Be Prepared: Medicare Review Contractors At A Glance

South Dakota Association of Healthcare Organizations (SDAHO)
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September 22, 2017

Medicare Claim Review Programs

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

Background

- Federal government estimates about 12.1% of all Medicare Fee-For-Service (FFS) claim payments are improper
- The Centers for Medicare & Medicaid Services (CMS) began several initiatives to prevent or identify improper payments before CMS processes a claim, and to identify and recover improper payments after paying a claim
- Overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types

Key Terms

Key Terms

- **Prepayment Review:** Review of claims prior to payment. Prepayment reviews result in an initial determination.
- **Postpayment Review:** Review of claims after payment. Postpayment reviews may result in either no change to the initial determination or a revised determination, indicating an underpayment or overpayment.
- **Underpayment:** A payment a provider receives under the amount due for services furnished under Medicare statute and regulations.
- **Overpayment:** A payment a provider receives over the amount due for services furnished under Medicare statutes and regulations. Common reasons for overpayment are:
  - Billing for excessive or non-covered services
  - Duplicate submission and subsequent payment of the same service or claim
  - Payment for excluded or medically unnecessary services
  - Payment for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition
  - Payment to an incorrect payee

Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1123.pdf

MLN Matters® Number: SE1123 | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: N/A**

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

Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities

Note: This article was updated on April 17, 2014, to show that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC). All other information remains unchanged.

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting

Medicare Contractor Responsibilities

Type of Contractor	Responsibilities
Medicare Administrative Contractors (MACs)	Process claims from physicians, hospitals, and other health care professionals, and submit payment to those providers according to Medicare rules and regulations (includes identifying and correcting underpayments and overpayments)
Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)*	Perform investigations that are unique and tailored to specific circumstances and occur only in situations where there is potential fraud, and take appropriate corrective actions
Supplemental Medical Review Contractor (SMRC)	Conduct nationwide medical review as directed by CMS (includes identifying underpayments and overpayments)
Comprehensive Error Rate Testing (CERT) Contractors	Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment rate
Medicare FFS Recovery Auditors	Review claims to identify potential underpayments and overpayments in Medicare FFS, as part of the Recovery Audit Program

* All PSCs transitioned to ZPICs with the exception of Zone 6. For more information, refer to The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs).

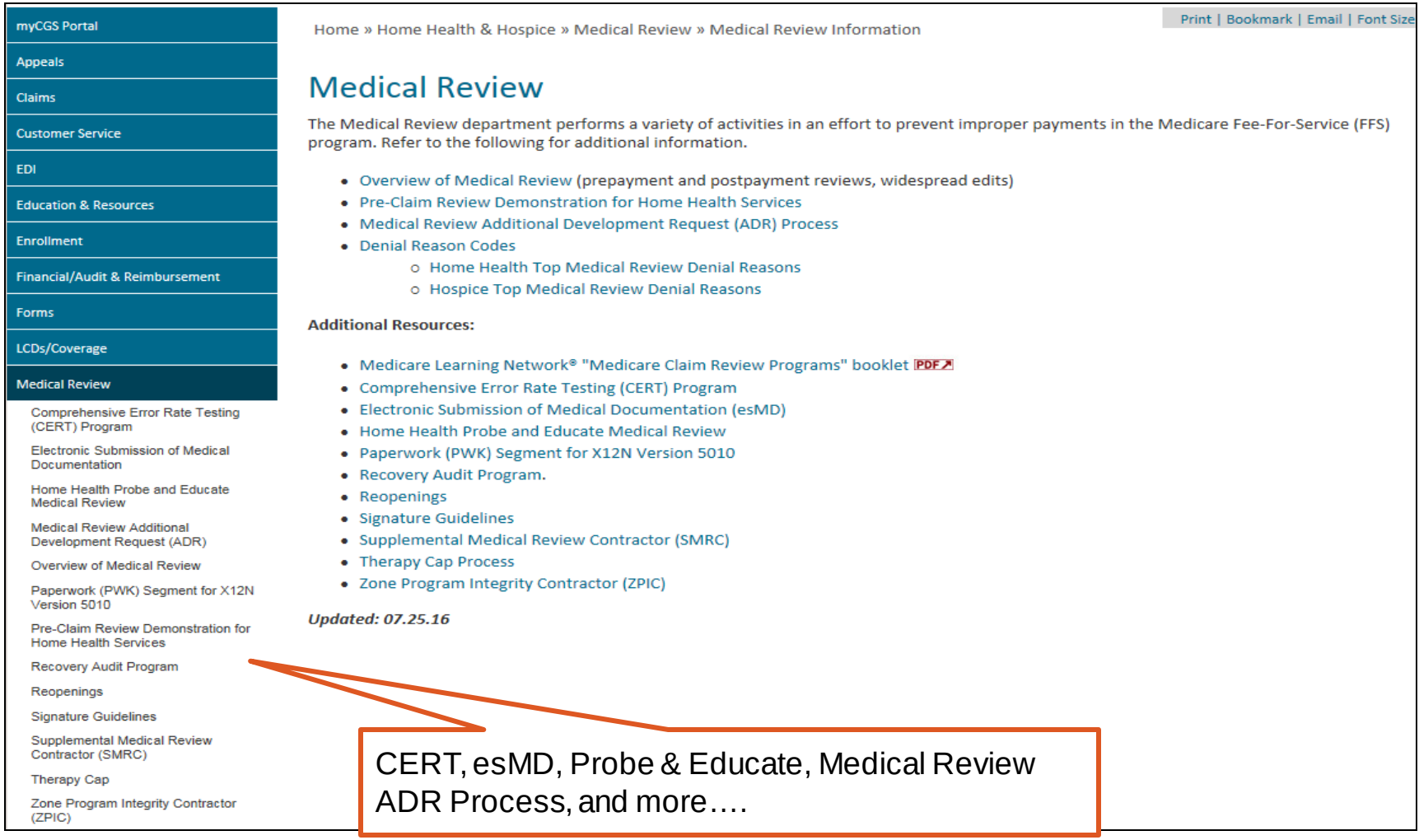
Medicare Administrative Contractors (MACs)

MACs may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

CGS Medical Review Web Page

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



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

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:

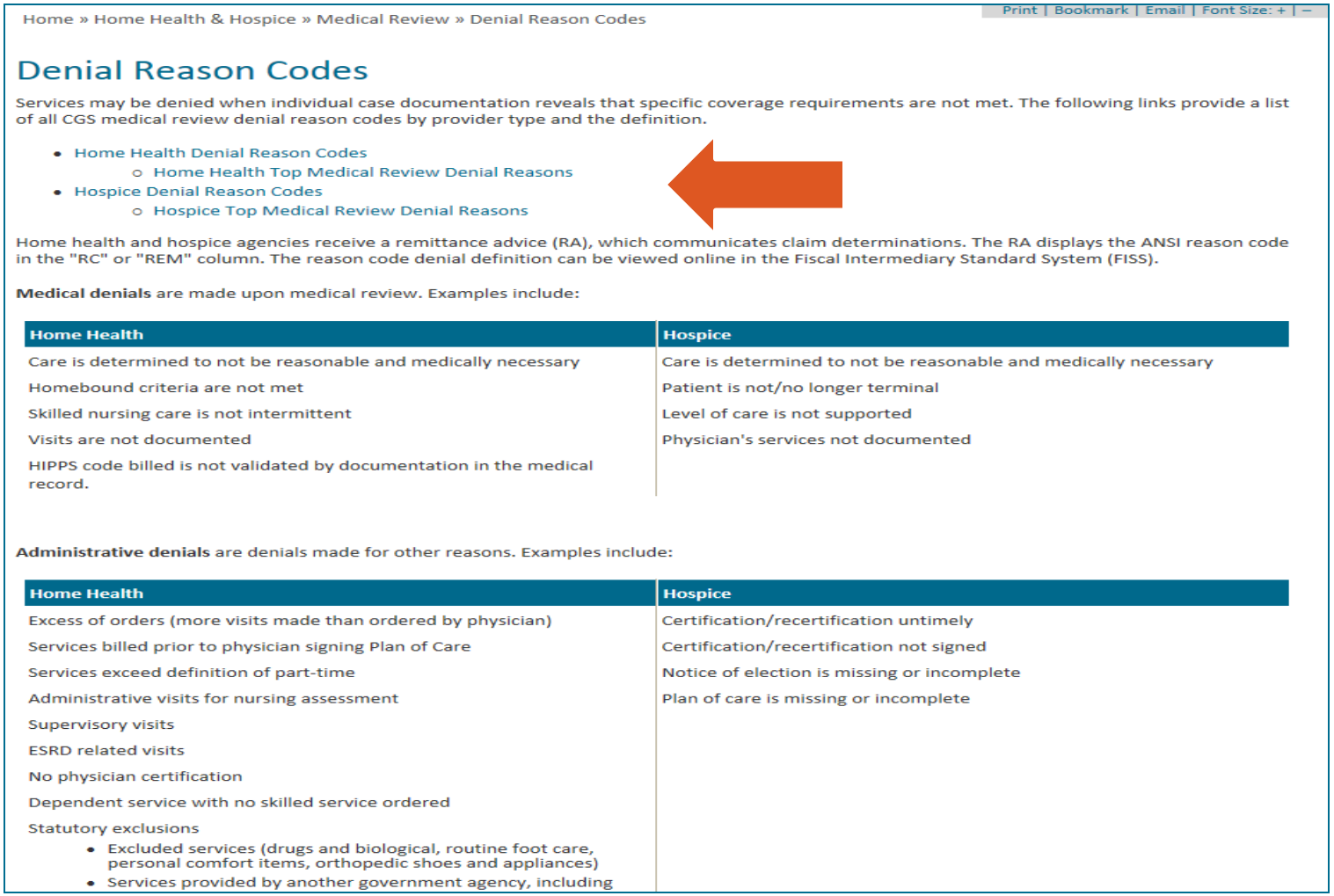
- Recovery Auditors (RAs)
- Zone Program Integrity Contractors (ZPICs)
- Supplemental Medical Review Contractor (SMRC)
- Comprehensive Error Rate Testing (CERT) Contractor

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

Medical Review Denial Reason Codes

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



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

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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:

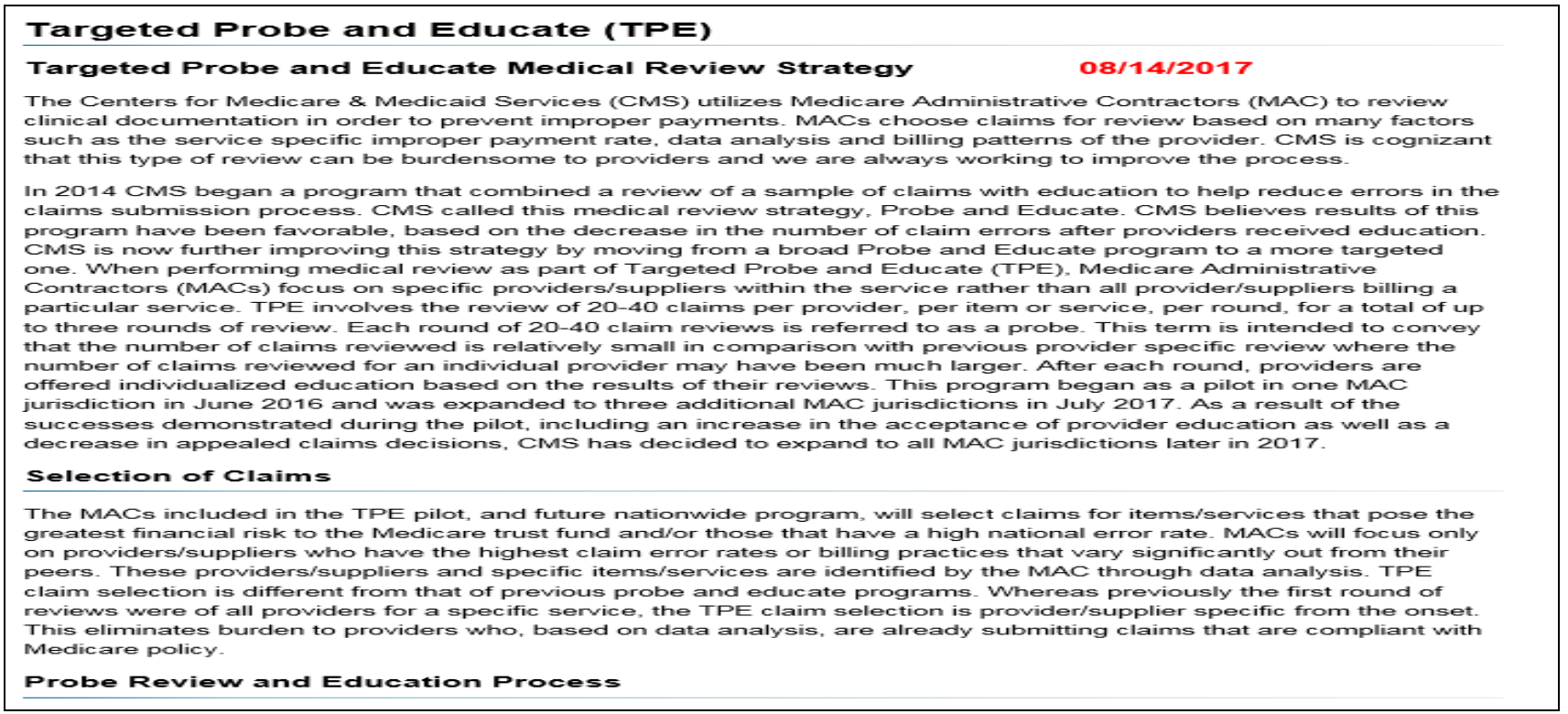
Home Health	Hospice
Excess of orders (more visits made than ordered by physician)	Certification/recertification untimely
Services billed prior to physician signing Plan of Care	Certification/recertification not signed
Services exceed definition of part-time	Notice of election is missing or incomplete
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 • Excluded services (drugs and biological, routine foot care, personal comfort items, orthopedic shoes and appliances) • Services provided by another government agency, including	

Top HH Medical Review Denial Reasons

Denial Code	Denial Description
5HC01	Physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely
56900	Requested documentation not received/received untimely
5HY01	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
5HN18	Skilled nursing services were not medically necessary
5HC08	Recertification estimate of how much longer skilled services are required is missing/incomplete/invalid.
Signature Concerns	

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

Targeted Probe and Educate (TPE)



Targeted Probe and Educate (TPE)

Targeted Probe and Educate Medical Review Strategy 08/14/2017

The Centers for Medicare & Medicaid Services (CMS) utilizes Medicare Administrative Contractors (MAC) to review clinical documentation in order to prevent improper payments. MACs choose claims for review based on many factors such as the service specific improper payment rate, data analysis and billing patterns of the provider. CMS is cognizant that this type of review can be burdensome to providers and we are always working to improve the process.

In 2014 CMS began a program that combined a review of a sample of claims with education to help reduce errors in the claims submission process. CMS called this medical review strategy, Probe and Educate. CMS believes results of this program have been favorable, based on the decrease in the number of claim errors after providers received education. CMS is now further improving this strategy by moving from a broad Probe and Educate program to a more targeted one. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers within the service rather than all provider/suppliers billing a particular service. TPE involves the review of 20-40 claims per provider, per item or service, per round, for a total of up to three rounds of review. Each round of 20-40 claim reviews is referred to as a probe. This term is intended to convey that the number of claims reviewed is relatively small in comparison with previous provider specific review where the number of claims reviewed for an individual provider may have been much larger. After each round, providers are offered individualized education based on the results of their reviews. This program began as a pilot in one MAC jurisdiction in June 2016 and was expanded to three additional MAC jurisdictions in July 2017. As a result of the successes demonstrated during the pilot, including an increase in the acceptance of provider education as well as a decrease in appealed claims decisions, CMS has decided to expand to all MAC jurisdictions later in 2017.

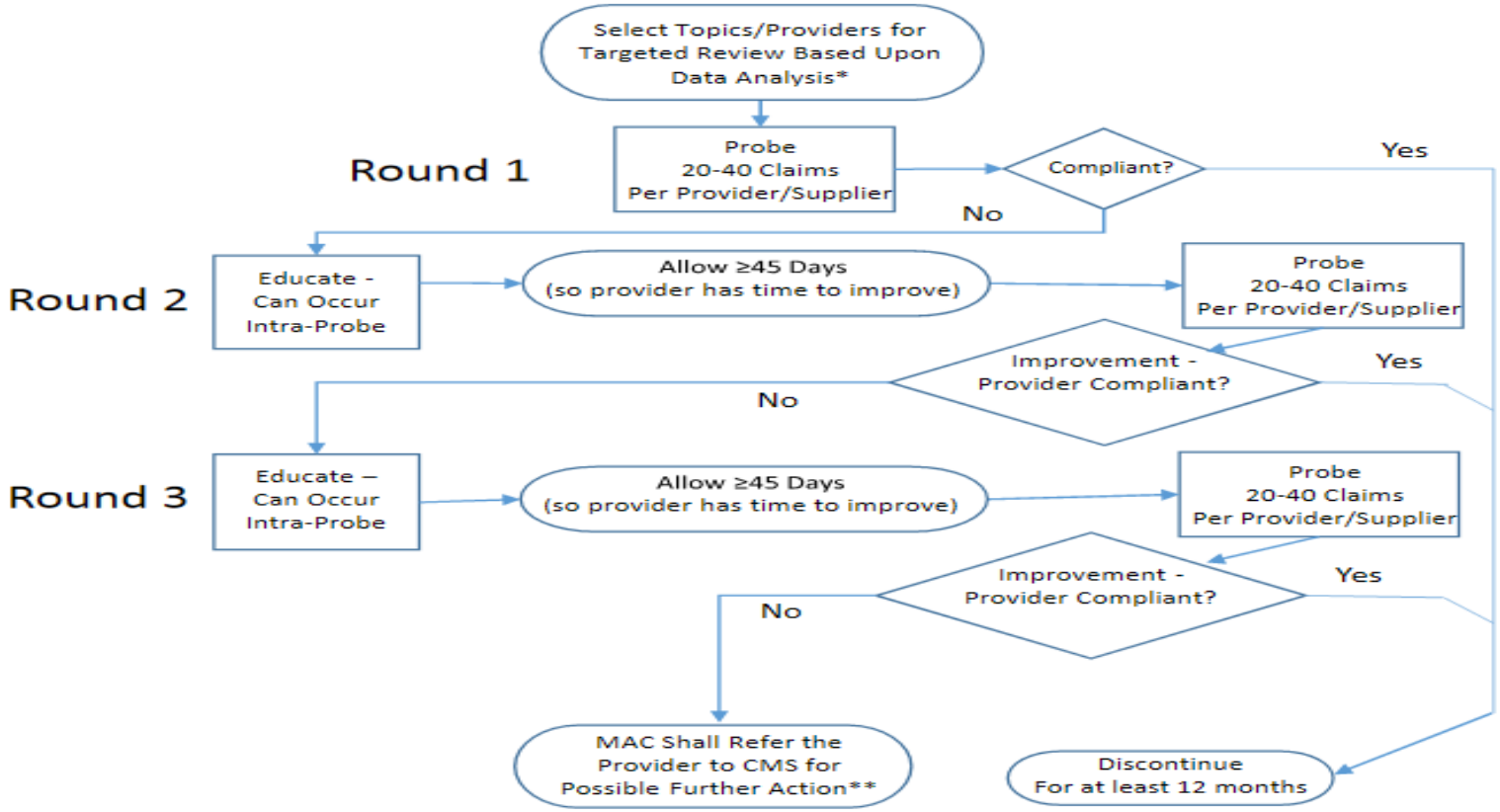
Selection of Claims

The MACs included in the TPE pilot, and future nationwide program, will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate. MACs will focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers. These providers/suppliers and specific items/services are identified by the MAC through data analysis. TPE claim selection is different from that of previous probe and educate programs. Whereas previously the first round of reviews were of all providers for a specific service, the TPE claim selection is provider/supplier specific from the onset. This eliminates burden to providers who, based on data analysis, are already submitting claims that are compliant with Medicare policy.

Probe Review and Education Process

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

Targeted Probe & Educate



*Data Analysis definition per PUB 100-08, §2.2
**Further Action May Include Extrapolation, Referral To ZPIC/UPIC, etc.

Top Hospice Medical Review Denial Reasons

Denial Code	Denial Description
5PM01	Information provided does not support a terminal prognosis of six months or less
56900	Requested documentation not received/received untimely
5PC09	Hospice plan of care does not meet the requirements set forth in the code of federal regulations
5PX06	Notice of Election is invalid because it does not meet statutory/regulatory requirements
5PC08	Face-to-Face Encounter requirements not met

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

56900 – Did You Know??

- Documentation must be received within 45 calendar days
- If documentation not received by day 46, claim denied with reason code 56900 (documentation not received or not received timely)
- Use Fiscal Intermediary Standard System (FISS) to check for MR ADRs at least once per week
- To check for MR ADRs, use Option 12 (Claim Inquiry), key your NPI number and status/location 'S B6001' and press Enter
- Claims selected for MR ADR will appear with reason code 39700
- Access the FISS Pages 07 and 08 to determine what is being requested and the date it must be received by CGS
- Consider using myCGS to respond to MR ADRs
  - Documentation may be submitted to CGS either by myCGS (CGS Web Portal), US Mail, Electronic Submission of Medical Documentation (esMD), Fax, or on CD/DVD

https://www.cgsmedicare.com/hhh/pubs/news/2017/0817/cope4170.html

Zone Program Integrity Contractors (ZPICs)

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

Zone Program Integrity Contractor (ZPIC)

The goal of the Zone Program Integrity Contractor (ZPIC) is to identify cases of suspected fraud, investigate them, and take action to ensure any inappropriate Medicare payments are recouped.

Fraud may include things such as:

- Billing for services not furnished
- Billing that appears to be deliberate for duplicate payment
- Altering claims or medical records to obtain a higher payment amount
- Soliciting, offering, or receiving a kickback or rebate for patient referrals
- Billing non-covered or non-chargeable services as covered

There are seven ZPIC zones. The names and jurisdiction for each ZPIC are listed below.

ZPIC	Zone	States in Zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, Virgin Islands

ZPIC actions to detect and deter fraud and abuse may include:

- Investigating potential fraud and abuse, including interviews and onsite visits
- Perform medical review, as appropriate
- Perform data analysis
- Identify the need for administrative actions, such as payment suspensions and prepayment, or auto-denial edits
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

For additional contact information, refer to the "Review Contractor Directory – Interactive Map EXT " link on the CMS website.

Additional Resources

ZPICs

There are seven ZPIC zones. The names and jurisdiction for each ZPIC are listed below.

ZPIC	Zone	States in Zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, Virgin Islands

Supplemental Medical Review Contractor (SMRC)

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

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Home » Home Health & Hospice » Medical Review » Supplemental Medical Review Contractor (SMRC)

Supplemental Medical Review Contractor (SMRC)

CMS has contracted with StrategicHealthSolutions, LLC, to perform activities as a Supplemental Medical Review Contractor (SMRC). These activities are aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare program.

SMRCs can review medical records and documentation to determine whether claims were billed according to Medicare coverage, coding, payment and billing regulations. Review may include vulnerabilities identified by CMS data analysis, the CERT program, professional organizations, and Federal oversight agencies.

The SMRC is responsible for notifying CMS of any identified improper payments and noncompliance with documentation requests. The MACs, including CGS, may initiate claim adjustments and/or overpayment recoupment actions through the usual overpayment recovery process.

Additional Resources

- "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" SE1123 PDF
- CMS "Program Integrity Manual" (CMS Pub. 100-08), Ch. 1 PDF
- CMS "Supplemental Medical Review Contractor (SMRC)" Web page EXT
- Change Request 8578, "Supplemental Medical Review Contractor" PDF
- StrategicHealthSolutions
- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" booklet PDF
- Current Supplemental Medical Review Contractor (SMRC) Projects EXT

Supplemental Medical Review Contractor

Project Y3P0440 — Hospice

Medicare Part A covers appropriate levels of hospice care for terminally ill beneficiaries with a life expectancy of 6 months or less to allow them to continue life with minimal disruptions. Hospice care is palliative rather than curative. There are four levels of hospice care: routine home care, continuous home care, general inpatient care (GIP), and inpatient respite care. GIP care is intended to be provided on a short-term basis and in a hospice inpatient unit, a hospital, or a skilled nursing facility. GIP is appropriate when pain or acute or chronic symptoms cannot be managed in another setting. For more information on claims for hospice care, refer to Medicare Learning Network® articles "Demand Billing of Hospice General Inpatient Care" and "Hospice Payment System," and CMS's "Medicare Claims Processing Manual, Chapter 11, Processing Hospice Claims."

The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) issued a report in March 2016 titled, "Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care." HHS-OIG reported that its analysis of claims for GIP stays in 2012 showed that one-third of payments for GIP in 2012 were improper, costing Medicare $268 million.

In response to the report, CMS agreed to determine an appropriate number of claims to review for GIP stays that may be billed inappropriately under Medicare coverage requirements. Accordingly, CMS has directed StrategicHealthSolutions, LLC, as the Supplemental Medical Review Contractor, to conduct post-payment review of claims for calendar year 2015 to identify claims for GIP care that may have been improperly paid under the Medicare Part A benefit.

To perform this review, Strategic will be requesting additional documentation from certain providers. A sample letter to providers requesting additional documentation is here.

CGS General Inpatient Care (GIP) Web page

https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/general_inpatient_care.html

General Inpatient Care

Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 9 §40.1.5 PDF

General inpatient care (GIP) is available to all hospice beneficiaries who are in need of pain control or symptom management that cannot be provided in any other setting. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.

GIP is not intended to be custodial or residential. Once a beneficiary's symptoms are stabilized, or pain is managed, he/she must return to a routine level of care. The beneficiary may remain in a facility due to safety, but Medicare will not pay for GIP unless the beneficiary is in need of this level of care, and it is clearly documented in the medical records.

Supportive Documentation for GIP

Upon transfer to GIP level of care, documentation should include both:

- A precipitating event (onset of uncontrolled symptoms or pain)
- The interventions tried in the home that have been unsuccessful at controlling the symptoms

Supporting documentation for pain control may include:

- Frequent evaluation by a doctor or nurse
- Frequent medication adjustment
- IVs that cannot be administered at home
- Aggressive pain management
- Complicated technical delivery of medication

Supporting documentation for symptom control may include:

- Sudden deterioration requiring intensive nursing intervention
- Uncontrolled nausea or vomiting
- Pathological fractures
- Open wounds requiring frequent skilled care
- Unmanageable respiratory distress
- New or worsening delirium

The POC should reflect the change in the level of care, the beneficiary's response, and the collaboration with the facility staff.

Comprehensive Error Rate Testing (CERT) Program

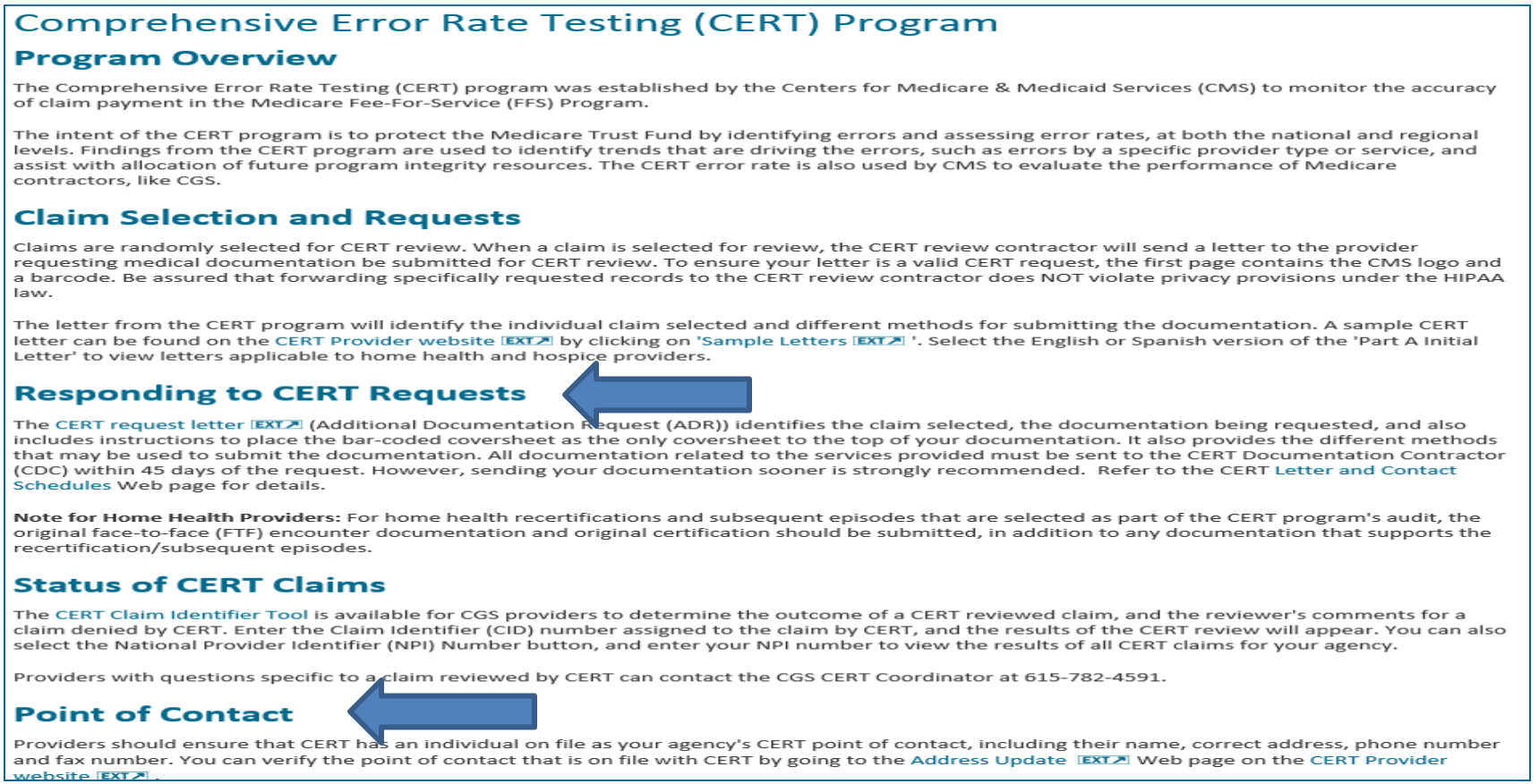
http://www.cgsmedicare.com/hhh/education/materials/cert.html

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 EXT by clicking on 'Sample Letters EXT '. 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 EXT (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 EXT Web page on the CERT Provider website EXT .

CERT Error Categories

Type of Error	Description
No Documentation	Provider or supplier fails to respond to repeated requests for the medical records or they do not have the requested documentation.
Insufficient Documentation	Submitted medical documentation is inadequate to support payment for the services billed; the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary; or a specific documentation element that is required as a condition of payment is missing (for example, a physician signature on an order).
Medical Necessity	There is adequate documentation in the medical records to make the informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.
Incorrect Coding	Provider or supplier submits medical documentation supporting: • A different code than was billed • The service was performed by someone other than the billing provider or supplier • The billed service was unbundled • A beneficiary was discharged to a site other than the one coded on a claim
Other	When a claim error does not fit in any other category (for example, duplicate payment error, non-covered, or unallowable service).

Top Home Health (HH) CERT Errors

Insufficient Documentation

- Face-to-Face (F2F) encounter issues
- Missing clinical notes
- Does not support HH certification

Signatures Issues

- Unsigned therapy notes

Incorrect Coding

- Transfer/discharge status codes

Medically Unnecessary

Top Hospice CERT Errors

Insufficient Documentation

- Hospice MD certification/recertification – missing a complete written certification of terminal illness
- Hospice Plan of Care
- Hospice Service documentation on billed Date of Service

Medically Unnecessary Service or Treatment

- Submitted documentation does not support terminal prognosis; beneficiary is stable, no evidence of decline; little change since election of the benefit

Top Hospice CERT Errors

Service Incorrectly Coded

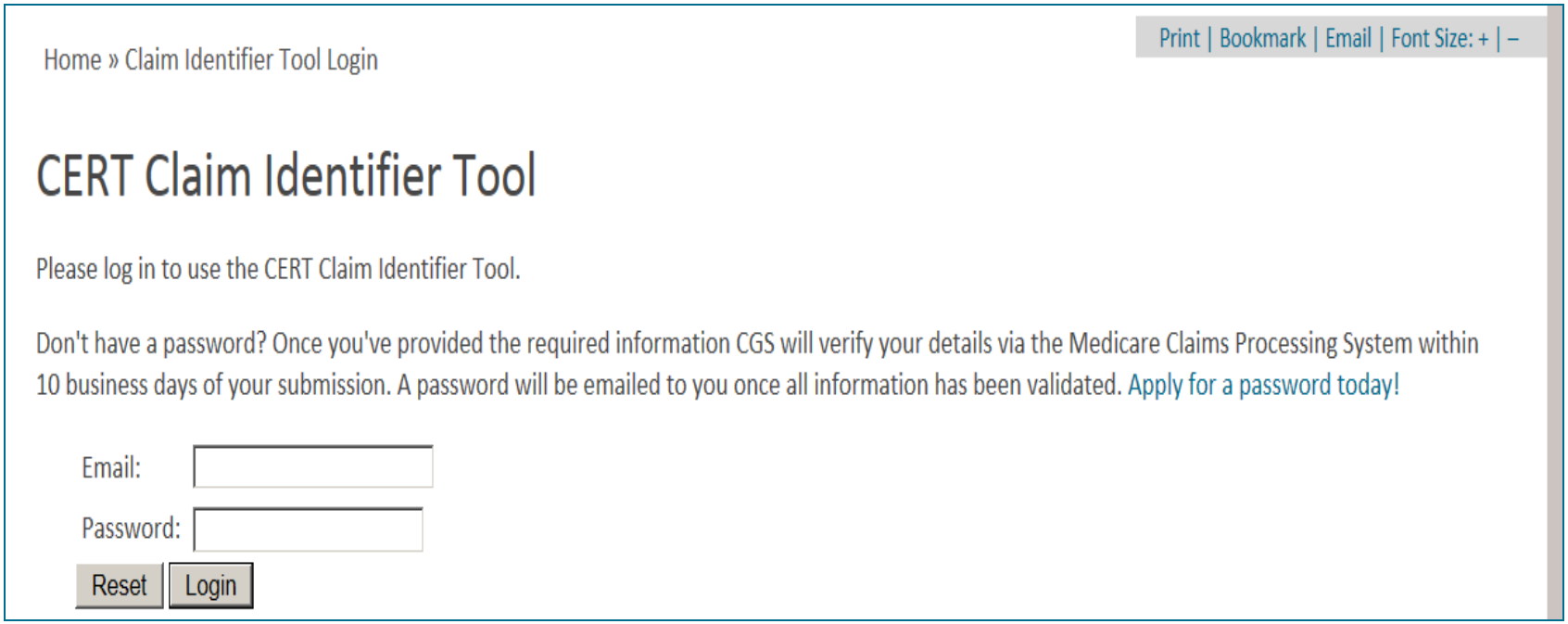
- Units of service on the line are incorrectly coded

Other

- No documentation was received, or no documentation related to the claim line under review was received from the provider, after full process was pursued and exhausted, and there is no evidence to support another error code
- Missing nursing visit notes to support billing

CERT Claim Identifier Tool

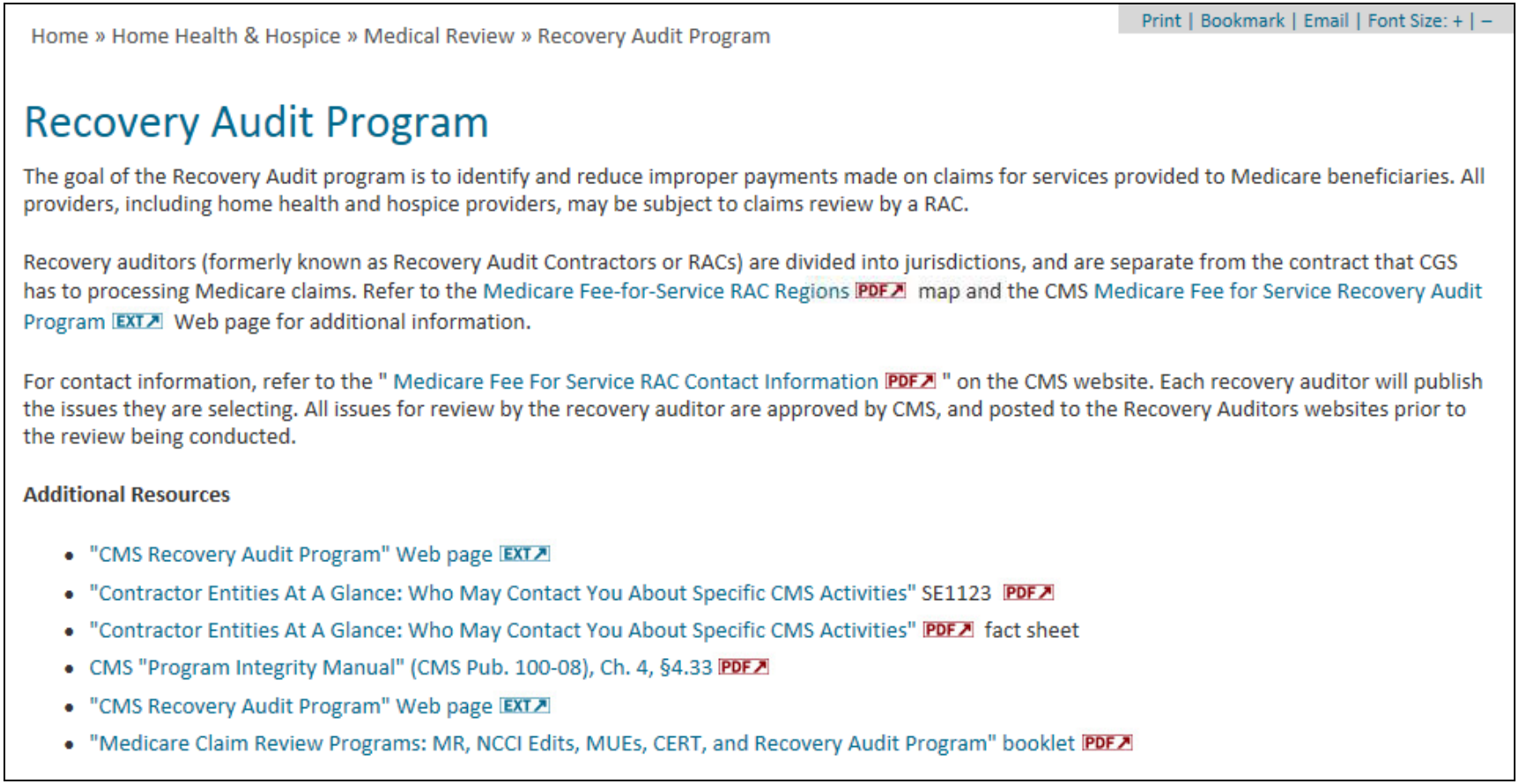
Need to check the status of a CERT claim? Use our CERT Claim Identifier Tool…..



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

Recovery Audit (RA) Contractor

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



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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

Medicare Fee For Service RAC Contact Information

Name	Website	E-mail	Phone Number
Region 1: Performant Recovery, Inc. **States**: CT, MI, IN, ME, MA, NH, NY, OH, KY, RI and VT	https://www.performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580
Region 2: Cotiviti, LLC **States**: IL, MN, WI, NE, IA, KS, MO, CO, NM, TX, OK, AR, LA, and MS	https://www.Cotiviti.com/RAC	RACInfo@Cotiviti.com	1-866-360-2507
Region 3: Cotiviti, Inc. **States**: AL, FL, GA, NC, SC, TN, VA, WV, Puerto Rico and U.S. Virgin Islands	https://www.Cotiviti.com/RAC	RACInfo@Cotiviti.com	1-866-360-2507
Region 4: HMS Federal Solutions **States**: AK, AZ, CA, DC, DE, HI, ID, MD, MT, ND, NJ, NV, PA, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	https://racinfo.healthdatainsights.com	racinfo@emailhdi.com	Part A: 1-866-590-5598 Part B: 1-866-376-2319
Region 5: Performant Recovery, Inc. Nationwide for DMEPOS/HHA/Hospice	https://www.performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580

CMS Resources

CMS Website

https://www.cms.gov/

Top 5 resources

- Manuals
- Medicare coverage database
- CMS forms
- Transmittals
- MLN Homepage

CMS Internet-Only Manuals (IOMs)

- **Medicare Benefit Policy Manual,** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html
  - Chapter 7 – Home Health Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
  - Chapter 9 – Coverage of Hospice Services Under Hospital Insurance, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Internet-Only Manuals (IOMs)

- **Medicare Claims Processing Manual,** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
  - Chapter 10 - Home Health Agency Billing, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
  - Chapter 11 – Processing Hospice Claims, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

Home Health Quality Initiatives

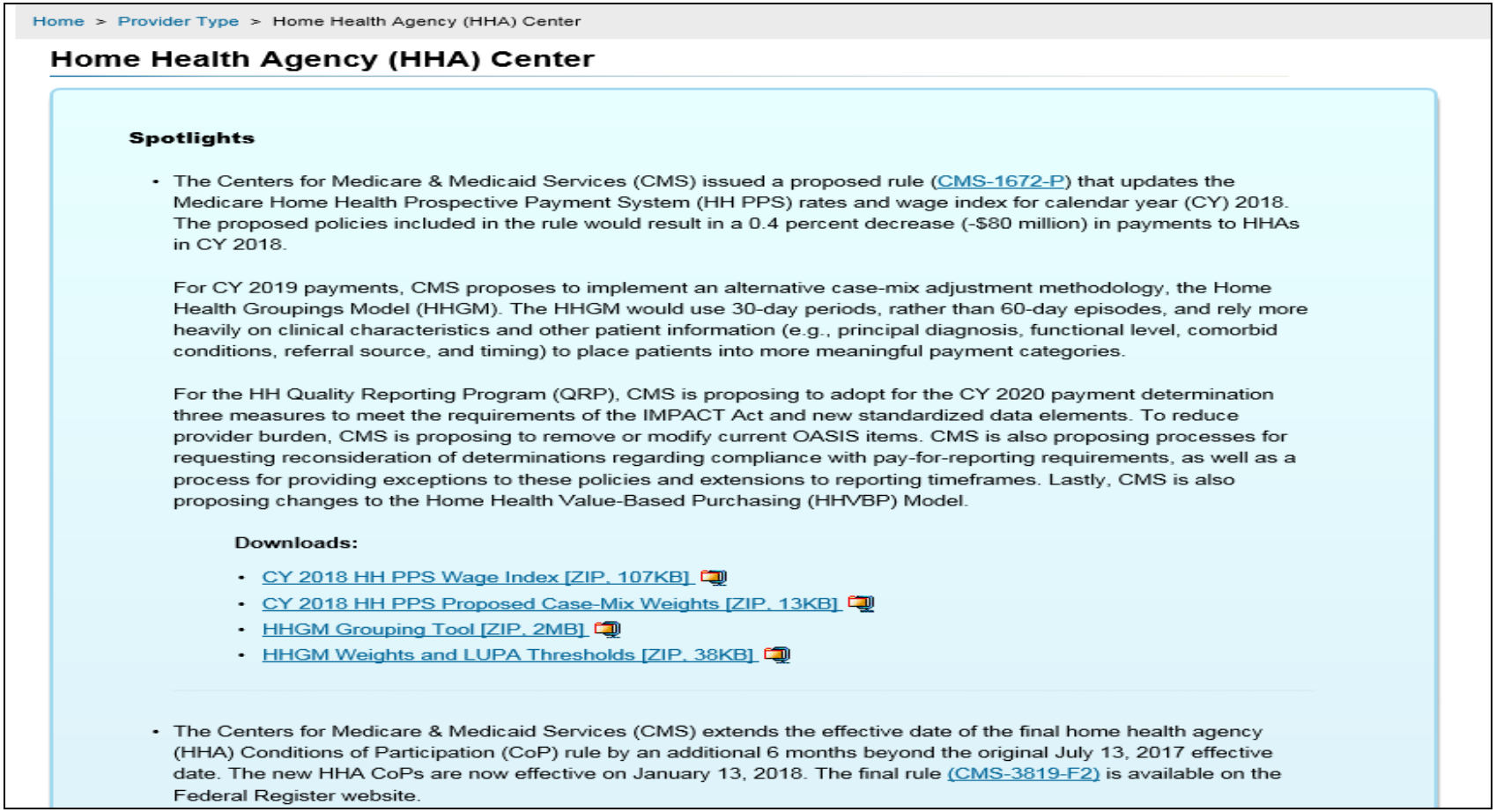
- **Information available on the CMS website,** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html
  - Goals
  - Measures
  - Process
  - Reporting Data
  - Resources
  - Notifications of National Provider Calls/Training

Hospice Quality Initiatives

- **Information available on the CMS website,** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
  - Measures
  - Reporting Data
  - Reconsideration Requests
  - Help Desks
  - Resources
  - Notifications of National Provider Calls/Training

Home Health Agency (HHA) Center

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



Home > Provider Type > Home Health Agency (HHA) Center

Home Health Agency (HHA) Center

Spotlights

- The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (CMS-1672-P) that updates the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2018. The proposed policies included in the rule would result in a 0.4 percent decrease (-$80 million) in payments to HHAs in CY 2018.

  For CY 2019 payments, CMS proposes to implement an alternative case-mix adjustment methodology, the Home Health Groupings Model (HHGM). The HHGM would use 30-day periods, rather than 60-day episodes, and rely more heavily on clinical characteristics and other patient information (e.g., principal diagnosis, functional level, comorbid conditions, referral source, and timing) to place patients into more meaningful payment categories.

  For the HH Quality Reporting Program (QRP), CMS is proposing to adopt for the CY 2020 payment determination three measures to meet the requirements of the IMPACT Act and new standardized data elements. To reduce provider burden, CMS is proposing to remove or modify current OASIS items. CMS is also proposing processes for requesting reconsideration of determinations regarding compliance with pay-for-reporting requirements, as well as a process for providing exceptions to these policies and extensions to reporting timeframes. Lastly, CMS is also proposing changes to the Home Health Value-Based Purchasing (HHVBP) Model.

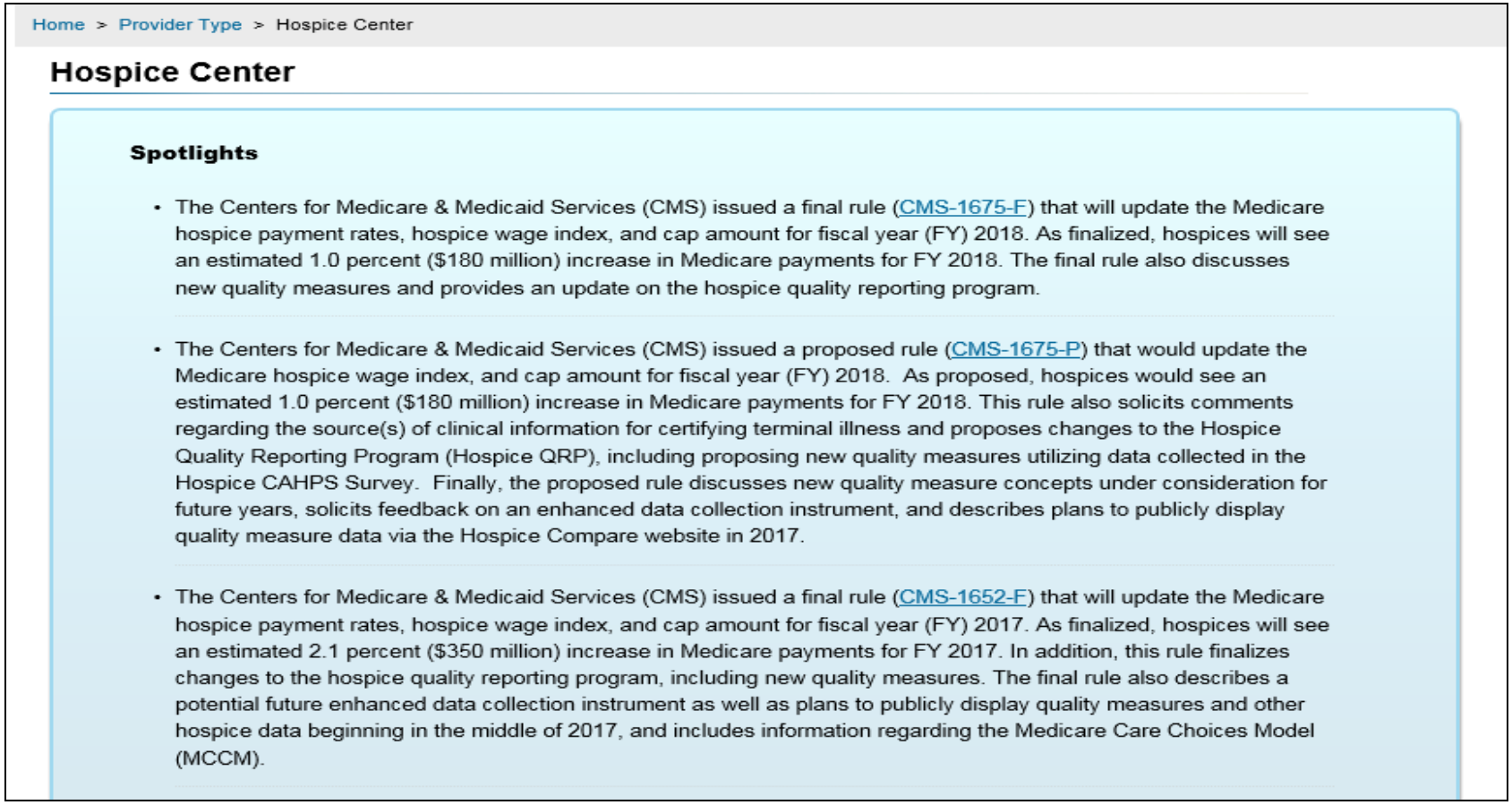
  Downloads:

  - CY 2018 HH PPS Wage Index [ZIP, 107KB]
  - CY 2018 HH PPS Proposed Case-Mix Weights [ZIP, 13KB]
  - HHGM Grouping Tool [ZIP, 2MB]
  - HHGM Weights and LUPA Thresholds [ZIP, 38KB]

- The Centers for Medicare & Medicaid Services (CMS) extends the effective date of the final home health agency (HHA) Conditions of Participation (CoP) rule by an additional 6 months beyond the original July 13, 2017 effective date. The new HHA CoPs are now effective on January 13, 2018. The final rule (CMS-3819-F2) is available on the Federal Register website.

Hospice Center

https://www.cms.gov/Center/Provider-Type/Hospice-Center.html



Home > Provider Type > Hospice Center

Hospice Center

Spotlights

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1675-F) that will update the Medicare hospice payment rates, hospice wage index, and cap amount for fiscal year (FY) 2018. As finalized, hospices will see an estimated 1.0 percent ($180 million) increase in Medicare payments for FY 2018. The final rule also discusses new quality measures and provides an update on the hospice quality reporting program.

- The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (CMS-1675-P) that would update the Medicare hospice wage index, and cap amount for fiscal year (FY) 2018. As proposed, hospices would see an estimated 1.0 percent ($180 million) increase in Medicare payments for FY 2018. This rule also solicits comments regarding the source(s) of clinical information for certifying terminal illness and proposes changes to the Hospice Quality Reporting Program (Hospice QRP), including proposing new quality measures utilizing data collected in the Hospice CAHPS Survey. Finally, the proposed rule discusses new quality measure concepts under consideration for future years, solicits feedback on an enhanced data collection instrument, and describes plans to publicly display quality measure data via the Hospice Compare website in 2017.

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1652-F) that will update the Medicare hospice payment rates, hospice wage index, and cap amount for fiscal year (FY) 2017. As finalized, hospices will see an estimated 2.1 percent ($350 million) increase in Medicare payments for FY 2017. In addition, this rule finalizes changes to the hospice quality reporting program, including new quality measures. The final rule also describes a potential future enhanced data collection instrument as well as plans to publicly display quality measures and other hospice data beginning in the middle of 2017, and includes information regarding the Medicare Care Choices Model (MCCM).

CGS Resources

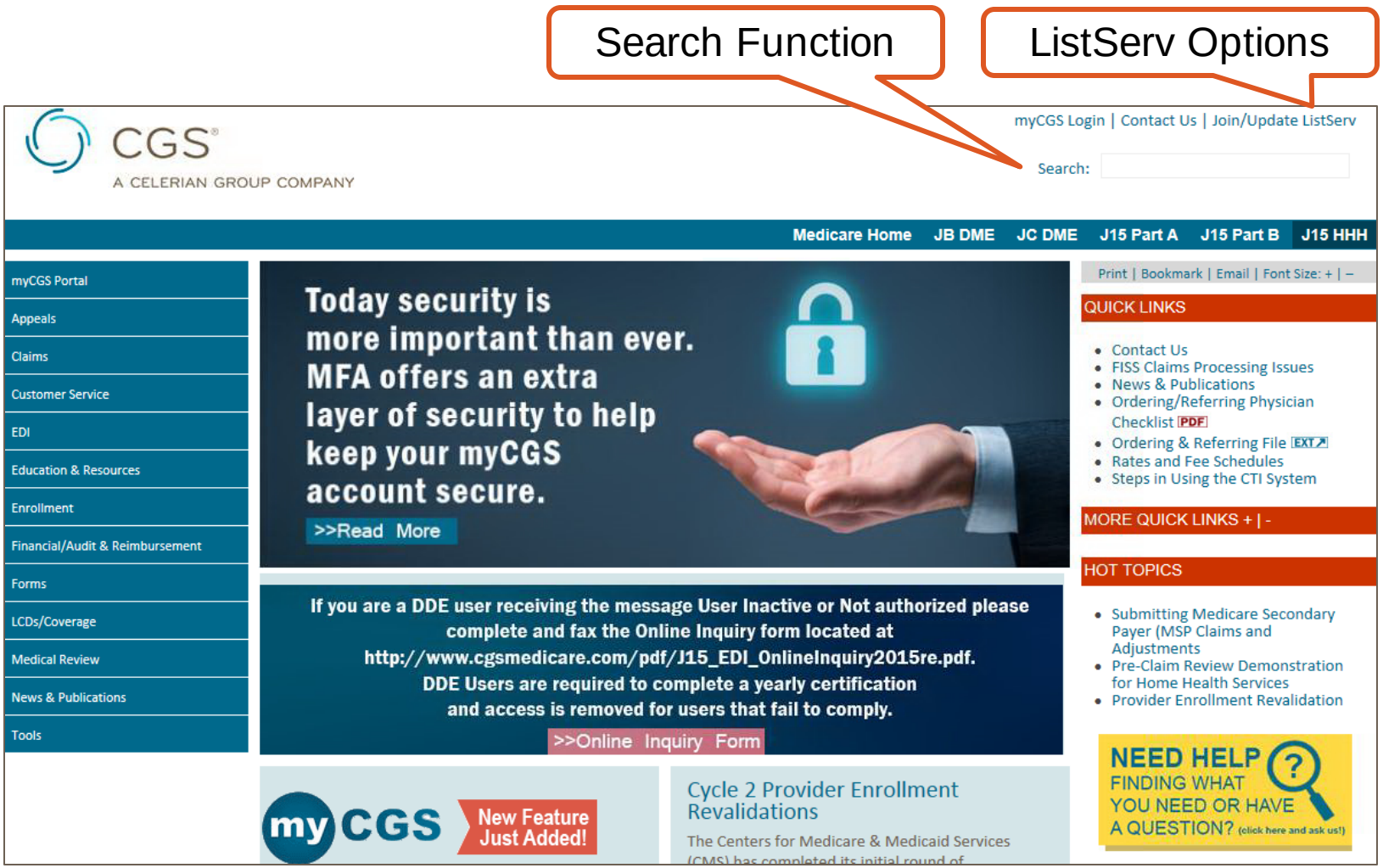
& Self-Service Tools

CGS HH&H Web Page

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

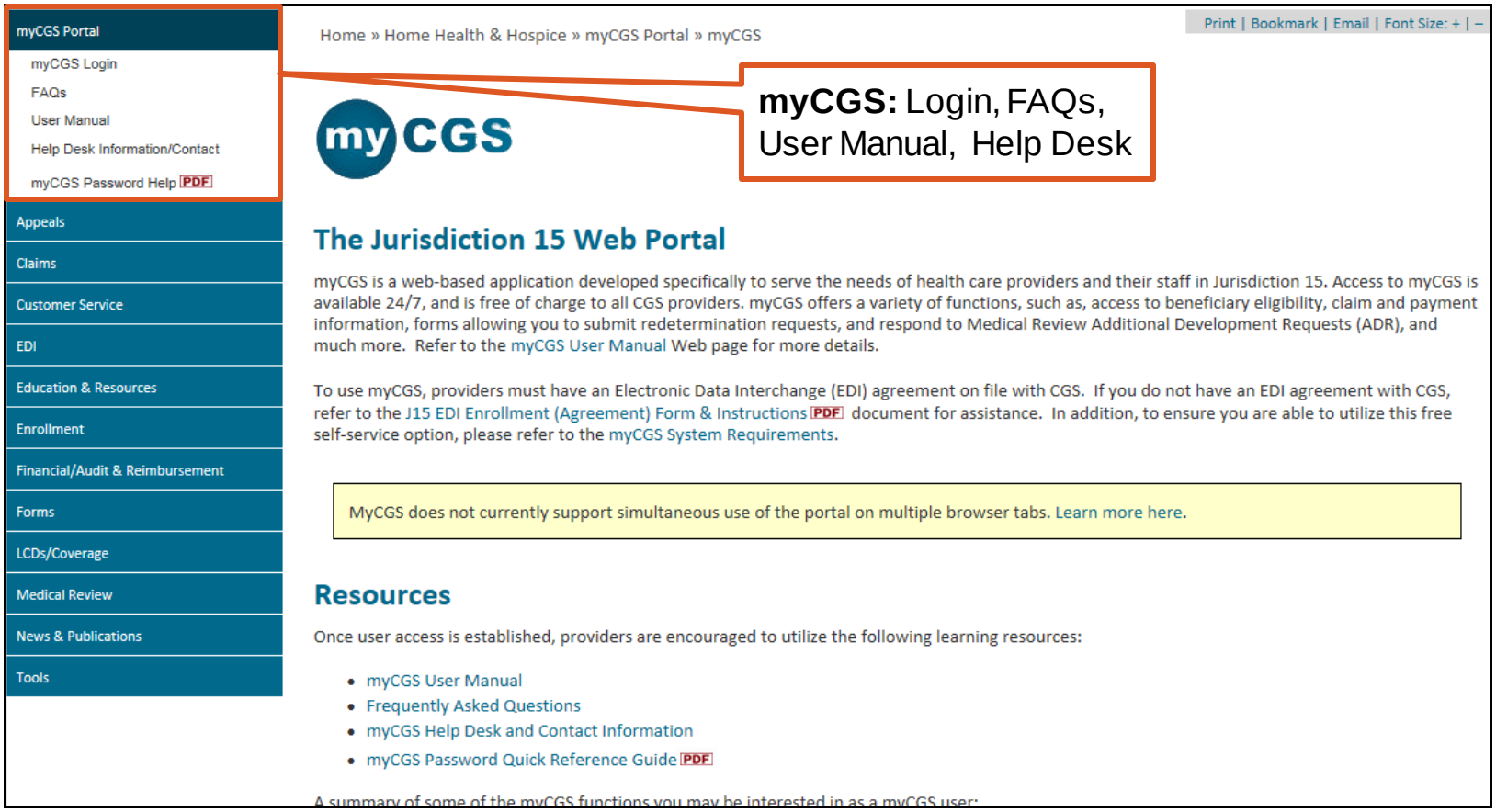
CGS HH&H Web Page

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



CGS HH&H Website: myCGS Portal

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



myCGS: Login, FAQs, User Manual, Help Desk

No costs associated with access to myCGS.

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