Medicare Clinical Updates from CGS

Nebraska Home Care Association

Presenter: Sandy Decker RN BSN
CGS Administrators, LLC
January 26, 2018

Home Health Requirements

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and:

1. Be confined to the home
2. Need skilled services
   - Intermittent skilled nursing care or physical therapy or speech-language pathology
3. Be under the care of a physician
4. Receive services under a plan of care established and reviewed by a physician
5. Had a face-to-face encounter performed by either:
   a) **Certifying physician** (must be Medicare enrolled)
   b) **Non-physician practitioner** (NPP) in collaboration with the certifying physician
   c) **Physician who cared for the patient** in an acute/post-acute facility during a recent stay and has privileges in that facility

Home Health Coverage Resources

CMS "Medicare Benefit Policy Manual" (CMS Pub. 100-02)

Chapter 7; Home Health

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

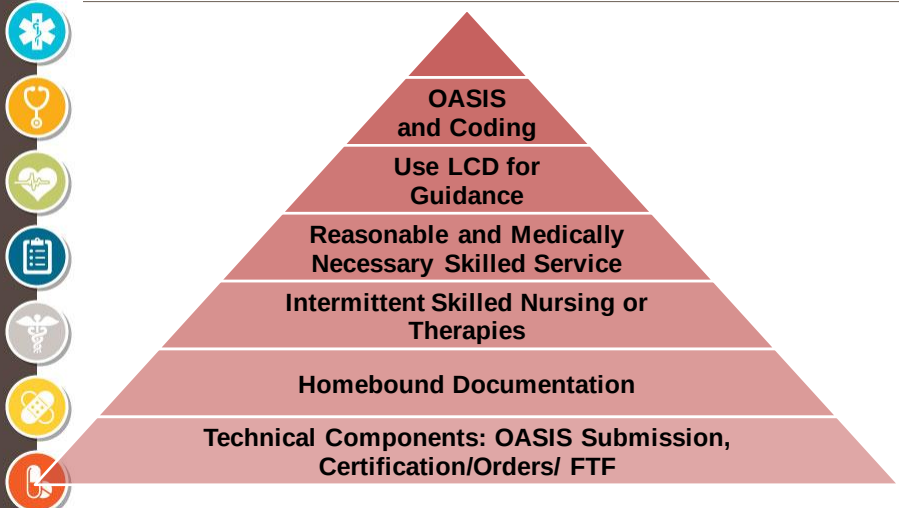
Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

Table of Contents
(Rev. 208, 05-11-15)

Transmittals for Chapter 7

10 - Home Health Prospective Payment System (*HH* PPS)

Essential Home Health Documentation



Comprehensive Error Rate Testing (CERT)

Comprehensive Error Rate Testing (CERT) Program

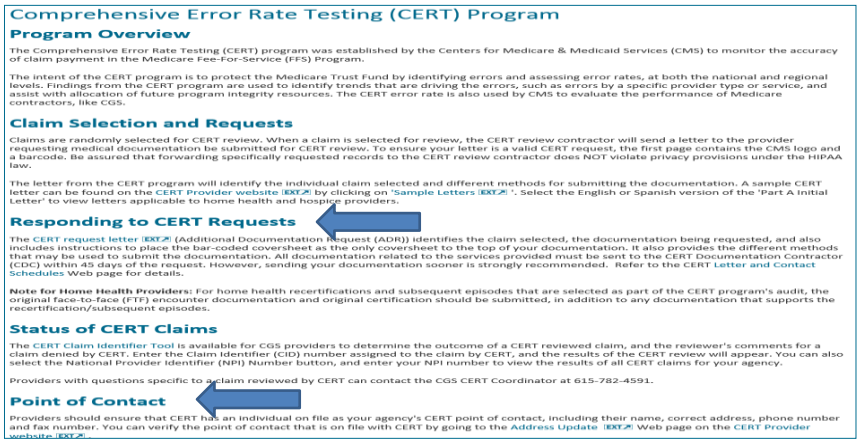
http://www.cgsmedicare.com/hhh/education/materials/cert.html

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.

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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

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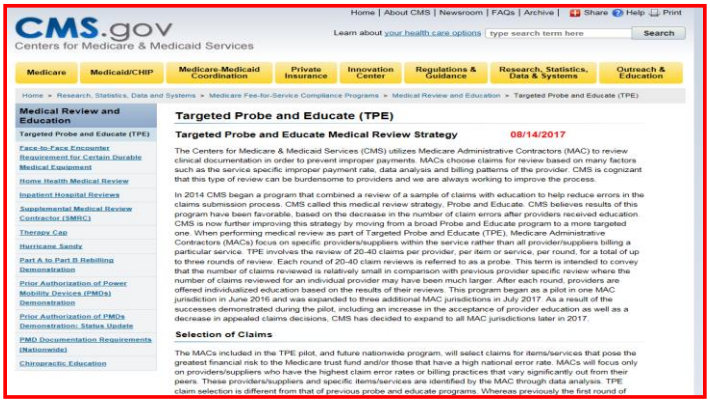
Targeted Probe and Educate

Targeted Probe and Educate (TPE)

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



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.

Targeted Probe and Educate (TPE)

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.

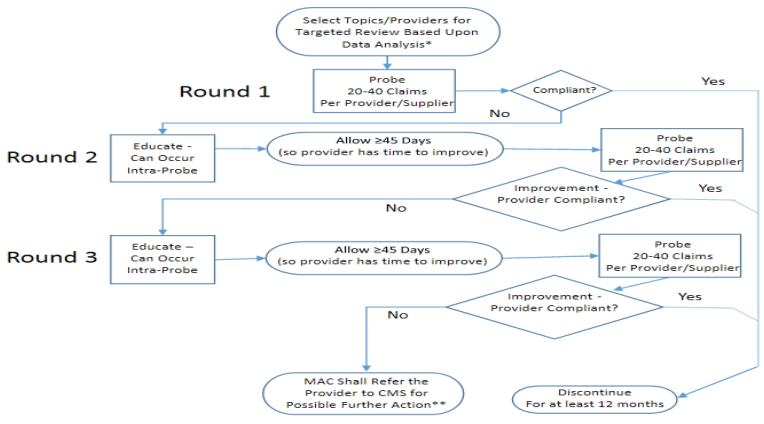
Targeted Probe and Educate (TPE)

Probe Review and Education Process

The TPE review and education process includes a review of 20-40 claims followed by one-on-one, provider-specific, education to address any errors with in the provider's reviewed claims. Providers/suppliers with moderate and high error rates in the first round of reviews, will continue on to a second round of 20-40 reviews, followed by additional, provider specific, one-on-one education. Providers/suppliers with high error rates after round two will continue to a third and final round of probe reviews and education (Please see the TPE Process Flowchart in the downloads section below). In addition to education at the conclusion of each 20-40 claim probe review, MACs also educate providers throughout the probe review process, when easily resolved errors are identified, helping the provider to avoid additional similar errors later in the process.

Providers/suppliers with continued high error rates after three rounds of TPE may be referred to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, or other action. Providers/supplier may be removed from the review process after any of the three rounds of probe review, if they demonstrate low error rates or sufficient improvement in error rates, as determined by CMS.

Targeted Probe & Educate



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

Targeted Probe and Educate

https://cgsmedicare.com/hhh/education/faqs/tpe_faqs.html

Targeted Probe and Educate FAQs

Click on a question to expand *or* Show All / Close All

1. What is Targeted Probe and Educate (TPE)?

   As a Medicare Administrative Contractor (MAC), CGS Administrators, LLC is required by the Centers for Medicare & Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment. CMS has authorized Jurisdiction 15 to conduct the Targeted Probe and Educate (TPE) review process.

   The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations. Targeted Probe and Educate Review consists of up to three rounds of review. A span of 20-40 pre or post payment claim sample will be selected for review with each round.

   New: 10.04.17

2. How and why was I selected?

   - Providers are selected based on analysis of billing data indicating aberrancies that may suggest questionable billing practices.

     OR

   - Provider was already on targeted review and transitioned to TPE based on error rate results.

     OR

   - Provider error rate results based on service specific review.

   New: 10.04.17

3. How many claims will be selected?

   A span of 20-40 pre or post payment claim samples will be selected for review with each round. Your notification and additional documentation request (ADR) letter or system notification will indicate if the sample is pre-payment or post-payment.

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Most Frequent Denial Reasons

Top HH Medical Review Denial Reasons
July – September 2017

Denial Code	Denial Description
5HC01 (24%)	Physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely
56900 (21%)	Requested documentation not received/received untimely
5HC08 (11%	Recertification estimate of how much longer skilled services are required is missing/incomplete/invalid
5HY01 (7%)	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
5HC09 (5%)	Initial certification was missing/incomplete/invalid, therefore the recertification episode is denied.
Signature Concerns Skilled Nursing Services Were Not Medically Necessary	

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

No Response to Additional Development Request (ADR)

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

56900 – Did You Know??

- Access the FISS Pages 07 and 08 to determine what is being requested and the date it must be received by CGS
- Strongly 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

No Response to ADR

http://cgsmedicare.com/hhh/education/materials/pdf/ADR_QRT.pdf

- Quick resource tool
- Chart of how claim is processed
- List of how to check for ADRs using FISS
- Recommendations
- Checklist
- Preferred order of document submission

No Response to ADR

Medical Review Additional Development Request (MR ADR) *Quick Resource Tool*

Checking for MR ADRs using FISS	
Step 1	Choose FISS Main Menu option 01 (Inquiries)
Step 2	Choose FISS Inquiry Menu option 12 (Claims)
Step 3	Press 'Shift' and 'Tab' to move to the NPI field and enter your NPI number
Step 4	Tab to S/LOC field and enter 'S B6001'
Step 5	Press Enter
Step 6	MR ADR claims will appear (Reason Code 39700)
Step 7	Select each MR ADR claim (key 'S' in SEL field)
Step 8	Go to FISS Page 07 to view the MR ADR message. Press F6 to continue reviewing the message. Press F5 to return.
Step 9	Screenprint FISS Page 07
Step 10	Identify the data in the following fields: DUE DATE, HIC, PATIENT NAME, FROM DATE and THRU DATE **Note:** The DUE DATE that appears is day 45. Allow enough time for CGS to receive the documentation by day 45. If not received by day 46, the claim will be denied.
Step 11	Go to FISS Page 08
Step 12	Screenprint FISS Page 08
Step 13	On FISS Page 08, identify the documentation requested for the MR ADR. **Note:** You may need to press F6 to view all requested documents.
Step 14	Copy/print requested documentation and arrange per preferred order on MR ADR checklist
Step 15	Ensure internal QA process to review documentation is complete and mailed timely
	Attach screenprint of FISS Page 07 to top of documentation

Recommendations

- Review chart documentation prior to sending. Ensure documentation complete and supports all services/levels of care billed. Documentation for dates before/after the claim may be necessary to support services.
- CGS recommends organizing documentation according to the MR ADR Checklist below, which will expedite the review process.
- **Ensure documentation is received by CGS on/ before 45 calendar days (DUE DATE on FISS Page 07).** Please allow enough time for mailing, and movement of the claim to S M50MR. MR ADR documentation may also be submitted via fax (1.515.471.7581), myCGS, CD/ DVD, or esMD.
- If claim is denied, review FISS Page 04 for Medical Review staff remarks to identify reason for denial.
- Review denial reasons and identify action plan to prevent further denials.
- Review, assess, and implement internal processes and plans to ensure staff understands the MR ADR process.
- Call the CGS Provider Contact Center (PCC) at 1.877.299.4500 (option 1) with questions about MR ADR process or denied claims.

Hospice MR ADR Checklist - Preferred Order	
1	FISS Page 7 screenprint
2	Signed election statement
3	Plan of care with physician certification/recertifications
	Physician Face-to-Face documentation (for third and

No Response to ADR

Step 15	Ensure internal QA process to review documentation is complete and mailed timely
Step 16	**Attach screenprint of FISS Page 07 to top of documentation.** Mail to CGS (address shown on Page 07) **by the DUE DATE (day 45).** J15 — HHH Correspondence CGS PO Box 20014 Nashville, TN 37202 MR ADR documentation may also be submitted via fax (1.515.471.7581), myCGS, CD/DVD, or esMD.
Step 17	Monitor MR ADR in FISS, using option 12, to identify when documentation received by CGS (appears in S M50MR)

ADR Process Resources

- **Program Integrity Manual** (CMS Pub. 100-08) Ch. 3 - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf
- CMS *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC* booklet - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf
- **FISS Guide**, Chapter 3: Inquiry Menu, *Accessing Additional Development Request Information* section - http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf
- **Medical Review Additional Development Request (ADR) Process** Web page, http://www.cgsmedicare.com/hhh/medreview/adr_process.html
- Electronic Submission of Medical Documentation Web page, https://www.cgsmedicare.com/hhh/medreview/ESMD.html
- **myCGS User Manual, Chapter 7: 'Forms' Tab** -

2	Signed election statement
3	Plan of care with physician certification/recertifications
4	Physician Face-to-Face documentation (for third and later benefit periods)
5	Physician orders
6	IDG reviews/POC updates **Note:** Include reviews for each 15-day period to cover the billing period. This may include reviews/updates that occurred prior to the billing period.
7	Admission initial assessment
8	Visit notes (nursing, social worker, chaplain, etc.)
9	Physician visit notes
10	Other relevant documentation

Home Health MR ADR Checklist - Preferred Order

1	FISS Page 7 screenprint
2	Physician Face-to-Face documentation
3	Plan of care with physician certification/recertifications
4	Interim/verbal orders
5	OASIS assessment
6	Nursing visit notes
7	Therapy visit notes including evaluations/re-evaluations
8	Social work visit notes
9	Aide visit notes
10	Other relevant documentation

No Response to ADR

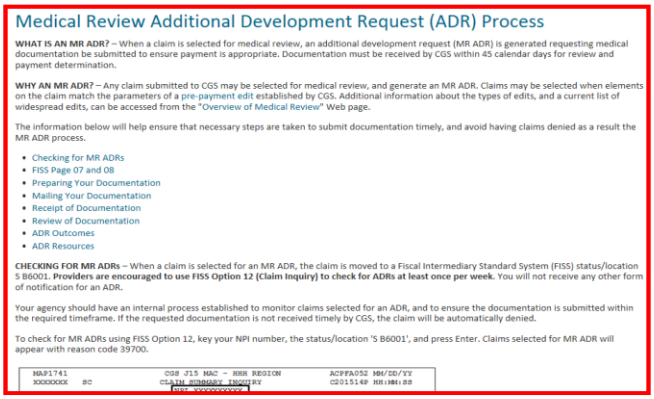
Home Health MR ADR Checklist - Preferred Order

1	FISS Page 7 screenprint
2	Physician Face-to-Face documentation
3	Plan of care with physician certification/recertifications
4	Interim/verbal orders
5	OASIS assessment
6	Nursing visit notes
7	Therapy visit notes including evaluations/re-evaluations
8	Social work visit notes
9	Aide visit notes
10	Other relevant documentation

ADR Process

CGS "Additional Development Request (ADR) Process" Web page

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



Medical Review Additional Development Request (ADR) Process

WHAT IS AN MR ADR? – When a claim is selected for medical review, an additional development request (MR ADR) is generated requesting medical documentation be submitted to ensure payment is appropriate. Documentation must be received by CGS within 45 calendar days for review and payment determination.

WHY AN MR ADR? – Any claim submitted to CGS may be selected for medical review, and generate an MR ADR. Claims may be selected when elements on the claim match the parameters of a pre-payment edit established by CGS. Additional information about the types of edits, and a current list of widespread edits, can be accessed from the "Overview of Medical Review" Web page.

The information below will help ensure that necessary steps are taken to submit documentation timely, and avoid having claims denied as a result the MR ADR process.

- Checking for MR ADRs
- FISS Page 07 and 08
- Preparing Your Documentation
- Mailing Your Documentation
- Receipt of Documentation
- Review of Documentation
- ADR Outcomes
- ADR Resources

CHECKING FOR MR ADRs – When a claim is selected for an MR ADR, the claim is moved to a Fiscal Intermediary Standard System (FISS) status/location 5 B6001. **Providers are encouraged to use FISS Option 12 (Claim Inquiry) to check for ADRs at least once per week.** You will not receive any other form of notification for an ADR.

Your agency should have an internal process established to monitor claims selected for an ADR, and to ensure the documentation is submitted within the required timeframe. If the requested documentation is not received timely by CGS, the claim will be automatically denied.

To check for MR ADRs using FISS Option 12, key your NPI number, the status/location '5 B6001', and press Enter. Claims selected for MR ADR will appear with reason code 39700.

Document Submission

Recommendations

- **Clinicians review all documents prior to sending**
- Providers may include an outline or a letter, but will **not** be considered actual documentation
- Draw the reviewer's eyes to important information

Face-to-Face (FTF) Encounter

FTF Documentation: Important Reminders

Medicare Benefit Policy Manual Chapter 7 100-02; Section 30.5.1.1 – Face-to-Face Encounter

FTF is requirement for Medicare payment

Missing/incomplete documentation results in **entire claim being denied**

Face-to-Face When?

Certifying physician must document FTF took place within

- **90 days prior to start of care (SOC),** or
- **30 days after SOC**

Reminder:

- FTF must be related to **primary reason** for home health admission
- **Exceptional** circumstance: Patient death **before** FTF can be performed

FTF Documentation: Important Reminders

As the billing entity, the home health agency's (HHA's) **responsibilities** include:

- Facilitating and coordinating between patient and physician to ensure FTF occurs timely
- Ensuring all FTF requirements are met
- Ensuring physician's documentation is complete
- Delaying submission of claim until documentation complete

Supporting Documentation

Documentation in the certifying physician's medical record and/or acute/post-acute care facility's medical record:

- Will be used as basis for patient's home health eligibility
- Must contain information to justify the referral for home health services including:
  - **Need for skilled services; and**
  - **Homebound status**

Supporting Documentation

HHAs may send information to the certifying physician:

- Created/generated by HHA
- Other information created/generated by and obtained from the acute/post-acute facility clinicians and staff

The certifying physician may consider and/or use any information sent by the HHA, that has been incorporated into the medical record, as the **basis for certification** of the patient's eligibility for home health services

Supporting Documentation

Some examples of supporting documentation to send to physician's medical record:

- Start of care (SOC) OASIS
- Face-to-face encounter documentation
- Plan of care
- Certification/recertification statement
- Discharge summaries
- History and physical examination (H&P)

Supporting Documentation

- Documentation created or generated by the HHA must be **signed/dated** by certifying physician to indicate acceptance of documentation into their medical records

- Physician's dated signature must be **on/before the time of claim submission**

Supporting Documentation

The physician's **sign-off** indicates the physician reviewed, accepted and incorporated the HHA generated documents into the patient's medical record held by the certifying physician (and/or the acute/post acute care facility).

Supporting Documentation

Documentation in the certifying physician's medical record and/or acute/post-acute care facility's medical record:

- **Must** be provided to home health agency (HHA) when requested

Home health agencies should obtain **as much documentation** from the physician's and/or facility's medical records as necessary to assure **eligibility criteria** has been met

Supporting Documentation

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9112.pdf

Medicare Learning Network® MLN Matters® CMS

Official Information Health Care Professionals Can Trust

REVISED product from the Medicare Learning Network®

- "The DMEPOS Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet, ICN 903624, downloadable

MLN Matters® Number: MM9112 | Change Request (CR) #: CR 9112
Related CR Release Date: April 17, 2015 | Implementation Date: July 20, 2015
Related Transmittal #: R587PI | Effective Date: July 20, 2015

Clarification of Ordering and Certifying Documentation Maintenance Requirements

Supporting Documentation

Section 30.5.1.2, certifying physician and/or acute/post-acute facility medical record (if the patient was directly admitted to home health) for the patient **must contain the actual clinical note for the FTF encounter visit** that demonstrates that the encounter:

- Occurred within required timeframe;
- Was related to primary reason patient requires home health services
- Was performed by an allowed provider type

Face-to-Face before Certification

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 208	Date: April 22, 2015
	Change Request 9119

B. Policy: The Affordable Care Act requires that the certifying physician or allowed non-physician provider (NPP) must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit. Regulations require that the encounter occur within 90 days before care begins or up to 30 days after care began. Previous regulations required that documentation of the encounter must include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of skilled services.

Documentation of FTF date

Patient discharged from acute/post-acute facility directly to home health services

- **Hospitalist** sees patient & **performs FTF encounter**
- **Community physician** will follow patient after discharge and **certifies HH services**
  - HH criteria requires patient to be under care of physician
  - Certifying physician must document the date of the FTF encounter before the claim is submitted for billing
    - (**Medicare Benefit Policy Manual 100-02 Ch. 7;** Section 30.5.1)

FTF with Certification

If the FTF encounter form **also certifies** patient for home health, the hospitalist must identify the community physician who will follow the patient.

Medicare Benefit Policy Manual 100-02 Ch. 7

Section 30.5.1

Common Denials Reasons

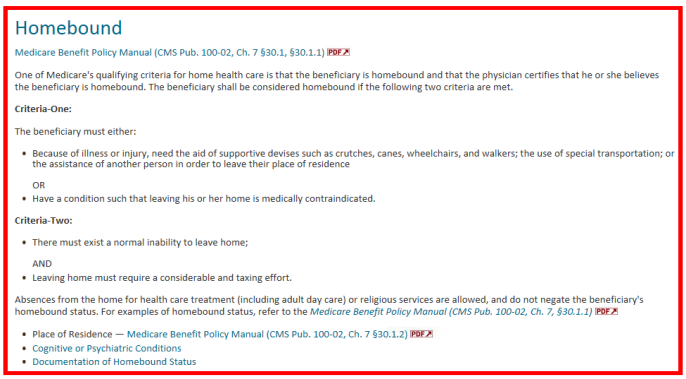
- Diagnoses/clinical findings on FTF not related to home care ordered
- No date of FTF encounter
- No actual clinical note
- Certifying physician did not document the date of the face-to-face encounter
- **Not clearly titled** as face-to-face encounter
- Missing, unidentified or undated signatures

Homebound Status

Homebound Status

CGS Homebound Web page

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



Homebound

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

One of Medicare's qualifying criteria for home health care is that the beneficiary is homebound and that the physician certifies that he or she believes the beneficiary is homebound. The beneficiary shall be considered homebound if the following two criteria are met.

Criteria-One:

The beneficiary must either:

- Because of illness or injury, need the aid of supportive devises such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

  OR
- Have a condition such that leaving his or her home is medically contraindicated.

Criteria-Two:

- There must exist a normal inability to leave home;

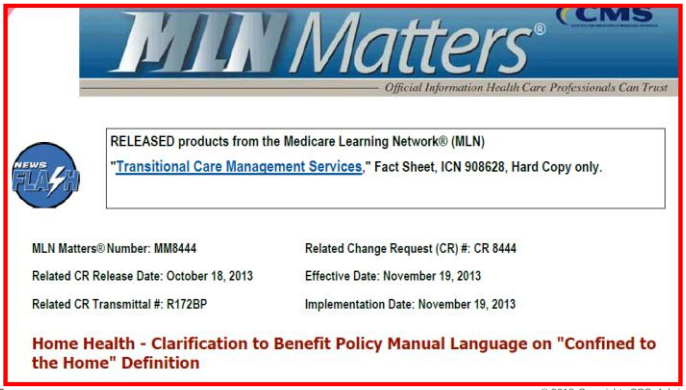
  AND
- Leaving home must require a considerable and taxing effort.

Absences from the home for health care treatment (including adult day care) or religious services are allowed, and do not negate the beneficiary's homebound status. For examples of homebound status, refer to the *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7, §30.1.1)* PDF

- Place of Residence — Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1.2) PDF
- Cognitive or Psychiatric Conditions
- Documentation of Homebound Status

Homebound Status

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



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"Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8444 | Related Change Request (CR) #: CR 8444

Related CR Release Date: October 18, 2013 | Effective Date: November 19, 2013

Related CR Transmittal #: R172BP | Implementation Date: November 19, 2013

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

Homebound Status

Two criteria are used to determine homebound status

Criteria-One:

The patient must **either**:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

OR

- Have a condition such that leaving his or her home is medically contraindicated.

Homebound Status

Two criteria are used to determine homebound status (continued)

Criteria-Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

Homebound Status

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

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

Homebound Status

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

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

Homebound Status

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

- "After ambulating 20 feet, patient has increased dyspnea where pulse ox shows 83 and complains of severe lower back pain of 5/10. Must sit for 4 minutes before able to continue."
- "Patient has unsteady gait, and must sit to rest for 3 minutes after 10 feet of ambulation due to uncontrolled vertigo."

Certification and Recertification

Physician Certification

Physician certification documentation requirements:

1. The patient needs intermittent SN care, PT, and/or SLP services
2. The patient is confined to the home
3. A plan of care has been established and will be periodically reviewed by a physician
4. Services will be furnished while the individual is under the care of a physician
5. A face-to-face encounter (if there is Start of Care OASIS)

Physician Initial Certification

ALWAYS include the initial certification

Physician Recertification

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

- As part of the **recertification document**
- A recertification that does not include this information may result in a claim denial

Physician Recertification

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

- **5 weeks.**
- **10 days.**

Physician Recertification

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

Unacceptable examples of treatment goals:

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

Medical Necessity

Medical Necessity

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

Medically Necessary and Reasonable

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

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

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

Impact of Caregivers on Medical Necessity

National and Local Coverage Determinations

Documenting Medical Necessity

Medical Necessity

Full denials

OR

Partial denials, may result in Low Utilization Payment Adjustment (LUPA) or therapy downcodes

Medical Necessity

All services must be reasonable and medically necessary **related to the patient's condition.**

- Observation and assessment
- Teaching
- Therapy

Medical Necessity

Does the documentation clearly answer "why home health and why now?"

Reminder: Good documentation should address:

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

Medical Necessity - "Do's"

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

Examples of **good documentation to support medical necessity**:

- "Wound care completed per POC to left great toe. No s/s of infection, but patient remains at risk due to diabetic status."
- "Range of motion (ROM) is tolerated to lower extremities. Unsafe to teach caregiver ROM due to patient's displaced fracture."

Medical Necessity – "Do's"

Demonstrate **medical necessity** of skilled observation and assessment by documenting complexity of beneficiary's condition and co-morbidities affecting outcomes.

Examples of **good documentation**:

- "Lungs sound coarse throughout. Patient finished antibiotic therapy today for pneumonia, and seeing pulmonologist tomorrow for follow up to due to COPD and emphysema."
- "Stasis wound on LLE continues to show 50% granulation and moderate serous drainage. Instructed patient on need to elevate legs and exercises related to peripheral vascular disease."

Medical Necessity – "Don'ts"

Skilled nursing **fables.** These are **NOT TRUE!**

- "As long as you document teaching, it is a billable visit."
- "As long as you document assessment, it is a billable visit."

Plan of Care

Plan of Care

Plan of care must be reviewed, **signed and dated** by physician who established the plan of care **at least every 60 days**, and **prior to** submitting the claim to Medicare

Orders must include

- **Patient's name**
- **Disciplines** being provided, including **frequency and duration**

Plan of Care Denials

Common denial reasons include:

- Dates: Verbal order, date of physician signature
- Incomplete orders/POC
- Timeliness: must be **SIGNED** and **DATED** by physician prior to billing
- Missing dates: "Received date" NOT accepted
- POC must be signed by correct physician

Plan of Care Denials

Common denial reasons include:

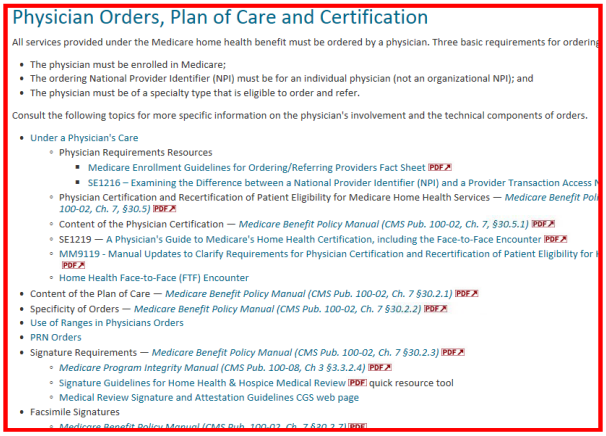
- POC must be signed by correct physician

24. Physician's Name and Address

27. Attending Physician's Signature and Date Signed

Plan of Care

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



Physician Orders, Plan of Care and Certification

All services provided under the Medicare home health benefit must be ordered by a physician. Three basic requirements for ordering

- The physician must be enrolled in Medicare;
- The ordering National Provider Identifier (NPI) must be for an individual physician (not an organizational NPI); and
- The physician must be of a specialty type that is eligible to order and refer.

Consult the following topics for more specific information on the physician's involvement and the technical components of orders.

- Under a Physician's Care
  - Physician Requirements Resources
    - Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet PDF
    - SE1216 – Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access N
  - Physician Certification and Recertification of Patient Eligibility for Medicare Home Health Services — *Medicare Benefit Poli 100-02, Ch. 7, §30.5)* PDF
  - Content of the Physician Certification — *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7, §30.5.1)* PDF
  - SE1219 — A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter PDF
  - MM9119 - Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for H PDF
  - Home Health Face-to-Face (FTF) Encounter
- Content of the Plan of Care — *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.2.1)* PDF
- Specificity of Orders — *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.2.2)* PDF
- Use of Ranges in Physicians Orders
- PRN Orders
- Signature Requirements — *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.2.3)* PDF
  - *Medicare Program Integrity Manual (CMS Pub. 100-08, Ch 3 §3.3.2.4)* PDF
  - Signature Guidelines for Home Health & Hospice Medical Review PDF quick resource tool
  - Medical Review Signature and Attestation Guidelines CGS web page
- Facsimile Signatures
  - *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.2.7)* PDF

Plan of Care

Certification must be obtained when POC is established, or soon after; and must be complete, signed and dated by the physician who established the POC **prior to** submitting the claim.

Required contents: CMS Medicare Benefit Policy Manual (Pub. 100-02) Ch. 7, § 30.2.1

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Resources

Home Health Clinical Resources

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 7)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

Table of Contents
(Rev. 208, 05-11-15)

Transmittals for Chapter 7

10 - Home Health Prospective Payment System (HH PPS)

Denial Resources

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

Home Health Top Medical Review Denial Reason Codes

July - September 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.	565	24%

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	494	21%

Home Health Coverage Resources

http://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html

Home Health Coverage Guidelines

Medicare Benefit Policy Manual, (CMS Publication 100-02, Ch. 7) PDF

CMS Quick Reference Information: Home Health Services PDF

Medicare pays for care in a beneficiary's home, when qualifying criteria are met, and documented. It is essential for home health agencies to have a complete understanding of these criteria, as you have the right and responsibility, in collaboration with the physician, to decide if the beneficiary qualifies for your services. The agency then must understand what services are covered, and how to document these services. Refer to the following topics for more information:

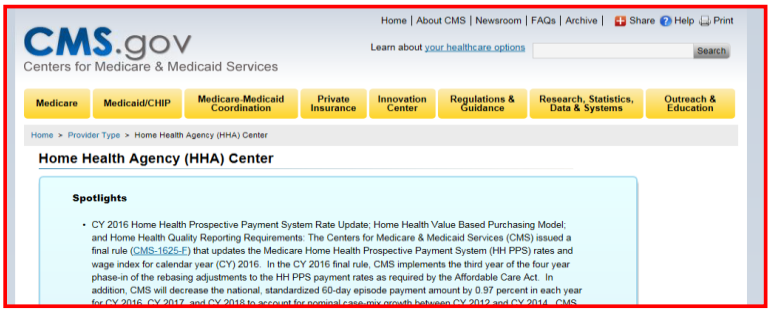
- Qualifying Criteria for Home Health Services
  - Physician orders, Plan of Care and Certification
    - Face-to-Face (FTF) Encounter
    - Face-To-Face Encounter Calendar Quick Resource Tool
  - Homebound;
  - Intermittent, if Skilled Nurse; and
  - Medically Necessary and Reasonable

Medicare-Covered Home Health Services	Additional Resources
• Defining "Visits"	• Advance Beneficiary Notice of Noncoverage (ABN)
• Foot Care under the Home Health Benefit	• Expedited Determination Process

CMS Home Health Agency Center

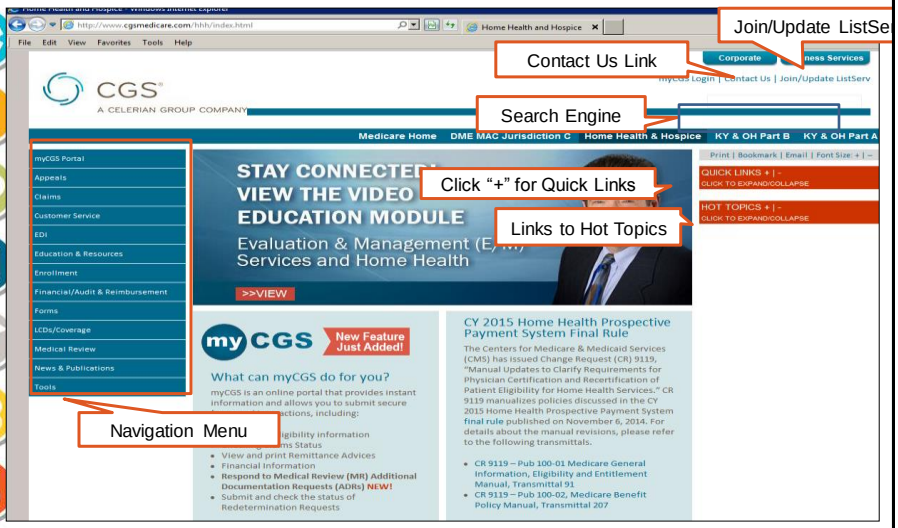
http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

- Spotlights current events & hot topics
- Provides information regarding Open Door Forums (ODF)



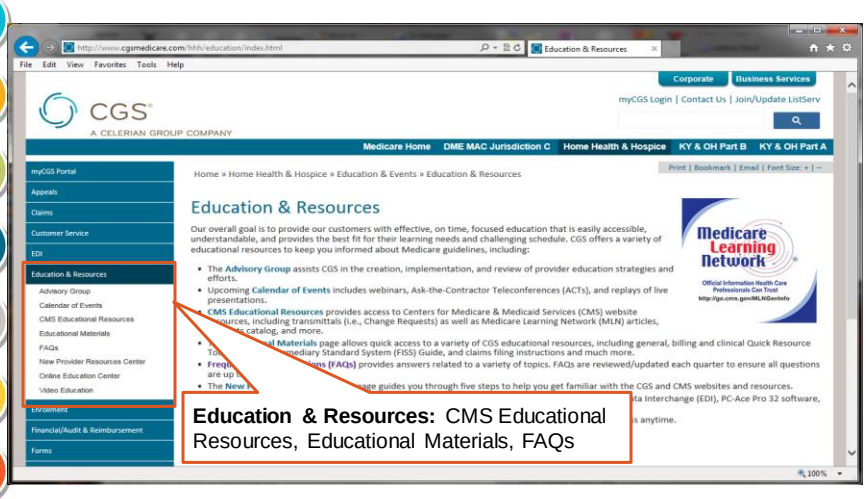
CGS HH&H Website

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



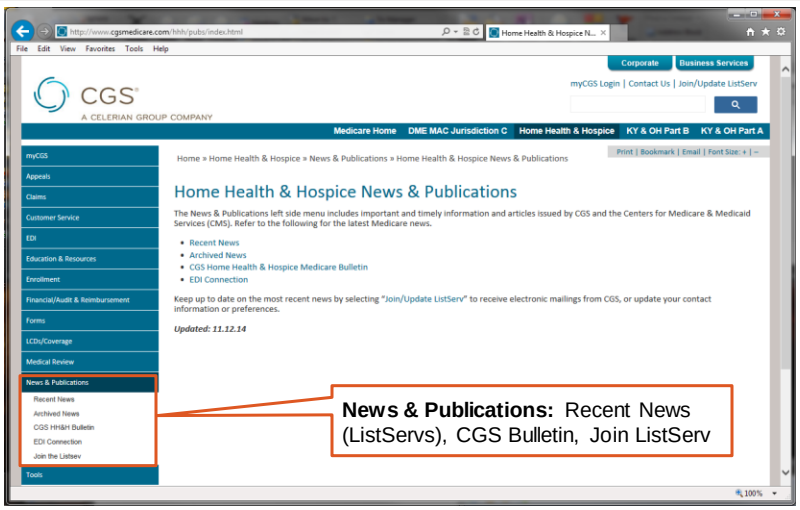
CGS HH&H Website: Education & Resources

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



CGS HH&H Website: News & Publications

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



Resources

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

Frequently Asked Questions (FAQs)

- Additional Development Request (ADR)/Medical Review
- Adjustments/Cancel
- Appeals
- Ask-the-Contractor Teleconference (ACT) Questions and Answers
- Beneficiary Eligibility Information
- Checking Claim Status
- Comprehensive Error Rate Testing (CERT) Program
- Cost Report
- Cost Report Reopening
- EDI
- Home Health Billing
- Home Health Clinical – Medical Review
- Hospice Billing
  - Change Request 8358
  - Change Request 8877
  - Change Request 8877: Updates from CGS on Timely Filing of NOEs and Exception Requests Ask-the-Contractor Teleconference (ACT), February 18, 2015
  - Change Request 8877 Ask-the-Contractor Teleconference (ACT), September 24, 2014
- Hospice Clinical
- Hospice Face-to-Face (FTF) Encounters
- Hospice Physician Billing
- ICD-10-CM/PCS
- Medicare Secondary Payer (MSP)

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)

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