provider type. Click on the link to access the specific reason code, as well as resources you can use to avoid future billing errors. For instructions on how to correct claims in your RTP file, refer to the Fiscal Intermediary Standard System (FISS) Guide: Chapter Five: Claims Correction PDF.

NOTE: As a Medicare provider, you are responsible to ensure the information submitted on your billing transaction is correct and compliant with Medicare regulations. Providers should be aware that action may be taken when they demonstrate a pattern of submitting claims inappropriately, incorrectly or erroneously, including a referral to the Office of Inspector General (OIG) for Medicare.

Home Health/Hospice	Home Health	Hospice
1461A	C7080	U5106
38200	C7010	U5150
N5052	U5233 and 7C521	U5181
39071, 39072 and 39073	U538I	31428
U5211	U538F	31485
	31018	32030
	31102	34923
	31147	34952
	31755	37402
	31790	38031
	32243	
	32907	
	38107	
	38157	

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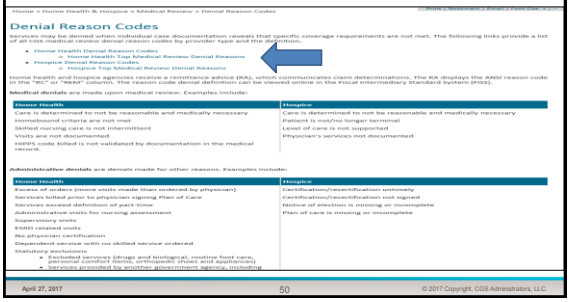
Medical Review Denial Reason Codes

http://www.cgsmedicare.com/hhh/medreview/drc.html



Home » Home Health & Hospice » Medical Review » Denial Reason Codes

Print | Bookmark | Email | Font Size: + |

Denial Reason Codes

Services may be denied when individual case documentation reveals that specific coverage requirements are not met. The following links provide a list of all CGS medical review denial reason codes by provider type and the description.

- Home Health Denial Reason Codes
  - Home Health Top Medical Review Denial Reasons
- Hospice Denial Reason Codes
  - Hospice Top Medical Review Denial Reasons

Home health and hospice agencies receive a remittance advice (RA), which communicates claim determinations. The RA displays the ANSI reason code in the "RC" or "RSN" column. The reason code denial definition can be viewed online in the Fiscal Intermediary Standard System (FISS).

Medical denials are made upon medical review. Examples include:

Home Health	Hospice
Care is determined to not be reasonable and medically necessary	Care is determined to not be reasonable and medically necessary
Homebound criteria are not met	Patient is not/no longer terminal
Skilled nursing care is not intermittent	Level of care is not supported
Visits are not documented	Physician's services not documented
HIPPS code billed is not validated by documentation in the medical record.	

Administrative denials are denials made for other reasons. Examples include:

Home Health	Hospice
Excess of orders (more visits made than ordered by physician)	Certification/recertification untimely
Services billed prior to physician signing Plan of Care	Certification/recertification not signed
Services exceed definition of part-time	Notice of election is missing or incomplete
Administrative visits for nursing assessment	Plan of care is missing or incomplete
Supervisory visits	
ESRD related visits	
No physician certification	
Dependent service with no skilled service ordered	
Statutory exclusions • Excluded services (drugs and biological, routine foot care, personal comfort items, orthopedic shoes and appliances) • Services provided by another government agency, including	

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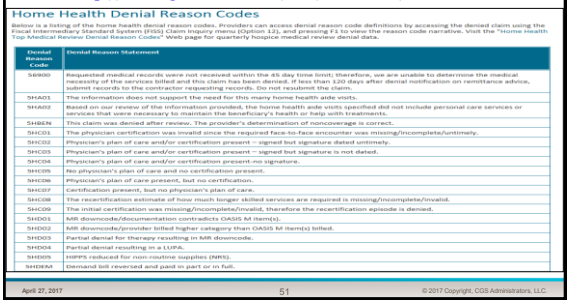
Medical Review HH Denial Reason Codes

http://www.cgsmedicare.com/hhh/medreview/hh_drc.html



Home Health Denial Reason Codes

Below is a listing of the home health denial reason codes. Providers can access denial reason code definitions by accessing the denied claim using the Fiscal Intermediary Standard System (FISS) Claim Inquiry menu (Option 12), and pressing F1 to view the reason code narrative. Visit the "Home Health Top Medical Review Denial Reason Codes" Web page for quarterly hospice medical review denial data.

Denial Reason Code	Denial Reason Statement
S6900	Requested medical records were not received within the 45 day time limit; therefore, we are unable to determine the medical necessity of the services billed and this claim has been denied. If less than 120 days after denial notification on remittance advice, submit records to the contractor requesting records. Do not resubmit the claim.
SHA01	The information does not support the need for this many home health aide visits.
SHA02	Based on our review of the information provided, the home health aide visits specified did not include personal care services or services that were necessary to maintain the beneficiary's health or help with treatments.
SHBEN	This claim was denied after review. The provider's determination of noncoverage is correct.
SHC01	The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.
SHC02	Physician's plan of care and/or certification present – signed but signature dated untimely.
SHC03	Physician's plan of care and/or certification present – signed but signature is not dated.
SHC04	Physician's plan of care and/or certification present-no signature.
SHC05	No physician's plan of care and no certification present.
SHC06	Physician's plan of care present, but no certification.
SHC07	Certification present, but no physician's plan of care.
SHC08	The recertification estimate of how much longer skilled services are required is missing/incomplete/invalid.
SHC09	The initial certification was missing/incomplete/invalid, therefore the recertification episode is denied.
SHD01	MR downcode/documentation contradicts OASIS M item(s).
SHD02	MR downcode/provider billed higher category than OASIS M item(s) billed.
SHD03	Partial denial for therapy resulting in MR downcode.
SHD04	Partial denial resulting in a LUPA.
SHD05	HIPPS reduced for non-routine supplies (NRS).
SHDEM	Demand bill reversed and paid in part or in full.

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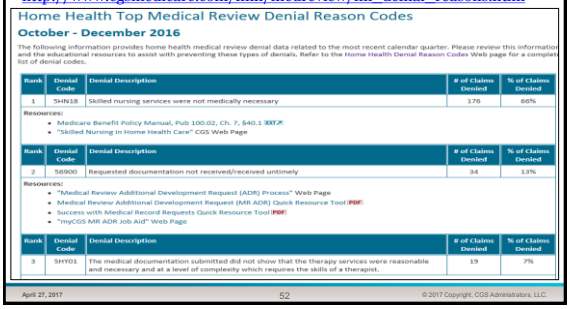
HH Medical Review Top Denial Codes

http://www.cgsmedicare.com/hhh/medreview/hh_denial_reasons.html



Home Health Top Medical Review Denial Reason Codes

October - December 2016

The following information provides home health medical review denial data related to the most recent calendar quarter. Please review this information and the educational resources to assist with preventing these types of denials. Refer to the Home Health Denial Reason Codes Web page for a complete list of denial codes.

Rank	Denial Code	Denial Description	# of Claims Denied	% of Claims Denied
1	5HN18	Skilled nursing services were not medically necessary	176	66%

Resources:

- Medicare Benefit Policy Manual, Pub 100.02, Ch. 7, §40.1
- "Skilled Nursing in Home Health Care" CGS Web Page

Rank	Denial Code	Denial Description	# of Claims Denied	% of Claims Denied
2	56900	Requested documentation not received/received untimely	34	13%

Resources:

- "Medical Review Additional Development Request (ADR) Process" Web Page
- Medical Review Additional Development Request (MR ADR) Quick Resource Tool
- Success with Medical Record Requests Quick Resource Tool
- "myCGS MR ADR Job Aid" Web Page

Rank	Denial Code	Denial Description	# of Claims Denied	% of Claims Denied
3	5HY01	The medical documentation submitted did not show that the therapy services were reasonable and necessary and at a level of complexity which requires the skills of a therapist.	19	7%

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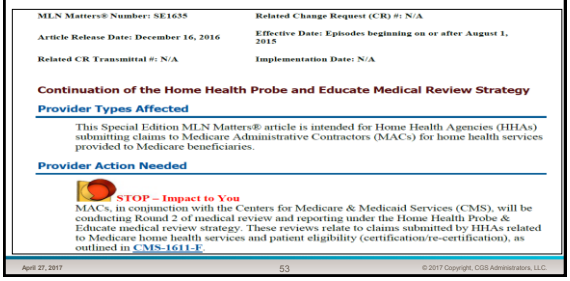
SE1635: Continuation of the Home Health Probe and Educate Medical Review Strategy

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1635.pdf



MLN Matters® Number: SE1635 **Related Change Request (CR) #: N/A**

Article Release Date: December 16, 2016 **Effective Date: Episodes beginning on or after August 1, 2015**

Related CR Transmittal #: N/A **Implementation Date: N/A**

Continuation of the Home Health Probe and Educate Medical Review Strategy

Provider Types Affected

This Special Edition MLN Matters® article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting Round 2 of medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in CMS-1611-F.

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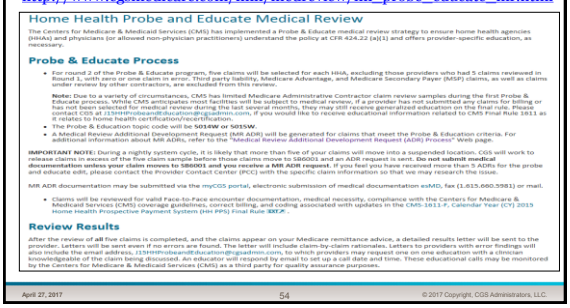
HH Probe & Educate – Round 2

http://www.cgsmedicare.com/hhh/medreview/hh_probe_educate_mr.html



Home Health Probe and Educate Medical Review

The Centers for Medicare & Medicaid Services (CMS) has implemented a Probe & Educate medical review strategy to ensure home health agencies (HHAs) and physicians (or allowed non-physician practitioners) understand the policy at CFR 424.22 (a)(1) and offers provider-specific education, as necessary.

Probe & Educate Process

- For round 2 of the Probe & Educate program, five claims will be selected for each HHA, excluding those providers who had 5 claims reviewed in Round 1, with zero or one claim in error. Third party liability, Medicare Advantage, and Medicare Secondary Payer (MSP) claims, as well as claims under review by other contractors, are excluded from this review.

  Note: Due to a variety of circumstances, CMS has limited Medicare Administrative Contractor claim review samples during the first Probe & Educate process. While CMS anticipates most facilities will be subject to medical review, if a provider has not submitted any claims for billing or has not been selected for medical review during the last several months, they may still receive generalized education on the final rule. Please contact CGS at J15HHProbeandEducation@cgsadmin.com, if you would like to receive educational information related to CMS Final Rule 1611 as it relates to home health certification/recertification.
- The Probe & Education topic code will be **5015W** or **5015W**.
- A Medical Review Additional Development Request (MR ADR) will be generated for claims that meet the Probe & Education criteria. For additional information about MR ADRs, refer to the "Medical Review Additional Development Request (ADR) Process" Web page.

IMPORTANT NOTE: During a nightly system cycle, it is likely that more than five of your claims will move into a suspended location. CGS will work to release claims in excess of the five claim sample before those claims move to 5B6001 and an ADR request is sent. **Do not submit medical documentation unless your claim moves to 5B6001 and you receive a MR ADR request.** If you feel you have received more than 5 ADRs for the probe and educate edit, please contact the Provider Contact Center (PCC) with the specific claim information so that we may research the issue.

MR ADR documentation may be submitted via the myCGS portal, electronic submission of medical documentation esMD, fax (1.615.660.5981) or mail.

- Claims will be reviewed for valid Face-to-Face encounter documentation, medical necessity, compliance with the Centers for Medicare & Medicaid Services (CMS) coverage guidelines, correct billing, and coding associated with updates in the CMS-1611-F, Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule

Review Results

After the review of **all** five claims is completed, and the claims appear on your Medicare remittance advice, a detailed results letter will be sent to the provider. Letters will be sent even if no errors are found. The letter will include claim-by-claim rationales. Letters to providers with error findings will also include the email address, J15HHProbeandEducation@cgsadmin.com, to which providers may request one on one education with a clinician knowledgeable of the claim being discussed. An educator will respond by email to set up a call date and time. These educational calls may be monitored by the Centers for Medicare & Medicaid Services (CMS) as a third party for quality assurance purposes.

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Medicare Billing Resources

myCGS & Web Resources

CGS HH&H Website: myCGS Portal

http://www.cgsmedicare.com/hhh/mycgs/index.html

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What Can myCGS Do For My Agency?

- Use myCGS to do all of this & more…
  - Submit Quarterly Credit Balance Reports
  - Submit Cost Reports
  - Respond to Medical Review (MR) Additional Documentation Requests (ADRs)
  - Submit Requests for Redeterminations (including attachments)
    - Upload attachments to your myCGS redetermination requests up to 40MBs in size (not to exceed a total attachment size of 150MBs)

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What Can myCGS Do For My Agency?

- View & Print Copies of Remittance Advices
- Check Patient Eligibility 24/7
- Request an "immediate offset" of a demanded overpayment (eOffset)
- View Number of Claims Approved for Payment & Approved Amounts
- Submit Pre Claim Review (PCR) Requests (for select demo states only)
- NEW: Submit general inquiries via myCGS

- Register TODAY, http://www.cgsmedicare.com/mycgs/index.html

Forms Tab

Allows Providers to:

- Submit Certain Forms Directly to CMS via myCGS Web Portal
  - Redeterminations & e-Offsets
- Respond to Medical Review (MR) Additional Development Requests (ADRs)
- Report Credit Balances (CMS-838 Report)
- Submit Cost Reports

myCGS Resources: User Manual

myCGS User Manual, http://www.cgsmedicare.com/mycgs/manual.html

- Chapter 1: Overview of myCGS
- Chapter 2: Claims Tab
- Chapter 3: Remittance Tab
- Chapter 4: Eligibility Tab
- Chapter 5: Financial Tools Tab
- Chapter 6: Messages Tab
- Chapter 7: Forms Tab *
- Chapter 8: Administration Tab

Multi-Factor Authentication (MFA)

Attention Web Portal Users: Due to Increased CMS Security Requirements, **myCGS Portal Users** MUST sign up for MFA by **July 1, 2017**.

Why You Need It:
MFA helps ensure the security of your myCGS account even if someone manages to obtain your password without your knowledge.

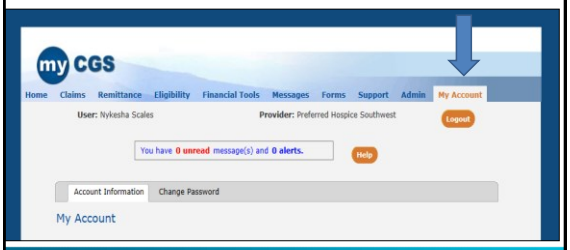
How It Works:
myCGS MFA is an extra layer of security which Users can voluntarily access before it becomes required. In order to do so, Users should log in to myCGS and then access the 'My Account' tab to turn on this optional feature.

MFA Timeline

When	Provider Action Needed
Now	myCGS Users may voluntarily sign up for MFA for each active user ID
May 1, 2017 to June 31, 2017	myCGS Users will be required to sign up for MFA at enrollment, password reset and account update
July 1, 2017	myCGS Users not signed up for MFA will automatically be set to MFA with the email address associated with the user ID

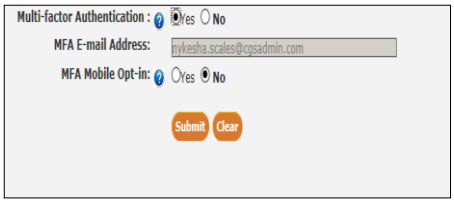
MFA – Step 1

After initial log in, select the 'My Account' tab…



MFA – Step 2

Scroll to bottom of page and look for 'Multi-factor Authentication', enter your preferred contact method (text or email) and click submit.....



myCGS Assistance

myCGS Frequently Asked Questions (FAQs),
http://www.cgsmedicare.com/hhh/myCGS/FAQs.html

myCGS Brochures/Resources,
http://www.cgsmedicare.com/hhh/mycgs/brochures_resources.html

myCGS Help Desk,

- Supported by CGS Electronic Data Interchange (EDI) staff
- 1.877.299.4500 (Option 2)

Home Health Agency Center

Home Health Agency Center,

http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

- Spotlights current events & hot topics
- Provides information regarding Open Door Forums (ODF)
- Links to MLN Matters Articles & Fact Sheets

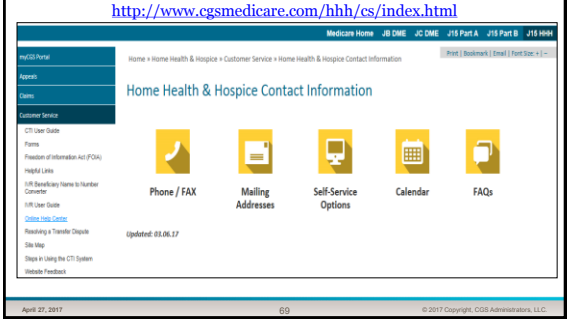
CGS HH&H Web Page

http://www.cgsmedicare.com/hhh/index.html

CGS HH&H Web Page

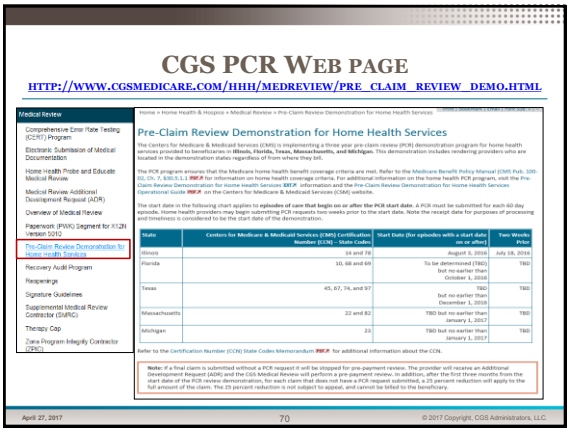
Updated: HH&H Customer Service Web Page

http://www.cgsmedicare.com/hhh/cs/index.html



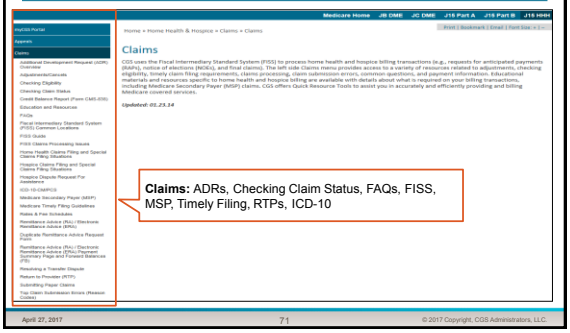
CGS PCR Web Page

http://www.cgsmedicare.com/hhh/medreview/pre_claim_review_demo.html



CGS HH&H Website: Claims

http://www.cgsmedicare.com/hhh/claims/index.html



CGS Resource: FISS Guide

Fiscal Intermediary Standard System (FISS) Guide, http://www.cgsmedicare.com/hhh/education/materials/FISS.html

- Chapter One: FISS Overview
  - Moving around in FISS, status/locations
- Chapter Two: Checking Beneficiary Eligibility
  - Eligibility screens, fields, data/codes
- Chapter Three: Inquiry Menu
  - Checking claim status, validity of codes
- Chapter Four: Claims and Attachments Menu
  - Entering NOEs/claims
- Chapter Five: Claims Correction
  - Correcting, adjusting, canceling claims

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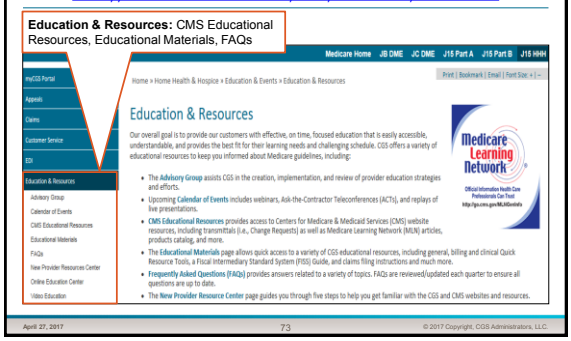
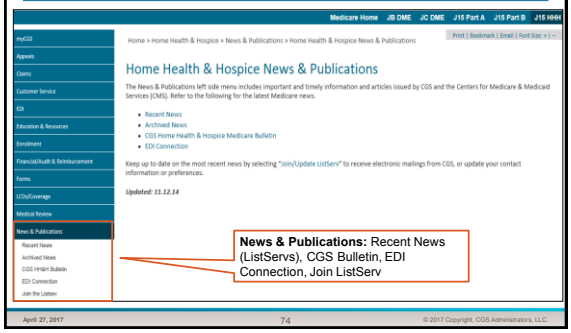
CGS HH&H Website: Education & Resources

http://www.cgsmedicare.com/hhh/education/index.html



CGS HH&H Website: News & Publications

http://www.cgsmedicare.com/hhh/pubs/index.html



Reminder: Join the ListServs

- Sign up for CMS ListServs
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MailingLists_FactSheet.pdf
- CGS Listserv
  - Join/update ListServ http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp

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QUESTIONS?

CGS Provider Contact Center: 1.877.299.4500
Option 1: Customer Service
Option 2: Electronic Data Interchange (EDI)
Option 3: Provider Enrollment
Option 4: Overpayment Recovery (OPR)
Option 5: PCR Assist
Twitter: http://www.twitter.com/hhhcgs
Facebook: http://www.facebook.com/hhhcgs