CGS Billing Updates for Home Health & Hospice Providers

South Dakota Association of Healthcare Organizations| SDAHO Annual Conference| Nykesha Scales, MBA| September 22, 2017

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

Revalidation

Who must Revalidate	All providers and suppliers enrolled with Medicare must revalidate their enrollment information on a periodic basis. Generally, physicians and NPPs revalidate enrollment every 5 years or when CMS requests it.
What is being Revalidated	The accuracy of provider/supplier enrollment information. This includes active PTANS(Medicare numbers on file with your MAC carrier)
When is Revalidation due	Generally every 5 years. Part A, HHH & B providers and suppliers will be issued a due date on https://data.cms.gov/revalidation. Provider/suppliers not due for revalidation will display a "TBD" (To Be Determined) in the due date field. This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
Where is Revalidation sent to	The fastest and most efficient way to submit your revalidation information is via PECOS, located at https://PECOS.cms.hhs.gov. However, Paper CMS-855 applications, which can be completed and submitted to your Medicare Administrative Contractor (MAC) for revalidation purposes are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html.
Why Revalidation delays and deactivations occur	Non-compliance to revalidation request letter. Corrections requested and not sent timely.

CMS Revalidation Due Date Tool

Getting Started (PDF)

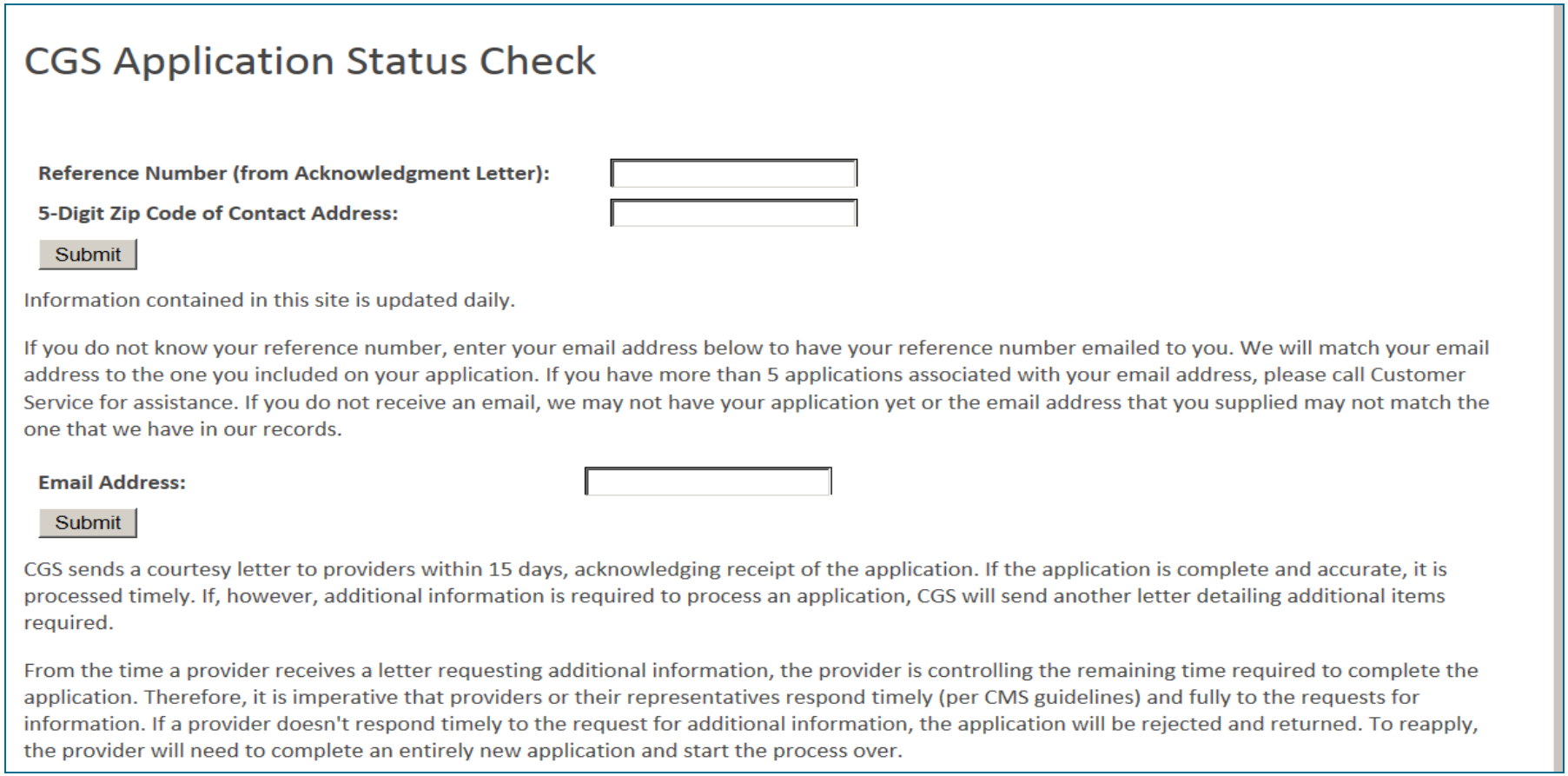
Checklist

Provider Enrollment/Revalidation Reminders & Tips

- 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

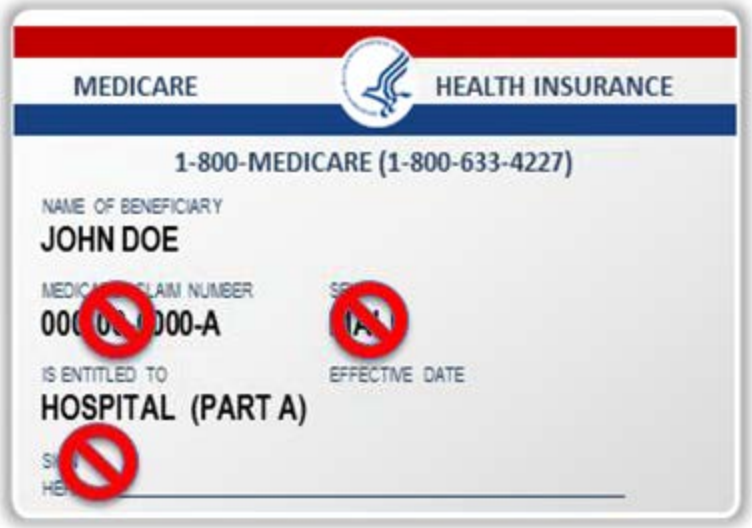
- Complete Annual DDE PPTN Recertification Form as soon as possible
- Verify all User IDs, indicate if the User ID is active or inactive, and include an authorized signature, contact email, and phone number
- FAX the Annual DDE PPTN Recertification Form as soon as possible to CGS at: **1.615.664.5947**

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

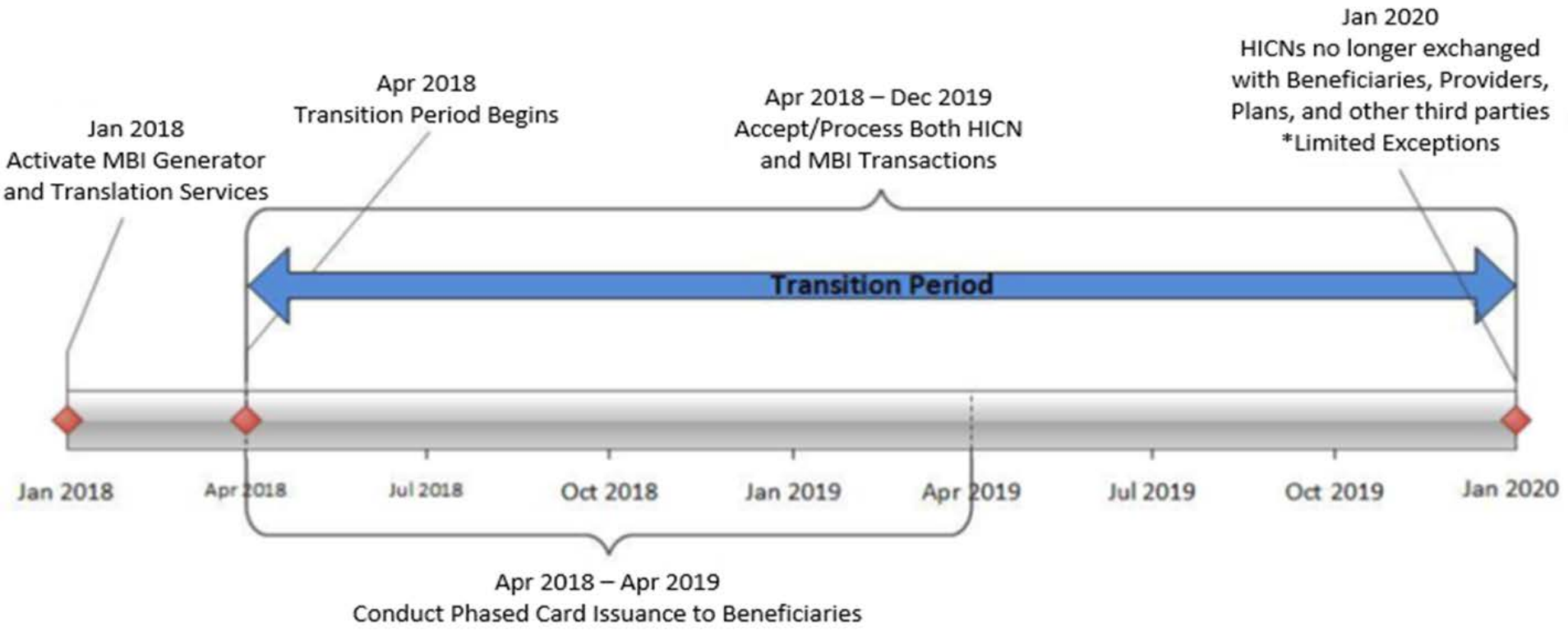
Medicare Beneficiary Identifier (MBI)

- 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

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

Final Rule: 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

MM10131, Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2018: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10131.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

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%

SD Top 5 HH Billing Errors

March 1, 2017 – August 31, 2017		
Reason Code	**Billing Error**	**# of Errors**
38107	FISS can't find matching RAP	289
31147	HIPPS 5th position is a letter and supply revenue codes are present	188
31018	Less than 60 days billed on home health claim and patient status code billed equals "30"	168
30720	Treatment Authorization Code not present or not valid	51
31755	HIPPS DOS mismatch	50

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

https://www.cgsmedicare.com/hhh/education/materials/38107.html

AVOIDING REASON CODE 38107 QUICK RESOURCE TOOL (QRT)

```
 MAP1711    PAGE 01          CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
 XXXXXX      SC              INST CLAIM ENTRY                    C20124BE HH:MM:SS
 HIC                TOB      S/LOC          OSCAR                 SV:     UB-FORM
 NPI           TRANS HOSP PROV                      PROCESS NEW HIC
 PAT.CNTL#:                          TAX#/SUB:                  TAXO.CD:
  STMT DATES FROM              TO          DAYS COV      N-C       CO       LTR
  LAST                               FIRST                  MI    DOB
  ADDR 1                                    2
  3                                    4                                CARR:
  5                                    6                                 LOC:
ZIP            SEX    MS   ADMIT DATE          HR    TYPE    SRC    D HM       STAT
```

```
MAP1712    PAGE 02          CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
XXXXXX      SC              INST CLAIM ENTRY                    C20124BE HH:MM:SS
                                                    REV CD PAGE 01
HIC                TOB      S/LOC S B0100   PROVIDER

                                TOT     COV                                SERV     RED
CL   REV    HCPC  MODIFS      RATE UNIT   UNIT   TOT CHARGE NCOV CHARGE    DATE     IND
     0023  1BFKS                                                          0101YY
```

To ensure the FISS data matches, use the following table to chart the information entered on the RAP and the claim.

FISS Field Name	Data Entered on RAP (TOB 322)	Data Entered on Claim (TOB 3X9)
NPI (Page 01)		
STMT DATES FROM (Page 01)		
ADMIT DATE (Page 01)		
HCPC – 0023 revenue line (Page 02)		
SERV DATE – 0023 revenue line (Page 02)		

https://www.cgsmedicare.com/hhh/education/materials/pdf/38107.pdf

Reason Code 31147

https://www.cgsmedicare.com/hhh/education/materials/31147.html

Reason for error: A home health final claim was received, and the fifth position of the HIPPS code billed contains the letters S, T, U, V, W, or X, but supply revenue codes are not present on the claim.

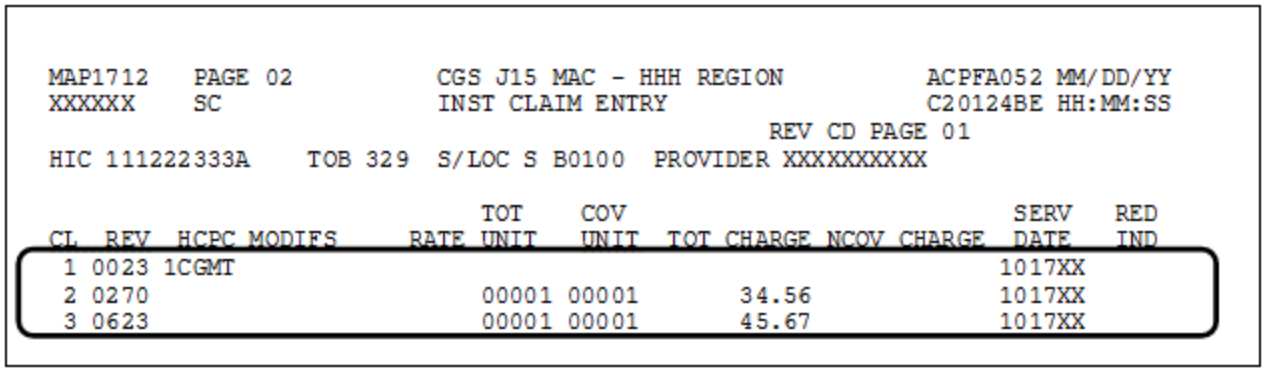
How to prevent/resolve:

If the HIPPS code on your claim has a 5th position of S, T, U, V, W, or X and you provided non-routine supplies to the beneficiary during the episode, report

- Supply revenue codes 027X and/or 0623
- Service units
- Charges and
- A date of service that falls within the "FROM" and "TO" date of the home health claim

REASON CODE 31147

CGS encourages you to use the first Medicare billable visit in the episode as the date of service submitted with revenue codes 027X or 0623.



```
MAP1712   PAGE 02          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC              INST CLAIM ENTRY                  C20124BE HH:MM:SS
                                                  REV CD PAGE 01
HIC 111222333A    TOB 329  S/LOC S B0100  PROVIDER XXXXXXXXXX

                              TOT    COV                              SERV   RED
CL  REV  HCPC MODIFS     RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE  DATE   IND
 1 0023 1CGMT                                                      1017XX
 2 0270                      00001 00001       34.56              1017XX
 3 0623                      00001 00001       45.67              1017XX
```

If non-routine supplies were NOT provided by your home health agency to the beneficiary during the episode, the 5th position of the HIPPS code must be changed to the appropriate numeric value of 1, 2, 3, 4, 5, or 6.

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%

SD Top 5 Hospice Billing Errors

March 1, 2017 – August 31, 2017		
Reason Code	**Billing Error**	**# of Errors**
34952	SVC facility NPI not included	85
38200	Duplicate claim	54
U5194	Hospice claim rec'd for untimely NOE & OSC 77 is missing or invalid	49
31605	Revenue code shows as covered but date of service is within occurrence span code 74, 76, 77 or 79	48
U5106	Notice of election (NOE) falls within current hospice election	39

REASON CODE 34952

Reason for error: Reason code indicates service facility National Provider Identifier (NPI) was required on claim, but was not reported. As required in Change Request 8358, effective for dates of service on/after April 1, 2014, hospice providers are required to report a service facility NPI when billing any of the following place of service HCPCS codes:

- Q5003 – hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
- Q5004 – hospice care provided in skilled nursing facility (SNF)
- Q5005 – hospice care provided in inpatient hospital
- Q5006 – hospice care provided in inpatient hospice facility (when not the same as the billing hospice)
- Q5007 – hospice care provided in long term care hospital (LTCH)
- Q5008 – hospice care provided in inpatient psychiatric facility

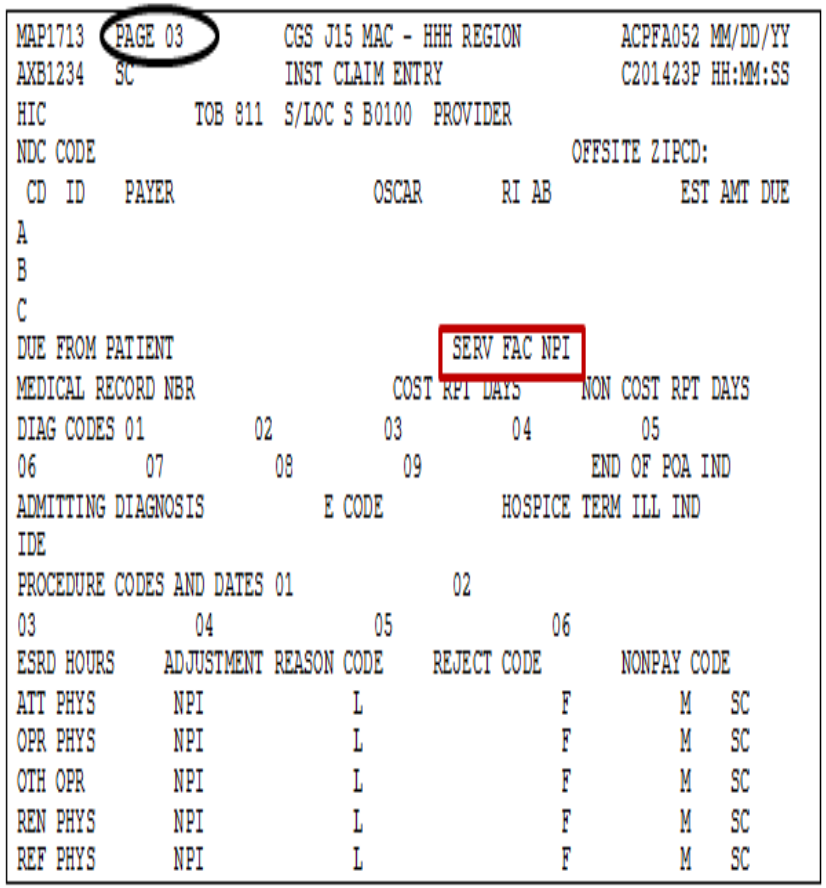
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8358.pdf

34952 – How to Prevent/Resolve

Before submitting claim, check to see if any of the place of service HCPCS are present....

If present:

- NPI of nursing facility, hospital, or inpatient facility where patient received services is required. Enter service facility NPI in:
  - Loop 2310E (when billing in the 5010 electronic claim format); or
  - SERV FAC NPI field in the Fiscal Intermediary Standard System (FISS) on Claim Page 03



https://www.cgsmedicare.com/hhh/education/materials/34952.html

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

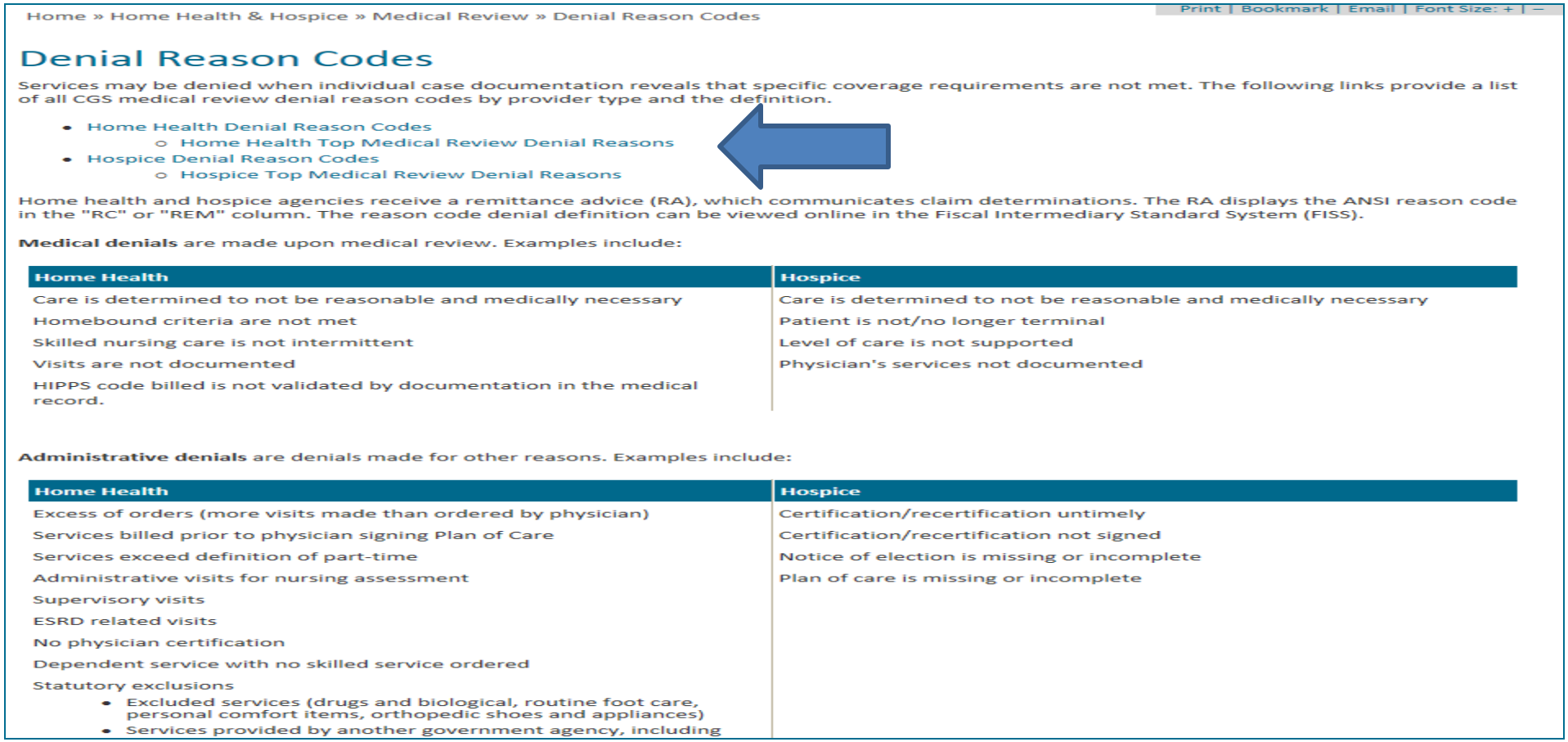
https://www.cgsmedicare.com/hhh/education/materials/cses.html

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



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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	

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

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

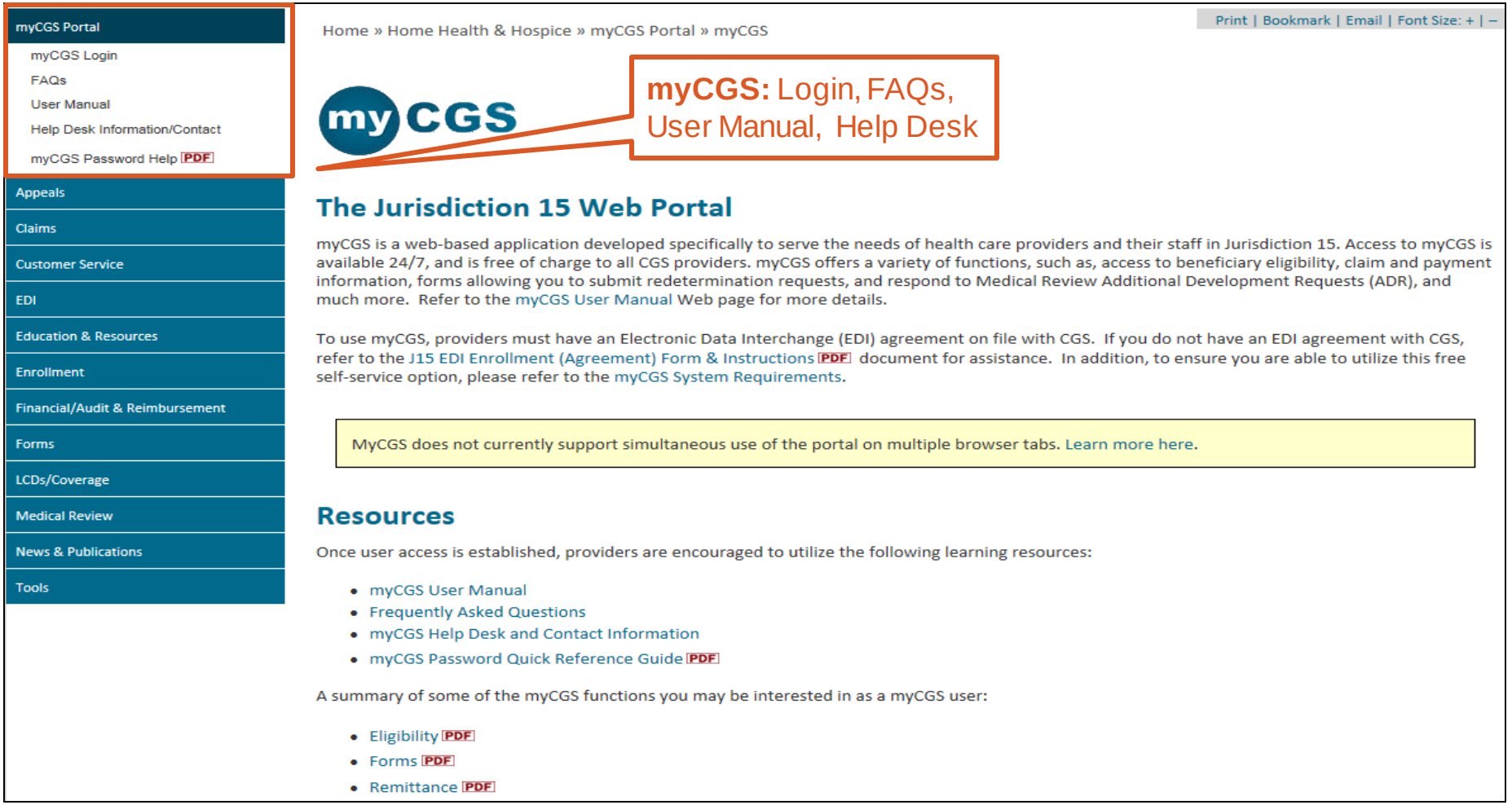
Rank	Denial Code	Denial Description	# of Claims Denied	% of Claims Denied
3	5PC09	The hospice plan of care does not meet the requirements set forth in the code of federal regulations.	29	7%

- 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)

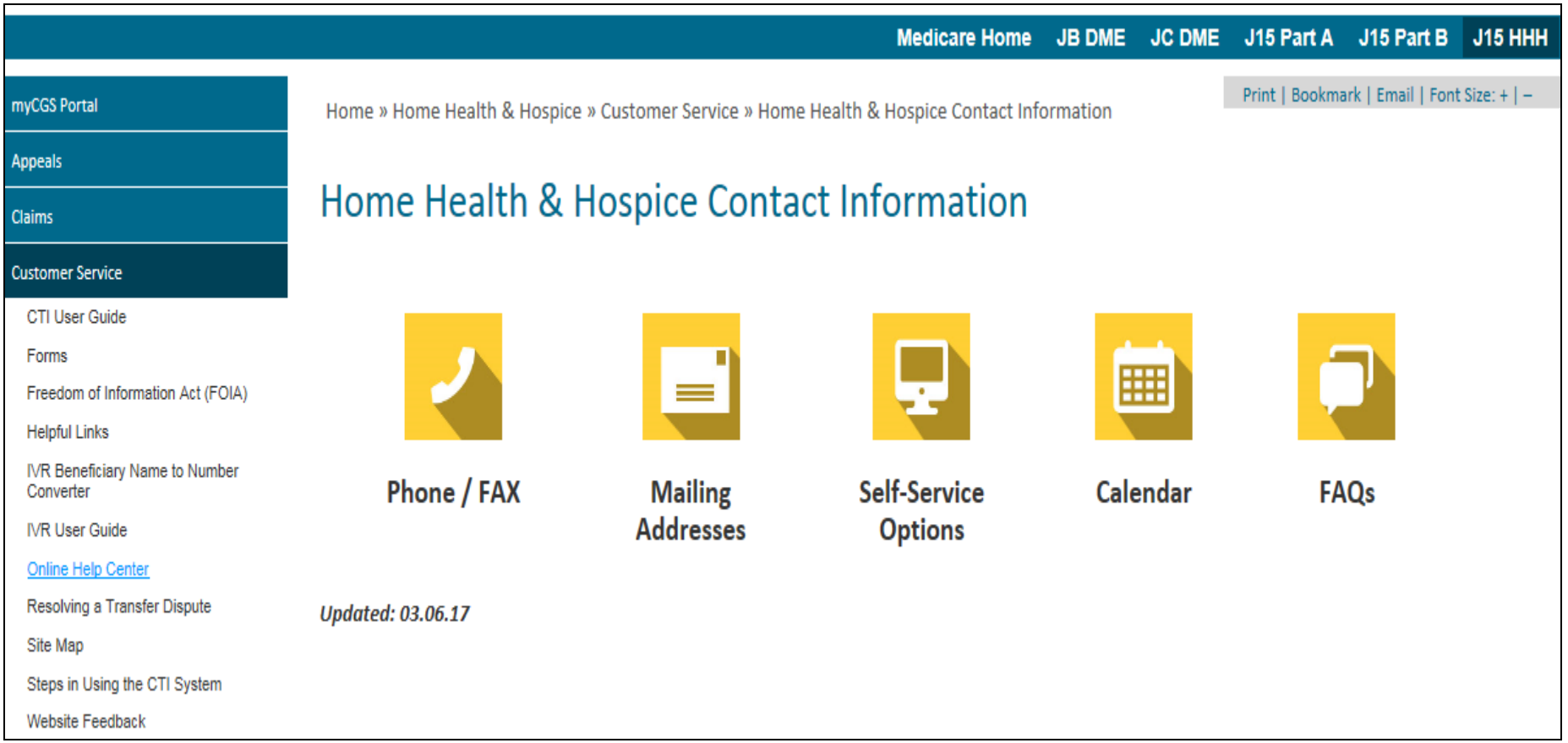
CGS HH&H Web Page

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

CGS HH&H Web Page

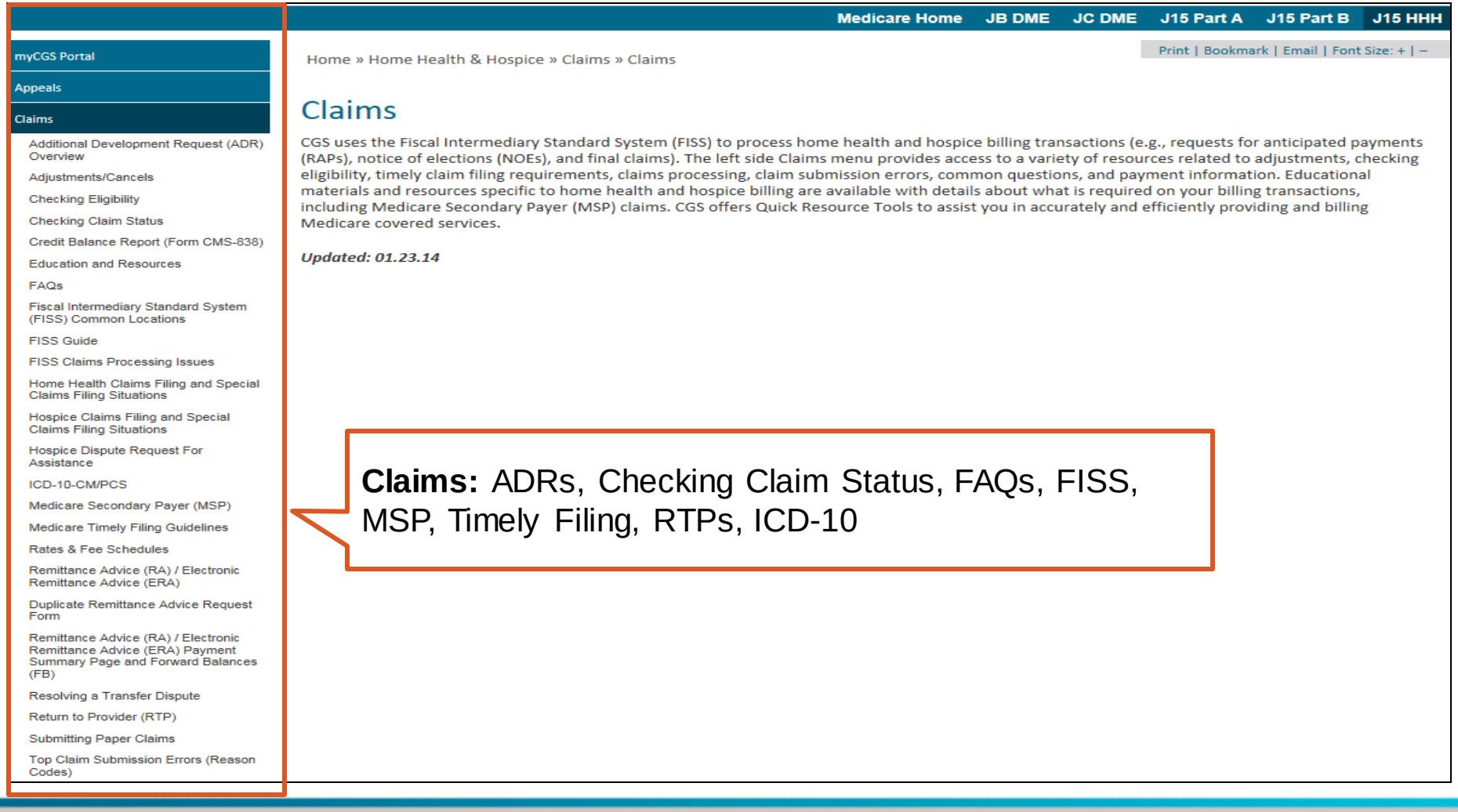
UPDATED: HH&H CUSTOMER SERVICE WEB PAGE

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



CGS HH&H Website: Claims

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



Claims: ADRs, Checking Claim Status, FAQs, FISS, MSP, Timely Filing, RTPs, ICD-10

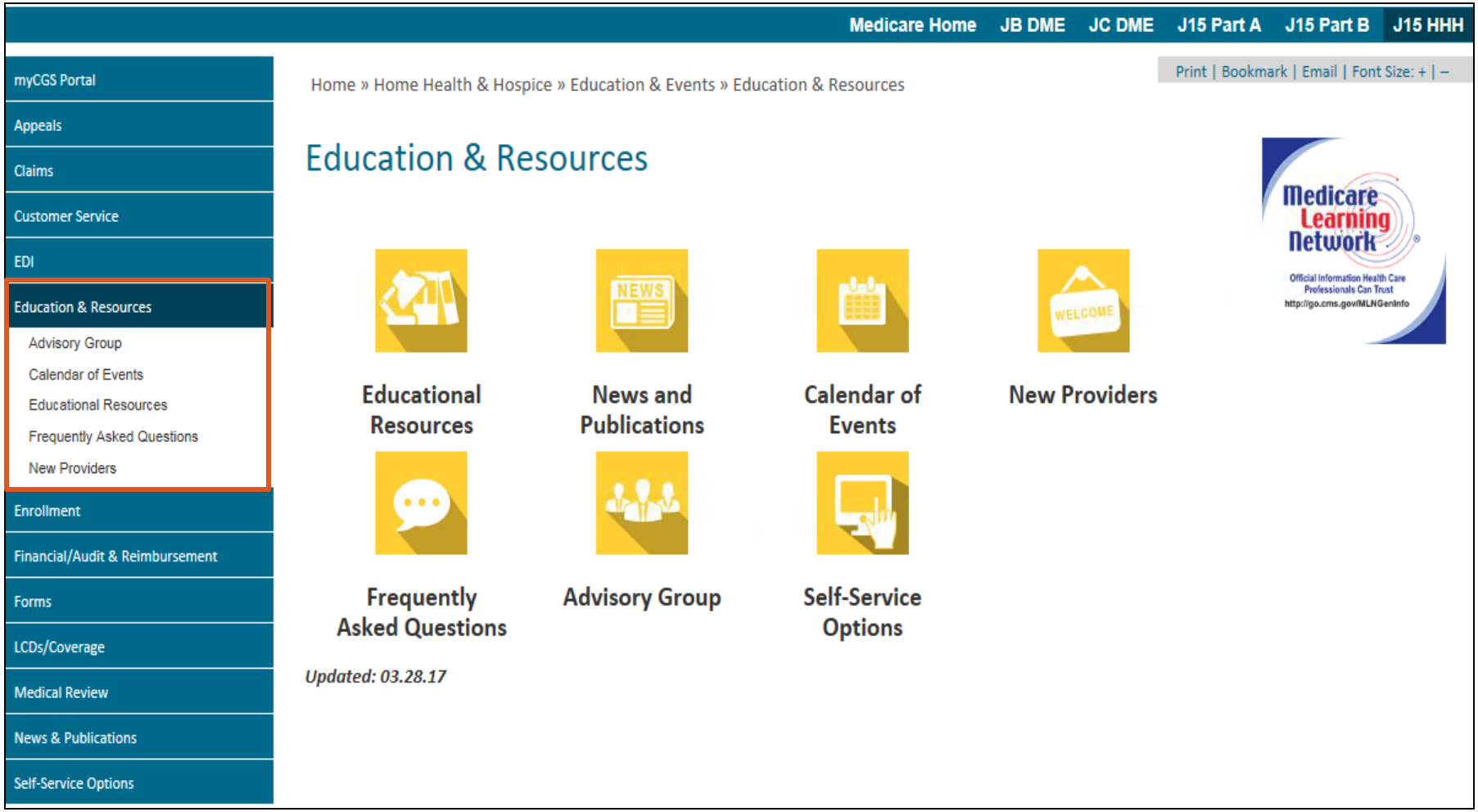
CGS Resource: FISS Guide

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**