CGS Regulatory Updates for Home Health + Hospice (HHH) Providers

Working Together

October 2024

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HOME CARE AND HOSPICE CONFERENCE AND EXPO

PURPO/E DRIVEN

HOMECARE&HOSPICE
National Association for Home Care & Hospice

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Disclaimer

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This publication is a general summary that explains certain aspects of the Medicare Program but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Objectives

 Discuss Recent Medicare HH&H Updates

 Examine HH&H Billing Requirements and Guidelines

 Analyze Data to Improve Provider Reimbursement

 Explore Available Self-Service Options & Tools

 Review CGS & CMS Resources

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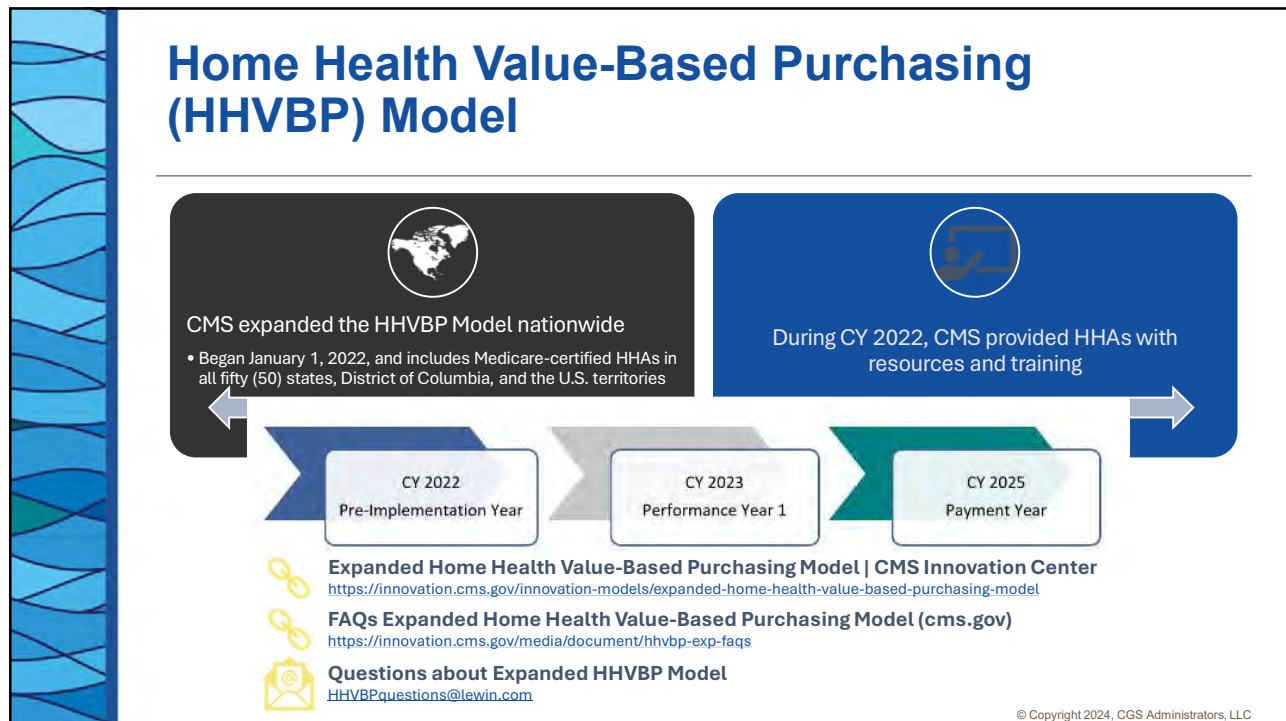
Home Health Updates & Reminders

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Home Health Value-Based Purchasing (HHVBP) Model

CMS expanded the HHVBP Model nationwide

• Began January 1, 2022, and includes Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories

During CY 2022, CMS provided HHAs with resources and training

CY 2022 Pre-Implementation Year	CY 2023 Performance Year 1	CY 2025 Payment Year

Expanded Home Health Value-Based Purchasing Model | CMS Innovation Center
https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model

FAQs Expanded Home Health Value-Based Purchasing Model (cms.gov)
https://innovation.cms.gov/media/document/hhvbp-exp-faqs

Questions about Expanded HHVBP Model
HHVBPquestions@lewin.com

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Slide 7

Expanded HHVBP Model
Sample Reports Available Now

For learning purposes only, CMS provided two sample reports:

Interim Performance Report (IPR) **Annual Performance Report (APR)**

Information Includes:

- An overview of the IPR and APR;
- Achievement, Improvement, Care Points, Measure Scorecard, and TNC Change Reference tabs;
- Annual Payment Adjustment tab in the APR;
- Formulas and Notes to explain the calculations of the Total Performance Score (TPS) in both reports, and the Final TPS-adjusted payment percentage in the APR; and
- Sample percentile rankings reflecting the agency's performance relative to the performance of other CCNs in their cohort.

Expanded HHVBP Model Webpage
https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model

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CMS HHVBP Training

Each CY, HHAs receive **two types of reports:**

Interim Performance Reports (IPRs)
Four quarterly IPRs published in January, April, July, and October.

Annual Performance Reports (APRs)
One APR published in August.

- The HHVBP CY 2024 Annual Performance Report (APR) (cms.gov)

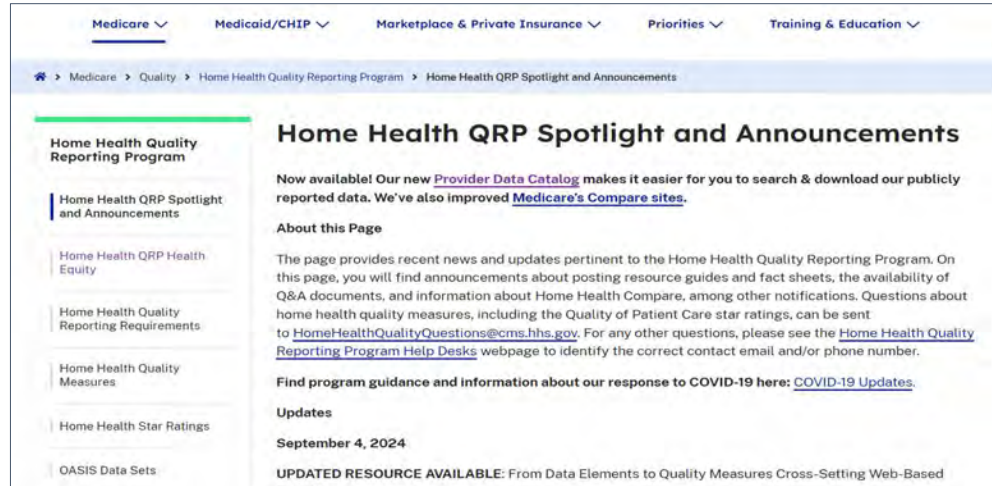*TPS = Total Performance Score

CY 2024 APR Eligibility
- HHAs receive an APR and APP if they:
  - Were Medicare-certified prior to January 1, 2022, **and**
  - Had sufficient data for at least five quality measures to calculate a TPS.

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Home Health Quality Reporting Program (HHQRP)

🔗 Home Health QRP Spotlight and Announcements | CMS

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HHQRP Updates

- **September 4, 2024**
- **UPDATED RESOURCE AVAILABLE**: From Data Elements to Quality Measures Cross-Setting Web-Based Training
- The Centers for Medicare & Medicaid Services (CMS) is offering an updated web-based training course that provides a high-level overview of how data elements are used to construct quality measures used across post-acute care settings.
- This resource can be accessed through the Home Health Quality Reporting Training page.
- **August 26, 2024**
- **UPDATED RESOURCE AVAILABLE**: Section GG Web-Based Training Series
- The Centers for Medicare & Medicaid Services (CMS) is offering an updated series of web-based training courses that provide an overview of the assessment and Section GG guidance found in the OASIS E-1 to promote accurate coding of the post-acute care (PAC) cross-setting data elements.
- This resource can be accessed through the Home Health Quality Reporting Training page.

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Negative Pressure Wound Therapy Devices (NPWT)

HHAs will submit their period of care claims with an applicable disposable NPWT device using the additional coding below.

Claim Field	Code	Description
TOB	032X	4th Digit - Definition • 9 - Final Claim for an HH PPS Period • 7 - Replacement of Prior Claim
Revenue Code	027x (other than 0274)	Medical/Surgical Supplies
HCPCS	A9272	Wound suction, disposable, includes dressing, all accessories and components, any type, each.
Service Date	Any date within the billing period is acceptable. The HHA may enter the date the device was applied or if there were more than one device applied during the period, the HHA may enter the date the first date the device was applied.	Required
Units	Represent the number of disposable devices provided during the billing period	Representing the number of disposable devices provided during the billing period
Charges	Report charges per the HHA's internal policy for determining charges	Required

CGS Article – Separate Payment for Disposable NPWT Devices on HH Claims
Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims (cgsmedicare.com)

CGS Home Health Special Claims Filing Situations
Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims (cgsmedicare.com)

MM13244 - Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims (cms.gov)

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2025 Home Health Prospective Payment System Proposed Rule

• Final Rule expected late October/ early November

Fact Sheets Jun 26, 2024

Calendar Year (CY) 2025 Home Health Prospective Payment System Proposed Rule Fact Sheet (CMS-1803-P)

Billing & payments   Policy   Home health agencies

Share

Calendar Year (CY) 2025 Home Health Prospective Payment System Proposed Rule Fact Sheet (CMS-1803-P) | CMS

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Hospice Updates & Reminders

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FY 2025 Hospice Final Rule

https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center

https://public-inspection.federalregister.gov/2024-16910.pdf

CMS-1810-F

Regulation No.	CMS-1810-F
Title	FY 2025 Hospice Wage Index and Payment Rate Update; Hospice Conditions of Participation Upda... Hospice Quality Reporting Program Requirements
Display Date	2024-07-30
Publication Date	2024-08-06

The final rule went on display at the Office of the Federal Register's Public Inspection Desk on July 30, 2024 and will be available until the regulation is published on August 6, 2024. See CMS-1810-F in the "Related Links" section below.

Downloads

FY 2025 Final Hospice Wage Index

Related Links

CMS-1810-F

Effective Date: 10/1/2024

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Medicare Hospice Payment Policies

Rule finalizes policy to adopt most recent Office of Management and Budget (OMB) statistical area delineations, which revise existing core-based statistical areas (CBSA) based on data collected during the 2020 Decennial Census.

https://www.cms.gov/medicare/payment/fee-service-providers/hospice/hospice-wage-index/fy-2025-final-hospice-wage-index

Hospices negatively affected by the change to their geographic wage index will only experience a maximum 5% reduction to their 2024 wage index, as there is a 5% cap on any decrease to the wage index from the prior year.

This permanent cap, finalized in the FY 2023 Hospice Final Rule, prevents a geographic area's wage index from falling below 95% of its wage index calculated in the prior FY.

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FY 2025 Routine Annual Rate Setting Changes

The FY 2025 hospice payment update percentage is 2.9% (an estimated increase of $790 million in payments from FY 2024).

The FY 2025 payment rates for hospices that do not submit the required quality data would reflect the finalized FY 2025 hospice payment update percentage of 2.9%, minus four percentage points, which results in a -1.1% update.
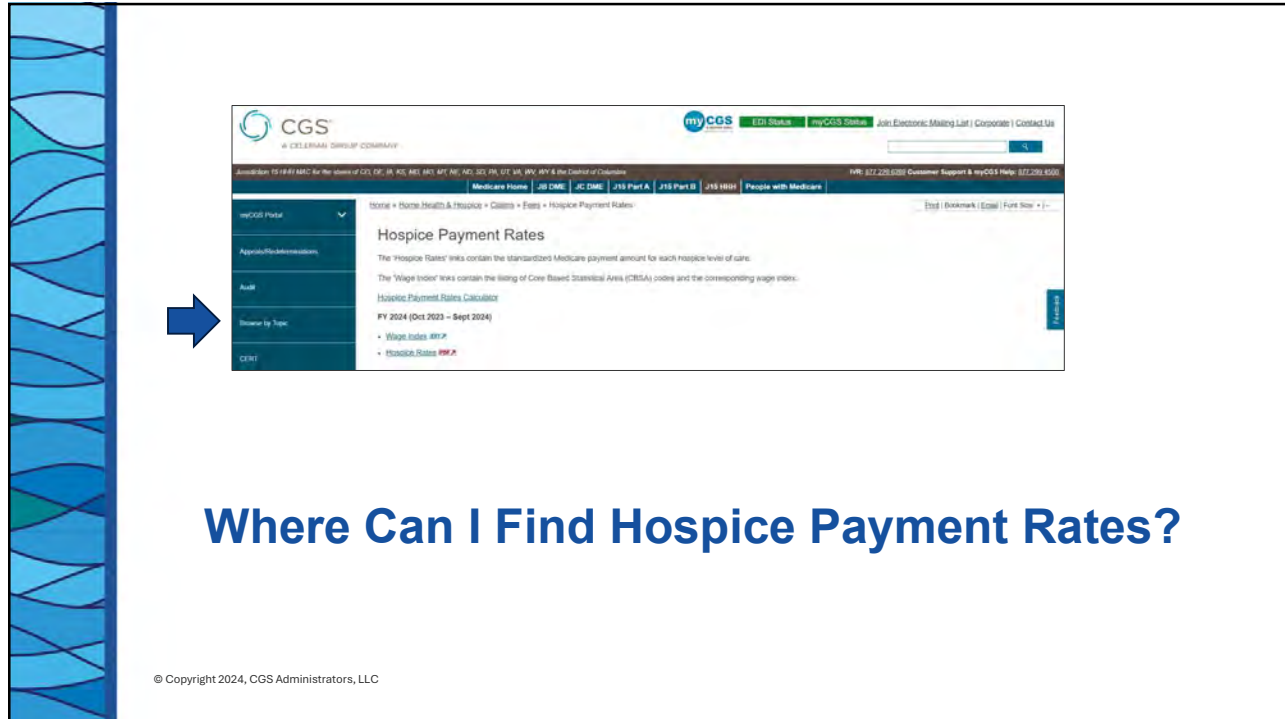
The hospice payment update includes a statutory aggregate cap that limits the overall payments per individual that may be made annually to a hospice. The finalized hospice cap amount for FY 2025 is $34,465.34 (FY 2024 cap amount of $33,494.01, increased by the FY 2025 hospice payment update percentage of 2.9%).

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Where Can I Find Hospice Payment Rates?

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Hospice Outcome and Patient Evaluation (HOPE)

- The rule also adopts and implements the HOPE patient-level data collection tool, beginning with FY 2025, and functionally replaces, upon implementation, the existing Hospice Item Set (HIS) structure.
  - **Expected to be available October 1, 2025**
- HOPE will collect data at multiple time points across the hospice stay, including admission, the HOPE Update Visit (HUV), and discharge. Compared to the HIS (which only collects data at hospice admission and discharge), HOPE will enable CMS to gather patient-level data during their hospice stay to improve patient quality of care. In addition, HOPE includes several domains that are new or expanded relative to HIS, including:
  - Sociodemographic (updated)
  - Diagnoses (expanded)
  - Symptom Impact Assessment
  - Skin Conditions
  - Imminent death

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New CMS HOPE Video

- CMS is offering a 4-minute, animated explainer video for hospice providers.
- This video describes HOPE, the timepoints, their data collection timeframes, and introduces the symptom follow-up visit (SFV), if triggered during a HOPE timepoint.
- HOPE data collection will be required for the Hospice Quality Reporting Program (HQRP) beginning on October 1, 2025 (FY 2026)
- HOPE Data Collection Timepoints Explainer Video – YouTube

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Hospice Quality Reporting Program (HQRP)

- Rule finalizes two new process measures to HQRP, expected to begin in FY 2028.
  - *Timely Follow-up for Pain Impact*
  - *Timely Follow-up for Non-Pain Symptom Impact*
- Reporting of these two measures would be through the new HOPE instrument.
- These process measures address hospice care delivery as they document whether a follow-up visit occurred within 48 hours of an initial assessment where there was an impact of moderate or severe symptoms with and without pain.
- https://www.cms.gov/medicare/quality/hospice

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Did You Know?

Notice of Election: Commonly known as the NOE – billing transaction

Election Statement: To receive hospice services under the Medicare Hospice Benefit, the patient (or authorized representative) must elect hospice care by signing an election statement.

https://cgsmedicare.com/hhh/coverage/coverage_guidelines/election_requirements.html

Additionally, CMS is proposing regulation text changes related to clarify the requirements related to the election statement and NOE in the CoPs. These regulation text changes do not change current policy but are intended to reorganize and more clearly distinguish the separate requirements for the "election statement" and the NOE.

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Value Based Insurance Design (VBID) – Hospice Benefit Component

- **Hospice Benefit Component**
- The Centers for Medicare & Medicaid Services announced in January 2019 that beginning in CY 2021, through the VBID Model Hospice Benefit Component, participating MAOs could include the Medicare hospice benefit in their Part A benefits package.
- After careful consideration, **CMS has decided to terminate the Hospice Benefit Component as of 11:59 PM, December 31, 2024**.
- CMS will not be accepting applications to the previously released CY 2025 Request for Applications for the Hospice Benefit Component of the VBID Model.

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VBID Transition
CY2024 VBID-Hospice Technical and Operational Guidance (cms.gov)

Patients will revert to traditional Medicare as of January 1, 2025

Smooth transition
- Providers already submitting notices and claims to traditional Medicare and VBID plan

Maintain same hospice benefit offered by traditional Medicare

Supplemental benefits will end December 31, 2024
- Transitional & palliative offered under VBID plans

VBID plans to notify patients and caregivers
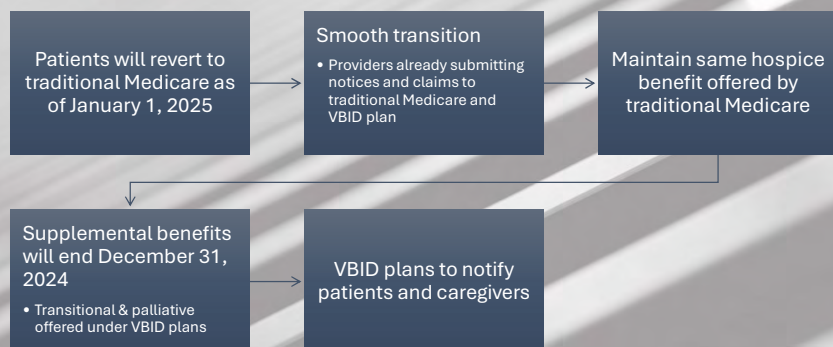
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Hospice Certifying Physician Enrollment Background

- "Under our existing regulations, (1) the hospice medical director or the physician member of the hospice interdisciplinary group (hereafter the "hospice physician") and (2) the attending physician (if the beneficiary has one) must initially certify the patient's terminal condition. (For subsequent periods, only the hospice physician must do so.) As part of CMS' larger strategy to address hospice program integrity and quality of care, and under our authority under section 6405 of the Affordable Care Act, we are finalizing our proposal that these two categories of physicians must be enrolled in or opted out of Medicare for hospice services to be paid. Requiring enrollment or opt-out will allow us to screen the physician to ensure they are qualified (e.g., licensed) to certify the terminal condition."

- In response to concerns raised by commenters, we will not implement or enforce this requirement until May 1, 2024, to give unenrolled and non-opted-out physicians more time to enroll in or opt-out of the Medicare program.

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Reason Code 17729

- **Subject**
  Effective **June 3, 2024**, (delayed from May 1, 2024), for claim "from" dates on or after this date, CMS implemented edits to enforce a new rule that would deny hospice claims if the certifying physician entered in the **Attending** field on the claim is not in the Provider Enrollment Chain and Ownership System (PECOS) as an enrolled or opted-out physician.

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Reason Code 17729 Description

The attending physician's National Provider Identifier (NPI) data on the claim does not match the PECOS Enrolled Physicians File, or the dates do not fall within the physicians effective/termination dates.

- This reason code will edit the claim's attending physician's NPI data against the PECOS Enrolled Physicians File for hospice claims, type of bill 81X and 82X (excluding 8XA, 8XB, 8XC, 8XD and 8XE) with a statement "from" date on or after June 3, 2024, and will assign when:

  - Occurrence Code 27 and associated date (hospice certification or recertification date) are present, and the Occurrence Code 27 date does not fall on or after the physician's effective date but before the termination date on the PECOS Enrolled Physicians File

  - Occurrence Code 27 and associated date are not present and the claim statement "from" date is not on or after the physician's effective date but before the termination date

  - The attending physician's NPI and/or the first four characters of the physician's last name does not match the NPI and/or the first four characters of the physician's last name

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Reason Code 17729 Resolution

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The CMS Order and Referring Dataset provides information on all physicians, as well as nurse practitioners (NPs) or physician assistants (PAs) by their NPI, who are of a type/specialty that is legally eligible to order, certify and refer in the Medicare program and who have current enrollment records in Medicare. Check the dataset to ensure the attending physician entered on the claim is:

- Listed on the CMS Order and Referring Dataset with a "Y" in the hospice column. If the physician has an "N" in the hospice column, they are not eligible to certify for hospice and the claim cannot be approved for payment.
- Their NPI is correct
- Their first four (4) characters of their last name exactly matches the dataset. Ensure the first and last name are not entered in reverse on the claim.

- For initial benefit periods, complete the **Attending Physician** and **Other** fields (with the hospice certifying physician listed in the latter field) unless the patient's designated attending physician is the same as the hospice physician certifying the terminal illness
  - When the attending physician is also the hospice certifying physician, only populate the **Attending Physician** field

- For subsequent benefit periods, the hospice certifying physician may be listed in the claim's **Attending Physician** field to avoid this denial
  - Leave the **Other** field blank

- Reopenings (cgsmedicare.com)

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HH+H Data Analytics

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Data Analytics: Claims Submission Errors (CSEs)

Effects of CSEs

Costs your agency money

- Staff time
- Delayed Medicare payment
- No Medicare payment

Costs your agency time

- To check for claim errors
- To research problem
- To resolve issue
- To correct claim or rebill

Benefits of Reducing CSEs

Timely Medicare payments

- Consistent cash flow
- Avoiding no payment for services, interruptions in payment for services

Increased productivity

- Decreased repetition of errors/staff hours needed for rework

Avoiding negative consequences of appearing in Medicare Administrative Contractor (MAC) data analysis

- Inappropriate billing/payment
- Unnecessary Medicare program costs

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HH+H CSE Data: June – August 2024

June - Dec 2024

Month	# of HH Claims Submitted	Total # of HH CSEs	HH CSE Error Rate	# of Hospice Claims Submitted	Total # of Hospice CSEs	Hospice CSE Error Rate	# of HH+H Claims Submitted	Total # of HH+H CSEs	HH+H CSE Error Rate
Jun-24	113,834	19,065	16.75%	98,085	11,351	11.57%	211,919	30,416	14.35%
Jul-24	120,085	24,492	20.40%	104,715	15,260	14.57%	224,800	39,752	17.68%
Aug-24	118,109	58,380	49.43%	103,009	42,411	41.17%	221,118	100,791	45.58%
Total	352,028	101,937	28.96%	305,809	69,022	22.57%	657,837	170,959	25.99%

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Home Health Top 5 CSEs: June – August 2024

Reason Code	Billing Error	# of Errors
U537F	From date on Notice of Admission (NOA) falls w/in an existing HH admission period	18,847
19963	Statement From Date is on or after 01/01/2022 and less than 24 months from claim Admit Date and a matching Home Health NOA cannot be found	8,336
U5233	Services within HMO Period and NO Hospice involvement or services not within Hospice Period. No Medicare Payment can be made.	7,757
37253	No OASIS assessment	7,211
31755	HIPPS DOS Mismatch	4,166

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Hospice Top 5 CSEs : June – August 2024

Reason Code	Billing Error	# of Errors
37402	Hospice sequential billing error	8,398
17729	Physician certification/Occ cd 27 Issue	7,947
U5106	NOE falls within current hospice election	4,482
U523A	Patient enrolled in VBID	4,424
38200	Duplicate claim	2,839

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Reason Code Search and Resolution

Reason Code Search and Resolution Tool (cgsmedicare.com)

Reason Code Search and Resolution

Disclaimer: This is not a complete list of reason codes.

The Reason Code Search and Resolution tool allows you to view a reason code description and determine how to prevent/resolve the edit. You may search by reason code or keyword. All records matching your search criteria will be returned for your review. You may also select "Show all Reason Codes" to view the complete list.

If the reason code you enter does not display here, you may access any reason code description in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Reason Codes Inquiry Menu (Option 17). For additional information, please reference the FISS DDE User Manual.

Search by: ⦿ Reason Code
◯ Keyword
[   ] [Search >>]

Disclaimer: CGS' online tools and calculators are informational and educational tools only, designed to assist suppliers and providers in submitting claims correctly. CGS makes no guarantee that this resource will result in Medicare reimbursement for services provided. Although we've made every reasonable effort to provide effective resources, CGS is not responsible for the consequences of any decisions or actions taken in reliance upon or as a result of the information that these tools provide. CGS is not responsible for any human or mechanical errors or omissions.

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Medical Review Denials

- [Home Health Denial Reason Codes (cgsmedicare.com)](#)
- [Hospice Denial Reason Codes (cgsmedicare.com)](#)
- [Home Health Top Medical Denial Reason Codes (cgsmedicare.com)](#)
- [Hospice Top Medical Denial Reason Codes (cgsmedicare.com)](#)

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myCGS Portal

All the resources and tools for success at your fingertips!

[myCGS (cgsmedicare.com)](#)

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myCGS Portal webpage

myCGS (cgsmedicare.com)

myCGS Tutorial Video

myCGS User Manual (cgsmedicare.com)

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What Does myCGS Offer?

- Beneficiary eligibility
- Claims status
- View and print Remittance Advices
- Access to financial information
- Submit Redetermination requests
- Receive correspondence from CGS
- Obtain a patient's Medicare Beneficiary Identifier (MBI)
- Check eligibility dates for Medicare-covered preventive services

- Determine Medicare Secondary Payer (MSP) status
- Identify Medicare Advantage (MA) enrollment
- Respond to claims and Medical Review Additional Documentation/Development Request (ADR) letters
- Request Comparative Billing Reports (CBRs)
- Submit roster claims for mass immunizers
- And MUCH more!

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Why Use myCGS?

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myCGS – MBI Look Up Tool

- Must enter the **PATIENT'S**
  - First and last name
  - Social security number
    - Not the *HICN*
  - Date of birth

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Systems for Checking Medicare Eligibility

Features	FISS/DDE (Option 10)	myCGS	HETs
Verify Eligibility	√	√	√
Check Claim Status		√	
View/Print Remittance Advices		√	
Access Financial Information		√	
Submit Redetermination Request		√	
General Medicare Information		√	

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CGSMedicare.com

Every department, resource, and self-service options in one spot!

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CGSMedicare.com

https://www.cgsmedicare.com/index.html

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CGS HH&H Web Page

Home Health and Hospice (cgsmedicare.com)

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Self-Service Tools & Resources

[Self-Service Options (cgsmedicare.com)](https://www.cgsmedicare.com)

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CGS Virtual Education Platform

https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/hhh_report/hhh_report.aspx

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New Provider Resource Center

🔗 **Home Health and Hospice New Provider Resource Center (cgsmedicare.com)**

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New Hospice Provider Resources

🔗 Hospice Quick Resource Tools (cgsmedicare.com)

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New Home Health Provider Resources

Home Health Quick Resource Tools

Home Health Quick Resource Tools (cgsmedicare.com)

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Are you signed up for our email list?

https://cgsmedicare.com/hhh/index.html

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CGS Medicare Mobile App

🔗 **CGS Medicare Mobile App**

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CGS Resources

🔗 **https://www.cgsmedicare.com**

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CMS Resources

Publication # ⇕	Title ⇕
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual
100-05	Medicare Secondary Payer Manual
100-06	Medicare Financial Management Manual
100-07	State Operations Manual
100-08	Medicare Program Integrity Manual
100-09	Medicare Contractor Beneficiary and Provider Communications Manual

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Resources

Medicare Benefit Policy Manual, CMS Pub. 100-02 Ch. 9, §40.1.5
Medicare Benefit Policy Manual (cms.gov)https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 11 §30.1 and 30.3
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf

Expanded HHVBP Model Webpage
https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model

CMS | MLN Homepage
https://www.cms.gov/training-education/medicare-learning-network/resources-training

CMS Resource - Medicare Claims Processing Manual, Section 40.2 HH PPS Claims
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

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Thank You!

CGS Provider Contact Center: 1.877.299.4500

Option 1: Customer Service
Option 2: Electronic Data Interchange (EDI)
Option 3: Provider Enrollment (PE)
Option 4: Overpayment Recovery (OPR)

POE Mailbox: J15_HHH_Education@cgsadmin.com

TPE Mailbox: J15HHProbeandEducation@cgsadmin.com

We Value Your Feedback!

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