

Shoot for the Stars: Make the Most of Your Medicare Journey with Cahaba GBA

Missouri Alliance for Home Care Annual Meeting
April 26, 2010

Presented by
Cahaba Government Benefit Administrators®, LLC
A CMS Contracted Intermediary



"Web Help" for Resolving Common Inquiries & CSEs

- Accessible from Cahaba's "Claims" Web page: www.cahabagba.com/rhhi/claims/index.htm
 - » Inquiries: "Resources for the Most Common Home Health and Hospice Medicare Questions" link
 - » CSEs: "Top Claim Submission Errors and How to Resolve" link
- Review information posted/click on links for resources
- Updated quarterly
 - » Add new reason codes/inquiry topics
 - » Assure accuracy of posted information
 - » Provide access to new resources

2

Claim Submission Errors (CSEs)

- RAP or claim that can't process as billed
 - » Return to provider (RTP) = T B9997
 - Missing, incomplete or incorrect information
 - » Reject = R B9997
 - Contains information inconsistent with Common Working File (CWF)
 - Duplicate billing

3

Claim Submission Errors (CSEs)

- Costs your home health agency time
 - » To check for claim errors
 - » To research problem
 - » To resolve issue
 - » To correct claim or rebill
- Costs your home health agency money
 - » Staff time
 - » Delayed Medicare payment
 - » No Medicare payment

4

Cahaba Claims Snapshot January 1 – December 31, 2009

Number of Home Health/Hospice "Claims" Submitted	2,938,027
Number of Home Health/Hospice Claim Submission Errors (CSEs)	367,098
Percent of Errors	12.5% (1 error for every 8 "claims")
Sum of Top 7 Home Health CSE Reasons	137,446
Percent of Total CSEs	37.4%

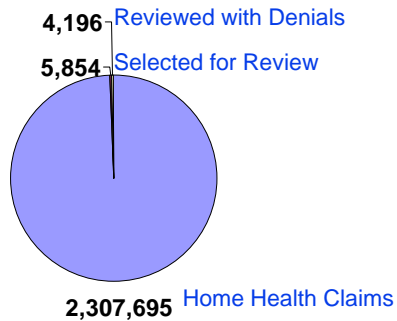
5

Cahaba Claims Snapshot II January 1 – December 31, 2009

Number of Home Health/Hospice "Claims" Submitted	2,938,027
Number of HH/Hospice Claims Selected for Medical Review	7,839 (5,854 HH)
Number of Beneficiary's Claims Selected for Medical Review	6,603 (5,137 HH)
Percentage of HH Claims Selected	0.25%
Percent of Selected Denied	71.68%

6

Home Health Medical Review

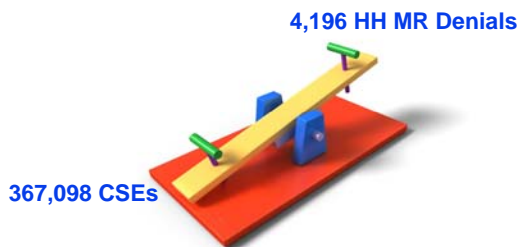


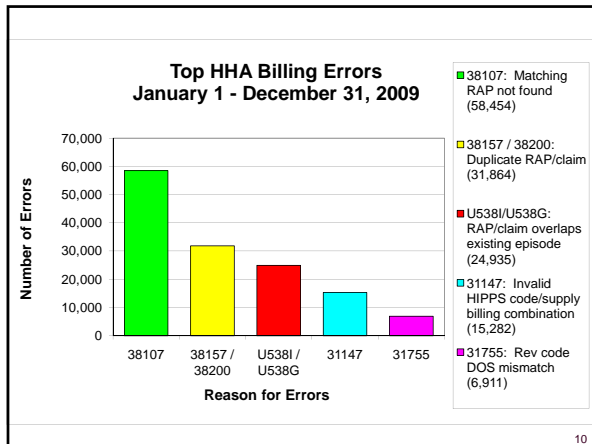
Cahaba Claims Snapshot III January 1 – December 31, 2009

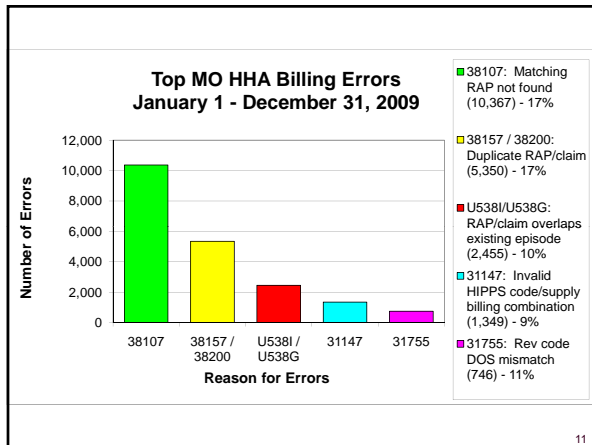
Average Visits per Episode	17.10
Average Episodes per Beneficiary	1.54
Percentage of LUPA Episodes	12.29%
Average Therapy Visits per Claim (when therapy was included)	10.26
Missouri's Average Therapy Visits	10.19

8

Time is Money







Duplicates – RC 38157, 38200

- **What it says:** "RAP/claim is exact duplicate of previously submitted RAP/claim with the same provider number..."
- **What the edit does:** Checks to ensure only one RAP/claim processes for each episode of care
- **What causes it:** 2nd RAP/claim submitted with same HICN, dates of service, billing provider number, and original RAP/claim not cancelled
- **How many:** 31,864 (Jan. – Dec. 2009)
MO HHAs: 5,350 (17%)

12

Duplicates – RC 38157, 38200

- **Best way to prevent the error:**
 - » If batch file software, delete batches once submitted to Medicare
 - » Use RA or FISS Option 12 to monitor/track Medicare RAPs/claims and stay timely in posting Medicare payments
 - » Don't correct **and** resubmit RAPs/claims in RTP file for same HICN and DOS
 - Recommend: If resubmitting, suppress view (SV) of RTP RAP/claim
 - Claims available for correction in RTP file for 36 months

13

Duplicates – RC 38157, 38200

- **Best way to prevent the error (cont.)**
 - » Adjust final claims (P B9997 or R B9997) instead of resubmitting, when appropriate
 - Example: inpatient stay overlap
 - » Cancel RAPs/final claims (P B9997) to remove incorrect episode information
 - Example: incorrect "From" date
 - » Ensure "original" TOB is processed prior to submitting adjustment/cancel
 - RAPs (P B9997)
 - Final claims (P B9997 or R B9997)

14

Overlapping HH PPS Episodes – RC U538G/U538I

- **What it says:** "A RAP or home health claim overlaps an existing episode with the same provider number..." OR "A RAP or home health claim overlaps an existing episode with a different provider number..."
- **What the edit does:** checks CWF (ELGH/ELGA) for HH PPS episodes posted to beneficiary eligibility file
- **What causes it:** "FROM" date submitted on RAP/claim falls within posted episode, and source of admission code doesn't indicate transfer or discharge/readmit
- **How many:** 24,935 (Jan. – Dec. 2009)
MO HHAs: 2,455 (10%)

15

Overlapping HH PPS Episodes – RC U538G/U538I

- Most common cause:
 - » Not checking ELGH/ELGA for episodes prior to admission or billing RAPs/claims
 - Use APP DATE field if “FROM” date isn’t current
- Best way to prevent the error:
 - » If transfer or discharge/re-admit, ensure appropriate Source of Admission code - SRC (FL 15) - submitted
 - “B” for transfer between HHAs during episode
 - “C” for re-admit by same HHA during episode

16

Change Request (CR) 6757

- For dates of service on/after 07/01/10, HHAs may no longer submit SRC codes “B” and “C” to Medicare
 - » “B” replaced by condition code 47 to reflect transfer from another HHA
 - » If HHA bills date of service that falls within own established episode, PEP generated for shortened dates of service
 - Example: HHA has episode for 07/02/10 – 08/30/10 posted to CWF; bills 2nd RAP for 07/25/10; PEP generated for episode 07/02/10 – 07/24/10
- More information available at www.cms.hhs.gov/MLNMattersArticles/downloads/MM6757.pdf

17

Discharge Clarification

- If admitted to inpatient facility during episode, discharge not recognized for payment purposes
 - » All HH services provided prior to and after inpatient admission during episode billed on one claim
- If patient discharged due to meeting goals of POC prior to day 60 **AND** later readmitted to same HHA during same episode
 - » New OASIS and POC generated for readmission
 - New episode created with readmission

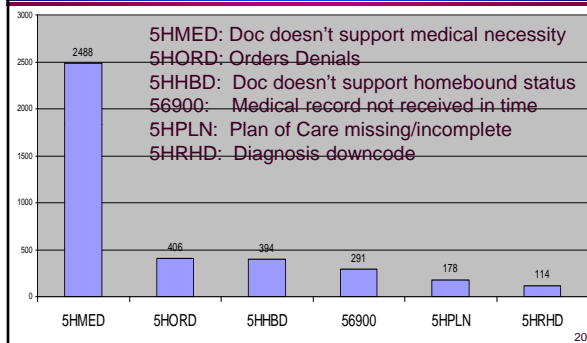
18

Resources for Avoiding Top Home Health Billing Errors

- 38107 – Top 38107 CSE Web page
www.cahabagba.com/rhhi/claims/errors_38107.htm
- 38157, 38200 – Top 38157, 38200 CSE Web page
www.cahabagba.com/rhhi/claims/errors_38200.htm
- U538G, U538I
 - » Top CSE U538G Web page
www.cahabagba.com/rhhi/claims/errors_U538G.htm
 - » Top CSE U538I Web page
www.cahabagba.com/rhhi/claims/errors_U538I.htm
- 31147 – Top CSE 31147 Web page
www.cahabagba.com/rhhi/claims/errors_31147.htm
- 31755 – Top CSE 31755 Web page
www.cahabagba.com/rhhi/claims/errors_31755.htm

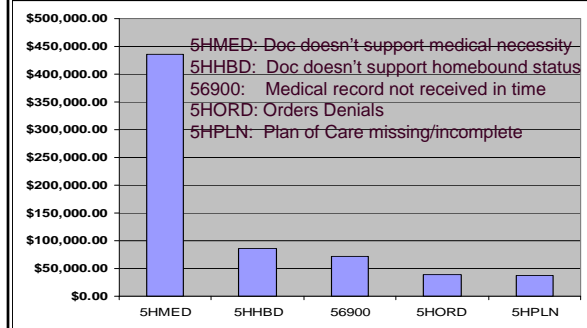
19

Top 2009 Home Health Denials



20

Missouri Top HH 2009 Denials



Denial Codes

- Reviewers assign codes after review if not able to pay claim as billed
- Explanation available of reason code with "PF1"
- Further clinical information available on claim page 4, under "Remarks"

#1 Denial: 5HMED- Medical Necessity

www.cahabagba.com/rhhi/coverage/home_health/index.htm

- Covers all disciplines
 - » Nursing
 - » Physical therapy
 - » Occupational therapy
 - » Speech language pathology
 - » Medical social worker
- Full denials
- Partial denials, resulting in LUPA

23

Medical Necessity

- All services must be reasonable and medically necessary related to the patient's condition
 - » Observation and assessment
 - » Injections
 - » Therapy
 - Refer to LCDs

#2 Denial: 5HHBD- Homebound

www.cahabagba.com/rhhi/coverage/home_health/homebound.htm

- Documentation must support throughout
- Beware of vague descriptions
- Utilize objective, measurable language
 - » "After ambulating 20 feet, pt has increased dyspnea and c/o back pain"
 - » "Patient has unsteady gait, and requires sitting rest periods after 20 feet of ambulation"

25

Homebound Equation



26

#3 Denial: 56900: No Response to ADR

www.cahabagba.com/rhhi/education/materials/quick_adr.pdf

- Additional Development Requests (ADR) are requesting the medical record to support claim
- Must receive medical record by 45th day
- Multiple types of edits
 - » Widespread
 - » Provider specific
 - » Beneficiary specific

27

#4 Denial: 5HORD- Orders Denials

www.cahabagba.com/rhhi/coverage/home_health/physician_orders.htm

- Denial covers multiple problems
 - » Lacking orders for services in medical record
 - » Incomplete orders
 - » Timeliness
 - » Missing dates

28

Complete Orders

- Discipline
- Modalities
- Frequency
- Duration

- "PT to eval and treat" covers the evaluation

29

Certification Narrative

- When providing care under the qualifying skilled service of Management and Evaluation of the Careplan, the physician must write a narrative to justify
 - » If on same cert form, signature must immediately follow narrative
 - » If on addendum, physician must sign the addendum also
- Upon recertification, statement must indicate the continuing need and estimate how much longer services will be required
- See December 2009 Newslines

Change Request 6698

- Additional guidance regarding physician and clinician's signatures
 - » Handwritten (legible), fax or electronic
 - May also provide signature logs or attestation statements
 - » No stamped signatures
 - » Certifications, orders, visit notes
- If medical review contacts provider for lack of signature documentation, provider has 20 days to respond

#5 Denial: 5HPLN: Plan of Care

- 485 no longer mandated form
- POC must still contain the information contained in the fields on 485
- Must be signed by the physician and dated prior to billing final claim

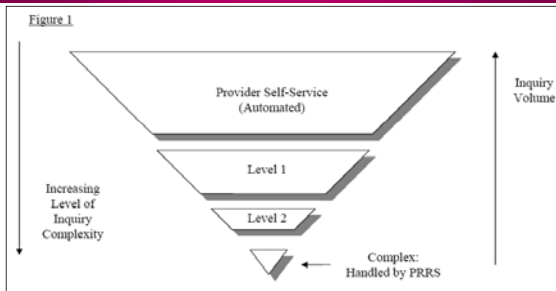
32

Provider Inquiries

- CMS requirements for provider questions handled by claims processing contractors
 - » Top provider inquiry data drives education/resources
 - » Develop/enhance self-service technology
 - » Require providers to use self-service tools to handle inquiry volume
 - CSRs answer questions that cannot be addressed using self-service means
 - » Inquiry triage process
 - Questions elevated through tiers depending on complexity/research required for response

33

Inquiry Triage Process



- Source of Information: CMS Pub. 100-9, Ch. 6, § 30.1

34

Outliers

- Received for episodes with costs exceeding a threshold amount
 - » Outliers never intended to fully compensate HHAs for episodes incurring unusually high costs
 - Amount of outlier payment proportion of costs beyond threshold amount
 - Paid in addition to episode payment
- An individual HHA's outlier payments may not exceed 10% of the HHA's total HH PPS payments
 - » Impacts all HH PPS billing transactions when "TO" date on/after January 1, 2010
 - Exception: RAPs

35

Outliers

- If outlier amount is greater than 10%, not paid when claim processes
 - » Claim adjustment reason code (CARC) 45 will show on RA
 - » Will see "02" in Pricer Return Code (PRICER RTC) field
 - Field found on MAP171A
 - Instructions for accessing/reviewing information on this screen in "Inquiry Menu" section of *FISS Reference Guide* - www.cahabagba.com/rhhi/education/materials/fiss_menu.pdf

36

Outliers

- Beginning May 1, 2010, FISS reviews HH PPS claims with unpaid outliers
 - » If outlier payable, adjustment made to claim
 - Adjustment TOB = 32I or 33I
 - Will display value code 17 and outlier amount
 - » If outlier not payable, 3XI will move to “I” status
 - Claim should not be resubmitted
 - If changes needed, submit adjustment
- Quarterly adjustments made February 1, May 1, August 1, and November 1

37

Outliers

- New FISS screens available to monitor total HH PPS payments and outlier payments made in calendar year
 - » Begins with CY 2010 payments
 - » Will have 3 year history with CY 2012 payments
- Instructions for accessing/using screens in “Inquiry Menu” section of *FISS Reference Guide*
 - » See slide 35 for URL

38

Outliers

- Reminders
 - » Outlier payment amount shown with value code 17 on claim

V.A.H.U.E..C.O.D.E.S	A M O U N T S	A N S I	M S P	A P P	I N D
01:17.....2058.60	02 61 XXXXX.00	03 65	1880.15		
04	05	06			
07	08	09			
37186					<== REASON CODES

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT

- » Medicare does not make partial outlier payments
 - Outlier paid in full if able to be paid
- » Episode payment made even if outlier cannot be paid

39

Outlier Resources

- CY 2010 HH PPS Rates Proposed/Final Rules
www.cahabagba.com/rhhi/claims/rates/rates_hhpps.htm
- Change Request 6759, Transmittal 1883,
www.cms.hhs.gov/transmittals/downloads/R1883CP.pdf
- CMS FAQs, <http://questions.cms.hhs.gov>
» Questions 9913 and 9914
- *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 10),
www.cms.hhs.gov/manuals/downloads/clm104c10.pdf
» § 10.1.21, § 70.4.A.4, § 70.4.B.4

40

Clinical View of Outliers

- Home Health benefit only pays for intermittent and part-time care
 - » Exceptions: Daily + insulin injections for patients who cannot provide themselves and no willing/able CG
 - » Exception: Daily + nursing visits for other SN need when a finite endpoint is documented
- SN and HHA visit hours may not exceed 35/wk

Payment and the OASIS

- OASIS was developed for outcomes
- Part of comprehensive assessment
- Prospective Payment System (PPS) was added
 - » Refined in January 2008
- OASIS-C, January 2010
 - » No change to payment

42

Why Changes?

- Harmonization
- Utilization
- Process Measures
 - » End result-outcomes vs. Process Measures
 - Process Measures not mandated by CoPs, and not tied to payment

43

Payment and the OASIS

- Cahaba's role with OASIS
 - » Supportive of medical necessity
 - » Reviews to ensure payment supported
 - » Ensures upon medical review that the OASIS was submitted
 - If not submitted to state, entire claim may be denied for "No OASIS submission"

44

Clinician's Tools for OASIS-C

- OASIS-C Guidance Manual
 - » www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp
- CMS Q&As (Updated Fall 2009)
 - » www.qtso.com/hhdownload.html
- CMS OCCB Q&As (Quarterly)
 - » www.oasiscertificate.org

45

Clinician's Tools for OASIS-C

- Your OASIS Education Coordinator (OEC)
- www.cms.hhs.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf

- Each state has a designated OEC to assist in:
 - » Training in the OASIS data set administration for assessing patients
 - » Training and technical support in integrating the OASIS items in the agency's record keeping system
 - » Technical support in answering questions on the clinical aspects of OASIS

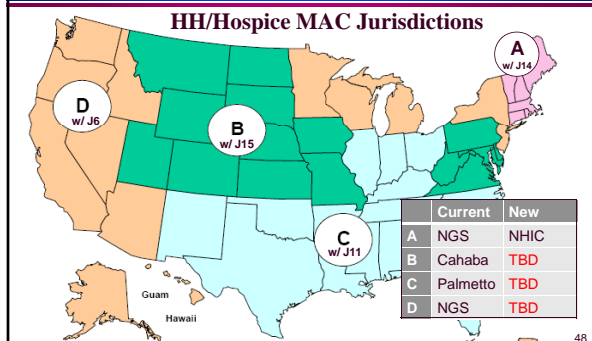
46

Medicare Contractor Reform

- Mandated by section 911 of Medicare Modernization Act (MMA) of 2003
- Requires current contracting authority to be replaced with new Medicare Administrative Contractors (MACs)
 - » 14 A/B MACs
 - Includes 4 home health and hospice (HH&H) MACs
 - » 4 DME MACs

47

HH/Hospice MACs




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Medicare Contractor Reform

- Important dates to know for J15
 - » Awarded January 7, 2009
 - » Protest sustained on May 8, 2009
- Under stay of performance pending CMS corrective action
 - » In meantime, Cahaba continue under current contract
- Contractor Reform Web page
www.cms.hhs.gov/MedicareContractingReform

49

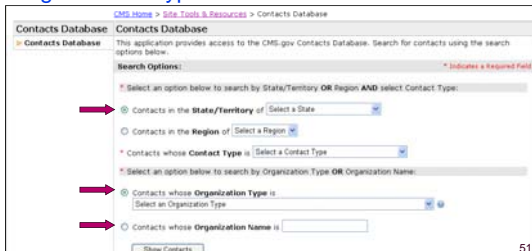
Other CMS Contractors

- Quality Improvement Organizations (QIOs)
 - » Work with patients, physicians and hospitals to ensure quality of care for patients
- State Survey Agencies
 - » Carry out Medicare certification process
 - » Set and enforce standards for CLIA and Medicaid
 - » OASIS Coordinators
- Program Safeguard Contractors (PSCs)  Zone Program Integrity Contractors (ZPICs)
 - » Ensure integrity of Medicare program (i.e. fraud and abuse)

50

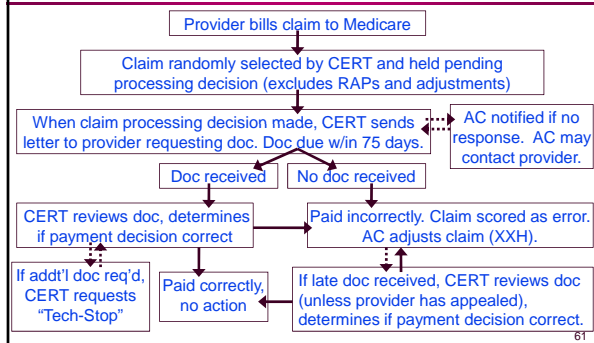
CMS Contacts Database

- www.cms.hhs.gov/apps/contacts/
- State
- Organization Type or Name



51

CERT Program – How it Works



CERT vs. Medical Review

	CERT	Medical Review
Claim selection process	Random	Focused on topic, beneficiary, provider
Notification of claim selection	Letter	ADR via FISS S/LOC S B6001
Timeframe to send documentation	75 days	45 days
Method to send documentation	Fax (preferred) or mail	Mail only
Doc reviewed for coverage, billing, coding	Yes	Yes
Provider contacted if no doc received	Possible	No
Provider contacted if additional doc needed	Yes	No
Late documentation accepted	Yes	No
Appeal rights	Yes	Yes

CERT Errors

- Types of errors
 - » No documentation
 - » Insufficient documentation
 - » Medically unnecessary
 - » Incorrect coding
 - » Other errors
- Can be overpayments or underpayment
- Paid claims error rate used to calculate “projected improper payments”

CERT Resources

- CMS Web site, www.cms.hhs.gov/CERT
 - » Overview
 - » CERT reports
- CERT provider Web site, www.certprovider.org
 - » Sample provider letters
 - » Update provider address
- Cahaba's Web site, www.cahabagba.com/rhi/education/cert/index.htm
 - » CERT brochure
 - » Summary of common errors
 - » FAQs
 - » CERT online course

64

Avoiding Reason Code 38107

To learn more about avoiding this reason code, please access the Cahaba Web page, “Top Claim Submission Errors for Home Health Providers: Error 38107” http://www.cahabagba.com/rhhi/claims/errors_38107.htm

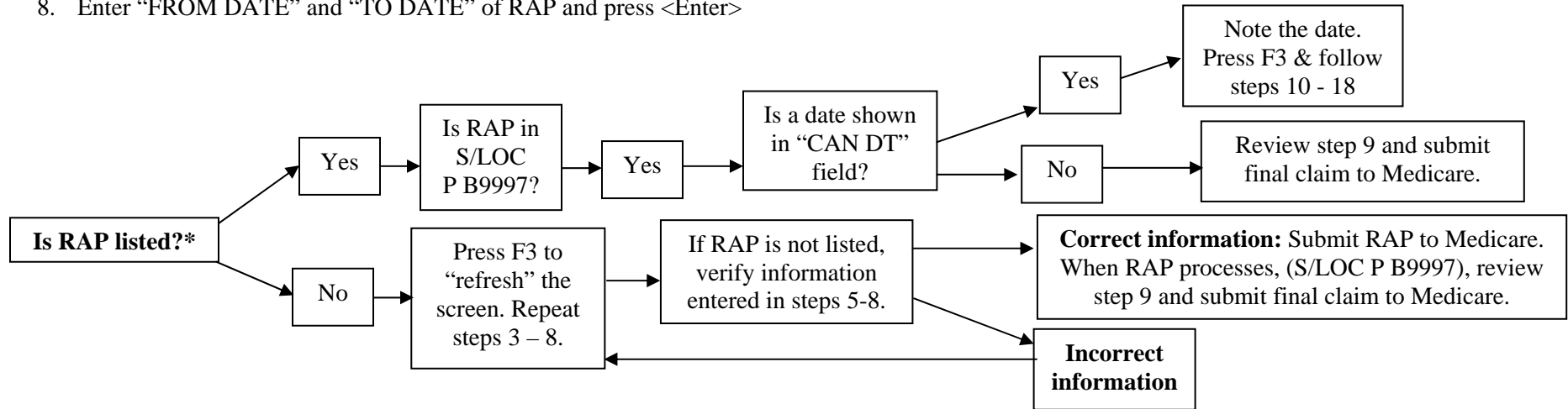
Check for Processed RAP

Prior to submitting the final home health claim for an episode, check for a processed RAP by following the steps below:

1. Log on to FISS
2. Enter “01” and press <Enter>
3. Enter “12” and press <Enter>
4. MAP 1741 will appear
5. Enter your National Provider Identifier (NPI)
6. Enter Patient’s HIC Number
7. Enter “322” in TOB
8. Enter “FROM DATE” and “TO DATE” of RAP and press <Enter>

MAP1741 XXXXXX SC		CAHABA GBA - RHHI CLAIM SUMMARY INQUIRY		ACPFAT01 MM/DD/YY C20093YE HH:MM:SS	
HIC OPERATOR ID XXXXXXXX		PROVIDER FROM DATE		S/LOC TO DATE	
MEDICAL REVIEW SELECT		TOB		DDE SORT	
HIC		PROV/MRN		S/LOC	
SEL LAST NAME		FIRST INIT		TOT CHG	
		PROV REIMB PD DT		CAN DT REAS NPC #DAYS	

Note: Fields where information can be keyed in MAP 1741 are bolded.



***REMINDER:** Under HH PPS, HHAs are not required to submit RAPs when 4 or fewer visits have been provided during the episode. If a RAP is required, it must be in S/LOC P B9997 prior to the claim’s submission to Medicare to avoid receiving reason code 38107. Please also ensure when reviewing the RAPs listed for the episode in question on MAP 1741, you are looking at the RAP with the most recent date in the PD DT (paid date) field.

Avoiding Reason Code 38107

Matching RAP & Claim Information

9. Prior to submitting the final claim to Medicare, ensure the information in each of the following fields matches between the RAP and final claim:
 - National Provider Identifier (NPI) of billing provider (FL 56)
 - “FROM” date (FL 6)
 - “ADMIT” date (FL 12)
 - First four positions of the HIPPS code (FL 44)
 - Note: FISS edits changes to the fifth position of the HIPPS code to ensure the letter or number submitted does not change the supply severity level.
 - Service date on 0023 revenue line (FL 45)
 - This must be the date of the first Medicare billable service.

Checking for Auto-Canceled RAPs

10. Follow steps 1-6
11. Enter “P B9997” in S/LOC field
12. Enter “328” in TOB
13. Enter “FROM DATE” and “TO DATE” of RAP and press <Enter>
14. Review list of billing transactions. If no “328” appears, RAP not auto-canceled.
15. Select “328” TOB with “CAN DT” matching “CAN DT” on “322” TOB
16. View Claim Page 3 for “ADJUSTMENT REASON CODE” field
17. If “NF” in “ADJUSTMENT REASON CODE” field, RAP auto-canceled
18. Re-bill RAP. When processed (S/LOC P B9997), review step 9 and submit final claim to Medicare.

Resolving Rejected Home Health Claims Caused by Billing Errors

When a billing error is the reason a claim rejected (status/location R B9997), home health agencies (HHAs) may resolve the error by resubmitting a new claim electronically adjusting, or submitting a paper claim adjustment.



Tips for Avoiding Claims from Rejecting

- Always check a beneficiary's eligibility using the ELGH or ELGA eligibility systems prior to admission and billing Medicare. Access the "[Checking Beneficiary Eligibility](#)" section of the *FISS Reference Guide* for more information.
- Review the "[Top Claim Submission Errors for All Providers: Errors 38200 and 38157](#)" Web page to avoid receiving duplicate billing errors.

Resubmit a New Claim or Submit an Electronic Adjustment.

Check TPE-TO-TPE (tape-to-tape) field (FISS MAP171D) to determine if rejected claim information appears on the Common Working File (CWF).

- Log on to FISS
- At the Main Menu screen, enter "01" and press <ENTER>
- At the Inquiry Menu screen, enter "12" and press <ENTER>
- At the Claim Summary Inquiry screen, type your National Provider Identifier (NPI) in the NPI field, the beneficiary's Health Insurance Claim Number (HICN) in the HIC field, and FISS status/location R B9997 in the S/LOC field and press <ENTER>.
- Select the rejected claim by typing an "S" in the SEL field next to the HICN of the claim and press <ENTER>.
- FISS Page 01 will appear. Press the F8 key to move forward to Page 02.
- Press the F2 key to access MAP171D.
- If an "X" displays in the **TPE-TO-TPE** field the original rejected claim data **did not** post to the CWF. **Resubmit a new claim** with the correct information to Medicare.
- If an "X" does not display in the **TPE-TO-TPE** field, the original rejected claim data **did** post to the CWF. **Submit an electronic adjustment.** Instructions are available in the "[Claims Correction](#)" section of the *FISS Reference Guide*.
 - If the message "ADJUSTMENT CLAIM IS ALREADY CANCELED" displays at the bottom of the page, the claim cannot be adjusted. Instead, a new claim should be submitted to Cahaba with the changed information.

REMINDER: Charges on a rejected claim display in the "NCOV CHARGES" (non-covered charges) field on Page 02. You must delete the revenue detail lines and add them back by re-entering the revenue code, HCPCS, units, charges, and service date information in new detail lines. See the "[Claims Correction](#)" section of the *FISS Reference Guide* for instructions on deleting and adding revenue code lines.

Note: If the claim contains MSP information, see the Cahaba "[Submitting Medicare Secondary Payer \(MSP\) Claims and Adjustments](#)" Web page for more information.

Submitting a Paper Claim Adjustment

In the rare circumstance that an electronic adjustment is not possible, submit a paper adjustment (UB-04). The following form locators (FL) must be completed correctly:

- Type of bill (TOB) FL 4—The third position must be a "7" (e.g., 327 or 337).
- Condition Codes (CC) FL 18-28—First available CC must include a Claim Change Reason Code (CCRC). Refer to the "[Claims Correction](#)" section of the *FISS Reference Guide* for a list of CCRCs used for claims adjustment.
- Document Control Number (DCN) FL 64—The DCN of the rejected claim in (Found in the "DCN" field on FISS Page 01 or on the Remittance Advice (RA)).
- Remarks (FL 80)—An explanation as to why you are submitting the paper adjustment.

Go to the "[Write Us](#)" page of Cahaba's Web site for the address to mail paper claim adjustments.



Before You Call Cahaba, Read This!

From October 1, 2008, through September 30, 2009, the home health (877-299-4500) and hospice (866-539-5592) Customer Service Representatives (CSRs) answered 51,690 questions from home health and hospice providers. Based on a review of the topics most asked during October through December 2009, the Frequently Asked Questions (FAQs) for the top inquiries received in Cahaba’s Home Health & Hospice Provider Call Center (PCC) have been updated. The updated FAQs can be accessed on our Web site using the following link: <http://www.cahabagba.com/rhhi/faqs/index.htm>

Providers should use all of our self-service technology tools to resolve their Medicare questions before contacting a CSR*. A variety of resources are available to assist you. The FAQs and the “[Resources for the Most Common Medicare Part A Provider Questions](#)” Web page are valuable resources to refer to before calling a CSR. Additional resources include Cahaba’s [Interactive Voice Response](#) (IVR) unit or other self-service technology, Cahaba’s and CMS’s [Web site](#), Cahaba and CMS Listserv messages, and a wide variety of Internet-based [provider educational offerings](#). Providers without Internet access may request a copy of the FAQs or other materials posted to Cahaba’s Web site by calling the Provider Outreach and Education department at 515-471-7335.

In looking at the reasons why home health and hospice agencies most frequently call Cahaba, the five issues below represent 34% of all inquiries received. Please review the following information and use the resources cited prior to calling Cahaba for assistance. If the issue still is not resolved, we would encourage you then to call the PCC for help.

Reason for Call	Number of Calls	Prior to Calling Cahaba:
<p>Explain reason code assigned to claim needing correction. The reason codes most inquired about include:</p> <p>Hospice 37402 U5181</p> <p>Home Health 31147 31755 38107 U538G U538I</p>	<p>4,774</p>	<p>Review the Top Claim Submission Errors and How to Resolve Web page, which includes links to “Web help” pages for each of the reason codes listed.</p>

Reason for Call	Number of Calls	Prior to Calling Cahaba:
Claim submitted overlaps another episode, benefit period or claim	4,372	<p>At a minimum, ensure that you are reviewing ELGH pages 3, 9 and/or ELGA pages 2, 4 for home health episodes of care or hospice benefit periods prior to admission and submitting home health or hospice billing transactions to Medicare. For more information about these screens, use the Checking Beneficiary Eligibility section of <i>FISS Reference Guide</i> to assist.</p> <p>Prior to transferring or receiving a home health or hospice patient to/from another home health or hospice facility, review the information on the following Web pages:</p> <p>Home Health www.cahabagba.com/rhhi/claims/home_health/bene_transfer.htm www.cahabagba.com/rhhi/claims/errors_U538I.htm</p> <p>Hospice www.cahabagba.com/rhhi/claims/hospice/transfer.htm www.cahabagba.com/rhhi/claims/hospice/seq_billing.htm www.cahabagba.com/rhhi/claims/errors_u5106.htm</p> <p>Prior to discharging or readmitting a home health or hospice patient, review the information on the following Web pages:</p> <p>Home Health www.cahabagba.com/rhhi/claims/home_health/discharge_readmit.htm www.cahabagba.com/rhhi/claims/errors_U538G.htm</p> <p>If the dates of service of a home health episode overlap an inpatient stay, review: www.cahabagba.com/rhhi/claims/home_health/overlap.htm www.cahabagba.com/rhhi/claims/errors_c7080.htm</p> <p>Hospice www.cahabagba.com/rhhi/claims/hospice/discharge_revoke.htm</p>

Reason for Call	Number of Calls	Prior to Calling Cahaba:
Claim needing correction due to missing or invalid code	3,610	<p>For assistance in billing appropriate codes (i.e., source of admission, patient status, revenue, HCPC) on home health and hospice billing transactions, review:</p> <p>Home Health</p> <ul style="list-style-type: none"> • Claims Filing Web pages • Billing Codes quick reference tool <p>For questions regarding which positions of the HIPPS code must match on home health RAPs/claims or submitting the appropriate HIPPS code when billing supplies on home health claims, review: www.cahabagba.com/rhi/claims/errors_38107.htm www.cahabagba.com/rhi/claims/errors_31147.htm</p> <p>Hospice</p> <ul style="list-style-type: none"> • Claims Filing Web pages • Billing Codes quick reference tool <p>Home Health and Hospice</p> <p>For information on the codes required for Medicare Secondary Payer (MSP) claims, or adjusted or cancelled claims, review:</p> <ul style="list-style-type: none"> • MSP Billing quick reference tool • MSP Web page • Claims Correction section, <i>FISS Reference Guide</i> • Adjustments/Cancels Web page
Request instructions for filing/billing services to Medicare	3,142	<p>Instructions most requested:</p> <p>Home Health</p> <ul style="list-style-type: none"> • Billing RAPs/final claims: Claims Filing Web pages • Billing non-routine supplies: HH PPS Claims With Non-Routine Supplies (NRS) Web page Claims Processing and Reimbursement Changes for Home Health Supplies Web page Claim Page 02 – Entering a RAP or Claim Web page <p>Hospice</p> <ul style="list-style-type: none"> • Billing Hospice Physician Services quick reference tool • Submitting hospice revocation indicator: Claim Page 01 — Entering a Hospice Claim Web page Occurrence Code 42 Omitted Web page

Reason for Call	Number of Calls	Prior to Calling Cahaba:
Claim rejected because of beneficiary eligibility record	1,686	<p>Check ELGH/ELGA screens prior to submitting claims to Medicare.</p> <p>For assistance in updating the beneficiary’s name, Medicare entitlement dates, or date of death, contact the Social Security Administration at 1-800-772-1213.</p> <p>Medicare Advantage plan enrollment dates:</p> <ul style="list-style-type: none"> • Contact individual MA plan to update incorrect dates • Submit services to MA Plan, if Option Code “C” on ELGH pg. 5 or ELGA pg. 1, and no hospice election impacts dates of service (DOS) <p>Medicare Secondary Payer records:</p> <ul style="list-style-type: none"> • Contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 to update records • If date(s) of service overlap an MSP record: <ul style="list-style-type: none"> ▪ Submit claim to primary insurance, if appropriate ▪ Submit Medicare claim with MSP information (see the resources listed above for assistance with Medicare MSP claims) <p>NOTE: RAPs/NOEs are always submitted with Medicare as the primary payer</p> <p>If the dates of service on your home health final claim fall outside episodes posted to beneficiary record, review the information on the Correcting Home Health Episode Information Posted to the Common Working File (CWF) Web page.</p> <p>For additional information for home health providers, see the Resolving Rejected Home Health Claims Caused by Billing Errors Web page.</p> <p>If incorrect dates were posted for a hospice benefit period provided by your hospice facility, see the Canceling a Notice of Election or Benefit Period Web page.</p>

*Source of information, the *Medicare Contractor Beneficiary and Provider Communications Manual* (Pub. 100-9, Chapter 6)