CGS Clinical & Billing Updates for Home Health

2017 Pennsylvania Homecare Association
Annual Conference & Exposition
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May 3, 2017

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

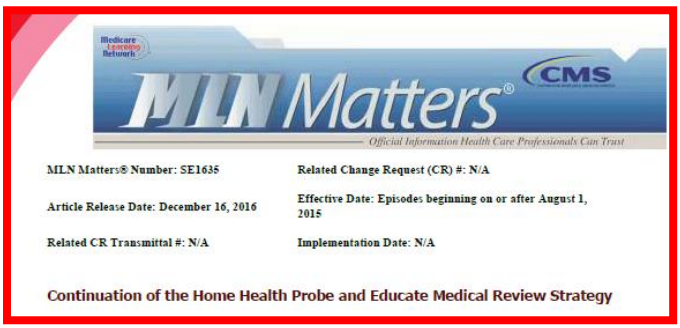
Clinical News

For Home Health Providers

PROBE & EDUCATE ROUND 2

PROBE AND EDUCATE

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


MLN Matters®

Official Information Health Care Professionals Can Trust

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

PROBE AND EDUCATE – ROUND 2

- CGS began sending Additional Documentation Requests (ADRs) on January 19, 2017.
- This round of claim reviews and provider education will conclude in approximately one year.
- Letters to providers will be sent via the postal service at the conclusion of the probe review portion of the process.
- One-on-one education is available to ALL providers.

IMPORTANT

If you choose not to reach out for education, this will be tracked as a refused offer. Please note that the purpose of the P&E process is to identify areas of confusion and to address these areas through education, supporting providers in their goal of submitting claims that are in compliance with Medicare policy.

PROBE AND EDUCATE

Home Health PPS Denial Detail Report by Provider 22-Mar-16

(Date Range From 1/1/2016 through 2/29/2016)

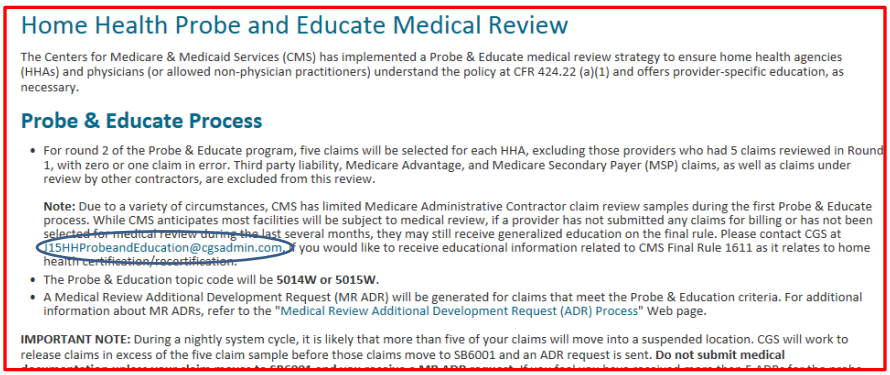
HICN	From Dt	Thru Dt	Clms Revd	Clms Dnyd	Provider Submitted Payment	Medical Review Payment	Difference in Payment	Denial Rate	Denial Code	Denial Reason
123456 123123123 Bert and Ernie's Home Health Agency										
XXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99			
XXXXXXXXD	10/01/15	11/29/15			$999.99	$999.99	$0.00		5HC01	F2F missing/incomplete/untimely
Provider Total			5	4	$4,999.95	$999.99	$3,999.96	80%		

PROBE AND EDUCATE – ROUND 2

	No or Minor Concerns	Moderate/Major Concerns
5 claim sample	0-1*	2-5*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: 1. Deny non-compliant claims; and 2. Send detailed review results letters explaining each denial. 3. Send summary letter that: • Offers the provider a 1:1 phone call to discuss claim denials if any; and • Indicates that no more reviews will be conducted under the Probe & Educate process. 4. **Await further instruction from CMS**	For each provider with major to moderate concerns CMS will direct the MAC to: 1. Deny non-compliant claims; and 2. Send detailed review results letters explaining each denial. 3. Send summary letter that: • Offers the provider a one-to-one phone call to discuss; • Indicates the review contractor may REPEAT Probe & Educate process with an additional claim sample 4. **Repeat Probe & Educate of five claims with dates of after the implementation of education.**

PROBE AND EDUCATE

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 **5014W 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 SB6001 and an ADR request is sent. **Do not submit medical**

COMMON DENIAL REASONS FROM ROUND 1

- Face-to-Face
- Recertification Estimate
- Initial Certification Missing
- Therapy Services Require Skills of a Therapist
- Homebound Status

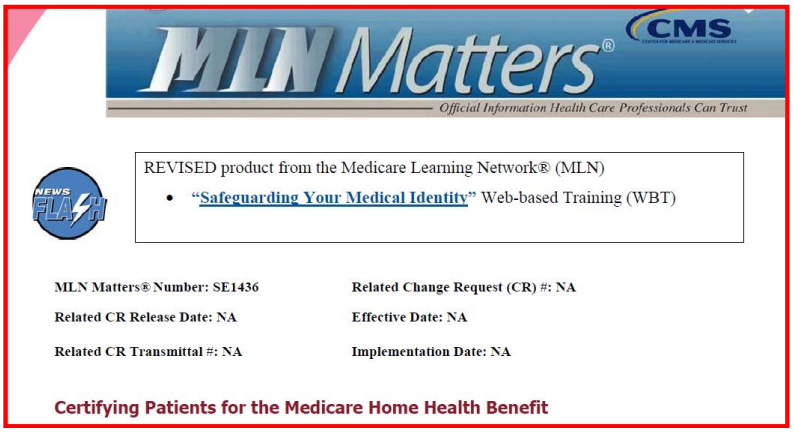
FACE-TO-FACE (FTF) ENCOUNTER

IMPORTANT

Documentation submitted must contain the actual clinical note for the FTF encounter visit

MLN MATTERS® SE1436

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf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REVISED product from the Medicare Learning Network® (MLN)

- "Safeguarding Your Medical Identity" Web-based Training (WBT)

MLN Matters® Number: SE1436 | Related Change Request (CR) #: NA

Related CR Release Date: NA | Effective Date: NA

Related CR Transmittal #: NA | Implementation Date: NA

Certifying Patients for the Medicare Home Health Benefit

IMPORTANT

Certifying physician must document the date of the FTF encounter before the claim is submitted for billing

EXAMPLES OF FTF DOCUMENTATION "DON'TS"

Insufficient documentation – Miscellaneous

- Diagnoses/clinical findings on FTF **not related to reason for home care**
- Altered documentation without **acceptable** notations for changes
- **No date** of FTF encounter
- **Not clearly titled** as face-to-face encounter

RECERTIFICATION

PHYSICIAN RECERTIFICATION

The physician must include an estimate of how much longer skilled services will be required (preferably a timespan or interval of time)

- As part of the **recertification document**

PHYSICIAN RECERTIFICATION

The achievement of a treatment goal as an estimate of how much longer a patient may need HH services is **not acceptable.**

Unacceptable examples of treatment goals:

- Services will be required **until the patient can walk safely**
- Services will be required **until the ulcer heals**

PHYSICIAN RECERTIFICATION

Acceptable examples of timespan used to convey how much longer the services will be needed:

- **Another 60 days.**
- **Another 4 weeks**.

INITIAL CERTIFICATION MISSING

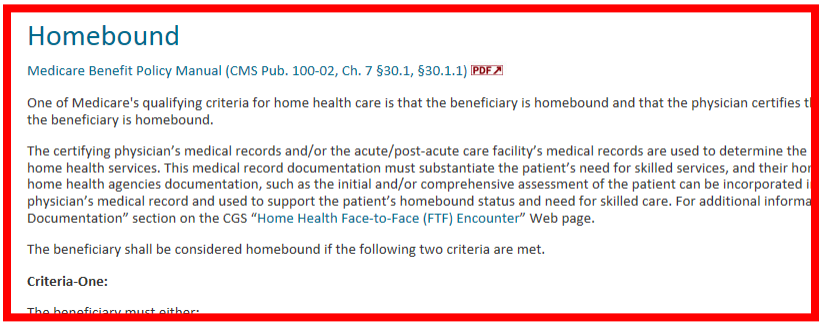
INITIAL CERTIFICATION

Always send initial certification and initial F2F, along with the current certification.

HOMEBOUND STATUS

HOMEBOUND STATUS

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1C.html



Homebound

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1, §30.1.1) PDF

One of Medicare's qualifying criteria for home health care is that the beneficiary is homebound and that the physician certifies t
the beneficiary is homebound.

The certifying physician's medical records and/or the acute/post-acute care facility's medical records are used to determine the
home health services. This medical record documentation must substantiate the patient's need for skilled services, and their hor
home health agencies documentation, such as the initial and/or comprehensive assessment of the patient can be incorporated i
physician's medical record and used to support the patient's homebound status and need for skilled care. For additional informa
Documentation" section on the CGS "Home Health Face-to-Face (FTF) Encounter" Web page.

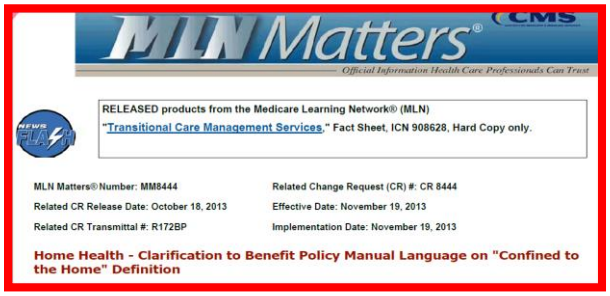
The beneficiary shall be considered homebound if the following two criteria are met.

Criteria-One:

The beneficiary must either:

HOMEBOUND STATUS

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8444.pdf



MLN Matters®

Official Information Health Care Professionals Can Trust

RELEASED products from the Medicare Learning Network® (MLN)
"Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8444 — Related Change Request (CR) #: CR 8444
Related CR Release Date: October 18, 2013 — Effective Date: November 19, 2013
Related CR Transmittal #: R172BP — Implementation Date: November 19, 2013

Home Health - Clarification to Benefit Policy Manual Language on "Confined to the Home" Definition

HOMEBOUND STATUS

First Criteria One of the Following must be met:	Second Criteria Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

HOMEBOUND STATUS

The patient may be considered homebound (confined to the home) if absences from the home are:

- infrequent
- for periods of relatively short duration
- for the need to receive health care treatment
- for religious services
- to attend adult daycare programs
- for other unique or infrequent events
- the patient may have more than one home
  - vacation home, home of caregiver, seasonal home

HOMEBOUND STATUS

- Documentation must support **homebound status** throughout
- Beware of vague descriptions:

  "taxing effort", "unable to leave home"
- Utilize **objective, measurable language**

HOMEBOUND SUPPORTING DOCUMENTATION

Examples of **good documentation to support homebound status**:

- "After ambulating 20 feet, patient has increased dyspnea and complains of back pain."
- "Patient has unsteady gait, and must sit to rest after 10 feet of ambulation due to uncontrolled vertigo."

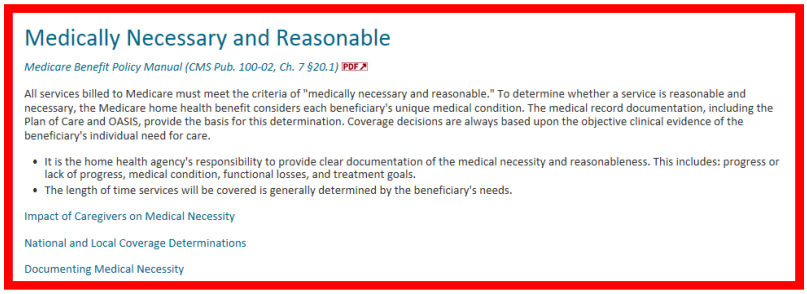
HOMEBOUND SUPPORTING DOCUMENTATION

- In her current condition, she becomes significantly short of breath with even minimal physical activity such as walking 10 feet or less. She is unable to navigate stairs (?). This makes travel outside the house very difficult and taxing.

MEDICAL NECESSITY

MEDICAL NECESSITY

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1E.html



Medically Necessary and Reasonable

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §20.1) PDF

All services billed to Medicare must meet the criteria of "medically necessary and reasonable." To determine whether a service is reasonable and necessary, the Medicare home health benefit considers each beneficiary's unique medical condition. The medical record documentation, including the Plan of Care and OASIS, provide the basis for this determination. Coverage decisions are always based upon the objective clinical evidence of the beneficiary's individual need for care.

- It is the home health agency's responsibility to provide clear documentation of the medical necessity and reasonableness. This includes: progress or lack of progress, medical condition, functional losses, and treatment goals.
- The length of time services will be covered is generally determined by the beneficiary's needs.

Impact of Caregivers on Medical Necessity

National and Local Coverage Determinations

Documenting Medical Necessity

MEDICAL NECESSITY

"Why home health and why now?"

Good documentation should address:

- Objective clinical evidence of patient's individual need for care
- Progress or lack of progress
- Medical condition
- Functional losses
- Treatment goals
- Discharge planning

MEDICAL NECESSITY - "DO'S"

Identify skilled service, and **reason** skilled service is necessary for beneficiary in objective terms

- "Wound care completed per POC to left great toe. No s/s of infection, but patient remains at risk due to diabetic status."
- "Lungs sound coarse throughout. Patient finished antibiotic therapy today for pneumonia, and seeing pulmonologist tomorrow for follow up to due to COPD and emphysema."

THERAPY

Patient requires supervision and frequent rest breaks with ambulation due to CHF and gait instability after 70-80 feet and then 2-3 hours to recover after extended outings

THERAPY

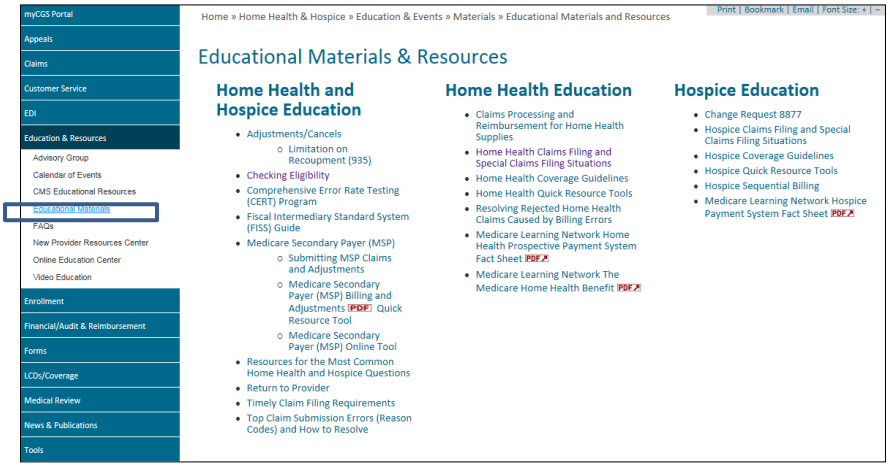
Patient is able to ambulate and transfer, but it is a taxing effort. Patient is able to do most ADLs, but accepts help if available.

HEP plan has been in place for 2 weeks for patient to increase strength and confidence without skilled services. Patient understands and agrees with HEP.

RESOURCES

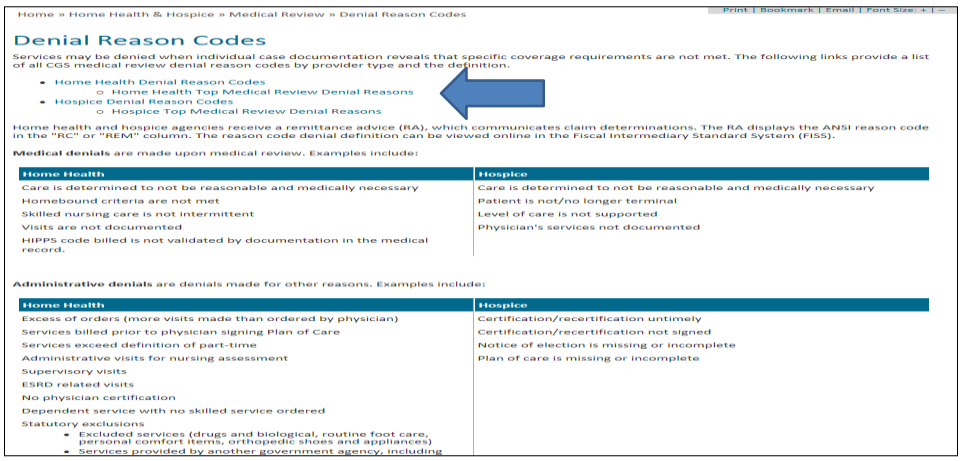
CGS HH&H Website: Educational Materials

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



Medical Review Denial Reason Codes

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



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
56900	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.
5HA01	The information does not support the need for this many home health aide visits.
5HA02	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.
5HBEN	This claim was denied after review. The provider's determination of noncoverage is correct.
5HC01	The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.
5HC02	Physician's plan of care and/or certification present – signed but signature dated untimely.
5HC03	Physician's plan of care and/or certification present – signed but signature is not dated.
5HC04	Physician's plan of care and/or certification present-no signature.
5HC05	No physician's plan of care and no certification present.
5HC06	Physician's plan of care present, but no certification.
5HC07	Certification present, but no physician's plan of care.
5HC08	The recertification estimate of how much longer skilled services are required is missing/incomplete/invalid.
5HC09	The initial certification was missing/incomplete/invalid, therefore the recertification episode is denied.
5HD01	MR downcode/documentation contradicts OASIS M item(s).
5HD02	MR downcode/provider billed higher category than OASIS M item(s) billed.
5HD03	Partial denial for therapy resulting in MR downcode.
5HD04	Partial denial resulting in a LUPA.
5HD05	HIPPS reduced for non-routine supplies (NRS).
5HDEM	Demand bill reversed and paid in part or in full.

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 EXT
- "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 PDF
- Success with Medical Record Requests Quick Resource Tool PDF
- "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%

BILLING NEWS

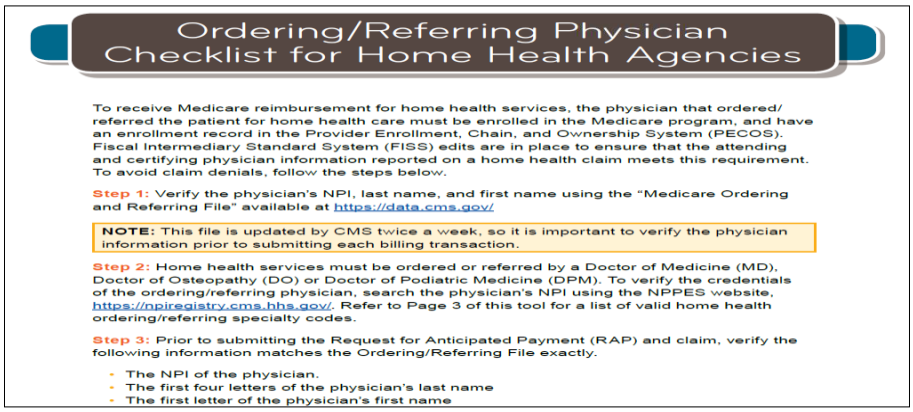
For Home Health Providers

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

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

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

SE17009, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17009.pdf

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

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

Home » Home Health & Hospice » Medical Review » Overview of Medical Review

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Overview of Medical Review

Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 3 PDF

The Medical Review (MR) Program is designed to promote a structured approach in the interpretation and implementation of Medicare policies. CMS makes it a priority to automate this process; however, it may require the evaluation of medical records to determine the medical necessity of Medicare claims. The following summarizes the different activities performed by the Medical Review Department.

- Prepayment Review occurs when edits in the Fiscal Intermediary Standard System (FISS) suspend a claim for medical review before the claim is paid. Prepayment edits may include:
  - Widespread Edits are developed based on data analysis that identifies provider billing practices and services that pose the greatest risk to the Medicare program. All providers are subject to a widespread edit when the claim meets the parameters of the edit.
  - Provider Specific Edits suspend an individual provider's claims based on specific parameters determined by CGS's Medical Review Department. Providers are notified in advance in writing when being placed on a Provider Specific Edit.
  - Beneficiary Specific Edits are implemented on individual beneficiary's based on claims that have been previously reviewed and denied by MR.
- Providers that have claims selected for prepayment review will receive an Additional Development Request (ADR) notice via the FISS.
- Medical Review Denial Reason Codes explain the reason home health and hospice services are denied based on medical review decisions.
- Postpayment Review is a comprehensive review of individual beneficiary medical records, conducted either onsite at your facility, or done in the Medicare contractor's Medical Review Department.
- Progressive Corrective Action (PCA) provides Medicare contractors with further guidance, underlying principles and approaches to be used in deciding how to deploy resources and tools for Medical Review.

In addition to CGS's medical review activities, other entities may contract with CMS to perform additional medical review activities through various programs. These may include:

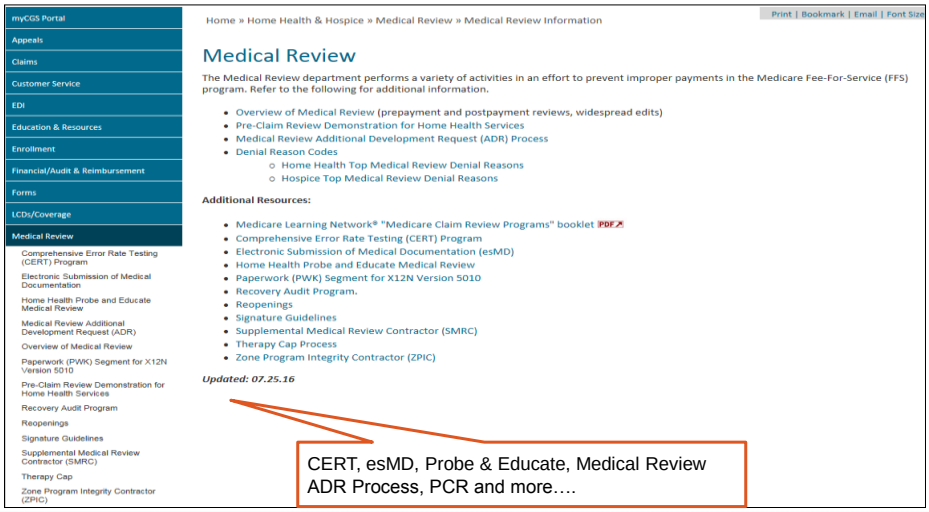
- Recovery Auditors (RAs)
- Zone Program Integrity Contractors (ZPICs)
- Supplemental Medical Review Contractor (SMRC)
- Comprehensive Error Rate Testing (CERT) Contractor

CMS Educational Resources

- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" PDF Educational Tool
- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC PDF " booklet
- "How to Use the National Correct Coding Initiative (NCCI) Tools PDF " booklet

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

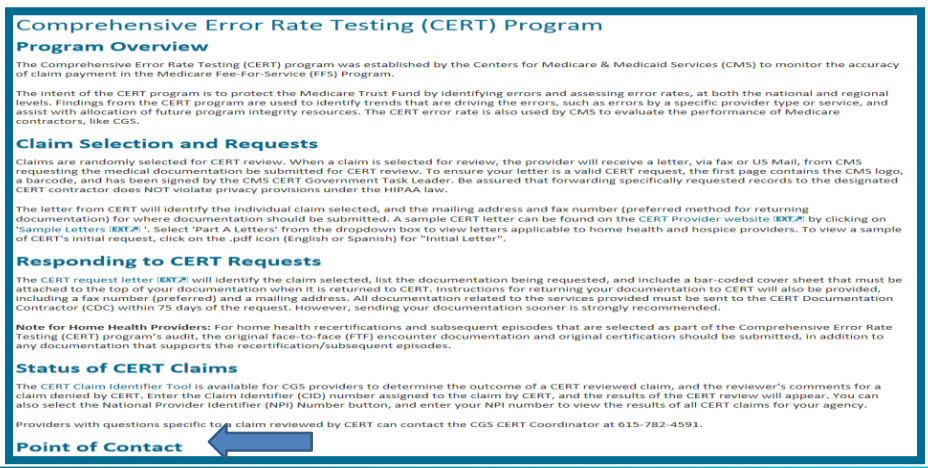
http://www.cgsmedicare.com/hhh/education/materials/cert.html

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 [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

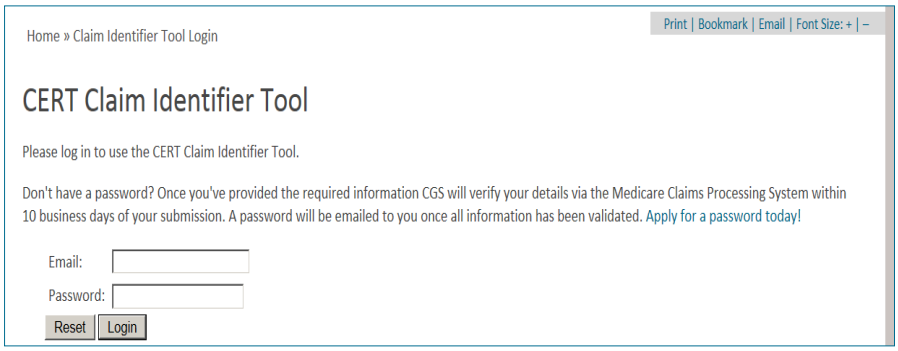
The CERT Claim Identifier Tool is available for CGS providers to determine the outcome of a CERT reviewed claim, and the reviewer's comments for a claim denied by CERT. Enter the Claim Identifier (CID) number assigned to the claim by CERT, and the results of the CERT review will appear. You can also 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

CERT Claim Identifier Tool

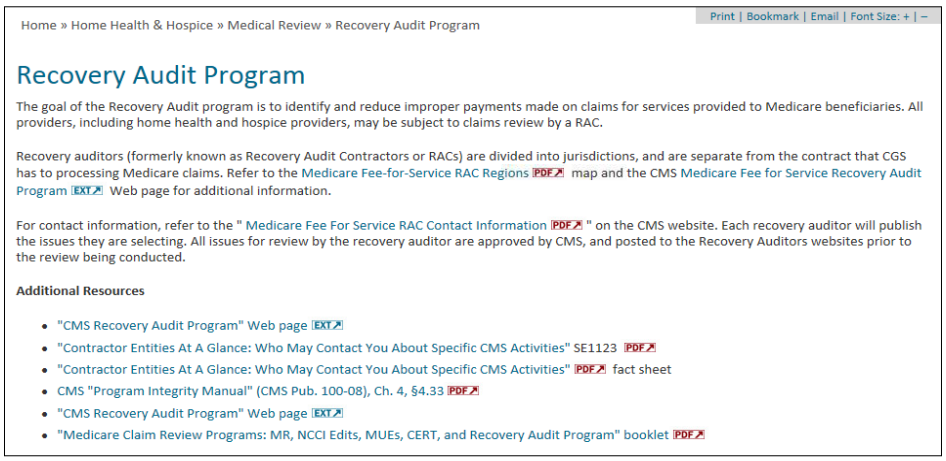
Need to check the status of a CERT claim? Use our CERT Claim Identifier Tool.....



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

Recovery Audit (RA) Contractor

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



Top Billing Errors & Reminders

Claim Submission Errors (CSEs)

Top Billing Errors (September 2016 – March 2017)

Overview of HH Claim Submissions and CSEs	
# of HH "Claims" Submitted	1,576,466
# of HH CSEs	220,004
Percent of billing errors	13.96%

CGS Billing Errors – Home Health

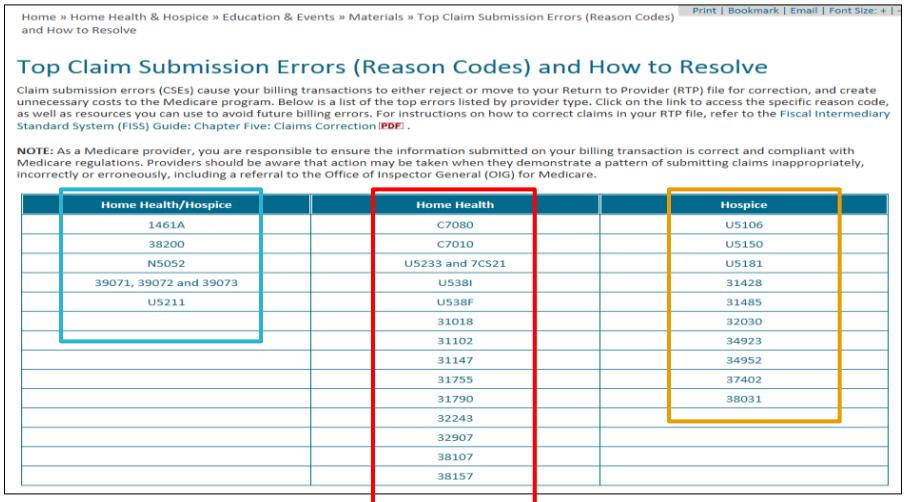
September 1, 2016 – March 31, 2017		
Reason Code	**Billing Error**	**# of Errors**
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	61,312
38107	FISS can't find matching RAP	50,767
U538I	Overlap another HHA's episode	12,248
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	5,953
31755	HIPPS DOS mismatch	2,918

PA Top HH Billing Errors

September 2016 – March 31, 2017		
Reason Code	**Billing Error**	**# of Errors**
38157, 38200	Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider	32,774
38107	FISS can't find matching RAP	11,103
U538I	Overlap another HHA's episode	2,666
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	1,253
10414	Invalid/missing ADMIT Date	974
U538F	Overlap same HHA's episode	856

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] .

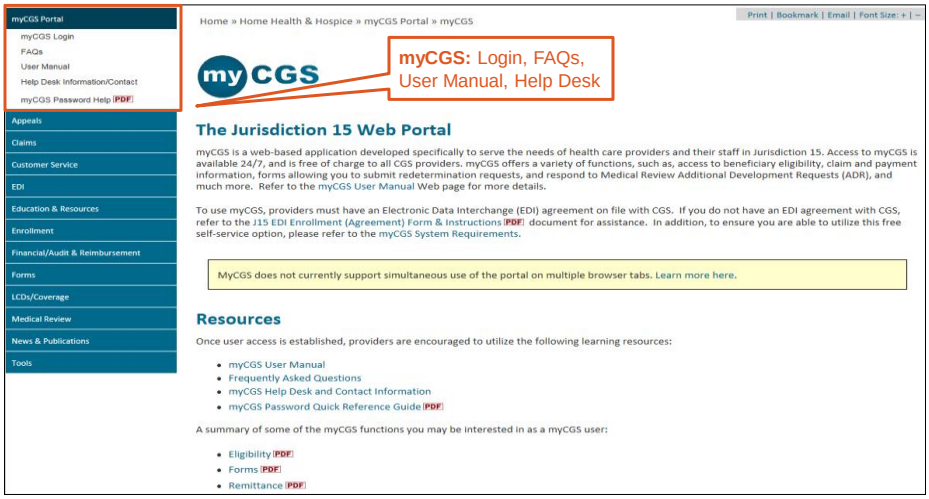
NOTE: As a Medicare provider, you are responsible to ensure the information submitted on your billing transaction is correct and compliant with Medicare regulations. Providers should be aware that action may be taken when they demonstrate a pattern of submitting claims inappropriately, incorrectly or 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 7CS21	U5181
39071, 39072 and 39073	U538I	31428
U5211	U538F	31485
	31018	32030
	31102	34923
	31147	34952
	31755	37402
	31790	38031
	32243	
	32907	
	38107	
	38157	

Medicare Resources

CGS HH&H Website: myCGS Portal

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



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)

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:

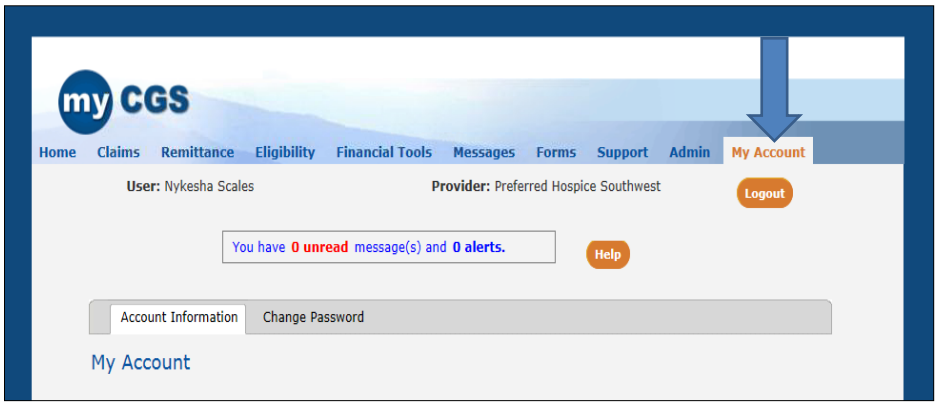
myCGS MFA is an extra layer of security which Users can voluntarily access before it becomes required. In order to do so, Users should log in to myCGS and then access the 'My Account' tab to turn on this optional feature.

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 30, 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

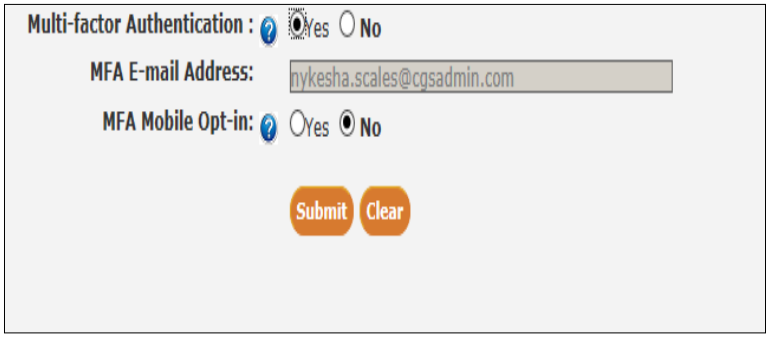
MFA – Step 1

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

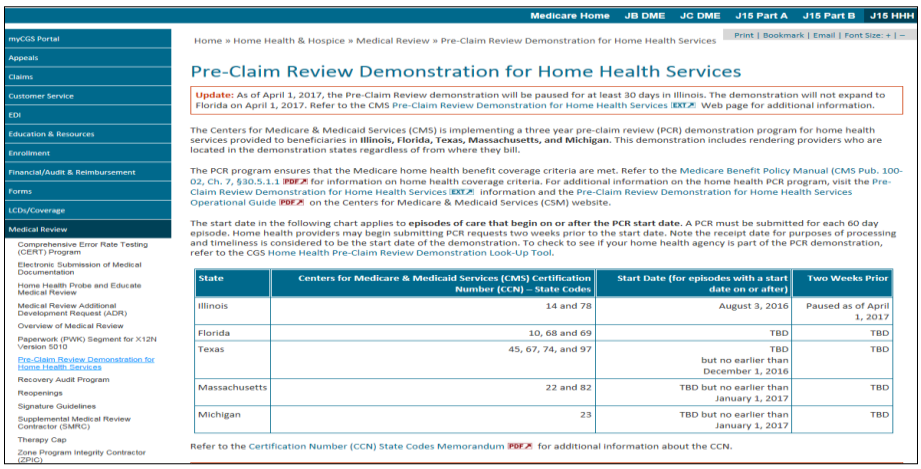
CGS HH&H WEB PAGE

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

CGS HH&H Web Page

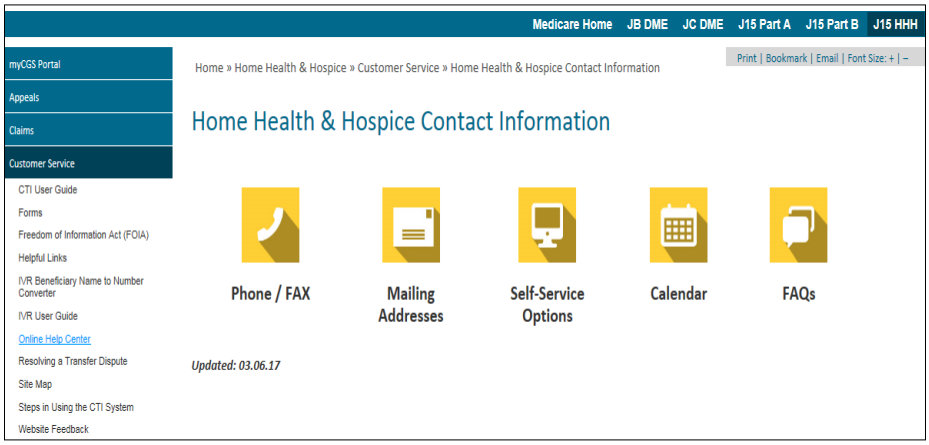
CGS Pre-Claim Review Web Page

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



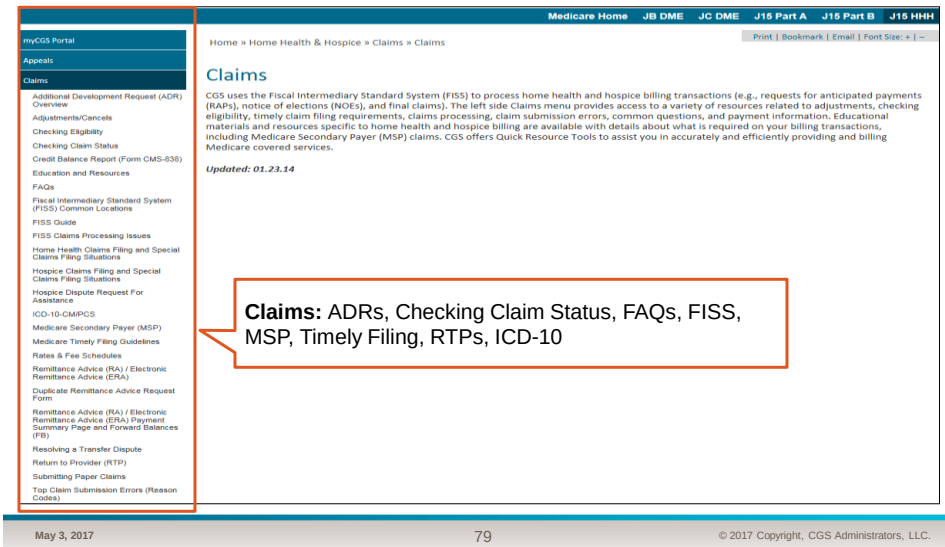
UPDATED: HH&H CUSTOMER SERVICE WEB PAGE

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

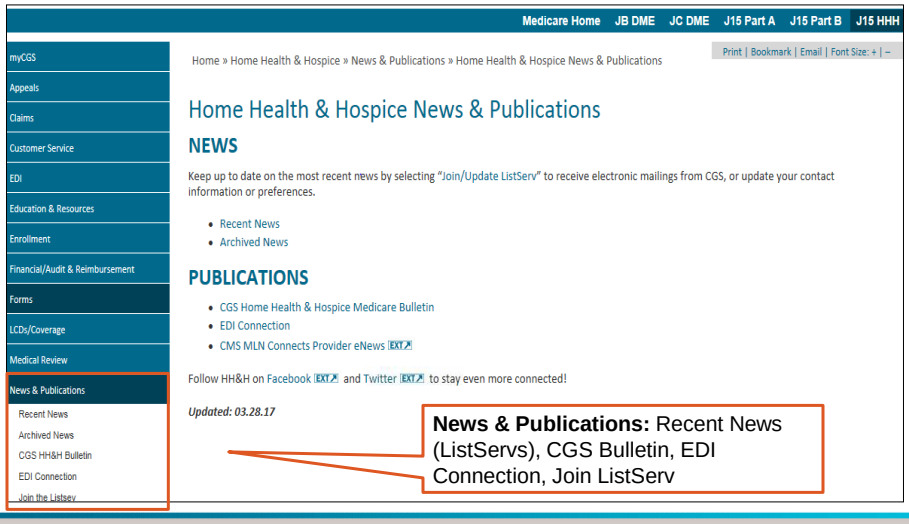
- Chapter One: FISS Overview
  - Moving around in FISS, status/locations
- Chapter Two: Checking Beneficiary Eligibility
  - Eligibility screens, fields, data/codes
- Chapter Three: Inquiry Menu
  - Checking claim status, validity of codes
- Chapter Four: Claims and Attachments Menu
  - Entering NOEs/claims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

CGS HH&H WEBSITE: EDUCATION & RESOURCES

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

CGS HH&H Website: News & Publications

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

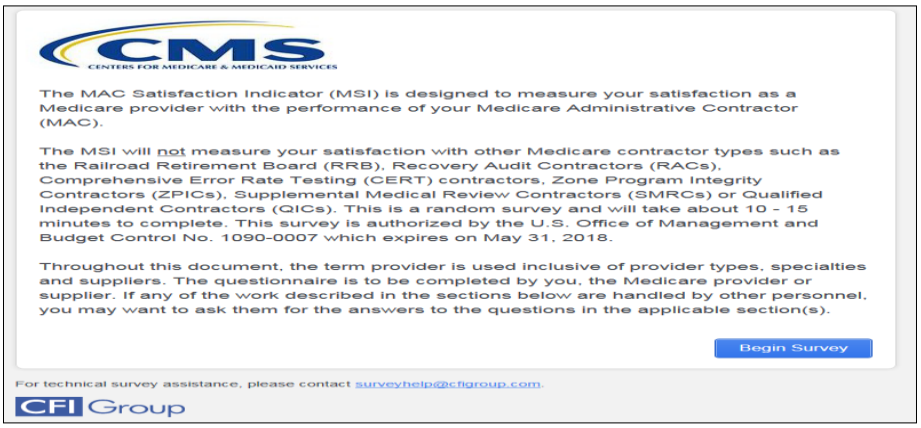


Reminder: Join the ListServs

- 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

MAC Satisfaction Indicator (MSI) Survey: We Need Your Feedback

https://cfigroup.qualtrics.com/jfe3/form/SV_3WeVjGWpc5NQXOJ?MAC_BRNC=16&MAC=J15%20Â–%20CGS



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**