Public Policy

HCA Public Policy No. 2-2020

TO: **HCA CHHA PROVIDER MEMBERS**

FROM: **PATRICK CONOLE, VICE PRESIDENT, FINANCE & MANAGEMENT**

RE: **UPDATES FROM NGS HOME HEALTH ADVISORY MEETING**

DATE: **APRIL 3, 2020**

National Government Services (NGS), New York's Medicare Administrative Contractor (MAC) for Jurisdiction 6 (J6), conducted a Home Health Advisory Meeting this week for the state associations and home health representatives in the U.S. Centers for Medicare and Medicaid Services (CMS) J6 region. HCA participated in the meeting and received important updates, posed questions and advocated on behalf of our Medicare certified home health membership.

NGS Website Changes

- NGS has added a COVID-19 banner to its website with all of the latest news articles, information and resources from NGS and CMS.

- NGS is also in the process of providing a single point of entry to all sites a provider or state association may use, starting with NGSConnex along with NGS's main website at www.ngsmedicare.com.

- NGS has also recently rolled out a Voice-Activated Preventative Screening & Service (VPaSS) mobile application.

- NGS's Interactive Voice Response (IVR) system is the process of developing a call-back process as an alternative so that users do not have to wait in the queue. Another upcoming change will allow providers to schedule appointments with a specific customer service representative.

C2C Appeals Demonstration

Beginning May 1, 2019, CMS extended to home health agencies an existing demonstration project for second-level appeals that was previously in effect solely for Durable Medical Equipment (DME) suppliers. The demo involves a Telephone Discussion and Reopening Process with CMS's Qualified Independent Contractors (QICs). The QIC for New York and other jurisdictions is C2C Innovative Solutions (C2C).

Under the demo, selected provider/suppliers have the voluntary opportunity to participate in a recorded telephone discussion that will be included and considered as part of the appeals case file prior to C2C's reconsideration decision.

Emily Barnes from C2C said that home health providers who utilized this process between May 2019 and February 2020 were 53 percent more successful in seeing Medicare appeals overturned and paid to the provider. During this time period, the highest MAC denial reasons **that were overturned** included: 1) evidence did not support medical necessity; 2) covered diagnosis not indicated; and 3) problems with the home health face-to-face (F2F) encounter documentation.

More information is on the C2C website at https://www.c2cinc.com/.

CERT Results

CMS's Comprehensive Error Rate Testing (CERT) program monitors the accuracy of Medicare fee-for-service (FFS) payments by a random sample selection of paid claims and medical records. CERT contractors also review claims for compliance with Medicare coverage, coding and billing rules.

As of March 13, 2020 (for claims received from July 1, 2018 through June 30, 2019), the unofficial J6 home health CERT error rate was 9.95 percent, which is significantly higher than the 5.95 percent reported at NGS's last meeting in November of 2019. The overall error rate for J6 CERT audits of all Part A providers was 4.24 percent, which is lower than the 5.04 percent also reported at the November meeting. The most common home health denials to date included:

- **Error 21**: Insufficient or inadequate F2F or plan of care (POC) documentation and/or visit notes.
- **Error 91**: Billing requirement error(s).
- **Error 90**: Other technical errors such as the physician who signed the certification or plan of care does not match the physician on the claim or in the common working file (CWF).
- **Error 25**: Medically unnecessary service or treatment.
- **Error 31**: Services incorrectly coded.

CMS's overall goal for MACs in 2020 is a CERT denial rate at 7.15 percent, and NGS expects to achieve that overall goal when the November 2020 report is released.

Some resources to assist providers in lowering their CERT denials are available under the "Medical Policy and Review" tab of NGS's Home Health and Hospice (HHA) J6 homepage. CERT also has a public website at www.certprovider.admedcorp.com

Providers who disagree with a CERT denial are strongly encouraged to exercise their right to appeal. Your appeal should be submitted to NGS via a redetermination; visit "About Appeals" on NGS's website for more information.

Provider Enrollment

CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR Section 424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

Revalidation notices will occur by regular mail or e-mail within two to three months prior to the due date. The cost of revalidation is $595. Impacted providers need to use the most current 855-R form no more than seven months prior to their due dates.

Medical Review and Appeals Data Review

Effective March 26, **NGS has suspended all Targeted Probe and Educate (TPE) activities due to the COVID-19 emergency**. Any pended claims – due to additional documentation requests (ADRs) – are being released for payment.

NGS's Lauri Domingo summarized the following top three denials for the last four months and then provided some basic tips on how to avoid them:

- **55HTP** – The initial certification was missing or incomplete or invalid; therefore, the recertification episode was denied.

  NGS will review for the certifying physician statement which must indicate the continuing need for services and estimate how much longer the services will be required. If the submitted certification documentation (submitted with the recertification documentation) does not support home health eligibility, the claim associated with the recertification period will not be paid.

- **55H3V** – Skilled nursing services were not medically necessary.

  To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

- **55HTW** – The physician certification was invalid because the required F2F encounter was missing, incomplete or untimely.

  Providers need to ensure there is documentation (a physician or allowed non-physician practitioner's clinical notes) in the medical record that demonstrates that a face-to-face encounter has occurred within the required timeframe.

NGS's Kathy Gates then summarized the following top three provider appeal issues for the last quarter of 2019:

- The medical documentation submitted did not show that the therapy services were reasonable and necessary and at a level of complexity which requires the skills of a therapist.

- Certification missing or invalid, especially with regards to F2F.

- Recertification denials due to not submitting the initial POC and F2F clinical notes.

OASIS Matching Requirements

Ms. Domingo reminded participants to ensure the information on a home health claim matches the OASIS supporting the home health agency's billing in the iQIES OASIS claim data match. If there is no matching assessment found in iQIES when a claim is submitted, the agency's claim will be returned with reason code 37253. There are several areas that need to be verified to help correct or avoid this error. If a claim gets returned for this reason code, providers should use the following questions as a checklist to ensure all areas have been verified and corrected:

- Have you checked your iQIES verification report to confirm the receipt date was accepted prior to submitting your claim? This is on page 1 of the report under "Completion Date/Time." If the OASIS was submitted after the claim, resubmit the claim.

- Have you verified the assessment hasn't been inactivated? If it was inactivated, resubmit the assessment.

- Have you verified the reason for assessment (from M0100) is equal to 01, 03, 04 or 05? The date reported under occurrence code 50 must match an applicable assessment. If the assessment to which the claim is matched is not one with an appropriate reason for assessment, update occurrence code 50 to match the M0090 date of the appropriate assessment. If there is no occurrence code 50 on the claim, correct and resubmit.

- Have you verified your provider number, the beneficiary Medicare number and the assessment completion date match on the assessment and claim? If any items do not match, correct the assessment or claim and resubmit.

- Have you verified the Medicare Beneficiary Identifier (MBI) reported on the OASIS and claim? If the MBI has changed, verify that the MBI in M0063 on the OASIS matches the MBI submitted on the claim.

If you have verified all of this information and have proof of verification, providers will need to contact NGS at (866) 275-3033 and be prepared to send the claim DCN, page 1 of the OASIS validation report and any other pages showing the reason for assessment, the patient's Medicare number and the date of the assessment (M0090), as well as the assessment ID number and your state.

For further information on this issue, see the following CMS *Medlearn Matters* article: https://www.cms.gov/files/document/se20010.pdf.

Upcoming J6 Home Health Education

NGS will be offering the following home health education programs via conference call and/or webinar:

- April 7– Home Health Billing Under the Patient Driven Groupings Model
- April 7 – Home Health Eligibility: Clinical Documentation Requirements
- April 14 – Lunch and Learn Series: Home Health Billing Basics
- April 27 – Home Health Eligibility: Clinical Documentation Requirements
- May 7 – Documentation Requirements for Physicians Who Order or Certify Home Health Services
- May 19 – Lunch and Learn: Home Health Billing Questions and Answers

NGS's education or training events can be found in the events calendar on NGS's website at www.NGSMedicare.com. Providers should click the "HHH" home page link for the Home Health and Hospice portal and enter their state, then click "Accept" on the HCPCS/CPT code attestation page. Once in the Home Health and Hospice portal, click the education tab, then click the Webinar, Teleconference and Event tab.

2020 Medicare Summit Overview

NGS is holding a Home Health and Hospice Summit at the Rio Convention Center in Las Vegas on September 23-24. The two-day conference will be having two general sessions each day that focus on global issues within the Medicare program, impacting all Part A and B providers including a Meet the Medicare Contractors session and then break-out sessions on each day with home health and hospice tracks. Some of the sessions during the conference include:

- Regulatory and Compliance: Partnering to Meet the Challenges
- Home Health and Hospice Medicare Secondary Payor Billing
- Home Health Certification Requirements
- All-Inclusive Provider Enrollment Processes for Home Health and Hospice
- Hospice Admission through Discharge Documentation
- Home Health Agency Cost Reporting Tips
- Home Health and Hospice Medical Review and Targeted Probe and Educate
- Medicare and Legislative Updates
- Hospice Billing: Avoiding Costly Mistakes
- Best Practices for Home Health Agencies
- Home Health Patient Driven Groupings Model
- Documentation of the Hospice Transfer, Revocation and Discharge
- Hospice Cap and Hospice Cost Reporting Tips

Next Meeting

NGS's next J6 Home Health Advisory Meeting is scheduled for June 11 and NGS will continue its policy of conducting three Home Health Advisory Meetings for state association representatives during the upcoming fiscal year (FY) 2020. HCA will provide a detailed *Public Policy Memorandum* to the membership after each of these meetings.

HCA will also provide updates via our newsletter on any news related to NGS or Medicare payment matters, including future CMS instructions to MACs on any COVID-19 waivers or information and any news regarding the Targeted Probe and Educate (TPE) initiative, upcoming education, and HCA's advocacy in these areas.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.