601. National Government Services (NGS): Updates From Your Medicare Administrative Contractor (MAC)

10/22/2024

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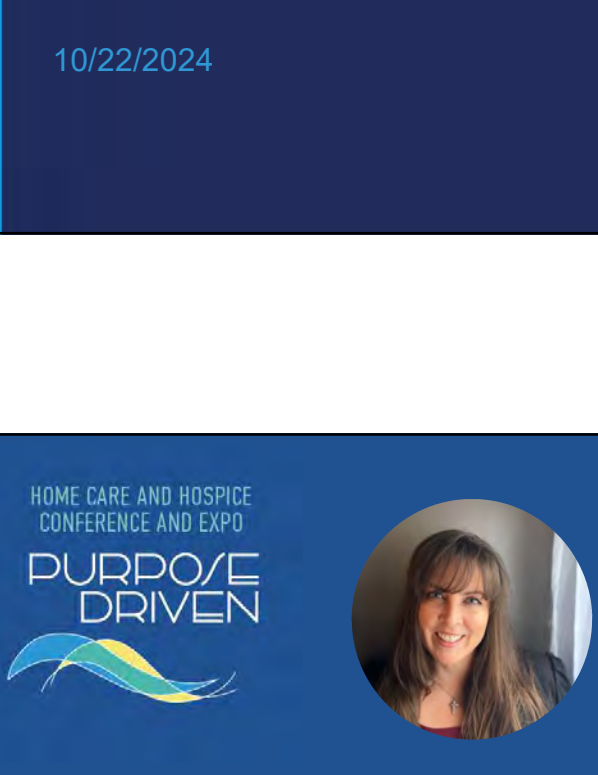

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Learning Outcomes

- Upon completing this session, participants will be able to:
  1. Identify relevant updates/changes to the Medicare home health and hospice programs.
  2. Understand responding to current claim audits, and ways to avoid documentation and billing errors.

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Who is National Government Services?

- Contracted by CMS to serve as the primary operation contact between the Original Medicare program and health care providers enrolled in the program
  - MAC for J6 and JK Home Health and Hospice
- Process claims – including everything involved
  - Medical Review, Audit & Reimbursement, Overpayment Recovery, Enroll providers in Medicare program, First level appeals
- Educational Resource for HHH JK & J6
  - Respond to provider inquiries; provide education over a variety of platforms

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Hospice Updates

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Implementation of Hospice Claim Edits

Summary of Changes

- Any hospice claim with an attending or rendering National Provider Identifier (NPI), have to be in the PECOS ordering and referring files as part of a new rule as of June 3, 2024
- The hospice certifying physician, including the hospice physician and attending physician need to be enrolled/opted-out at the time they make the certification or recertification of hospice care for a patient

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Occurrence Code 27

- When Occurrence Code 27 and its associated date are present on the claim, Medicare will allow payment when:
  - The Occurrence Code 27 date falls on or after the physician's effective date but before the termination date, if present, on the PECOS Hospice O/R – Attending Physician File
    - Occurrence code 27 is required on the claim for the billing period in which the certification or re-certification was obtained
      - It may be optionally reported on other claims
- Claims received on or after October 7, 2024, will only edit when Occurrence Code 27 and its associated date are present on the claim

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17729 Reason Code

- FISS created reason code 17729 to assign on hospice claims, Type of Bill (TOB) 81X or 82X
  - Narrative: TOB 81X and 82X (excluding 8XA, 8XB, 8XC, 8XD and 8XE) with a Statement From Date on or after June 3, 2024 when the ATT PHYS NPI data does not match the new PECOS Hospice O/R – Referring Physician file.
- If the NPI and first four (4) letters of the physician's last name submitted on the claim in the Attending field do not match the physician's NPI and first 4 letters of the physician's last name on the PECOS file, the claim will reject with reason code 17729.

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Physician Claim Reporting

Effective for claims submitted on or after October 7, 2024 with dates of service June 3, 2024 or later for initial certifications:

- Report the name and NPI of the attending physician in the ATT PHYS field (if the patient has chosen one)
  - If an NP or a PA is serving as the designated attending, only the REF PHYS NPI field will be subject to the ordering and referring denial edits.
- Report the name and NPI of the physician responsible for certifying the patient's terminal illness in the REF PHYS field
- If the certifying and attending physician are the same, only report the name and NPI of the physician in the ATT PHYS field

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Physician Claim Reporting (cont.)

Effective for claims submitted on or after October 7, 2024 with dates of service June 3, 2024 or later for subsequent certifications:

- Report the name and NPI of the certifying physician in the REF PHYS field
- Report the name and NPI of the attending physician in the ATT PHYS field (if the patient has chosen one)
- If the patient doesn't have an attending physician, report the name and NPI of the certifying/recertifying physician in the ATT PHYS field

NOTE: Edits will only apply to both fields if both the ATT PHYS and REF PHYS fields are completed.

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Adjustment Requirements

- An adjustment should be submitted when an input error (i.e., incorrect NPI, incorrect name spelling) is being corrected or the physician's PECOS record has been updated.
- The physician's name needs match the name on the Order and Referring | CMS Data file.
- If the physician's name on the file is incorrect, the physician needs to contact the Part B with which they are enrolled.

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Adjustment Requirements (cont.)

- Enter bill type XX7
- Condition code "D9" (FL 18–28)
- Ensure the claim number of the denied final claim is entered in the cross-reference (X-Ref) Document Control Number field
- Correct attending physician's NPI and name, if applicable
- Enter remarks (FL 80) indicating the reason for the adjustment
  - E.g., Correction to attending physician's NPI and/or name, or the physician's PECOS record has been updated

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Ordering and Certifying Files

- The Ordering & Certifying Files contain a list of all providers who are currently eligible to order and certify
  - These files are only available on the CMS Data website
- CMS has updated the existing ordering and referring file on data.cms.gov with an additional column for hospice ordering and referring eligibility
  - Order and Referring — Centers for Medicare & Medicaid Services Data (cms.gov)
  - Different Medicare Benefits listed on this file have different requirements for certifications, as non-physician practitioners may certify for home health, but not for hospice

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Updates to the Hospice Election Statement and Addendum

- Hospice election statement and election statement addendum updated in March 2024
- No regulation changes at this time
- After a side-by-side review, the differences noted are:
  - BFCC/QIO info section was updated to include website and phone number
  - Date and timing of the addendum language was added as a note to the addendum statement (see highlighted portion of the signature section)

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Home Health Updates

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dNPWT

- Period of care claims (32x TOB) with through dates on or after 1/1/2024 include dNPWT
  - Line item billing:
    - Revenue code 27x (other than 274)
    - HCPCS A9272
    - Date of service
    - Units
    - Total charges

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FIPS Reporting Enforcement

- Claims (32x TOB) processed on or after 10/1/2024 editing for FIPS reporting
  - Value code 85
- CBSA code still also required
  - Value code 61

FIPS State and County Codes

CBSA Codes

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Telehealth Reporting

- Services furnished via telecommunications technology reported on 32x TOB as separately dated line items:
  - Valid revenue codes: 042x, 043x, 044x, 055x, 056x, and 057x
  - Valid HCPCs codes: G0320, G0321, G0322
  - Date of service
  - Units
  - Total charges – **must be submitted as covered charges**

Note: Two occurrences of G0320 or G0321 on the same day for the same revenue code shall be reported as separate line items with the same date of service and with service units reporting 1. Services furnished via telecommunications technology are not considered by Medicare systems when enforcing requirements for matching visit dates on home health claims.

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Additional Documentation Request (ADR)

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What is an ADR?

Generated when documentation is necessary to support a Medicare claim

- Support payment of an item(s) or service(s) reported on the claim
- Ensure compliance with Medicare's coverage, coding, payment and billing policies

Providers can receive ADRs via:

- Fiscal Intermediary Standard System/Direct Data Entry (FISS/DDE)
- NGS self-service portal, NGSConnex
- Notification Letter via mail (USPS)

Additional Documentation Request (ADR) Quick Reference Guide

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ADR Best Practice Tips

- Check DAILY for ADRs!
- Ensure your address is accurate within the Provider Enrollment, Chain and Ownership System (PECOS)
  - Report a Change of Information in PECOS
  - Resolving PECOS Common Errors and Warnings
- Respond timely!
  - ADR Timeline Calculator
- Utilize all the FREE NGS self-service resources available:
  - www.NGSMedicare.com
  - Tips for Responding to a Hospice ADR
  - Hospice Documentation Checklist
  - Home Health Documentation Checklist
  - Additional Development Request Letters Guide

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Additional ADR Best Practice Tips

- Implement and maintain a policy & procedure for responding effectively, efficiently, and timely.
- Start conversations with your internal staff/patient care team and ensure everyone is involved and aware and reviews policy and checklist items.
  - Review instructional information within ADR
  - Utilize self-service resources
  - Develop audit tool/checklist
  - Determine schedule and staff
  - Perform routine audits
  - Implement audit results

HEALTH CARE COMPLIANCE PROGRAM TIPS

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Preparation Checklist

- ✓ Verify all pages are for the right patient
- ✓ Check for accuracy of all documentation, especially handwritten
- ✓ Identifiable credentials for each clinician signature
- ✓ Signature sheets as appropriate from outside agency and referring facility/office
- ✓ Proof of Provider Enrollment, Chain & Ownership System (PECOS) – Validation for all physicians involved in the patient's care for all DOS in the period of care
- ✓ Check for patient's name on each page (front and back where applicable)
- ✓ Verify correct dates of service for the claimed period of care
- ✓ Confirm all dates and signatures are clear, identifiable, and appropriate
- ✓ Provider contact name and telephone number

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Preparation Checklist

- ✓Black ink copies best
- ✓Copy both sides of the documents
- ✓Copy all pages as one PDF
- ✓Organize the documents
- ✓Paginate each page
- ✓ADR is placed on top
- ✓Cover letter directly after ADR letter
- ✓Return records to the MAC within 45-day time frame

- X **Do not** use highlighter
- X **Do not** bind the records
- X **Do not** use staples, paperclips, binder clips, sticky notes, rubber bands, etc.
- X **Do not** alter the records
- X **Do not** fold over, crinkle or cut-off pages during copying/printing/faxing

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Avoiding Hospice Denials

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Home Health and Hospice TPE MR Topics

- Targeted Probe and Educate Topics – NGSMEDICARE (J6)
- Targeted Probe and Educate Topics – NGSMEDICARE (JK)

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55H1R – The notice of election is invalid because it doesn't meet statutory/regulatory requirements

- Consider adapting the Model Example Hospice Election Statement - March 2024 (PDF) provided at cms.gov to your agency's needs as it includes all required statutory elements.
- Compare your agency's beneficiary election statement to CMS IOM 100-02, Section 20.2.1.1 to confirm that all required information is present in your form
- Be aware that the election statement requirements were revised effective October 1, 2020, with new requirements (#3 and #7) in Section 20.2.1.1; update your election form to be in compliance.
- Make sure all staff are utilizing the most current forms! Updated March 2024.

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55H1L – According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less

- The documentation in the medical record must support a life expectancy of six months or less.
- Clinical progress notes show evidence of a steady decline or downward trajectory in the beneficiary's clinical status over time. Documentation should be objective and measurable.
- Beneficiaries who have improved or stabilized and no longer have a reasonable expectation of a prognosis of six months or less should be discharged from the Medicare hospice benefit.
- Consistency between the certification documents and the hospice clinical progress notes

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55H1S – Face to face encounter requirements not met

- Include all face-to-face encounter attestations for the third benefit period and after with your medical record submission to the ADR.
- Ensure that the CMS requirements for the face-to-face encounter have been met in IOM CMS 100-02, Chapter 9, Section 20.1(#5).
  - Failure to meet these requirements results in a failure by the hospice to meet the recertification obligation. The beneficiary would cease to be eligible for the benefit.
- Remember to verify the benefit period that the beneficiary is in with every admission, as the beneficiary may have received hospice services in the past.

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55H1M – According to Medicare hospice requirements, the documentation indicates the general inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

- General inpatient (GIP) care is coverable when the beneficiary's medical condition shows acute or chronic symptoms that are not adequately managed, and care cannot feasibly be provided in other settings.
- Include the documentation from the facility where GIP level of care was provided, to support the intensity of the interventions and frequency of assessments, medication administration etc. Failure to submit the facility notes with the ADR could result in a denial.
- The GIP level of care is not intended for routine end-of-life care or caregiver breakdown.
- Refer to CMS IOM 100-02, Chapter 9, Section 40.1.5

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56900 – Requested medical records were not received within the 45-day time limit; therefore, we are unable to determine the medical necessity of the services billed and this claim has been denied. If less than 120 days after denial notification on remittance advice, submit records to the contractor requesting records. Do not resubmit the claim.

- This denial occurs when providers do not respond to the additional documentation request (ADR).
- This denial is preventable by responding to the ADR before the due date listed.
- Providers should start gathering the documentation being requested immediately on receipt of the ADR to ensure there is adequate time to obtain all of the specific records requested.
- Use of the NGSConnex portal to receive ADRs electronically is the most reliable and preferred method for provider management of ADRs.

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Avoiding Home Health Denials

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55H3V: Skilled nursing services were not medically necessary

- Skilled nursing care is necessary only when:
  - The particular beneficiary's special medical complications require the skills of a registered nurse(RN) or licensed practical nurse(LPN)
  - The needed services are of such complexity that the skills of a RN or LPN are required to furnish the services
  - When the beneficiary is generally stable and there are no longer specific skilled nursing needs, they should be discharged from SN services
  - General assessment and repetitive teaching do not constitute medically necessary skilled care
- Refer to CMS IOM 100-02 Chapter 7, Section 40.1

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55H2B – Documentation submitted does not support homebound status.

- Ensure that the beneficiary meets **criterion one and two** outlined in IOM 100-02, Chapter 7, Section 30.1 to be considered confined to the home.
- The medical record documentation should be beneficiary-specific and provide detailed evidence of how the beneficiary meets both homebound criteria.
- Avoid the use of standardized phrases such as “difficult and taxing effort to leave home”. Answer the question “Specifically, what makes it difficult and taxing for this beneficiary to leave home?”
- Absences from the home should be infrequent, for periods or relatively short duration, or related to the need to receive health care treatment.
- Refer to CMS IOM 100-02, Chapter 7, Section 30.1

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55HTP – The initial certification was missing/incomplete/invalid. Therefore, the recertification episode is denied.

- These are denials on claims in a recertification episode.
  - Include the initial certification/plan of care from the start of care (SOC) episode. It must include all five elements as required by CMS.
  - Include the actual clinical note of the face-to-face encounter that was performed by an allowed practitioner within 90 days before to 30 days after the SOC per requirements in IOM 100-02, Chapter 7, Section 30.5.1.1 and 30.5.1.2.
- Refer to CMS IOM 100-02 Chapter 7, Section 30.5.1 – 30.5.3

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55HTA – Certification missing or invalid.

- Do not bill the claim to Medicare until you have a complete certification/plan of care that has been signed and dated by the certifying practitioner.
- A complete certification containing all required elements **must be signed and dated** by the certifying physician or allowed practitioner, prior to billing Medicare.
- The five elements of the initial certification must be attested to by the certifying practitioner in order to be considered complete.
- The certifying practitioner must attest to the date of the face-to-face encounter on initial certifications.
- Consider using the example certification provided by CMS in the following citation.
- Refer to CMS IOM 100-02 Chapter 7, Section 30.5.1 – 30.5.3

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56900 – Requested medical records were not received within the 45-day time limit; therefore, we are unable to determine the medical necessity of the services billed and this claim has been denied. If less than 120 days after denial notification on remittance advice, submit records to the contractor requesting records. Do not resubmit the claim.

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Avoiding Common Home Health and Hospice Billing Errors

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Top Hospice Errors

Reason Code	Reason for Return/Rejection	How to Avoid/Correct
37402	Hospice sequential billing error	Hospice claims must be submitted sequentially per calendar month billing (not a 30-day billing period). A previous month's claim must process and finalize before the next month's claim will process. FISS will search the claim history for a prior a claim; there cannot be any skipped dates between the 'To' date and the next month claim's 'From' date. If the prior claim RTP'd and needs correcting, that claim must be corrected and finalized before the subsequent claim can be submitted. Verify the previous month's claim is submitted and in a finalized location prior to billing the subsequent claim.
38200	Claim is an exact duplicate of a previously submitted claim from the same provider	Verify billing already submitted. Develop and implement a process to ensure that duplicate claims are not being submitted.
U523A	The dates of service are during both a hospice election period and a Medicare Advantage (MA) Plan's period that is in the VBID model.	Hospice providers must continue to send all notices and claims to both the VBID-participating MAO and the relevant MAC on a timely basis. The MAO will process the claim for payment. The Original Medicare claim will process for informational and operational purposes and reject with RC U523A.

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Top Hospice Errors (cont.)

Reason Code	Reason for Return/Rejection	How to Avoid/Correct
U5106	Hospice NOE received to add a new election period with a start date which falls within a previously established hospice election period.	Ensure the NOE is not a duplicate of a previously submitted or processed NOE. Before submitting an NOE, review the hospice benefit periods prior to billing to ensure the 'Admit' date on the NOE being submitted is not within the 'Start Date' and 'Term Date' of the benefit period in the beneficiary's eligibility file.
17729	Provider in ATT PHYS field not in PECOS for hospice	Ensure the physician 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. Verify the physician NPI is correct. The first four characters of the last name needs to exactly match the dataset. Verify that the first and last name are not entered in reverse on the claim. Ensure the name and NPI is not for a nurse practitioner (NP) or physician assistant (PA). NPs and PAs cannot certify patients for hospice. A physician must be entered. Adjust if rejected/submit a clerical reopening if denied.

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Top Home Health Errors

Reason Code	Reason for Return/Rejection	How to Avoid/Correct
U537F	The 'From' date on the HH NOA falls within an existing home health admission period	Verify open home health admission periods before billing; follow appropriate transfer protocol
19963	Statement 'From' date is on or after 1/1/2022 and less than 24 months from claim 'Admit' date and a matching HH NOA cannot be found	System error scheduled for fix. Correctly applied for the following conditions: There is no NOA on file for that admission; The NOA was submitted but was rejected/RTP'd; The NOA was cancelled by the HHA and never resubmitted; The NOA and claim admission dates do not match, or; The admission was closed by another claim with an earlier service date.
38200	Claim is an exact duplicate of a previously submitted claim from the same provider	If the NOA and claim were submitted at the same time, and no NOA has yet been processed for the admission period, resubmit the NOA and wait for it to process before submitting the claim. If the submitted needs to be corrected, cancel the processed NOA and after it has canceled, submit the NOA with the corrected information.

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Top Home Health Errors (cont.)

Reason Code	Reason for Return/Rejection	How to Avoid/Correct
U5233	No Medicare payment can be made because services fall within or overlap Medicare Advantage enrollment	If patient starts period of care under MA plan then switches to Original Medicare, complete new OASIS and submit NOA to open admission period under Original Medicare. If patient starts period of care under Original Medicare then switches to MA plan, bill Medicare up to the MAO enrollment date, and submit claim with patient status code '06'
37364	The dates of service fall within the span of days between the NOA receipt date and the claim 'From' date on TOB 32X, the NOA receipt date is 30 or more days from the claim From date, and payment is equal to zero	Applies when the receipt date of the NOA is more than 30 days out from the start of admission (i.e., the From/Thru date on the NOA) and the claim From date falls within that period of 30 days causing zero payment. If the NOA was late due to billing error, the rejection with zero payment is correct. If the NOA was late due to system error, a late penalty exception request may be submitted.
37253	HH claim through date on/after 4/1/17 denied-no OASIS assessment found	Before submitting the claim, ensure OASIS items used to match the claim with the OASIS are correct. Also ensure OASIS was successfully submitted and accepted by iQIES.

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References and Resources

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CMS Hospice References

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11
- Hospice CMS Webpage
- Medical Review & Compliance: Respond to Additional Documentation Requests
- MLN Matters Number MM13531: *Hospice Claims Edits for Certifying Physicians*
- Change Request 13342: *Implement Edits on Hospice Claims*
- Model Example of Hospice Election Statement - March 2024 (PDF)
- Model Hospice Election Statement Addendum - March 2024 (PDF)

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CMS Home Health References

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- Home Health CMS Webpage
- Additional Documentation Request | CMS
- Conditions of Participation: Home Health Care (484.1 - 484.375)
- Medicare Learning Network (MLN home page | CMS)
  - Resource Materials
  - Training
  - MLN Matters Articles
- Home Health Agency (HHA) Center | CMS

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Navigating Medicare: Home Health & Hospice Insights for Providers

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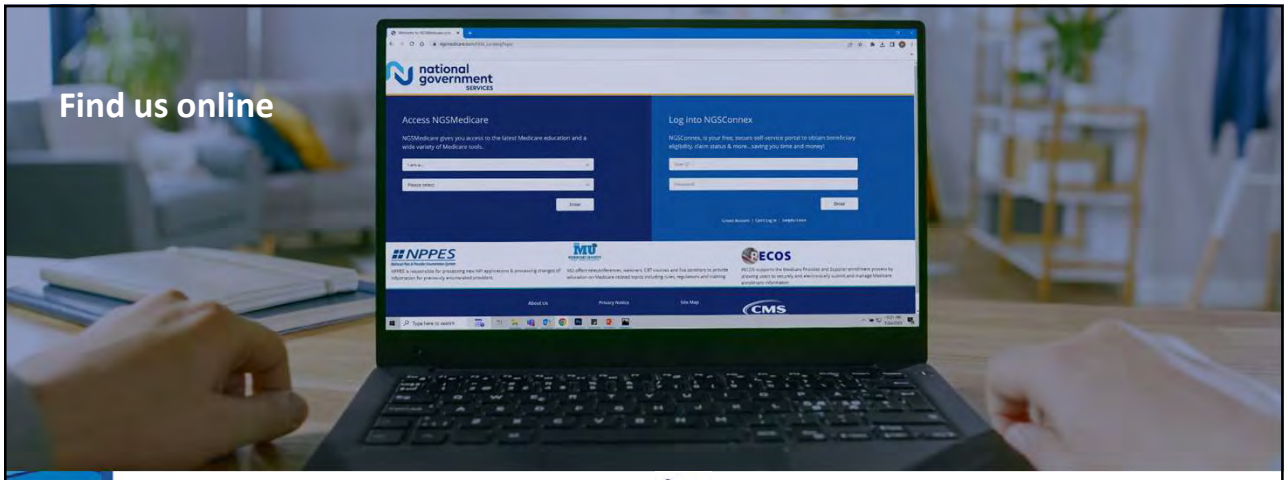

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Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

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Thank You!

- Follow-up questions specific to this presentation can be sent to:
  - NGSHHHPOE@elevancehealth.com

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