2024 Jurisdiction M (JM) Medicare Home Health Workshop Series

Back with More in 2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FOR HOME CARE & HOSPICE

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The information provided in this handout was current as of the date of this presentation. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after this presentation are posted at www.PalmettoGBA.com/HHH.

Agenda

- 2024 Final Rule Summary
  - **Home Health Payment Rates for CY 2024**
- Home Health Updates
  - **Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims**
  - **Corrections to Home Health Claims Edits**
  - **Top Billing Errors**

Agenda

- Home Health Reminders
  - **Updates and Reminders for Notice of Admission (NOA)**
  - **Late NOA Exception Process**
- Review Choice Demonstration (RCD) Hot Topics
- Palmetto GBA's eServices Portal
  - **How to Use the eServices' Eligibility Tabs**
  - **Using eServices' Newest Self-Service Tools**
- Comprehensive Error Rate Testing (CERT) Updates
- Educational Resources for Providers

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2024 Final Rule Summary

- Fact Sheet — Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F)

Prospective Payment System (HH PPS) Rate Update

CMS estimates that Medicare payments to HHAs in CY 2024 will increase in the aggregate by 0.8 percent or $140 million compared to CY 2023, based on the finalized policies

- Increase of 3.0 percent home health payment update percentage ($525 million increase)
- Estimated 2.6 percent decrease that reflects the net effects of the finalized prospective permanent behavior assumption adjustment across all payments (half of the full adjustment)
- Estimated 0.4 percent increase that reflects the effects of an update to the fixed-dollar loss ratio (FDL) used in determining outlier payments ($70 million increase)

Recalibration of Case-Mix Weights

- Each of the 432 payment groups under the Patient-Driven Groupings Model (PDGM) has an associated case-mix weight and low utilization payment adjustment (LUPA) threshold
- CMS' policy is to annually recalibrate the case-mix weights and LUPA thresholds using the most complete utilization data available at the time of rulemaking.
- CMS is finalizing its proposal to recalibrate the case-mix weights (including the functional levels and comorbidity adjustment subgroups) and LUPA thresholds using CY 2022 data to more accurately pay for the types of patients HHAs serve.

Disposable Negative Pressure Wound Therapy

In accordance with Division FF, section 4136 of the Consolidated Appropriations Act (CAA), 2023, CMS is finalized its proposal to codify statutory requirements for negative pressure wound therapy (NPWT) using a disposable device for patients under a home health plan of care.

- The CAA, 2023 requires that beginning January 1, 2024, there is a separate payment for the device only.
  - **Payment for the services to apply the device is to be included in the 30-day payment under the home health prospective payment system.**
- There are also changes that allow HHAs to now report the disposable device on the type of home health claim most familiar to HHAs.

Home Health (HH) Quality Reporting Program (QRP)

CMS is finalizing the following measures:

1. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure to the HH QRP beginning with the CY 2025 HH QRP.
2. Functional Discharge Score (DC Function) measure to the HH QRP beginning with the CY 2025 HH QRP.

Home Health (HH) Quality Reporting Program (QRP)

CMS is finalizing the removal of the following measures:

1. With the addition of the Discharge Function measure, we finalized to remove the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure from the HH QRP beginning with the CY 2025 HH QRP.
2. Additionally, CMS finalized removal of two OASIS items that are no longer necessary for collection, the M0110 – Episode Timing and M2220- Therapy Needs items.

Home Health (HH) Quality Reporting Program (QRP)

CMS is finalizing the public reporting of four measures:

1. Discharge Function;
2. Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider);
3. Transfer of Health (TOH) Information to the Patient—Post-Acute Care (PAC) Measure (TOH-Patient); and
4. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

For the expanded HHVBP Model, CMS is finalizing its proposals to:

- Codify in the Code of Federal Regulations the measure removal factors finalized in the CY 2022 HH PPS final rule;
- Replace the two Total Normalized Composite Measures (for Self-Care and Mobility) with the Discharge Function Score measure effective January 1, 2025;

Expanded Home Health Value-Based Purchasing (HHVBP) Model

For the expanded HHVBP Model, CMS is finalizing its proposals to:

- Replace the OASIS-based Discharge to Community (DTC) measure with the claims-based Discharge to Community-Post Acute Care (PAC) Measure for Home Health Agencies, effective January 1, 2025;
- Replace the claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use and the Emergency Department Use without Hospitalization During the First

Expanded Home Health Value-Based Purchasing (HHVBP) Model

60 Days of Home Health measures with the claims-based Potentially Preventable Hospitalization measure effective January 1, 2025;

- Change the weights of individual measures due to the change in the total number of measures; and
- Beginning with performance year CY 2025, update the Model baseline year to CY 2023 for all applicable measures in the finalized measure set, including those measures included in the current measure set with the exception of the 2-year DTC-PAC measure, which would be CY 2022 and CY 2023.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

- Appeals Process
  - **CMS is finalizing an additional opportunity to request a reconsideration of the annual Total Performance Score (TPS) and payment adjustment.**

- Public Reporting Reminder
  - **CMS is including a reminder for HHAs and other stakeholders that public reporting of HHVBP performance data and payment adjustments will begin in December 2024.**

Expanded Home Health Value-Based Purchasing (HHVBP) Model

- CMS Expanded Home Health Value-Based Purchasing Model Homepage
- If you are interested in receiving additional information, updates or have questions about the Expanded Home Health Value-Based Purchasing Model, please engage with the below resources
  - **Listerserv:** Subscribe to the HHVBP Model Expansion listserv
  - **Email:** HHVBPquestions@lewin.com

Safeguarding Taxpayer Dollars

To further protect the Trust Funds and Medicare beneficiaries, we are also finalizing additional provider enrollment provisions, which include, but are not limited to, the following:

- Reducing the period of Medicare non-billing for which a provider or supplier can be deactivated under § 424.540(a)(1) from 12 months to 6 months.
- Strengthening the program integrity safeguards associated with a provisional period of enhanced oversight under section 1866(j)(3) of the Social Security Act.

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Home Health Updates

Disposable Negative Pressure Wound Therapy Devices

Separate Payment for Disposable Negative Pressure Wound Therapy (NPWT) Devices on Home Health Prospective Payment System Claims

- MLN Matters Number: MM13244
- Related Change Request (CR) Number: CR 13244
- Effective Date: January 1, 2024
  - **Claim "Through" Dates on or after this date**
- Jurisdiction M HHH - Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims (palmettogba.com)

Disposable NPWT Devices

Make sure your billing staff knows that effective January 1, 2024

- Medicare will make separate payment for HCPCS code A9272 on type of bill (TOB) 032x, instead of 034x
- MACs will apply deductible and coinsurance
- No longer include payment for nursing or therapy services
  - **Payment for such nursing or therapy services would now be made under the Home Health Prospective Payment System (HH PPS) and is no longer separately billable**

Disposable NPWT Devices New Billing

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.

Disposable NPWT Devices New Billing

Claim Field	Code	Description
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

Disposable Negative Pressure Wound Therapy Devices

- Before CY 2024, under the home health benefit, Medicare made a separate payment for providing NPWT using a disposable device on a TOB 034x containing CPT codes 97607 or 97608
- That payment was for both the device and the services related to applying the device.
- Medicare will return claims on TOB 034x containing CPT codes 97607 or 97608 for a date of service on or after January 1, 2024.

Lymphedema Compression Treatment

Lymphedema Compression Treatment Items: Implementation

- MLN Matters Number: MM13286
- Related Change Request (CR) Number: CR 13286
- Effective Date: January 1, 2024
  - **The effective date is the date of service**

Lymphedema Compression Treatment

Section 4133 of the Consolidated Appropriations Act (CAA), 2023, establishes a new Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) benefit category for standard and custom-fitted compression garments and additional lymphedema compression treatment items to service a medical purpose.

Lymphedema Compression Treatment

- Per Section 4133 of the CAA, 2023, only enrolled DMEPOS suppliers may provide lymphedema compression treatment items.
- The DME MACs will process all claims for lymphedema compression treatment items.
- Suppliers of lymphedema compression treatment items will be subject to the DMEPOS:
  - **Supplier standards**
  - **Accreditation requirements**
  - **Quality standards**
  - **All other requirements that apply to enrolled DMEPOS suppliers**

Lymphedema Compression Treatment

- CMS will deny payment if you submit a claim for lymphedema treatment items that don't have an appropriate diagnosis for lymphedema
- The frequency limitations for replacement of lymphedema compression treatment items are:
  - **Once every 6 months for 3 gradient compression garments or wraps with adjustable straps per each affected extremity or part of the body**
  - **Once every 2 years for 2 nighttime garments per each affected extremity or part of the body**

Corrections to Home Health Claims Edits

- Corrections to Home Health Processing
  - **Claims with Condition DR or Claims Receiving Admission Source Edits**
- MLN Matters Number: MM13225
- Related Change Request (CR) Number: CR 13225
  - **Effective Date: January 1, 2024**
    - Claims processed on or after this date

Corrections to Home Health Claims Edits

The purpose of this Change Request (CR) is to

- No longer bypass the edit requiring a matching patient assessment when a home health (HH) claim reports condition code DR.
- It also corrects processing of HH claims to ensure the medical review information is not lost if a reviewed claim later receives an admission source edit.
- Adds instructions to manual sections regarding how to avoid delayed submission of home health Notices of Admission (NOA)

Corrections to Home Health Claims Edits

Condition code DR is used when submission of Outcome and Assessment Information Set (OASIS) assessments is entirely waived due to the disaster.

- CMS must announce a waiver to use condition code DR
- Your MAC will return to home health claims Type of Bill (TOB) 032x, other than TOBs 032A or 032D) when there's no corresponding OASIS assessment on file and condition code DR and occurrence code 50 are present on the claim.

Corrections to Home Health Processing

- CR 12790, effective January 1, 2023, corrected an issue with claims medically reviewed and later identified for adjustment due to an incorrect period sequence.
- In processing the adjustment, Medicare systems changed the User Action Code from the code applied by the medical review to "Z."
  - **This erased additional medical review coding on the claim. If the provider is still on review, this triggered an unnecessary additional record request to you. CR 13225**
  - **CR 13225 corrects this new problem.**

Corrections to Home Health Claims Edits

Finally, CR 13225 adds instructions to manual sections about how to avoid delayed submission of a HH NOA

- 10.1.10.3 - Submission of the Notice of Admission (NOA)
  - **HHAs can reduce the number of errors and exception requests related changes to the Beneficiary Identifier (MBI) by performing an eligibility check immediately before admission.**
  - **A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the HHA more than two weeks prior to the admission date.**

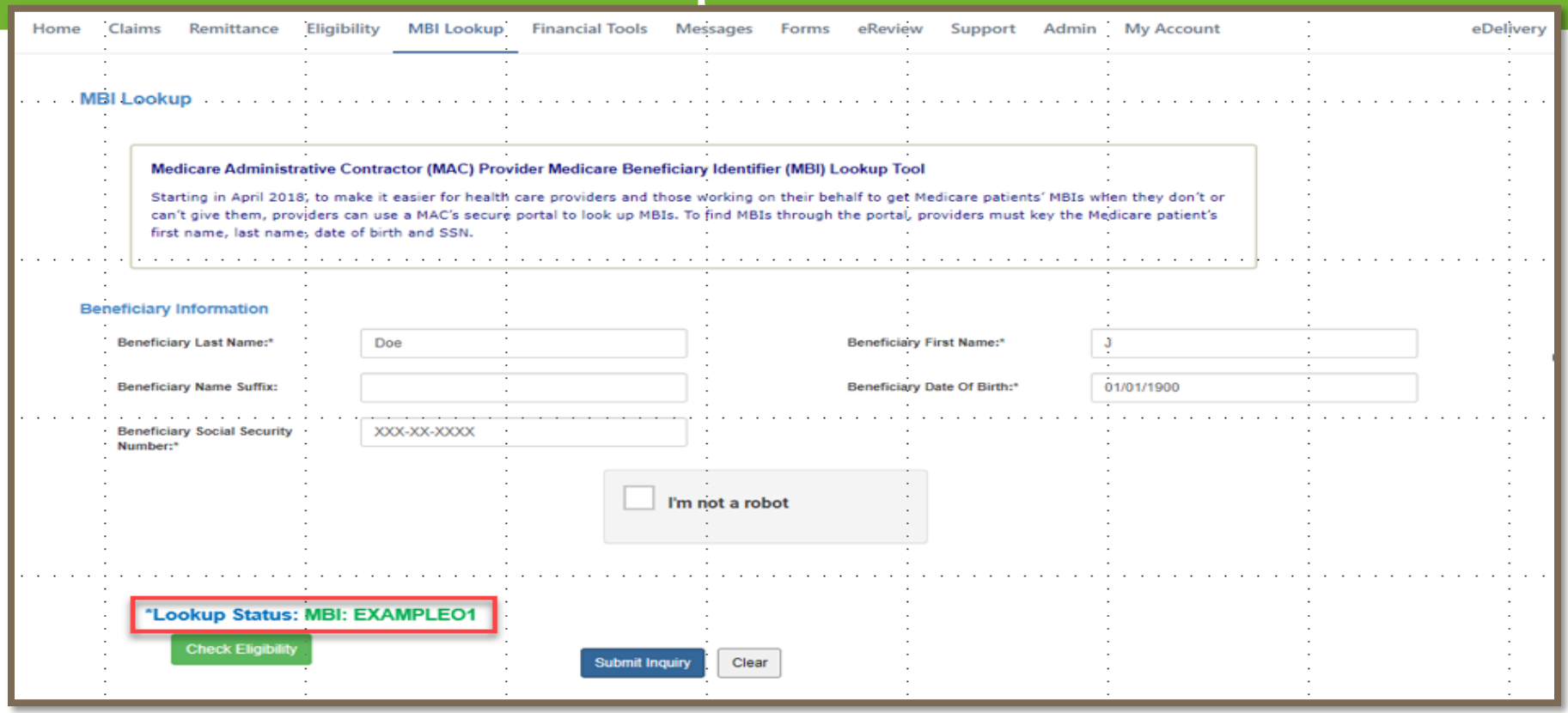
Medicare Beneficiary Identifier (MBI) Changes

- Requests to change a MBI may occur if a Medicare beneficiary, their authorized representative, requests it or CMS suspects a number is compromised.
  - **If CMS reissues MBIs, it is possible your patients will seek care before receiving a new card with their new MBI.**
- When an MBI changes, the beneficiary is advised to share the new MBI with their providers.
  - **If you cannot obtain the new MBI from the patient, you can get it from the eServices MBI Lookup Tool.**

eServices MBI Lookup

- How to successfully perform an MBI lookup?
  - **When you click on the MBI Lookup tab, you will be presented with the MBI Lookup screen**
- The following fields are required
  - **Beneficiary Last Name**
  - **Beneficiary First Name**
  - **Beneficiary Date of Birth**
  - **Beneficiary's Social Security Number (not a spouse's SSN)**
- Only the current MBI will populate

eServices MBI Lookup



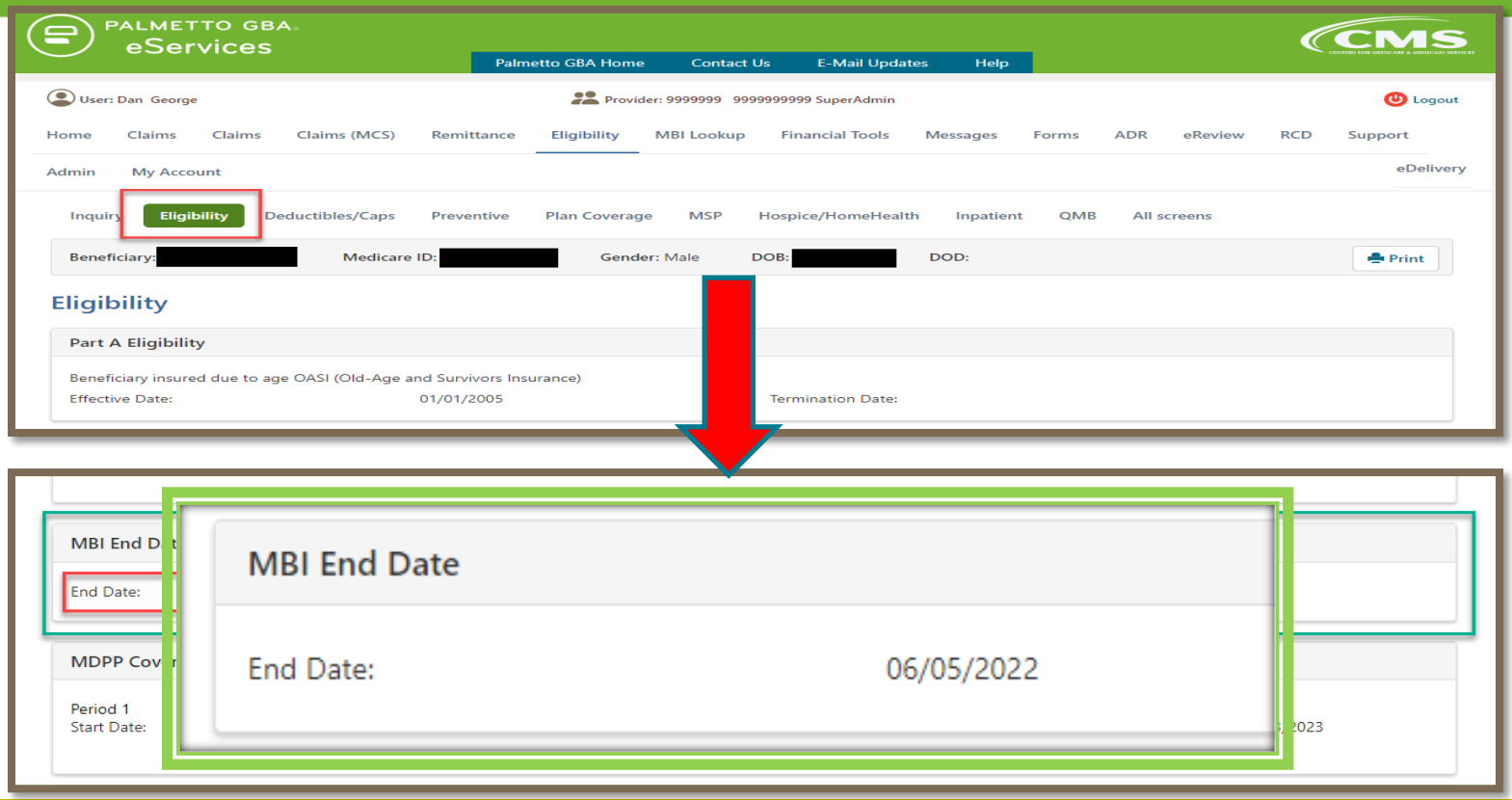
MBI Changes

You can find the termination date of the old MBI by doing a historic eligibility search in eServices. The termination date will be returned in the MBI End Date field of the Eligibility tab.

- Use a date range in the Eligibility tab search
  - **The entered date range may include a future date (up to (4) months in the future) to insure the MBI is not pending an upcoming change.**

Jurisdiction M HHH - Home Health and Hospice Billing When a New Medicare Beneficiary Identifier Is Assigned (palmettogba.com)

MBI End Date


PALMETTO GBA
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Palmetto GBA Home
Contact Us
E-Mail Updates
Help
CMS
User: Dan George
Provider: 9999999 9999999999 SuperAdmin
Logout
Home
Claims
Claims
Claims (MCS)
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
ADR
eReview
RCD
Support
Admin
My Account
eDelivery
Inquiry
Eligibility
Deductibles/Caps
Preventive
Plan Coverage
MSP
Hospice/HomeHealth
Inpatient
QMB
All screens
Beneficiary:
Medicare ID:
Gender: Male
DOB:
DOD:
Print
Eligibility
Part A Eligibility
Beneficiary insured due to age OASI (Old-Age and Survivors Insurance)
Effective Date: 01/01/2005
Termination Date:
MBI End Date
End Date:
MDPP Cov
Period 1
Start Date:
MBI End Date
End Date: 06/05/2022

MBI Changes

- NOAs and claims will be returned to the provider if they are not submitted with the current MBI
  - **Highly recommended that prior to submitting the NOA, the HHA confirms the MBI is current using the eServices MBI Lookup tool**
  - **This would prevent NOAs being returned for this issue and submitting late NOA exception requests**

Top Home Health Billing Errors

Reason Code 38158

- This home health claim is a duplicate of a paid, suspended or denied home health claim for the same provider number, MBI number and revenue code and line-item date of service, but without a cancel date.
- 14,660 claims were rejected in January 2024 for this reason
- Jurisdiction M HHH - Reason Codes 38031, 38157, 38158 and 38200 (palmettogba.com)

Reason Code U5233

- No Medicare payment can be made because the services on this claim fall within or overlap a Medicare Advantage (MA) HMO enrollment period.
- 1,776 claims were rejected in January 2024 for this reason
- Jurisdiction M HHH - Reason Code U5233 (palmettogba.com)

Home Health Reminders

- Updates and Reminders for Notice of Admission (NOA)
- Late NOA Exception Process

NOAs and Condition Code (CC) 47

- In home health, a transfer is when a HH beneficiary transfers from one HHA to another HHA within a 30-day period. In transfers from one agency to another, the receiving agency submits the NOA with condition code 47. This will close the prior admission period from the previous agency.
- CC 47 may also be used when the beneficiary has been discharged from another HHA, but the period of care claim has not been submitted or processed at the time of the new admission to discharge the beneficiary.

Reason Code U537F

Description

- Reason Code U537F will assign correctly to NOAs when:
  - **There is an open admission period on file (Patient Status 30) from a different home health agency in 2022 or later and Condition Code (CC) 47 was not applied**
  - **Duplicate NOAs were submitted (same beneficiary, admission date, provider, etc.)**
    - In this scenario, one of the two NOAs is usually returned with U537F

Reason Code U537F

Reason Code U537F will assign correctly to NOAs when:

- New NOA is submitted when a patient readmits to the same HHA in the same 30-day period that they were discharged because of admissions to other provider types (i.e., hospitals, skilled nursing facilities)
- If an agency chooses to discharge, based on an expectation that the beneficiary will not return, but does return to them in the same period, the discharge is not recognized for Medicare payment purposes
- All the HH services provided in the complete period of care, both before and after the inpatient stay, should be billed on one claim
  - **More information on this topic is available in the Medicare Claims Processing Manual Medicare Claims Processing Manual (Publication 100-04, Chapter 10, Section 10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects)**

Reason Code U537F

Resolution

- **Overlap of another HH admission:** Add CC 47 to your NOA if there is an open admission period on file (Patient Status 30) from another home health agency (HHA) in 2022 or later and the beneficiary has been discharged from the other HHA, but the final claim has not been submitted or processed at the time of the new admission.
- **If duplicate NOAs were submitted**: Verify if one of the NOAs processed and opened the HH admission. If so, no additional action is necessary. If neither NOAs processed, resubmit one NOA for the admission.
- **If the NOA was returned because the patient readmits to the same HHA in the same 30-day period that they were discharged because of admissions to other provider types (i.e., hospitals, skilled nursing facilities)**: Adjust the discharge claim and bill services both before and after the inpatient stay on one claim and make other necessary changes to the claim, such as updating the Patient Status code

Late NOA — The Exception Process

- NOAs must be submitted timely
  - **A timely-filed NOA is submitted to and accepted by the A/B Medicare Administrative C0ntractor (MAC), home health and hospice (HHH), within five calendar days after the start of care/admission date.**
    - Count five calendar days starting the day after the SOC/admission date to determine timely NOA submission.

Payment Reduction for Late NOAs

The reduction in payment amount would be equal to a 1/30th reduction to the wage adjusted, 30-day period payment amount for each day from the HH start of care date until the date the NOA was received by the MAC.

- The payment reduction may span multiple periods of care, if applicable
- No low utilization payment adjustment (LUPA) per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA
- Includes outlier payments
- This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it
- MAC applied value code QF will show the dollar amount that the claim payment was reduced due to the NOA being filed more than 5 days after the HH From date

Exception to Late NOA Payment Reduction

If the HHA fails to send the NOA timely, they may request an exception. The four circumstances that may qualify for an exception are:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate
2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond your control
3. You are a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
4. Other circumstances that we or your MAC determines to be beyond your control

Late NOA Exception Process

- HHA may request an exception on the final claim(s) that corresponds with the late NOA
  - MACs will accept the KX modifier when reported with the HIPPS code on the revenue code 0023 line of TOB 0329 (other than 032A, 032D and 0320) as an indicator that an HHA requests an exception to the late NOA penalty
- The HHA should provide sufficient information in the **Remarks section** of the claim to allow the MAC to research the exception request
  - The claim may be returned to provider if the remarks do not provide enough information

Late NOA Exception Process

The MAC will not grant exceptions if the HHA.

- Can correct the NOA without waiting for Medicare systems actions
- Submit a partial NOA to fulfill the timely-filing requirement
- Has multiple provider identifiers and submit the identifier of a location that didn’t actually provide the service
- MBI changes that were accessible to the HHA more than two weeks prior to the admission date

Exception Examples

- Scenario
  - NOA was late due to a beneficiary was disenrolled from a Medicare Advantage (MA) plan and Medicare's eligibility systems were not updated timely to show the termination
- Remarks
  - In this scenario, the HHA should apply "CR12256 disenroll MA XX/XX/XXXX" to the exception remarks. Please ensure to add the MA termination date in the remark, i.e., "CR12256 disenroll MA 12/31/2023"

Exception Examples

- Scenario
  - NOA was late due to natural disaster

- Remarks
  - NOA date 2/14/23. NOA was late due to power outage and state of emergency declared on 2/12/22 due to severe winter weather that is impacting (input county and state)

Exception Examples

- Scenario
  - NOA was returned due to an overlap with a different HHA

- Remark
  - NOA was submitted timely, but rejected due to an overlapping admission with a different HHA
    - This exception would be denied if Medicare's eligibility systems showed beneficiary was on service on with another HHA prior to the NOA's submission date and the admission would overlap. CC 47 is applicable.

Exception Examples

- Scenario
  - Data filing problem due to a CMS or MAC system's issue

- Remarks
  - Timely submitted NOA was returned on 1/15/24 for CPIL issue with reason code XXXXX before MAC suspended and bypassed issue on 1/27/24
    - Make sure you include the remarks provided in the CPIL or the reason code and name of the issue on Palmetto GBA's CPIL

Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!

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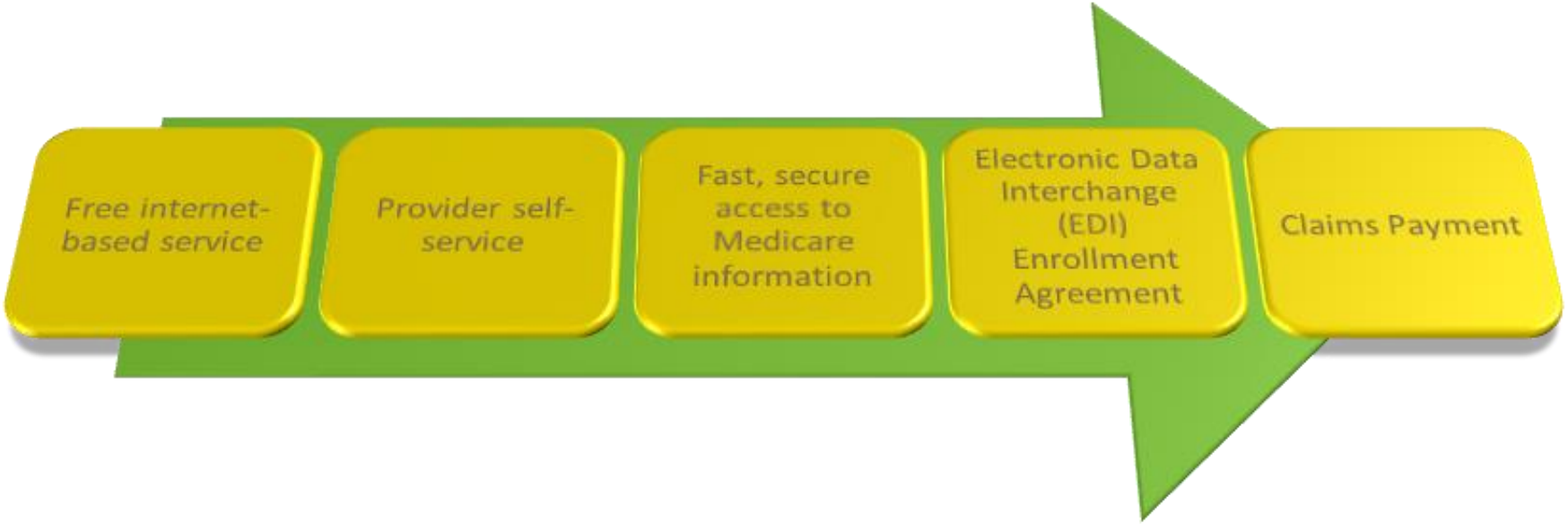
Palmetto GBA's eServices Portal

What Is eServices?



eServices Functions

- Eligibility
- Claims Status
- Remittances Online
- Financial Information
- Financial Forms
- Secure Forms
- eDelivery
- eReview (JM, JJ Part A, and RRB only)
- MBI (Medicare Beneficiary Identifier) Lookup

Accountable Care Organization Model Information

Accountable Care Organization (ACO) Models

- On January 2, 2024, eServices made an update to display information on the ACO models for Part A, Part B and HHH providers that are participating in an Accountable Care Organization.
- A new menu tab, ACO, will display to provider account administrators.
  - **Administrators can then add the permission to view the data to other users.**

[Jurisdiction M HHH - eServices Displays Accountable Care Organization Model Information (palmettogba.com)]

Accountable Care Organization Model Information

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

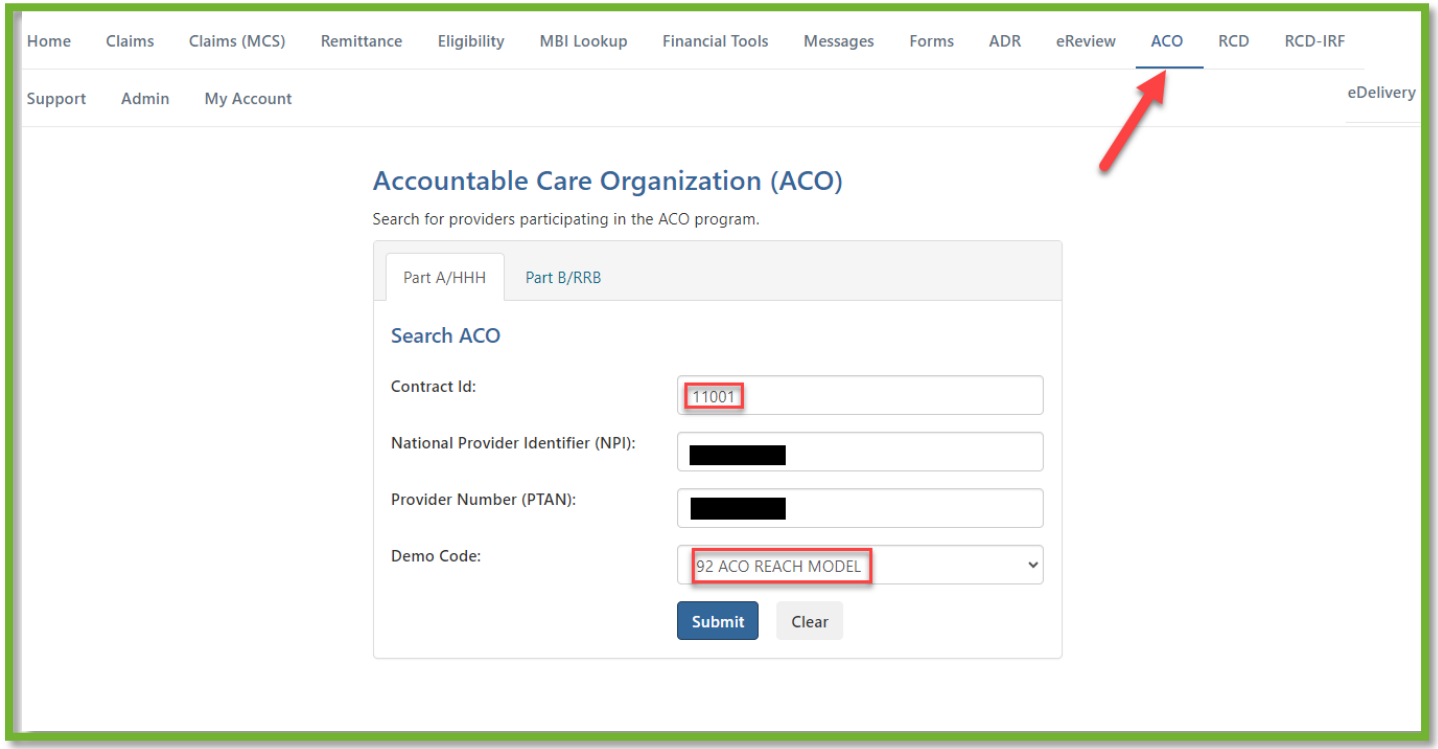
Accountable Care Organizations (ACOs): General Information | CMS

Accountable Care Organization Model Information

After logging into eServices

- Select the ACO tab
- Select the Part A/HHH tab
- Select the Demo Code for the Demo Model your ACO is participating in
- Press Submit

Accountable Care Organization Model Information



Accountable Care Organization Model Information

Accountable Care Organization (ACO)

Listing of providers and organizations participating in the ACO program

← Back to ACO Search

Registered Providers

Show Entries: 10 | Show Status: All | Demo Code: 92 | Search:

Status	Demo Code	Start Date	Termination Date	ACO ID	Provider Type	Reduction Amount	Update/ Maintenance Date	Enhancement Type	
Active	92	01/01/2024	12/31/2024	D0335	P	0.00	-	B	More
Active	92	01/01/2024	12/31/2024	D0335	P	0.00	-	0	More
Active	92	01/01/2024	12/31/2024	D0335	P	0.00	-	2	More
Active	92	01/01/2024	12/31/2024	D0335	P	0.00	-	9	More
Active	92	01/01/2023	12/31/2023	D0335	P	0.00	-	0	More
Active	92	01/01/2023	12/31/2023	D0335	P	0.00	-	2	More

Showing 1 to 6 of 6 entries

Previous 1 Next

eServices Eligibility Inquiry

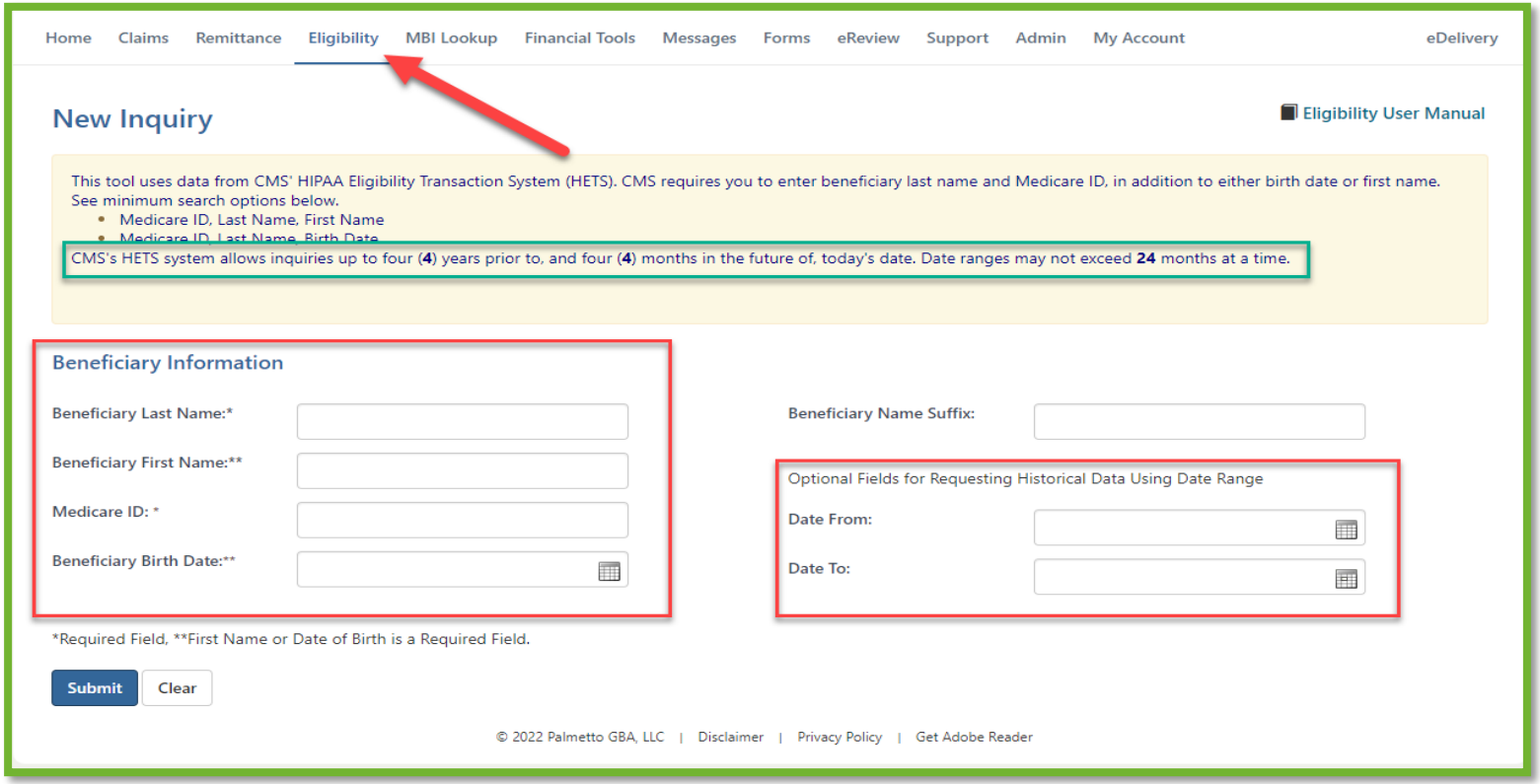
How do I successfully perform an eligibility inquiry?

- The following fields are required:
  - **Beneficiary's Last Name**
    - Only first six letters of last name needed
  - **Beneficiary's First Name**
    - Only first letter of first name needed
  - **Beneficiary's Birth Date**
  - **Beneficiary's Medicare ID**
  - **Enter a Date Range**

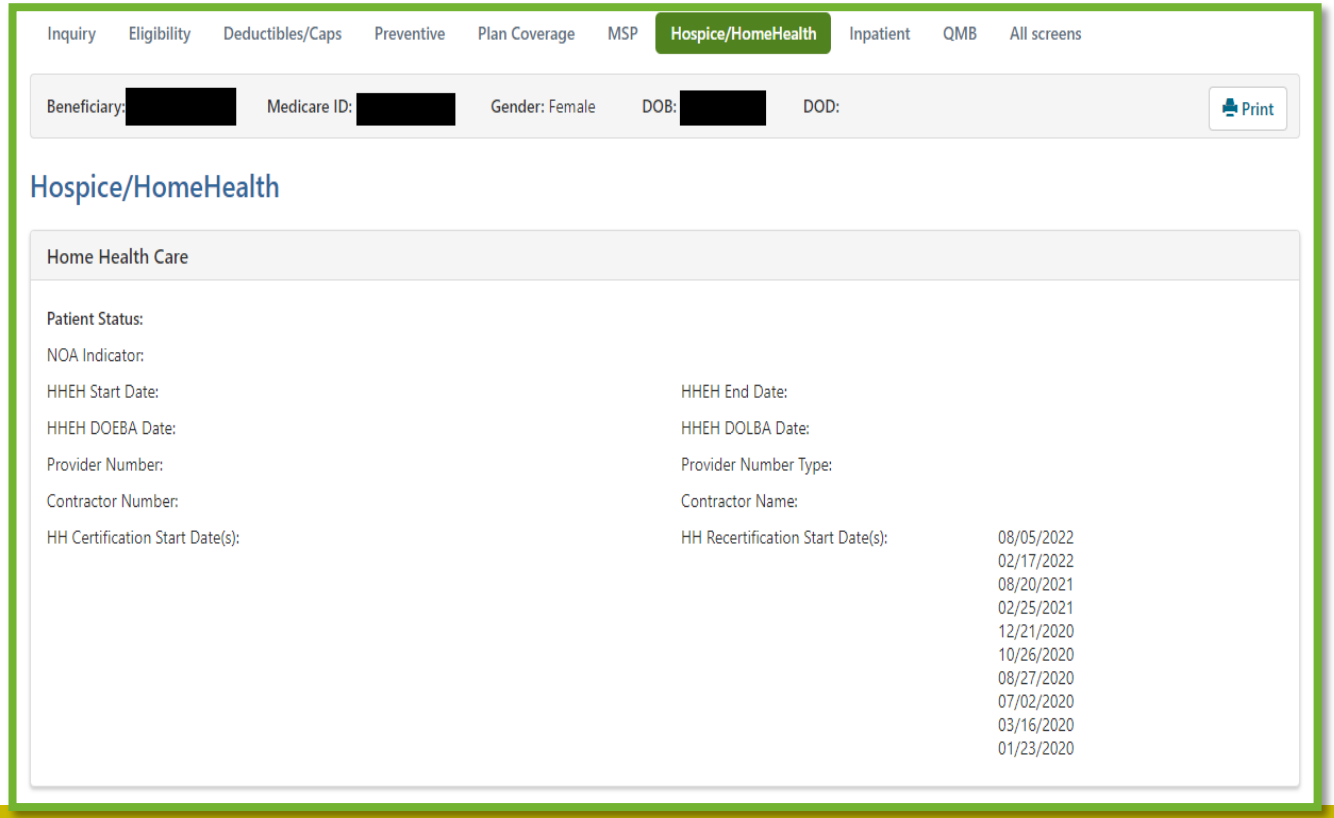
eServices Eligibility Inquiry

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests **up to four (4) years prior to, and four (4) months in the future of, the current date.** Date ranges may not exceed **24** months at a time.

eServices Eligibility Tab

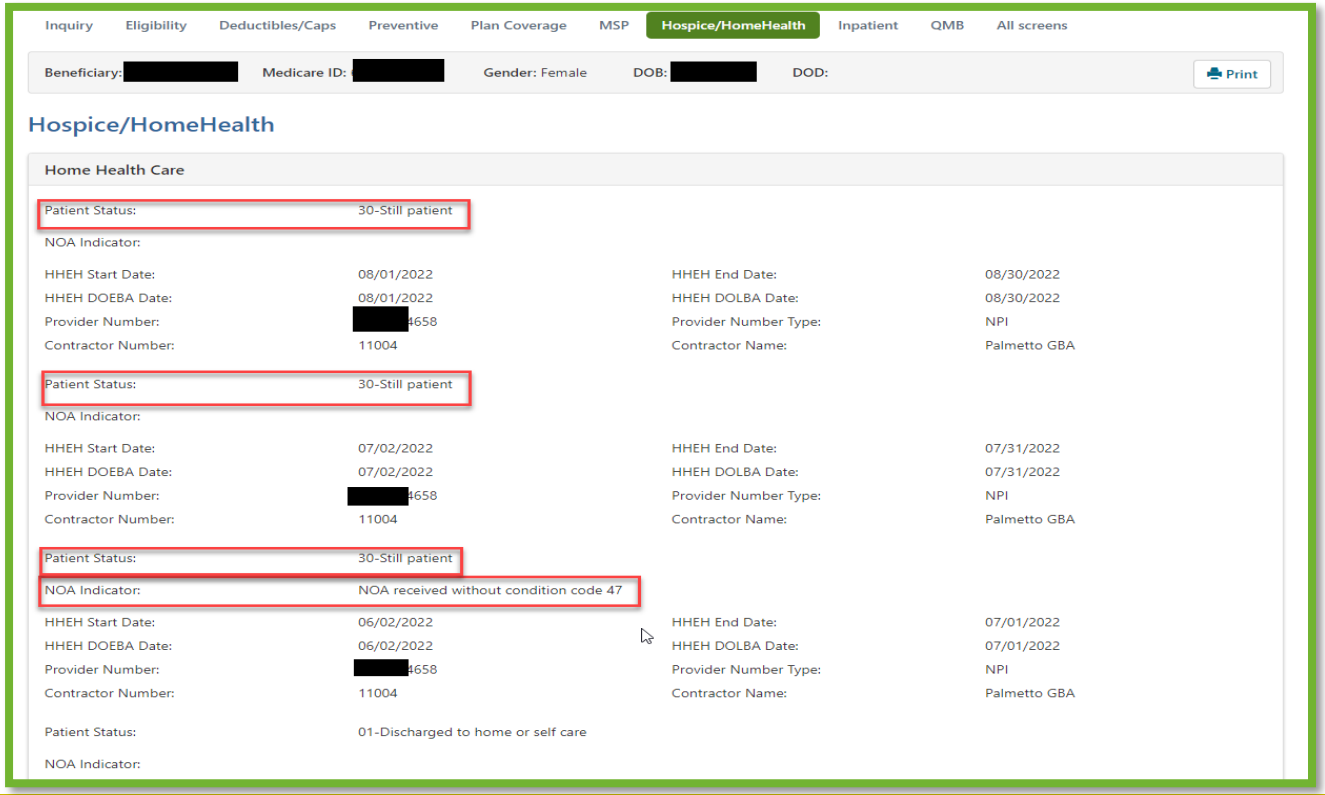


Example of Home Health Response with **No** Date Range Entered on Inquiry Page



Example of patient admitted to home health (HH) on 6/2/22 with 30-day claims submitted and processed for June, July and August 2022. Without date range, only HH recert dates populated.

Example of Home Health Response with Date Range Entered on Inquiry Page



Same patient entered with a date range in the inquiry screen of 1/1/22 to 9/30/22. HH periods and patient status information populated.

eServices – Hospice Elections Overview Fields

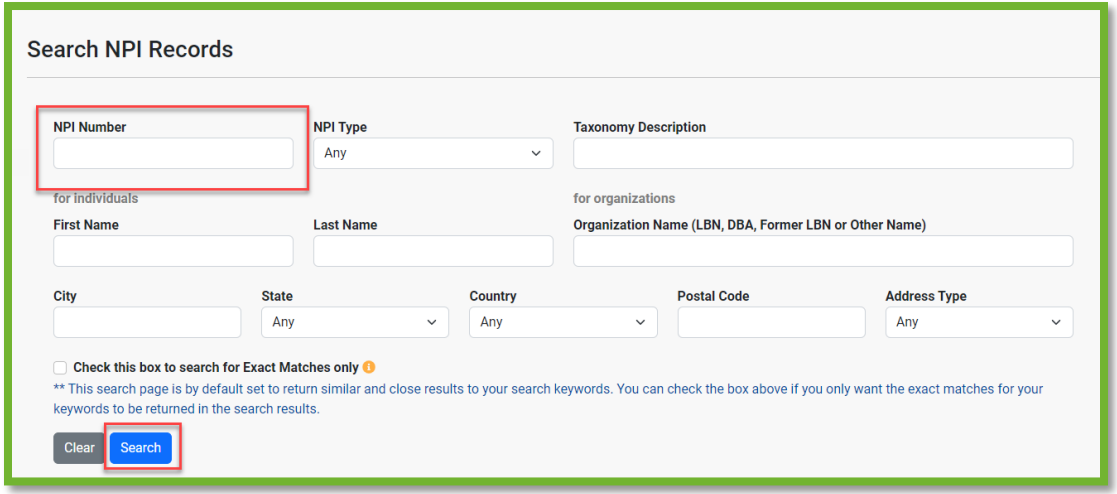
Notices of Election (NOE):

Date 1	Election Receipt Date 2	Provider Number 3	Provider Number Type 4	Revocation Code 5	Election Revocation Date 6
12/13/2022	12/15/2022	195	NPI	0	
08/09/2022	08/11/2022	816	NPI	1	11/28/2022
09/29/2021	10/01/2021	816	NPI	1	07/14/2022

1. **Date – Election Date**
2. Election Receipt Date – Date NOE was received
3. Provider Number – NPI of the hospice
4. Provider Number Type – NPI or CCN
5. **Revocation Code –**
   - **0 (still patient or deceased)**
   - **1-3 (Discharged)**
6. **Election Revocation Date – Discharge date**

NPI Lookup

If eServices provides the NPI, you may use the National Plan & Provider Enumeration System (NPPES) website to look up the HHA's contact information using the NPI.



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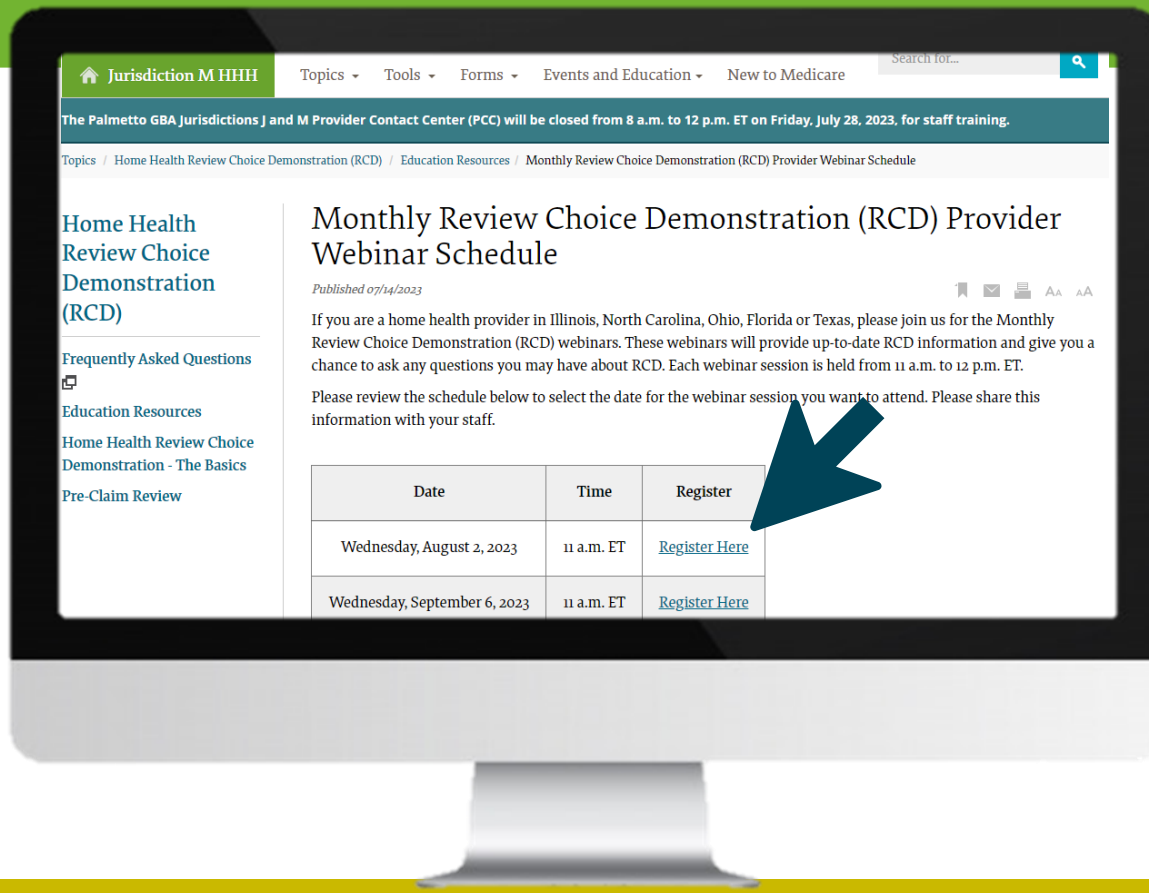
Review Choice Demonstration (RCD) Hot Topics

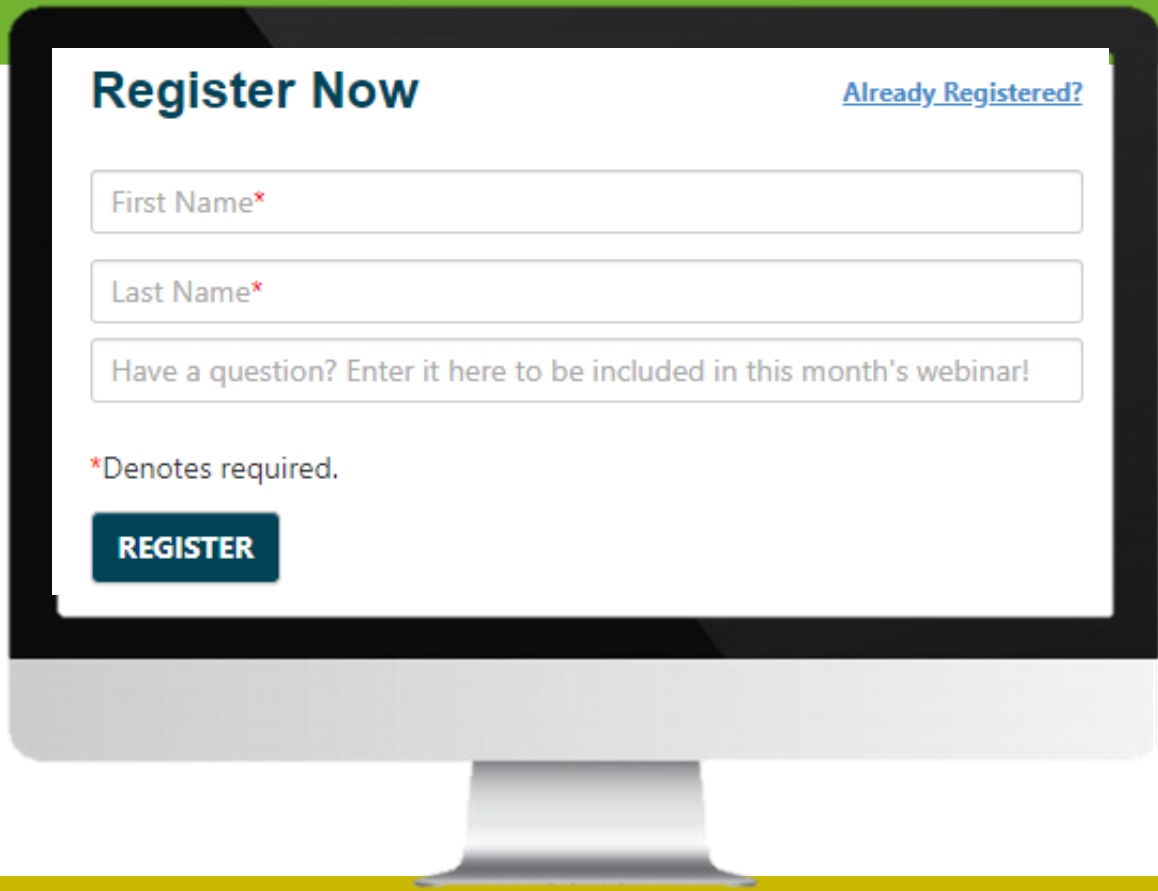
Monthly Webinar

- First Wednesday
- 11 a.m. ET



Monthly Webinar

- Submit questions during registration
- *Questions will be answered live or via email*



Unified Program Integrity Contractor (UPIC) and RCD

While the Review Choice Demonstration (RCD) is under way in your state, providers under review by a Unified Program Integrity Contractor (UPIC) are excluded from the program. Providers under Choice 1 (Pre-Claim Review) will receive a message indicating they are under UPIC review if they attempt to submit a Pre-Claim Review. Providers under an Additional Documentation Request (ADR) option will not receive ADRs from Palmetto GBA.

Once a UPIC review ends, providers should receive a letter from the UPIC confirming the date the review ended. If the review ends in the middle of a cycle for your state, your location is excluded from RCD until the next cycle begins.

Example — UPIC and RCD

- The UPIC review ends on March 5
- The next cycle begins on April 1
- Provider is excluded from RCD from March 5–31
- Provider will participate in RCD beginning April

Important Notes — UPIC and RCD

1. Providers are expected to make a choice selection for an upcoming cycle while they are actively under a UPIC review. If the UPIC review ends after the selection period but before the beginning of the next cycle, providers will start the RCD program cycle without delay.
2. Providers will also receive a letter from Palmetto GBA confirming the conclusion of the UPIC review. Please note, the effective date is determined by the letter sent by the UPIC.
3. All claims submitted with a date of submission on or after the start of the next cycle are subject to the demonstration.

FAQ — UPIC and RCD

Question: If I am under a Unified Program Integrity Contractor (UPIC) review, do I need to make an RCD selection?

Answer: Yes. All providers should make an RCD selection during the choice selection period, although providers under UPIC review will not participate in the demonstration while under review. If the UPIC review ends prior to the start date in your state, the review choice selection will become active for the upcoming cycle. If a provider is removed from UPIC review after the start date for the six-month review cycle, the provider will make a review choice selection and begin participating in the demonstration in the next cycle. Questions regarding UPIC review should be directed to the UPIC.

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RCD Cycle Status

HH RCD Cycles

Current Cycle 7
(8/1/23 – 1/31/24)

Next Selection
(3/1/24 – 3/16/24)

Current Cycle 7
(1/01/24 – 5/31/24)

Next Selection
(TBD)

Current Cycle 6
(8/1/23 – 1/31/24)

Next Selection
(3/1/24 – 3/16/24)

Current Cycle 6
(1/01/24 – 5/31/24)

Next Selection
(TBD)

Current Cycle 1
(12/1/23 – 5/31/24)

Next Selection
(TBD)

Top Non-Affirmations and Additional Documentation Request Denials

Top Non-Affirmations

The physician certification was invalid since the required face-to-face encounter was not related to the primary reason for home health services. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.2.

Top Non-Affirmations

The physician certification was invalid since the required face-to-face encounter was untimely and/or the certifying physician did not document the date of the encounter. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.

Top Non-Affirmations

Documentation submitted does not support homebound criteria-one is met. For criteria-one to be met, the patient must either because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walker; 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. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.1.1.

Top ADR Denials

Orders (including discipline, duration, frequency, treatment, legible, signed/dated appropriately) were not submitted to cover all of the skilled nursing visits billed. Refer to CMS IOM Publication 100-02, Chapter7, Section 30.2.2.

Top ADR Denials

The physician certification was invalid since the required face-to-face encounter was not related to the primary reason for home health services. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.2.

Top ADR Denials

Documentation submitted does not support homebound criteria-one is met. For criteria-one to be met, the patient must either because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walker; 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. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.1.1.

Additional RCD Resources

- Providers Under a UPIC Review Do Need to Make an RCD Selection
- Understanding ADRs When Participating in the RCD
- Review Contractor Directory — Interactive Map
- Review Choice Demonstration (RCD) for Home Health (HH) Services Frequently Asked Questions (FAQ) (PDF) — Questions 19 and 20
- RCD Frequently Asked Questions (FAQ)
- 2023 Review Choice Demonstration (RCD) for Home Health Services FAQs (cms.gov)

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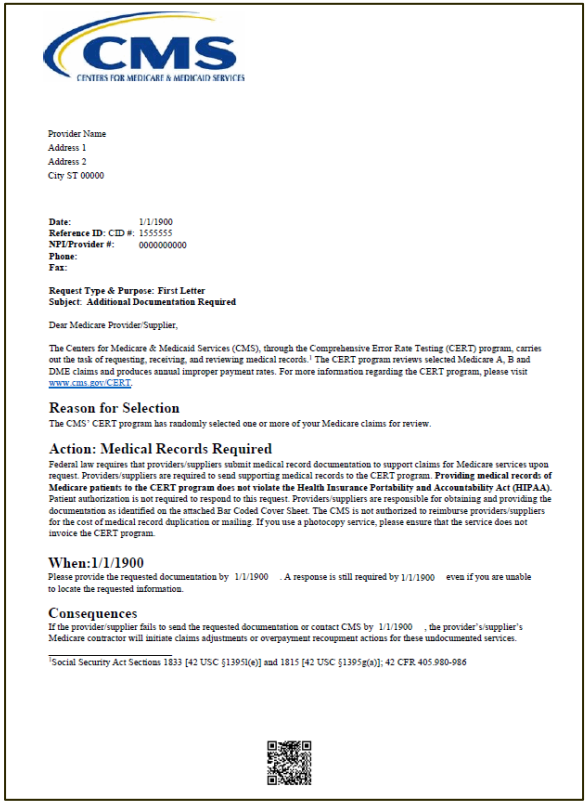
Comprehensive Error Rate Testing (CERT) Reminders

Responding to CERT Requests



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Name
Address 1
Address 2
City ST 00000

Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #: 0000000000
Phone:
Fax:

Request Type & Purpose: First Letter
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection
The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When:1/1/1900
Please provide the requested documentation by 1/1/1900 . A response is still required by 1/1/1900 even if you are unable to locate the requested information.

Consequences
If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

[1]Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986

- Responding to a CERT request is not optional
- A reply is still required if records can not be located
- This is not a HIPPA violation
- Contact the CERT Documentation Center at 888–779–7477, if you have questions regarding requested documentation

CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
1510 E. Parham Road
Henrico, VA 23228

Important Dated Information Enclosed

Immediate Response Required
Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

Responding to CERT Requests

Avoid general payment errors by ensuring that:

- You are aware of CERT requests
- Updates are made to your contact information when necessary
- The original barcoded cover sheet is used when responding to request

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor
GS-00F-263CA CERT

CID: 1555555

Due Date: 1/1/1900 Medicare Part B Provider
Patient Name: Patient Name
Date of Birth: 1/1/1900 **Date of Service: 1/1/1900 - 1/1/1900**
Claim Control Number: CCN0000000000
Universe Date: 1/1/1900 Request Date: 1/1/1900
Contractor Number: 99999 Contractor Type: B
Billing Provider NPI: 0000000000
Letter Sequence: ADR to Billing Provider (First Request)

Please send documentation to:
Fax #: 804-261-8100 or
Mail: CERT Documentation Office - Attn: CID # 1555555, 1510 East Parham Road, Henrico, VA 23228
Phone #: 888-779-7477 or 443-663-2699

The documents listed below may be required in support of a medical claim review. Please provide all of the **pertinent** medical records/ documentation listed **below and any additional documentation** to support the above listed claim for the specified date(s) of service. Please copy both sides of each page and please DO NOT cut off page edges when copying.

Note: If the medical record documentation is not signed or if the signature is illegible, submit an attestation statement or a signature log for those medical record entries. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. An attestation statement cannot be used when an order is not signed.

CERT Documentation Submission

Methods of Submission	
Postal Mail	CERT Documentation Center 1510 East Parham Road Henrico, Virginia 23228
Fax	Send a separate fax for each individual claim to 804-261-8100
Electronic Submission of Medical Documentation (esMD)	Include a CID# or Claim Number
Compact Disc (CD)	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via email to: CERTMail@nciinc.com or via fax to 804-264-9764 • Only images in TIFF or PDF are acceptable
Email Attachment	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via email to: CERTMail@nciinc.com or via fax to 804-264-9764 • Only images in TIFF or PDF are acceptable

Avoiding CERT Errors

Avoid Documentation errors by submitting:

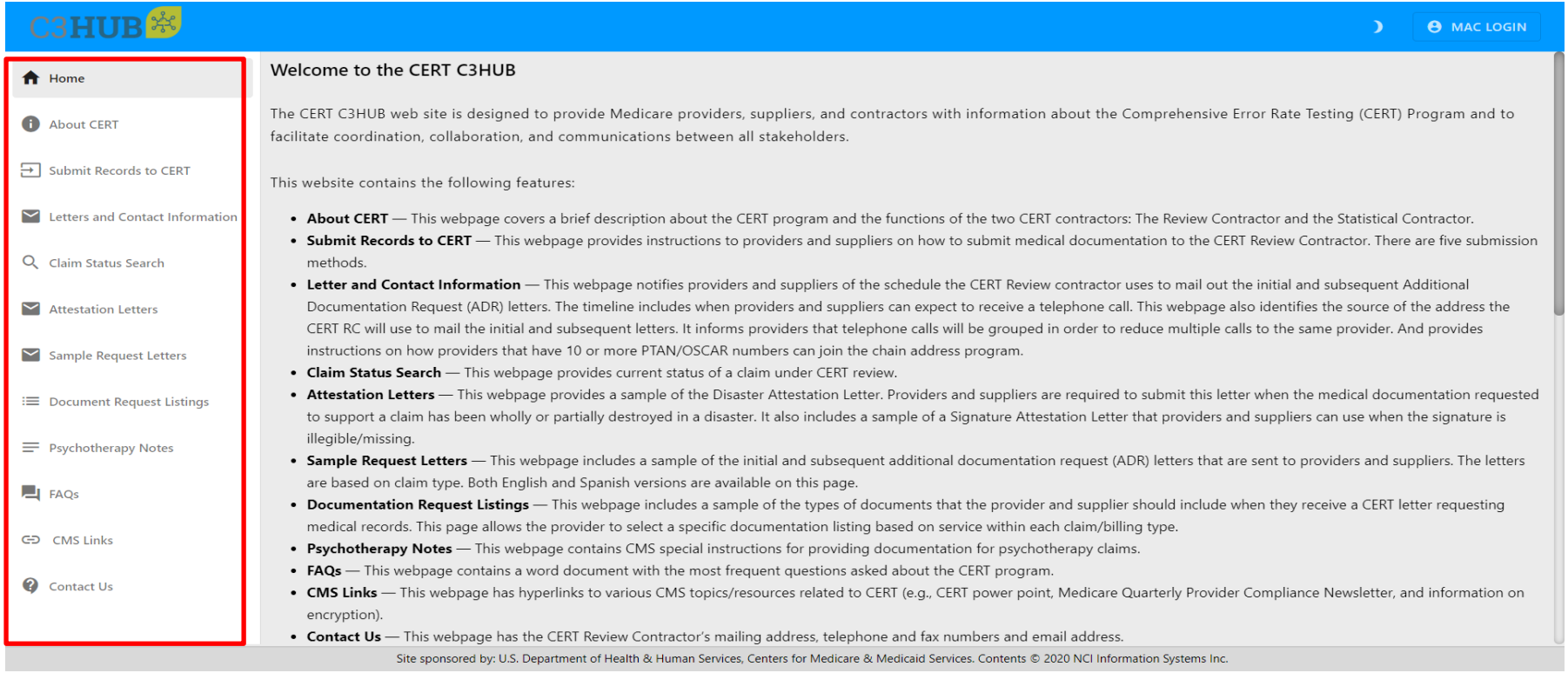
- Comprehensive documentation is submitted timely
- The code billed best reflects rendered services
- An order or an intent to order is obtained when necessary
- Documentation and signatures that are legible (signature logs and attestation statements should be used when necessary)

CERT Website – C3HUB

CERT website C3Hub

- The CERT C3HUB web site is designed to provide Medicare providers, suppliers, and contractors with information about the CERT Program and to facilitate coordination, collaboration, and communications between all stakeholders.

CERT Website – C3HUB



CERT Resources

- Palmetto GBA Comprehensive Error Rate Testing (CERT) Webpage
- Responding to CERT Documentation Request
- CERT website C3Hub

References and Resources

Medicare Program Integrity Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
Hospice Documentation Audit Tool	https://www.palmettogba.com/Palmetto/Providers.Nsf/files/Hospice_Documentation_Audit_Tool.pdf/$File/Hospice_Documentation_Audit_Tool.pdf
Notice of Election	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6KPD3187
Certification	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/9CWSWZ3714
GIP Reduction	https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6K632367
CERT	https://www.cms.gov/files/document/2020-medicare-fee-service-supplemental-improper-payment-data.pdf

CMS Home Health Resources

- CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 7
- CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 10
- CFR Part 484 - Home Health Services
- CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies
- Home Health Agency (HHA) Center

Palmetto GBA Home Health Resources

- Palmetto GBA Jurisdiction M Home Health and Hospice MAC Home page
- Home Health Billing Codes Job Aid
- Late Notice of Admission: The Exception Process
- Home Health Notice of Admission (NOA) Frequently Asked Questions (FAQ)
- Billing the Home Health Notice of Admission (NOA) Electronically
- Billing the Home Health Notice of Admission (NOA) via DDE

Palmetto GBA Home Health Resources

- Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims
- Telehealth Home Health Services: New G-Codes
- Home Health and Hospice Claim Correction Reopenings
- Home Health and Hospice Billing When a New Medicare Beneficiary Identifier Is Assigned

Connect With Us

FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on Twitter for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

Overall, how satisfied are you with your MAC?

- ☐ **Extremely satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Extremely dissatisfied**

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!