Focus on Medicare Billing Updates

2016 MAHC Annual Conference, Osage Beach, MO | Nykesha Scales | April 27, 2016

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Enrollment

Updates

Special Edition (SE) 1417

"Implementation of Fingerprint-Based Background Checks ," https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1417.pdf

- Fingerprint-based background checks required for all individuals with 5 % or greater ownership interest in provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application
  - Process conducted in phases
  - Notification letters issued by MACs
  - 30 days from letter date to be fingerprinted

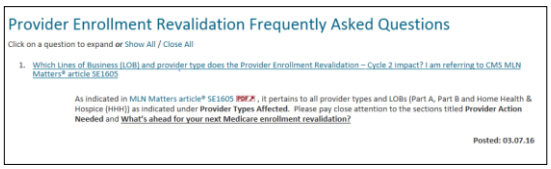
Provider Enrollment Revalidation – Cycle 2

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

- CMS completed initial round of revalidations
- Will resume regular revalidation cycles
- Implemented several revalidation improvements
- Does not change other aspects of enrollment process
- Provides web link to check for revalidation due date & further instructions

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

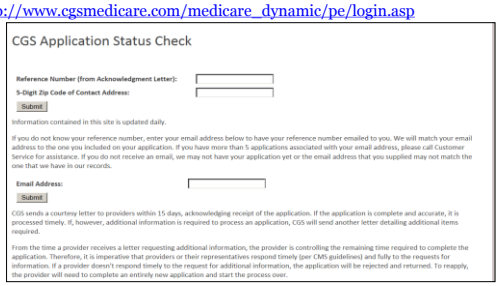
1. Which Lines of Business (LOB) and provider type does the Provider Enrollment Revalidation – Cycle 2 impact? I am referring to CMS MLN Matters® article SE1605

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?**

Posted: 03.07.16

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.

Update: 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 Home Health Agencies" quick resource tool, http://www.cgsmedicare.com/hhh/education/materials/pdf/ord_ref_phys_checklist_hha.pdf

Recent Change Requests & Process Changes

For Home Health Providers

ICD-10 Transition Moves Forward

'ICD-10 Transition Moves Forward' Fact Sheet, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-29.html

- Careful monitoring of transition
- Claims processing normally
- Metrics from 10/1 – 10/27/2015

Metrics	October 1-27	Historical Baseline*
Total Claims Submitted	4.6 million per day	4.6 million per day
Total Claims Rejected due to incomplete or invalid information	2.0% of total claims submitted	2.0% of total claims submitted
Total Claims Rejected due to invalid ICD-10 codes	0.09% of total claims submitted	0.17% of total claims submitted
Total Claims Rejected due to invalid ICD-9 codes	0.11% of total claims submitted	0.17% of total claims submitted
Total Claims Denied	10.1% of total claims processed	10% of total claims processed

NOTE: Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions.

Types of Errors We Are Seeing

- Invalid ICD-10 codes submitted
- Incorrect diagnosis codes on HH transactions with spanned dates
  - Remember, if episode started prior to 10/1/2015 but ends on 10/1 or later, must be submitted with ICD-10 diagnosis codes
- Transactions containing both ICD-9 and ICD-10 codes

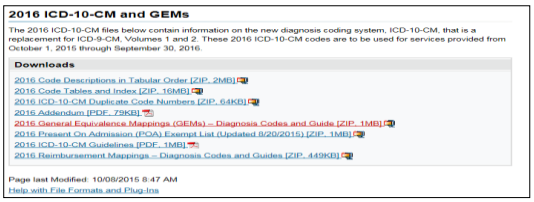
Types of Errors We Are Seeing (continued)

- Reason code 31276 (HH): 329 type of bill (TOB) has through date of service prior to 10/1/2015, and claim contains an ICD-10 diagnosis code
  - Final claims with a TO (or through) date prior to 10/1/2015, must include ICD-9 codes
- Reason code 34926 (Hospice): For TOB 81X & 82X, principal diagnosis code cannot begin with a "V" (for ICD-9) or "Z" (for ICD-10)
- Use of unspecified diagnosis codes as primary diagnosis

How do I find Valid ICD-10 Codes?

GEMs = General Equivalence Mappings

- 2016 ICD-10-CM & GEMS, https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html



2016 ICD-10-CM and GEMs

The 2016 ICD-10-CM files below contain information on the new diagnosis coding system, ICD-10-CM, that is a replacement for ICD-9-CM, Volumes 1 and 2. These 2016 ICD-10-CM codes are to be used for services provided from October 1, 2015 through September 30, 2016.

Downloads

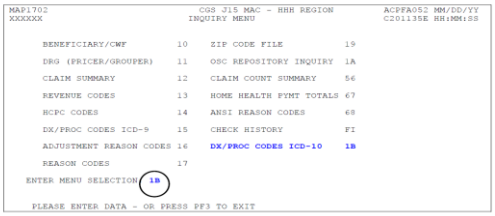
2016 Code Descriptions in Tabular Order [ZIP, 2MB]
2016 Code Tables and Index [ZIP, 16MB]
2016 ICD-10-CM Duplicate Code Numbers [ZIP, 64KB]
2016 Addendum [PDF, 79KB]
2016 General Equivalence Mappings (GEMs) – Diagnosis Codes and Guide [ZIP, 1MB]
2016 Present On Admission (POA) Exempt List (Updated 8/20/2015) [ZIP, 1MB]
2016 ICD-10-CM Guidelines [PDF, 1MB]
2016 Reimbursement Mappings – Diagnosis Codes and Guides [ZIP, 449KB]

Page last Modified: 10/09/2015 8:47 AM
Help with File Formats and Plug-Ins

CONFIRM VALIDITY OF ICD-10 CODES IN FISS

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

1. From the Inquiry Menu, type *1B* in the **Enter Menu Selection** field and press *Enter*.



WHO DO I CONTACT?

- Start with your Medicare Administrative Contractor (MAC)
  - CGS = J15 MAC including HH&H
- Providers can contact ICD-10 Ombudsman at ICD10_Ombudsman@cms.hhs.gov
- All others should contact ICD-10 Coordination Center at ICD10@cms.hhs.gov
- ICD-10: Provider Contacts for Medicare & Medicaid Questions, https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf

Q: SINCE MY MAC CAN'T TELL ME HOW TO CODE, HOW DO I SUBMIT A CODING QUESTION?

A: Coding questions may be submitted via http://www.codingclinicadvisor.com/

- Registration required
- Review FAQ sections for details on submitting questions
- Same process was used for ICD-9-CM questions
- Formulate coding question
  - Don't just ask what is the code for XYZ
- Provide documentation
- Identify if inquiry refers to a certain setting (hospice or home health)
- Be advised, Coding Clinic Advisor cannot answer payment, coverage, or etc. questions

The CMS ICD-10 Blog

http://blog.cms.gov/2015/10/01/welcome-to-icd-10/

- Monitors transition in real time
- Addresses issues sent to ICD-10 Coordination Center

CMS Website

Find all of these resources here,
https://www.cms.gov/Medicare/Coding/ICD10/index.html

- Latest news
- FAQs
- Fact sheets
- Infographics
  - NEW – Next Steps Toolkit
- ICD-10 code listings
- GEMs
- CMS training opportunities
  - NEW videos, https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html

Change Request 8581

- "Automation of the Request for Reopening Claims Process," http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8581.pdf
  - Effective for claims received on/after **October 1, 2015**
  - CR 8581 allows providers to electronically request reopenings of claims

CHANGE REQUEST 8581

- Reopening
  - Remedial action to change final decision that resulted in overpayment or underpayment, even if decision was correct based on evidence of record
  - CGS "Reopenings" Web page, http://www.cgsmedicare.com/hhh/appeals/Reopenings.html
  - SE1426 developed to assist providers with coding reopening request beyond filing timeframes, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf

CHANGE REQUEST 9112

- "Clarification of Ordering and Certifying Documentation Maintenance Requirements," http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9112.pdf
  - Effective date: **July 20, 2015**
  - Clarifies term "access to documentation" in chapter 15, section15.18 of Pub. 100-08, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf
  - Provides sufficient & deficient access to documentation examples
- CR 9112 instructs providers & suppliers to:
  - Maintain documentation for 7 years from date of service, and
  - Upon request of CMS or Medicare contractor, provide access to that documentation

CHANGE REQUEST 9198

CR 9198, "Corrections to the 2015 Home Health (HH) Pricer Program," https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9198.pdf

- Implementation date on/after **October 5, 2015**
- CR 9198 instructs MACs to install new HH Pricer program which contains updates to allow processing of type of bill 032Q or 033Q, as required by CR 8581
  - CR 9198 also corrects errors affecting payments on 2015 claims & instructs MACs to adjust claims to correct payment amounts
  - CR 9198 also corrects recoding issue with 2014 DOS (20+ therapy visits)

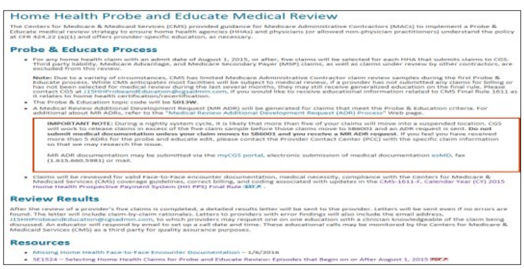
Special Edition (SE) 1524

Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1524.pdf

- MACs, in conjunction with CMS, will conduct medical review and reporting under the Home Health Probe & Educate medical review strategy
- Reviews relate to claims submitted by HHAs for Medicare home health services and patient eligibility (certification/re-certification), as outlined in **CMS-1611-F**
  - **CMS-1611-F** = CY 2015 Home Health Prospective Payment System (HH PPS) Final Rule
    - Eliminated requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for HH services

Home Health Probe and Educate Medical Review

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) provided guidance for Medicare Administrative Contractors (MACs) to implement 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 any home health claim with an admit date of August 1, 2015, or after, five claims will be selected for each HHA that submits claims to CGS. 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 **5013W**.
- A Medical Review Additional Development Request (MR ADR) will be generated for claims that meet the Probe & Education criteria. For additional 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 SB6001 and an ADR request is sent. **Do not submit medical documentation unless your claim moves to SB6001 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 EXT.

Review Results

After the review of a provider's five claims is completed, 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.

Resources

- Missing Home Health Face-to-Face Encounter Documentation – 1/8/2016
- SE1524 – Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015 PDF

CMS-1625-F: CY 2016 HH PPS Final Rule

CY 2016 HH PPS Rate Update: HH Value-Based Purchasing Model; and HH Quality Reporting Requirements, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1625-F.html

- Updates rates & wage index for 2016
- Implements third year of four year phase-in of rebasing adjustments as required by Affordable Care Act (ACA)
- Decreases national, standardized 60-day episode payment amount by 0.97% (CY 2016 -2018)
- Updates HH Quality Reporting Program
- Implements HHVBP Model

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

Home Health Value-Based Purchasing (HHVBP) Model

What: Designed to provide incentives to Medicare-certified HHAs who offer higher quality & more efficient care

When: January 1, 2016 for 9 states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee & Washington

Why: Supports greater quality & care efficiency

How: Payment adjustment to HHAs for services based on quality of care, not just quantity

HHVBP Model

Provider Action for HHAs in the 9 HHVBP model states:

1. Contact HHVBP Help Desk to identify HHA's HHVBP primary contact, HHVBPquestions@cms.hhs.gov
   - (include primary contact's name, email address, HHA's name, address, phone number & CMS Certification Number (CCN))
2. Create a User Account on the CMS Secure Portal, https://portal.cms.gov/wps/portal/unauthportal/home/

Questions: Helpdesk at (844) 280-5628 or email HHVBPquestions@cms.hhs.gov.

CY 2016 HH PPS Rate Update

CR 9406, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016

MM9406, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9406.pdf

- Implementation Date: **January 4, 2016**

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 2016

Change Request 9369

- "Additional G-Codes Differentiating RNs and LPNs in the Home Health and Hospice Settings," https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9369.pdf
  - Effective for services provided on/after **January 1, 2016**
  - Change Request creates new codes to distinguish whether Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided hospice or home health services
  - Current single G-code of G0154, "Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting" has been retired
  - Service provided by RN shall be coded as G0299
  - Service provided by LPN shall be coded as G0300

Medicare Secondary Payer (MSP) Updates

CR 8486, Instructions on Utilizing 837 Institutional Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A Claims in Direct Data Entry (DDE) and 837I 5010 Claims Transactions

MM8486, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8486.pdf

- Implementation Date: **January 4, 2016**

MSP Updates

- Provider Action: Include CAS segment adjustments from primary payers remittance advice on your 837I transaction, DDE, or paper claim when submitting claims to Medicare for secondary payment
- Updates previous MSP instructions outlined in CR 6426 which didn't allow acceptance of DDE MSP transactions
  - **MSP claims & adjustments can now be entered via DDE**

MSP Resources

CMS MSP Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html

CGS MSP Web page, http://www.cgsmedicare.com/hhh/education/materials/msp.html

CGS MSP Billing & Adjustments Quick Resource Tool, http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf

CGS Medicare Payment for MSP Claims, http://www.cgsmedicare.com/hhh/education/materials/Med_Payment_MSP.html

CGS MSP Frequently Asked Questions (FAQs) Web page, http://www.cgsmedicare.com/hhh/education/faqs/MSP_FAQs.html

Future Changes

CHANGE REQUEST (CR) 9474

New Condition Code for Reporting Home Health Episodes with No Skilled Visits, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9474.pdf

- Implementation Date: **July 5, 2016**
- Revises Medicare billing instructions for home health claims to allow the use of a new condition code - 54
  - Condition code 54 indicates HHA provided no skilled services during billing period has documentation on file of an allowable circumstance

CHANGE REQUEST (CR) 9474

Claims with no skilled visits and submitted without new condition code will be returned to the provider (RTP'd)...

Allows HHA to:

- Add any accidentally omitted skilled services to the claim;
- Submit the claim as noncovered, if appropriate; or
- Append the new condition code.

CHANGE REQUEST (CR) 9474

CR 9474 also addresses:

- Unintended consequences of implementation of new HCPCS codes G0299 and G0300 (skilled nursing visits announced in CR 9369)
- Contains number of routine maintenance revisions to home health billing contained in "Medicare Claims Processing Manual," Pub. 100-04, Chapter 10, Home Health Agency Billing, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

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

CERT

Comprehensive Error Rate Testing Program

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 EXT by clicking on 'Sample Letters EXT'. 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 EXT 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 services 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 615-782-4591.

Point of Contact

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CERT Claim Identifier Tool

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

Print | Bookmark | Email | Font Size: + | –

Home » Claim Identifier Tool Login

CERT Claim Identifier Tool

Please log in to use the CERT Claim Identifier Tool.

Don't have a password? Once you've provided the required information CGS will verify your details via the Medicare Claims Processing System within 10 business days of your submission. A password will be emailed to you once all information has been validated. Apply for a password today!

Email:

Password:

Reset Login

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

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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

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

Eligibility Systems – Feature Comparison

Features	ELGA/ELGH	HETS	myCGS	IVR
Verify Eligibility	√	√	√	√
Check Claim Status			√	√
View/Print Remittance Advices			√	
Access Financial Information			√	√
Submit Redetermination Request			√	
General Medicare Information				√
Cost	None	Yes	None	None

Beneficiary Eligibility Information

All systems provide same basic information

- Beneficiary name, date of birth/death
- Medicare Part A/B entitlement
- Deductibles/caps
- Preventive benefits
- Medicare Advantage (MA) Plan information
- Medicare Secondary Payer (MSP) information
- Home health and hospice information
- Inpatient hospital and SNF information

Top Billing Errors (November 2015 – February 2016)

Overview of HH Claim Submissions and CSEs	
# of HH "Claims" Submitted	881,641
# of HH CSEs	116,355
Percent of billing errors	13.20%
Total of top 5 billing errors	68,348

CGS Billing Errors – Home Health

November 1, 2015 – February 29, 2016		
Reason Code	**Billing Error**	**# of Errors**
38107	FISS can't find matching RAP	29,005
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	26,503
U538I	Overlap another HHA's episode	7,033
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	3,487
32006	"TO" date after Medicare provider termination date	2,320

MO Top HH Billing Errors

November 1, 2015 – February 29, 2016		
Reason Code	**Billing Error**	**# of Errors**
38107	FISS can't find matching RAP	2,408
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	1,067
U538I	Overlap another HHA's episode	604
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	307
32035	Value Code 61 & MSA/CBSA are required on bill types 32X/33X	236

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

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
  - Scroll down & click on "HHA-Reports (Supplemental Files and counts)" to open zip file that contains listing of home health provider ID information

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:

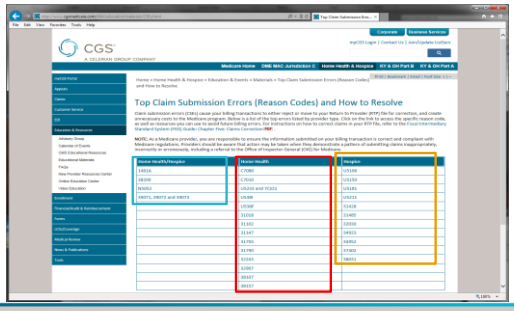
- Don't bill more than 60 days on a home health final claim – type of bill (TOB) 3X9
- One final claim per episode per agency
  - Unless beneficiary discharged (met POC goals) and re-admitted during same 60 day episode
- If billing less than 60 days, ensure patient status code is not "30"

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



Medicare Billing Resources

Home Health Agency Center

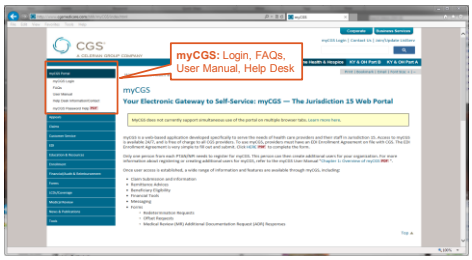
Home Health Agency Center,

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 Website: myCGS Portal

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



No costs associated with access to myCGS

MYCGS HAS THE TOOL FOR YOU!

- Use myCGS to do all of this & more…
  - Submit Quarterly Credit Balance 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)
  - 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
  - NEW: Submit general inquiries via myCGS
- Register TODAY, http://www.cgsmedicare.com/mycgs/index.html

MYCGS

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

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

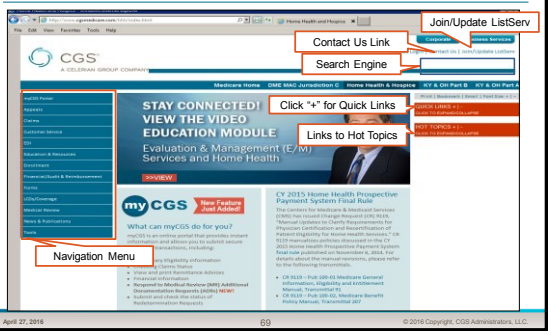
myCGS Brochures/Resources, http://www.cgsmedicare.com/hhh/mycgs/brochures_resources.html

myCGS Help Desk,

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

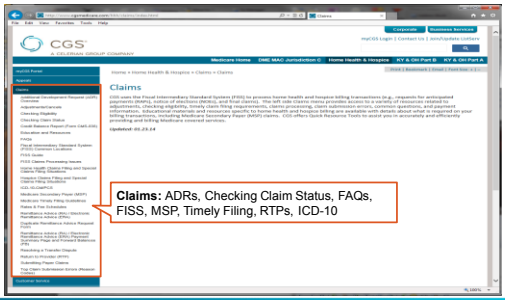
CGS HH&H WEBSITE

HTTP://WWW.CGSMEDICARE.COM/HHH/INDEX.HTML



CGS HH&H Website: Claims

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



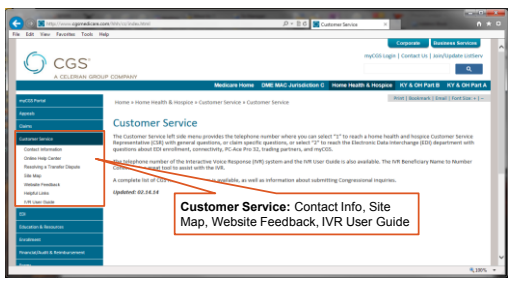
CGS Resource: FISS Guide

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

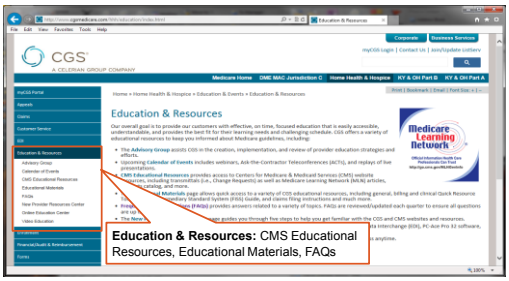
CGS HH&H Website: Customer Service

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



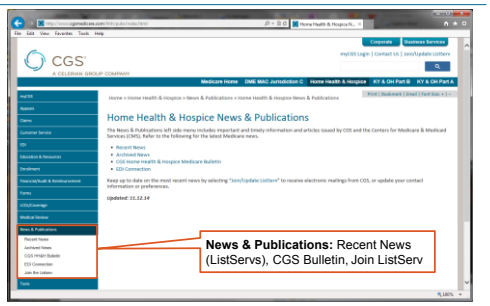
CGS HH&H Website: Education & Resources

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

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)
Twitter: http://www.twitter.com/hhhcgs
Facebook: http://www.facebook.com/hhhcgs