# JUST THE NUMBERS: BILLING UPDATE FROM CGS

PENNSYLVANIA HOMECARE ASSOCIATION| 2017 FINANCIAL MANAGEMENT CONFERENCE| NYKESHA SCALES, MBA| AUGUST 24, 2017

CGS
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# WHAT'S NEW FOR HOME HEALTH & HOSPICE PROVIDERS

Updates

# Provider Enrollment Revalidation – Cycle 2

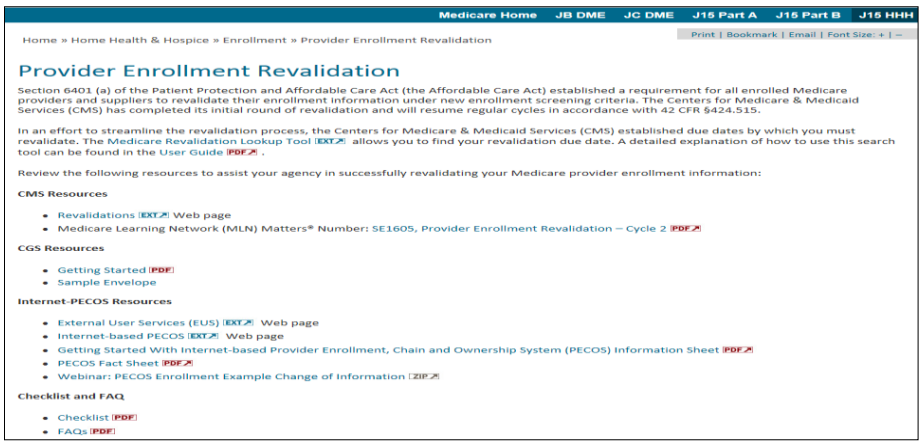
Revised, SE1605, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

- Resumes regular revalidation cycles
- Implements several revalidation improvements
- Does not change other aspects of enrollment process
- Provides web link to check for revalidation due date & further instructions, https://data.cms.gov/revalidation




# Provider Enrollment Revalidation Web Page

https://www.cgsmedicare.com/hhh/enrollment/revalidation.html



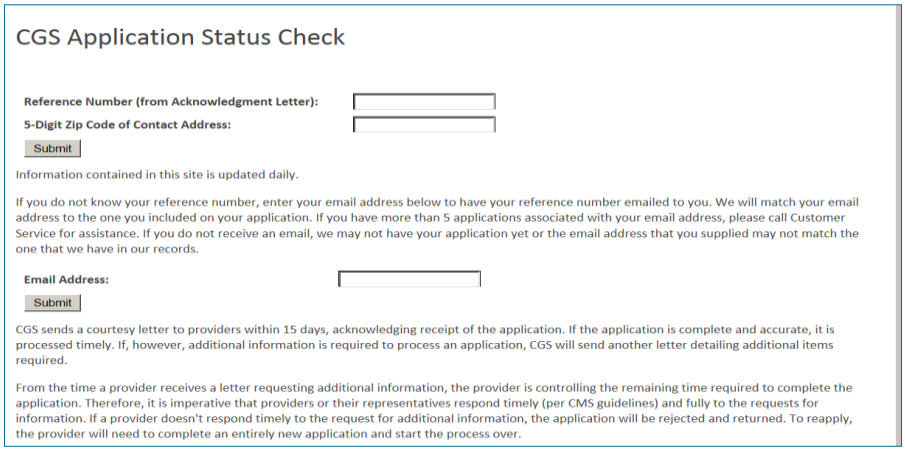
# Provider Enrollment/Revalidation Reminders & Tips

- Upcoming CMS National Provider Enrollment Conference (September 6/7, 2017), https://www.palmgba.com/events/NPEC2017/
- Only submit revalidation when due date is displayed
- When submitting revalidation via PECOS Web, ensure reason selected in PECOS is 'Revalidation'
  - If 'Change of Information' is selected instead, could face payment withholds




# 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.

## TAKE ACTION NOW: FISS/DDE USER ID ANNUAL RECERTIFICATION

Each year, Medicare providers are required to recertify their Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) user access.

- Recertification period now open for home health & hospice providers
- **Failure to recertify will result in termination of FISS DDE/PPTN services**

**What You Need to Do**

- Complete Annual DDE PPTN Recertification Form as soon as possible
- Verify all User IDs, indicate if the User ID is active or inactive, and include an authorized signature, contact email, and phone number
- FAX the Annual DDE PPTN Recertification Form as soon as possible to CGS at: **1.615.664.5947**

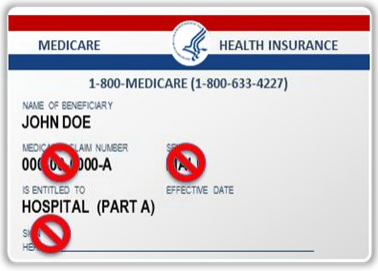
Questions concerning recertification process, contact EDI: **1.877.299.4500, Option 2**

**Hospice Providers**: Please be aware that failure to recertify your FISS DDE access will result in the termination of your DDE User ID. This may cause untimely filing of your hospice Notices of Election (NOEs) and an exception may not be granted.




## NEW MEDICARE CARDS

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires removal of Social Security Numbers (SSNs) from all Medicare cards by April 2019
- Medicare Beneficiary Identifier (MBI) will replace SSN-based Health Insurance Claim Number (HICN) on new Medicare cards for Medicare transactions like billing, eligibility status, and claim status
- Known before as Social Security Number Removal Initiative (SSNRI)




https://www.cms.gov/Medicare/New-Medicare-Card/index.html

# HICN vs MBI

**Health Insurance Claim Number (HICN)**

- Primary Beneficiary Account Holder Social Security Number (SSN) plus Beneficiary Identification Code (BIC)
- 9-byte SSN plus 1 or 2-byte BIC
- Key positions 1-9 are numeric

**Medicare Beneficiary Identifier (MBI)**

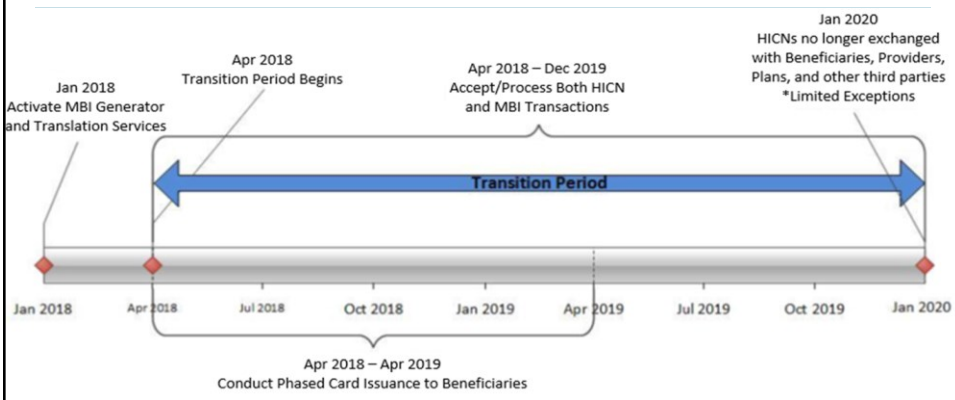
- New Non-Intelligent Unique Identifier
- 11 bytes
- Key positions 2, 5, 8, and 9 will always be alphabetic

| Key | Example |
|---|---|
| SSA HICN | 123-45-6789-A1 |
| MBI | 1EG4-TE5-MK73 |

Note: Identifiers are fictitious and dashes for display purposes only; they are not stored in the database nor used in file formats




# MBI Generation and Transition Period



## How to be Prepared

- Subscribe to the weekly MLN Connects newsletter for updates and new information, https://public.govdelivery.com/accounts/USCMS/subscriber/new
- Attend training events
- Verify your patients' addresses:
  - If address you have on file is different than address you get in electronic eligibility transaction responses, ask your patients to contact Social Security and update their Medicare records
- Inform patients new cards will be issued in 2018
- Get ready to use the new MBI Format:
  - Ask your billing and office staff if your system can accept the 11 digit alpha numeric MBI
  - If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change

For updates: https://www.cms.gov/Medicare/SSNRI/Providers/Providers.html and/or https://www.cms.gov/Medicare/SSNRI/Index.html




# Recent Change Requests & Process Changes

Home Health

## REASON CODE 37253: REQUESTING AN APPEAL FOR NO MATCHING OASIS FOUND

Change Request (CR) 9585 instructed MACs to automate the denial of home health claims when the requirement for submission of the Outcome and Assessment Information Set (OASIS) assessment has not been met.

The OASIS, which is a condition of payment, is to be transmitted to the Quality Improvement Evaluation System (QIES) within 30 days of completion. If the OASIS assessment is not found in the QIES upon receipt of a final claim, **and** is past due, Medicare will deny the claim with reason code 37253.

- Providers do have right to appeal denial
- Request for redetermination may be submitted by completing CGS Medicare HHH Jurisdiction 15 Redetermination Request Form or via myCGS, the secure web portal
- **Redetermination request must include verification of timely submission of the OASIS**
  - Can either be verification through QIES or other forms of documentation showing timely OASIS submission
  - Note that it is not necessary to submit the full medical record when appealing the denial for reason code 37253

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




## CMS PROPOSES 2018 & 2019 PAYMENT CHANGES

**Comments due by September 25, 2017**

On July 25, CMS issued proposed rule that would update payment rates and wage index for Home Health Agencies (HHAs) in 2018 and proposes redesign of payment system in 2019.

Under proposed rule, home health payment update percentage for HHAs that submit the required quality data for the Home Health Quality Reporting Program would be 1 percent in 2018.

The proposed rule also includes:

- Proposals to refine the HH PPS case-mix adjustment methodology, including a change in the unit of payment from 60-day episodes of care to 30-day periods of care, to be implemented for periods of care beginning on or after January 1, 2019
- Proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program
- A Request for Information to welcome continued feedback on the Medicare program.

https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf

# 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




# SE1635: CONTINUATION OF THE HOME HEALTH PROBE AND EDUCATE MEDICAL REVIEW STRATEGY

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

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

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

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

**Continuation of the Home Health Probe and Educate Medical Review Strategy**

**Provider Types Affected**

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

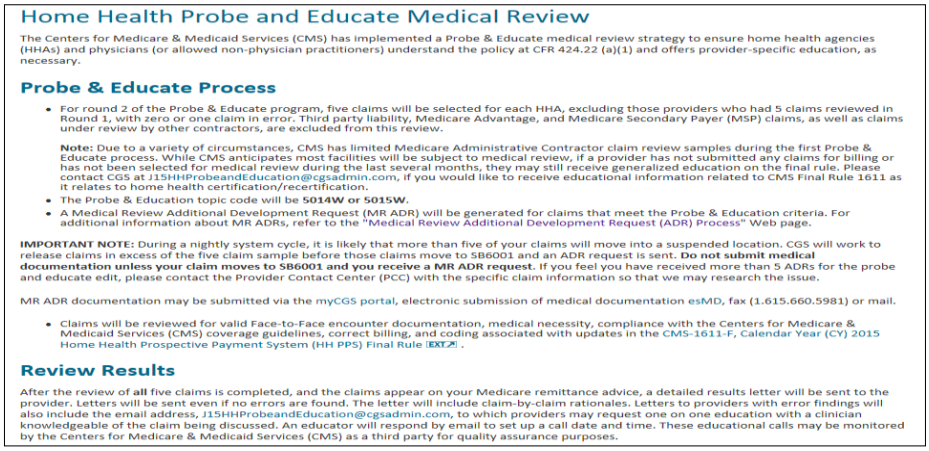
**Provider Action Needed**

**STOP – Impact to You**

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

# HH PROBE & EDUCATE – ROUND 2

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



## Home Health Probe and Educate Medical Review

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

### Probe & Educate Process

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

  **Note:** Due to a variety of circumstances, CMS has limited Medicare Administrative Contractor claim review samples during the first Probe & Educate process. While CMS anticipates most facilities will be subject to medical review, if a provider has not submitted any claims for billing or has not been selected for medical review during the last several months, they may still receive generalized education on the final rule. Please contact CGS at J15HHProbeandEducation@cgsadmin.com, if you would like to receive educational information related to CMS Final Rule 1611 as it relates to home health certification/recertification.
- The Probe & Education topic code will be **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 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 **all** five claims is completed, and the claims appear on your Medicare remittance advice, a detailed results letter will be sent to the provider. Letters will be sent even if no errors are found. The letter will include claim-by-claim rationales. Letters to providers with error findings will also include the email address, J15HHProbeandEducation@cgsadmin.com, to which providers may request one on one education with a clinician knowledgeable of the claim being discussed. An educator will respond by email to set up a call date and time. These educational calls may be monitored by the Centers for Medicare & Medicaid Services (CMS) as a third party for quality assurance purposes.




# 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

# Recent Change Requests & Process Changes

Hospice

## SE17014: Required Workaround for Hospices Submitting Routine Home Care (RHC) & Service Intensity Add-On (SIA) Payments at the End of Life

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17014.pdf

Special Edition (SE) article 17014 corrects two errors with regard to hospice payments by Medicare that could result in overpayments.

Also provides hospices with a workaround to deploy when submitting certain claims to ensure proper payment.

- Implementation Date: August 21, 2017
- Effective Date: August 21, 2017

## FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

Hospices to Get 1% Medicare Increase in FY2018

Cap amount for FY 2018 =$28,689.04

(2017 cap amount of $28,404.99 increased by 1 percent)

Finalizes 8 measures from CAHPS Hospice Survey data already submitted by hospices

Finalizes extension or exception for quality reporting purposes from 30 calendar days to 90 calendar days after date that an extraordinary circumstance occurred

CMS will begin public reporting hospice quality reporting program (HQRP) data via Hospice Compare Site in August 2017 to help consumers make informed choices

Discusses future considerations regarding Hospice Evaluation & Assessment Reporting Tool (HEART)

Regulations effective October 1, 2017

https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16294.pdf

Change Request 10131: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3828CP.pdf




## CR 10064: Accepting Hospice Notices of Election via Electronic Data Interchange (EDI)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3813CP.pdf

Medicare contractors and hospices may develop trading partner agreements to exchange NOE and related transaction data using a non-standard implementation of the 837I transaction.

Medicare will develop a companion guide for NOE transmissions. This guide will provide hospices instructions for how to complete data elements that are required by the 837I transaction but are not required by an NOE.

Hospices may voluntarily agree to adopt the companion guide and submit non-standard 837I transactions.

- Implementation Date: January 1, 2018
  - Transactions received on/after January 1, 2018
- Effective Date: January 2, 2018

## Future Changes

Future changes communicated by CMS via Change Requests (CRs)

- Providers can monitor CMS Hospice Center Web page, https://www.cms.gov/Center/Provider-Type/Hospice-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

myCGS Portal
Appeals
Claims
Customer Service
EDI
Education & Resources
Enrollment
Financial/Audit & Reimbursement
Forms
LCDs/Coverage
Medical Review
- Comprehensive Error Rate Testing (CERT) Program
- Electronic Submission of Medical Documentation
- Home Health Probe and Educate Medical Review
- Medical Review Additional Development Request (ADR)
- Overview of Medical Review
- Paperwork (PWK) Segment for X12N Version 5010
- Pre-Claim Review Demonstration for Home Health Services
- Recovery Audit Program
- Reopenings
- Signature Guidelines
- Supplemental Medical Review Contractor (SMRC)
- Therapy Cap
- Zone Program Integrity Contractor (ZPIC)

Home » Home Health & Hospice » Medical Review » Medical Review Information

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## Medical Review

The Medical Review department performs a variety of activities in an effort to prevent improper payments in the Medicare Fee-For-Service (FFS) program. Refer to the following for additional information.

- Overview of Medical Review (prepayment and postpayment reviews, widespread edits)
- Pre-Claim Review Demonstration for Home Health Services
- Medical Review Additional Development Request (ADR) Process
- Denial Reason Codes
  - Home Health Top Medical Review Denial Reasons
  - Hospice Top Medical Review Denial Reasons

**Additional Resources:**

- Medicare Learning Network® "Medicare Claim Review Programs" booklet PDF
- Comprehensive Error Rate Testing (CERT) Program
- Electronic Submission of Medical Documentation (esMD)
- Home Health Probe and Educate Medical Review
- Paperwork (PWK) Segment for X12N Version 5010
- Recovery Audit Program.
- Reopenings
- Signature Guidelines
- Supplemental Medical Review Contractor (SMRC)
- Therapy Cap Process
- Zone Program Integrity Contractor (ZPIC)

***Updated: 07.25.16***

CERT, esMD, Probe & Educate, Medical Review ADR Process, PCR and more….

# 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

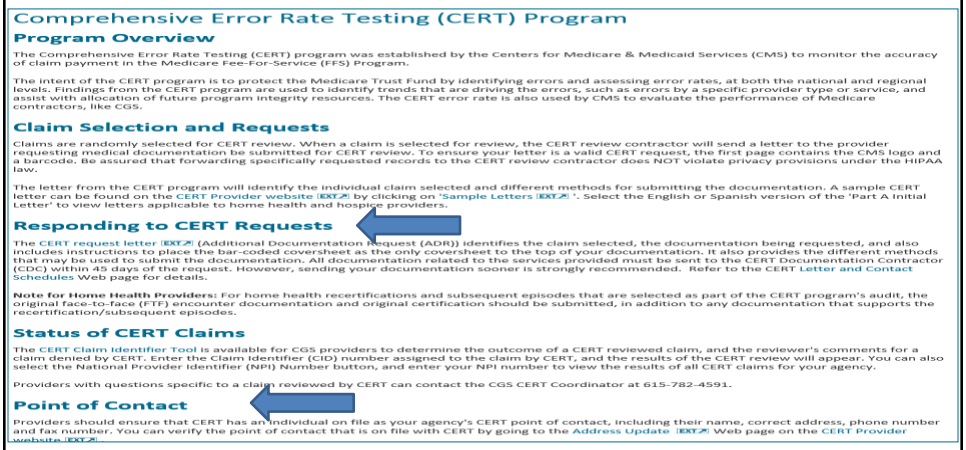
Dedicated CERT page with information such as:

- 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 CERT review contractor will send a letter to the provider requesting medical documentation be submitted for CERT review. To ensure your letter is a valid CERT request, the first page contains the CMS logo and a barcode. Be assured that forwarding specifically requested records to the CERT review contractor does NOT violate privacy provisions under the HIPAA law.

The letter from the CERT program will identify the individual claim selected and different methods for submitting the documentation. A sample CERT letter can be found on the CERT Provider website by clicking on 'Sample Letters'. Select the English or Spanish version of the 'Part A Initial Letter' to view letters applicable to home health and hospice providers.

**Responding to CERT Requests**

The CERT request letter (Additional Documentation Request (ADR)) identifies the claim selected, the documentation being requested, and also includes instructions to place the bar-coded coversheet as the only coversheet to the top of your documentation. It also provides the different methods that may be used to submit the documentation. All documentation related to the services provided must be sent to the CERT Documentation Contractor (CDC) within 45 days of the request. However, sending your documentation sooner is strongly recommended. Refer to the CERT Letter and Contact Schedules Web page for details.

**Note for Home Health Providers:** For home health recertifications and subsequent episodes that are selected as part of the 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.

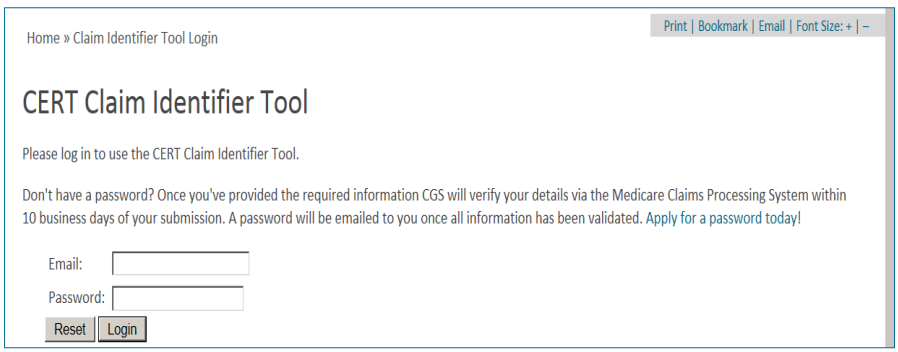
**Point of Contact**

Providers should ensure that CERT has an individual on file as your agency's CERT point of contact, including their name, correct address, phone number and fax number. You can verify the point of contact that is on file with CERT by going to the Address Update Web page on the CERT Provider website.




# CERT CLAIM IDENTIFIER TOOL

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



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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:

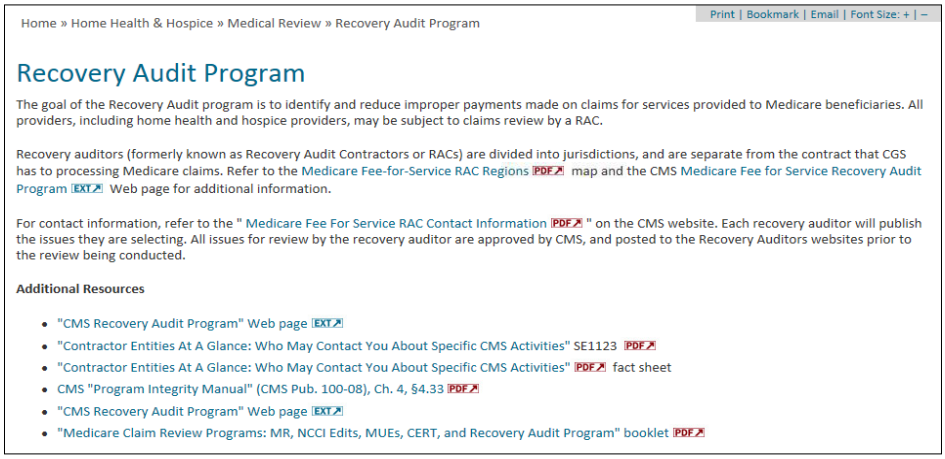
Password:

Reset Login

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

# Recovery Audit (RA) Contractor

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



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

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## Recovery Audit Program

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

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

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

**Additional Resources**

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

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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




## Home Health: Top Billing Errors (September 2016– July 2017)

| Overview of HH Claim Submissions and CSEs | |
|---|---|
| # of HH "Claims" Submitted | 2,459,910 |
| # of HH CSEs | 346,418 |
| Percent of billing errors | 14.08% |

# PA Top 5 HH Billing Errors

| September 1, 2016 – July 31, 2017 | | |
|---|---|---|
| **Reason Code** | **Billing Error** | **# of Errors** |
| 38157, 38200 | Duplicate RAP/claim – same beneficiary/same dates of service/same billing provider | 50,797 |
| 38107 | FISS can't find matching RAP | 18,017 |
| U538I | Overlap another HHA's episode | 4,118 |
| 31018 | Less than 60 days billed on home health claim and patient status code billed equals "30" | 2,033 |
| U538F | Overlap episode; CWF discrepancy | 1,332 |




# 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

## 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

# 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:** 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

# HOSPICE: TOP BILLING ERRORS (SEPTEMBER 2016– JULY 2017)

| Overview of Hospice Claim Submissions and CSEs | |
|---|---|
| # of Hospice "Claims" Submitted | 907,403 |
| # of Hospice CSEs | 183,614 |
| Percent of billing errors | 20.24% |




# PA TOP 5 HOSPICE BILLING ERRORS

| September 1, 2016 – July 31, 2017 | | |
|---|---|---|
| **Reason Code** | **Billing Error** | **# of Errors** |
| 37402 | Sequential billing – no prior processed claim | 6,329 |
| 38200 | Duplicate claim | 2,442 |
| U5194 | Hospice claim rec'd for untimely NOE & OSC 77 is missing or invalid | 2,006 |
| 34952 | SVC facility NPI not included | 1,887 |
| U5106 | Notice of election (NOE) falls within current hospice election | 1,691 |

## 37402 – Sequential Billing

Prior claim must be submitted **and** processed

- Processed means paid (P), denied (D) or rejected (R)
- Claims in RTP (T B9997) do not meet sequential billing requirements

Cannot be gap in dates between prior month's claim and next month's claim

- Ex: 10/1/16-10/31/16 and 11/2/16-11/30/16
- Edit will RTP claims with RC 31287 if patient status code = 30 (still a patient) and TO date is not last day of month




## Sequential Billing Rules

Rule #1: NOE must be processed (P B9997) before initial hospice claim can be submitted

Rule #2: Hospice claims must be submitted *monthly*

- One claim per beneficiary, per month
- Must conform to calendar month

# Sequential Billing Rules

Rule #3: Claims must be submitted *sequentially*

- Prior claim must be processed
  - Paid (P)
  - Rejected (R)
  - Denied (D)
- Prior claim that is suspended (S) doesn't ensure sequential billing requirements met
  - If prior claim suspended due to medical review additional development request (ADR), do not hold subsequent claims

Rule #4: Claims must be submitted *consecutively*

- No skip in dates between prior and subsequent claim




# U5194 – Hospice Claim Received for Untimely NOE & OSC 77 is Missing or Invalid

In addition to the usual hospice claim information, a claim reporting an untimely NOE should include the following on FISS Page 01 and FISS Page 02:

| FISS Page | Field Name | Description |
|---|---|---|
| 01 | SPAN CODES/ DATES | Enter '77' along with the dates of the noncovered days (date of admission to day before NOE received) (ex. 77 MMDDYY MMDDYY) Note: If the claim does not include OSC 77 and/or the dates reported with OSC 77 are incorrect, the claim will be returned to the provider (RTPd). |
| 02 | REV | Enter the level of care revenue code for the noncovered days |
| 02 | HCPCS | Enter the appropriate HCPCS (Q50XX) for the place of service |
| 02 | MODIFS | Enter a 'KX' **only if** you are Requesting an Exception for the untimely NOE. |
| 02 | TOT UNIT | Enter the total units that were noncovered |
| 02 | COV UNIT | Leave this field blank |
| 02 | TOT CHARGE | Enter the total charge for the noncovered days |
| 02 | NCOV CHARGE | Enter the total charge for the noncovered days |
| 02 | SERV DATE | Enter the hospice admission date (this will match the "TO" date of the claim) |

## U5194 – Hospice claim received for untimely NOE & OSC 77 is missing or invalid

If NOE is not timely, provider must use OSC 77 on claim even if not filing an exception

Refer to "Submitting Claims for Untimely Notices of Election (NOEs)" Web page, http://cgsmedicare.com/hhh/education/materials/submitting_claims_untimely_noes.html

**Billing Hints:**

- Ensure total level of care days reported (noncovered days + covered days) equals time period reported on the claim
- Ensure total units (TOT UNIT) for noncovered days equals number of days reflected by dates reported with OSC 77




## Top CSEs (Reason Codes) & How to Resolve

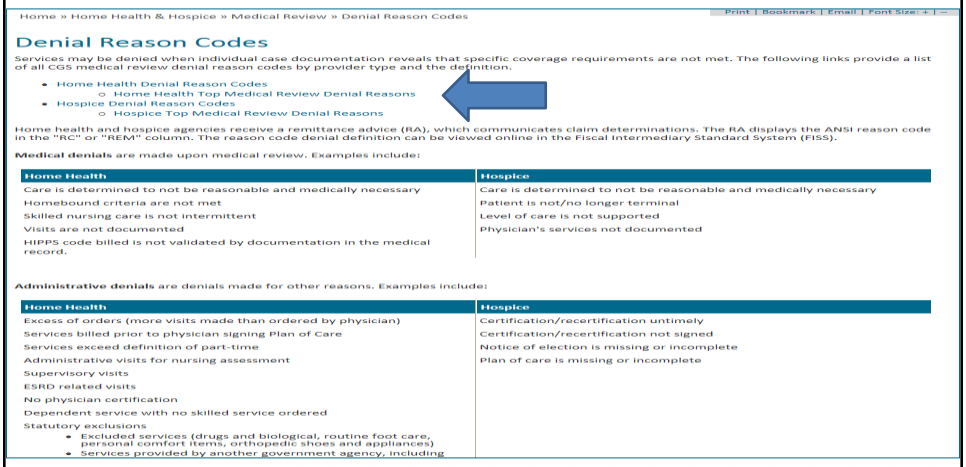
https://www.cgsmedicare.com/hhh/education/materials/cses.html

July 2017

| Home Health Top RTP Reason Codes | Short Narrative | Monthly Total |
|---|---|---|
| 38107 | FISS can't match claim billed to processed RAP | 7,103 |
| U538I | Overlapping episode of another HHA | 1,765 |
| 31018 | Episode "TO" date not 60 days greater than "FROM" date | 855 |
| 31755 | HIPSS date/date of service mismatch | 488 |
| U538F | Overlapping episode; CWF discrepancy | 500 |
| 31790 | HCPCS Q5001, Q5002, OR Q5009 are required but not present | 377 |
| **Home Health Top Rejected Reason Codes** | **Short Narrative** | **Monthly Total** |
| 38157 | Duplicate RAP | 6,584 |
| 37253 | HH claim through date on/after 4/1/17 denied – no OASIS assessment found | 1,804 |
| 38200 | Duplicate claim | 1,270 |
| U5211 | Services billed on claim provided after patient's date of death | 362 |
| **Hospice Top RTP Reason Codes** | **Short Narrative** | **Monthly Total** |
| 37402 | Hospice sequential billing error | 2,398 |
| 34952 | Service facility NPI not included | 821 |
| U5194 | Hospice claim received for untimely NOE & occurrence span code 77 is missing or invalid | 839 |
| U5106 | NOE falls within current hospice election | 676 |
| U5181 | Occurrence code 27 required when certification date falls within dates of service | 582 |

# MEDICAL REVIEW DENIAL REASON CODES

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



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

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

## Denial Reason Codes

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

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

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

**Medical denials** are made upon medical review. Examples include:

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

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

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

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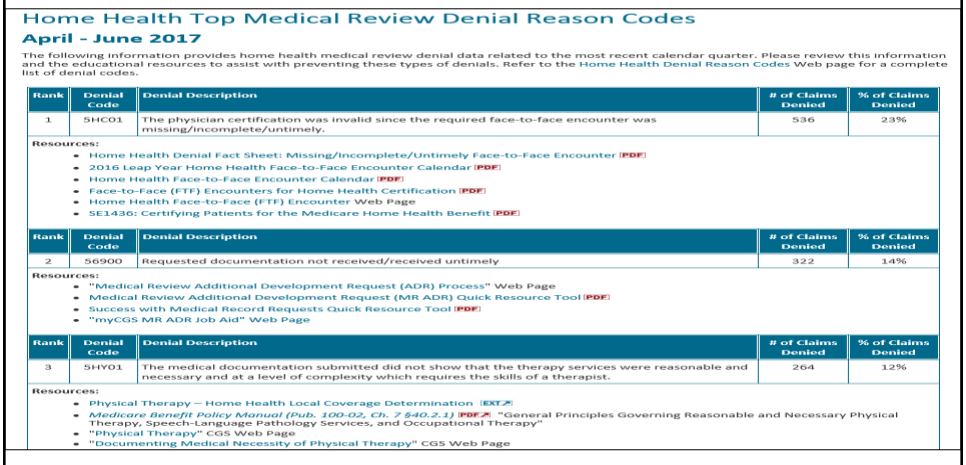
# HH MEDICAL REVIEW TOP DENIAL CODES

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



## Home Health Top Medical Review Denial Reason Codes

### April - June 2017

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 | 5HC01 | The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely. | 536 | 23% |

Resources:
- Home Health Denial Fact Sheet: Missing/Incomplete/Untimely Face-to-Face Encounter [PDF]
- 2016 Leap Year Home Health Face-to-Face Encounter Calendar [PDF]
- Home Health Face-to-Face Encounter Calendar [PDF]
- Face-to-Face (FTF) Encounters for Home Health Certification [PDF]
- Home Health Face-to-Face (FTF) Encounter Web Page
- SE1436: Certifying Patients for the Medicare Home Health Benefit [PDF]

| Rank | Denial Code | Denial Description | # of Claims Denied | % of Claims Denied |
|---|---|---|---|---|
| 2 | 56900 | Requested documentation not received/received untimely | 322 | 14% |

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. | 264 | 12% |

Resources:
- Physical Therapy – Home Health Local Coverage Determination [EXT]
- *Medicare Benefit Policy Manual (Pub. 100-02, Ch. 7 §40.2.1)* [PDF] "General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy"
- "Physical Therapy" CGS Web Page
- "Documenting Medical Necessity of Physical Therapy" CGS Web Page

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# Hospice Medical Review Top Denial Codes

https://www.cgsmedicare.com/hhh/medreview/hos_denial_reasons.html

## Hospice Top Medical Review Denial Reason Codes

**April – June 2017**

The following information provides hospice 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 Hospice Denial Reason Codes Web page for a complete list of denial codes.

| Rank | Denial Code | Denial Description | # of Claims Denied | % of Claims Denied |
|---|---|---|---|---|
| 1 | 5PM01 | According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less. | 250 | 63% |

**Resources:**

- Hospice Denial Fact Sheet: Six-Month Terminal Prognosis Not Supported [PDF] Quick Resource Tool
- Hospice Local Coverage Determination (LCD), "Determining Terminal Status" [EXT]
- Suggestions for Improved Documentation to Support Medicare Hospice Services [PDF] Quick Resource Tool
- Appropriate Clinical Factors to Consider During recertification of Medicare Hospice Patients [PDF] Quick Resource Tool

| Rank | Denial Code | Denial Description | # of Claims Denied | % of Claims Denied |
|---|---|---|---|---|
| 2 | 56900 | Requested documentation not received/received timely | 34 | 8% |

**Resources:**

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

| Rank | Denial Code | Denial Description | # of Claims Denied | % of Claims Denied |
|---|---|---|---|---|
| 3 | 5PC09 | The hospice plan of care does not meet the requirements set forth in the code of federal regulations. | 29 | 7% |

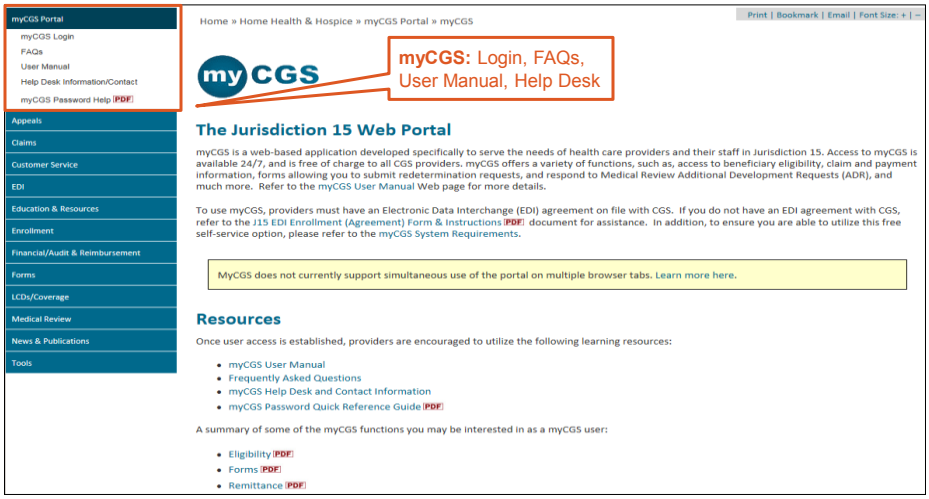
- Code of Federal Regulations, Title 42, Part 418 [EXT]
- Medicare Benefit Policy Manual (Pub. 100-02), Ch. 9 §40 [PDF]
- CGS Hospice Plan of Care Web page
- Hospice Denial Fact Sheet Denial Reason 5PC09: Plan of Care [PDF]




# Medicare Billing 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 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
- Respond to Medical Review (MR) Additional Development Requests (ADRs)
- Send General Inquires
- 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




## 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)

# CGS HH&H Web Page

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

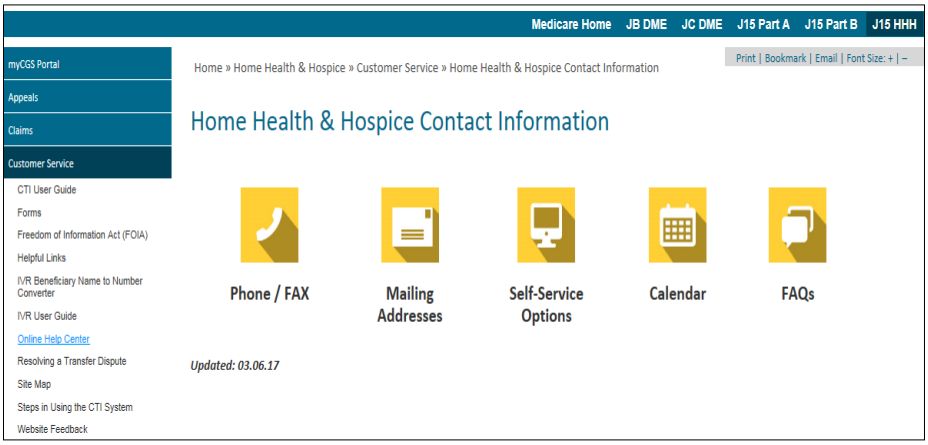




# CGS HH&H Web Page

# UPDATED: HH&H CUSTOMER SERVICE WEB PAGE

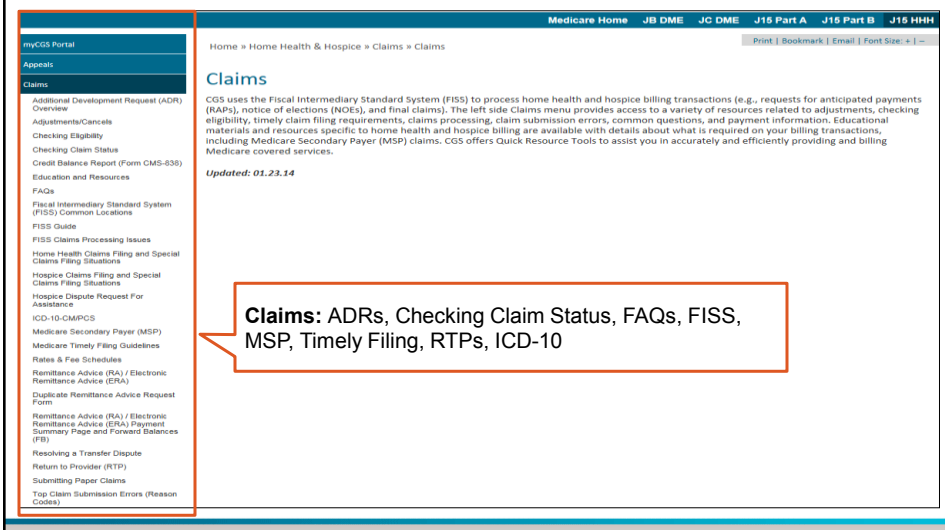
http://www.cgsmedicare.com/hhh/cs/index.html



# CGS 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

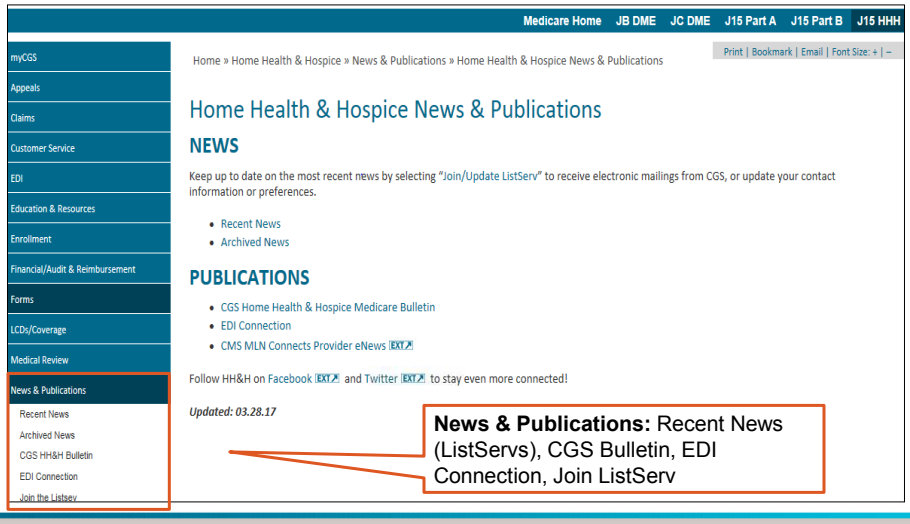



# UPDATED: CGS HH&H WEBSITE: EDUCATION & RESOURCES

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 ListServ
  - 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**