### FOR HOME HEALTH PROVIDERS

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<tr>
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### FOR HOME HEALTH AND HOSPICE PROVIDERS

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<td>MM11039</td>
<td>Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE</td>
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<tr>
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</tr>
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### MAILING NOW!

New Medicare cards with new numbers. Are you ready?

For Home Health Providers

MM10782: Home Health Rural Add-on Payments Based on County of Residence

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters Number: MM10782
Related CR Release Date: August 3, 2018
Related CR Transmittal Number: R4106CP

Related Change Request (CR) Number: CR10782
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Provider Type Affected

This MLN Matters Article is intended For Home Health Providers billing Part A and Home Health and Hospice Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in rural areas.

Provider Action Needed

CR 10782 implements recent legislation that requires home health rural add-on payments to vary, based on the county in which the service was furnished. Make sure your billing staffs are aware of these changes.

Background

On February 9, 2018, Congress passed the Bipartisan Budget Act (BBA) of 2018. Section 50208 of the BBA amended Section 421 of the Medicare Modernization Act (MMA) to increase the payment amount, otherwise made under section 1895 of the Act, for Home Health (HH) services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act). The percentage of the increase must vary based on the county within the particular rural area. The county-based increase applies to episodes and visits ending on or after January 1, 2019; and continues, at changing percentage levels, through calendar years 2020, 2021 and 2022.

Section 50208 also requires that “in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.” In response, Medicare requested that the National Uniform Billing Committee create a new code to meet this requirement. This new value code 85 is effective on January 1, 2019, and is defined as “County Where Service is Rendered” and providers should report the Federal Information Processing

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at https://www.cgsmedicare.com. © 2018 Copyright, CGS Administrators, LLC.
Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

When home health services are provided in rural (non-Core Based Statistical Area (CBSA)) areas for episodes and visits ending on or after January 1, 2019, and before January 1, 2023, a county-based rural add-on is applied to:

- The national, standardized episode rate;
- National per-visit payment rates;
- Low Utilization Payment Adjustment (LUPA) add-on payments; and
- The Non-Routine Supplies (NRS) conversion factor.

In response to this requirement, your MAC will:

- Accept value code 85 and an associated FIPS State and County Code on home health claims, Type of Bill (TOB) 032x, received on or after January 1, 2019.
- Apply rural payment rates based on whether the FIPS State and County Code is in the list of codes associated with one of three categories of rural counties.
- Return the claim to you for correction when the FIPS State and County Code is missing or invalid.

Note from CGS: Refer to the CMS’ SSA to FIPS State and County Crosswalk information at [http://www.nber.org/data/ssa-fips-state-county-crosswalk.html](http://www.nber.org/data/ssa-fips-state-county-crosswalk.html) to access the FIPS State and County Code. As an example, looking at the Excel file, the FIPS State and County Code 19153 would be reported with value code 85 for Polk county in Iowa.

Additional Information


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 16, 2018</td>
<td>Initial article released.</td>
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</tbody>
</table>

For Home Health Providers

**MM10992: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019**

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/)

**MLN Matters Number:** MM10992  
**Related CR Release Date:** October 19, 2018  
**Related CR Transmittal Number:** R4148CP  
**Related Change Request (CR) Number:** CR10992  
**Effective Date:** January 1, 2019  
**Implementation Date:** January 7, 2019

**Provider Type Affected**

This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know

CR10992 updates the 60-day national episode rates, the national per-visit amounts, Low Utilization Payment Adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for CY 2019. Make sure that your billing staffs are aware of these changes.

Background

Section 1895(b)(3)(B) of the Social Security Act (the Act) requires that the Medicare Home Health Prospective Payment System (HH PPS) rates provided to HHAs for furnishing home health services, must be updated annually. The CY 2019 HH PPS rate update includes an update to the case-mix weights as provided by Section 1895(b)(4)(A)(i) and (b)(4)(B) of the Act. The CY 2019 HH PPS rates for services provided to beneficiaries who reside in rural areas will be increased as required by Section 421(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as amended by Section 50208 of the Bipartisan Budget Act of 2018.

Market Basket Update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended Section 1895(b)(3)(B) of the Act, increasing the market basket percentage for home health payments for CY 2019 to 2.2 percent. Further, Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those Home Health Agencies (HHAs) that do not submit quality data as required by the Secretary of Health and Human Services. For HHAs that do not submit the required quality data for CY 2019, the home health payment update would be 0.2 percent (2.2 percent minus 2 percentage points). The CY 2019 HH PPS final rule also changed the labor-related share used to wage-adjust payments under the HH PPS to 76.1 percent and the corresponding non-labor-related share to 23.9 percent.

National, Standardized 60-Day Episode Payment

As described in the CY 2019 HH PPS final rule, in order to calculate the CY 2019 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) applies a wage index budget neutrality factor of 0.9985 and a case-mix budget neutrality factor of 1.0169 to the previous calendar year’s national, standardized 60-day episode rate ($3,039.64). Additionally, the national, standardized 60-day episode payment rate is updated by the CY 2019 HH payment update percentage of 2.2 percent for HHAs that submit the required quality data and by 2.2 percent minus 2 percentage points, or 0.2 percent, for HHAs that do not submit quality data. These two episode payment rates are shown in Tables 1 and 2, below. Please note that these payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,039.64</td>
<td>X 0.9985</td>
<td>X 1.0169</td>
<td>X 1.022</td>
<td>$3,154.27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,039.64</td>
<td>X 0.9985</td>
<td>X 1.0169</td>
<td>X 1.002</td>
<td>$3,092.55</td>
</tr>
</tbody>
</table>
National Per-Visit Rates

To calculate the CY 2019 national per-visit payment rates, CMS starts with the CY 2018 national per-visit rates and applies a wage index budget neutrality factor of 0.9996 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2019 wage index. The per-visit rates are then updated by the CY 2019 HH payment update of 2.2 percent for HHAs that submit the required quality data and by 0.2 percent for HHAs that do not submit quality data.

The per-visit rates are shown in Tables 3 and 4, below.

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2018 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2019 HH Payment Update</th>
<th>CY 2019 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.94</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$66.34</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$229.86</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$234.82</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$157.83</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$161.24</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$156.76</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$160.14</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$143.40</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$146.50</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$170.38</td>
<td>X 0.9996</td>
<td>X 1.022</td>
<td>$174.06</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2018 Per-Visit Rates</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2019 HH Payment Update Minus 2 Percentage Points</th>
<th>CY 2019 Per-Visit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.94</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$65.04</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$229.86</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$230.23</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$157.83</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$158.08</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$156.76</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$157.01</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$143.40</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$143.63</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$170.38</td>
<td>X 0.9996</td>
<td>X 1.002</td>
<td>$170.65</td>
</tr>
</tbody>
</table>

Non-Routine Supply Payments

CMS computes payments for Non-Routine Supplies (NRS) by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2019 NRS conversion factors, CMS updates the CY 2018 NRS conversion factor by the CY 2019 HH payment update of 2.2 percent for HHAs that submit the required quality data and by 0.2 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2019 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2019 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5A: CY 2019 NRS Conversion Factor for HHAs That DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2018 NRS Conversion Factor</th>
<th>CY 2019 HH Payment Update</th>
<th>CY 2019 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.03</td>
<td>X 1.022</td>
<td>$54.20</td>
</tr>
</tbody>
</table>

Table 5B: CY 2019 NRS Payment Amounts for HHAs That DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2019 NRS Conversion Factor</th>
<th>CY 2019 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$54.20</td>
<td>$14.62</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$54.20</td>
<td>$52.80</td>
</tr>
</tbody>
</table>
## Table 5B: CY 2019 NRS Payment Amounts for HHAs That **DO** Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2019 NRS Conversion Factor</th>
<th>CY 2019 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$54.20</td>
<td>$144.78</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$54.20</td>
<td>$215.10</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$54.20</td>
<td>$331.69</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$54.20</td>
<td>$570.48</td>
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</table>

## Table 6A: CY 2019 NRS Conversion Factor for HHAs That **DO NOT** Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2018 NRS Conversion Factor</th>
<th>CY 2019 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2019 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.03</td>
<td>X 1.002</td>
<td>$53.14</td>
</tr>
</tbody>
</table>

## Table 6B: CY 2019 NRS Payment Amounts for HHAs That **DO NOT** Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2019 NRS Conversion Factor</th>
<th>CY 2019 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$54.20</td>
<td>$14.34</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$54.20</td>
<td>$51.77</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$54.20</td>
<td>$141.95</td>
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<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
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<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$54.20</td>
<td>$325.21</td>
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<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$54.20</td>
<td>$559.32</td>
</tr>
</tbody>
</table>

### Rural Add-On Provision

Section 421(b)(1) of the MMA, as amended by Section 50208 of the BBA of 2018, provides that rural counties would be placed into one of three categories for purposes of receiving HH rural add-on payments:

1. Rural counties and equivalent areas in the highest quartile of all counties or equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of Medicare or enrolled for benefits under part B of Medicare only, but not enrolled in a Medicare Advantage plan under part C of Medicare, as provided in Section 421(b)(1) (A) of the MMA (the “High utilization” category)

2. Rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area and are not included in the category provided in Section 421(b)(1)(A) of the MMA, as provided in Section 421(b)(1)(B) of the MMA (the “Low population density” category)

3. Rural counties and equivalent areas not in the categories provided in either Sections 421(b)(1)(A) or 421(b)(1)(B) of the MMA, as provided in Section 421(b)(1)(C) of the MMA (the “All other” category)

CY 2019 HH PPS payments will be increased by:

- 1.5 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “High utilization” category
- 4.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “Low population density” category
- 3.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “All other” category.

Beginning in CY 2019, HHAs will be required to enter the Federal Information Processing Standards (FIPS) state and county code where the beneficiary resides on each claim. HHAs will continue to enter Core Based Statistical Area (CBSA) codes on the claims.
Outlier Payments

The Fixed Dollar Loss (FDL) ratio and the loss-sharing ratio used to calculate outlier payments must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by Section 1895(b)(5)(A) of the Act). Historically, CMS has used a value of 0.80 for the loss-sharing ratio which, it is believed, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount.

Given the statutory requirement that total outlier payments not exceed 2.5 percent of the total payments estimated to be made based under the HH PPS, CMS is revising the FDL ratio for CY 2019 from 0.55 to 0.51 to better approximate the 2.5 percent statutory maximum. It is not revising the loss-sharing ratio of 0.80.

In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are in the following Tables:

**Table 7a: Cost-Per-Unit Payment Rates for the Calculation of Outlier Payments for HHAs that DO Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY 2019 Per-Visit Payment</th>
<th>Cost-per-unit (1 unit = 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$66.34</td>
<td>$15.80</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$234.82</td>
<td>$62.34</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$161.24</td>
<td>$51.35</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$160.14</td>
<td>$51.55</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$146.50</td>
<td>$49.05</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$174.06</td>
<td>$54.28</td>
</tr>
</tbody>
</table>

**Table 7b: Cost-Per-Unit Payment Rates for the Calculation of Outlier Payments for HHAs that DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY 2019 Per-Visit Payment</th>
<th>Cost-per-unit (1 unit = 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$65.04</td>
<td>$15.49</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$230.23</td>
<td>$61.12</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$158.08</td>
<td>$50.34</td>
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<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$157.01</td>
<td>$50.54</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$143.63</td>
<td>$48.09</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$170.65</td>
<td>$53.22</td>
</tr>
</tbody>
</table>

**Additional Information**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).
For Home Health Providers

MM11040: Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters Number: MM11040
Related CR Release Date: November 16, 2018
Related CR Transmittal Number: R4170CP
Related Change Request (CR) Number: 11040
Effective Date: April 1, 2019
Implementation Date: April 1, 2019

Provider Types Affected
This MLN Matters Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 11040 which provides the quarterly update of Healthcare Common Procedure Coding System (HCPCS) codes used for Home Health (HH) consolidated billing effective April 1, 2019. Make sure that your billing staffs are aware of these changes.

Background
The Social Security Act (Section 1842(b)(6); https://www.ssa.gov/OP_Home/ssact/title18/1842.htm) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is in regulations at 42 CFR 409.100 (https://www.ecfr.gov/cgi-bin/text-idx?SID=dade79f01c6f93604262bb8e8a95e7e&mc=true&node=pt42.2.409&rgn=div5#se42.2.409_1100) and in Medicare instructions provided in Chapter 10, Section 20 of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf).

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians and supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to your MAC will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a HHA).

Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in...
order to reflect the creation of temporary HCPCS codes (for example, ‘K’ codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

There are no codes being added to the HH consolidated billing non-routine supply code list in this update. However, the following code is being added to the HH consolidated billing therapy code list:

- 92597 - Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech

**Note:** This is not a new therapy code. This code was removed from the HH consolidated billing therapy code list in error in January 2003. CR11040 corrects this error and restores the code to the list.

**Additional Information**


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**Document History**

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**For Home Health Providers**

**SE1436 Revised: Certifying Patients for the Medicare Home Health Benefit**

The Centers for Medicare & Medicaid Services (CMS) revised the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/.

**MLN Matters® Number:** SE1436 Revised  
**Related CR Release Date:** N/A  
**Related CR Transmittal #:** N/A  
**Related Change Request (CR) #:** N/A  
**Effective Date:** N/A  
**Implementation Date:** N/A

**Note:** This article was revised on November 5, 2018, to reflect policies finalized in the Calendar Year (CY) 2019 Home Health PPS Final Rule (CMS-1689-FC). Specifically, the regulation at 42 CFR 424.22(b)(2) has been revised to remove the requirement that the recertification statement must include an estimate of how much longer the services will be required. This change is effective January 1, 2019. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Special Edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.

**What You Need to Know**

This MLN Matters® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.
**Key Points**

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed Non-Physician Practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating Home Health Agency (HHA).

**Patient Eligibility—Confined to Home**

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered “confined to the home” (homebound) if the following two criteria are met:

<table>
<thead>
<tr>
<th>First Criteria</th>
<th>Second Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of the Following must be met:</td>
<td>Both of the following must be met:</td>
</tr>
<tr>
<td>1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.</td>
<td>1. There must exist a normal inability to leave home.</td>
</tr>
<tr>
<td>2. Have a condition such that leaving his or her home is medically contraindicated.</td>
<td>2. Leaving home must require a considerable and taxing effort.</td>
</tr>
</tbody>
</table>

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

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to the home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

**Patient Eligibility—Need Skilled Services**

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions
in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);

- Physical Therapy (PT);
- Speech-Language Pathology (SLP) services; or
- Continuing Occupational Therapy (OT).

Patient Eligibility—Under the Care of a Physician and Receiving Services Under a Plan of Care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 CFR 424.22(a)(1)(iii) as follows:

- Doctor of Medicine;
- Doctor of Osteopathy; or
- Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on 42 CFR 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

Physician Certification of Patient Eligibility

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)(v); and
- The physician who establishes the plan of care must sign and date the certification.

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient requires home health services; and
   c. Was performed by a physician or allowed Non-Physician Practitioner.

   **Note:** The certifying physician must also document the date of the face-to-face encounter.

According to the regulations at 42 CFR 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

Certification Requirements: Who Can Perform a Face-to-Face Encounter

According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

**Certification Requirements: Management and Evaluation Narrative**

According to 42 CFR 424.22(a)(1)(i) if a patient’s underlying condition or complication requires a Registered Nurse (RN) to ensure that essential non-skilled care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient’s care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician’s signature. If the narrative exists as an addendum to the certification form in addition to the physician’s signature on the certification form, the physician must sign immediately following the narrative in the addendum.

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient’s plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient’s recovery and medical safety in view of the patient’s overall condition.


**Certification Requirements: Supporting Documentation**

- Documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.
- Information from the HHA, such as the patient’s comprehensive assessment, can be incorporated into the certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient.
  - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - The certifying physician must review and sign off on anything incorporated into the patient’s medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient’s:

1. Need for the skilled services; and
2. Homebound status.

The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

1. Occurred within the required timeframe;
2. Was related to the primary reason the patient requires home health services; and
3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge Summary;
2. Progress Note;
3. Progress Note and Problem List; or
4. Discharge Summary and Comprehensive Assessment.

**Recertification**

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care. (These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

**Recertification Requirements**

1. Must be signed and dated by the physician who reviews the plan of care; and
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services).

**Physician Billing for Certification/Recertification**

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient’s needs.

2. HCPCS code G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for “Medicare-covered” home health services if the HHA claim itself was non-covered because the certification/
recertification of eligibility was not complete or because there was insufficient
documentation to support that the patient was eligible for the Medicare home health benefit.

**Additional Information**

If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

More information is available at the Medicare Home Health Agency website at [https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html).

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<td>December 23, 2014</td>
<td>Initial article release</td>
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**Example 1**

**AAA Hospital Discharge Summary**

**Department of Surgery**

**Date of Encounter**: 02-17-2014

**Admit Date**: 02-13-2014

**Discharge Date**: 02-17-2014

**Patient Name**: Jane Doe

**Medicare No.**: 00001123

**NPI**: 1234567890

**Physician**: John A. Doe, M.D.

**Discharge Diagnosis**: Right knee osteoarthritis.

**ADMISSION DIAGNOSIS**: Right knee osteoarthritis.

**CONSULTATIONS**:
- 1. Physical Therapy
- 2. Occupational Therapy

**PROCEDURES**: 02/14/2014: Total Right knee arthroscopy.

**DISCHARGE MEDICATIONS**:
- Colace 100 mg daily, Diclofenac 50 mg every 4 hours as needed for pain.
- Lisinopril 10 mg daily.
- Candesartan 4 mg daily.
- Blood draw for INR ordered for 2/20/2014.

**DISCHARGE CONDITION**:
- Discharge Diagnosis: Ms. Doe is a stable status post right total knee replacement and has made good progress with her discharge and rehabilitation. Ms. Doe is to be discharged to home with home health services, physical therapy and nursing visits, instead. The patient is temporarily homebound secondary to status post total knee replacement and currently unable to walk, dependent on painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new Condua medical regimen.

**PAST MEDICAL HISTORY**: Hypertension, Gout.

**PAST SURGICAL HISTORY**: Hypertensive.

**DESCRIPTION OF DISCHARGE PROCEDURE**: Ms. Doe is a stable status post right total knee replacement and has made good progress with her discharge and rehabilitation. Ms. Doe is to be discharged to home with home health services, physical therapy and nursing visits, instead. The patient is temporarily homebound secondary to status post total knee replacement and currently unable to walk, dependent on painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new Condua medical regimen.

**INSTRUCTIONS**:
- The patient is discharged to home in the case of her own. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient proceeded Condua 4 mg a day as the INR was 3.8 on discharge with twice weekly labs checks. Request home medications. Call the office or return to the emergency room for any concerns including increased edema, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

**Transcribed by**: A.M. 02/17/2014

**Electrocardiogram**: John A. Doe, M.D. 02/17/2014 17:52
Example 2

Progress Notes

Patient: John Doe, M.D.
DOB: 04/10/1954
Address: 174 Main St., Pampa TX 79102

Subjective:

CC: Wound on left heel.

HPI: Pt is here for evaluation of wound on left heel. Patient reports he noticed the wound on patient's heel when he was walking his feet. Patient states he has difficulty with walking his feet and his daughter will sometimes come for him. She reports the use of a shoe box to put on her shoes.

ROS:

No weight change, no fever, no weakness, no fatigue.

Cardiology:

No chest pain, no palpitations, no dyspnea, no shortness of breath.

Skin:

Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothyroidism, DDD.

Medication: zolpidem 10 mg tablet 1 tab once a day (at bedtime), 1 tablet 2 tablets 1 tablet once a day. Lipitor 10 mg tablet 1 tablet once a day.

Allergies: NKA.

Objective:

Vitals: Temp 96.8, BP 150/88, HR 62, RR 19, Wt 225 lb 5' 4”

Examination: General appearance pleasant. MENT normal. Heart rate regular and rhythm, lungs clear. BS present. Pupils: 2, binoculars, normal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.6 cm deep. Wound bed is red, with without, minimal amount of yellow drainage noted on removed bandage.

Assessment:

1. Open wound left heel

Plan:

- OFF-WOUND Begin hydrocellular with silver dressing changes. Minimal weight bear on left leg with a crutch or cane on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on weight to promote wound healing. She is currently using a wheelchair. She plans to use a wheelchair as needed for wound care, medication for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return within 2-3 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane
DOB: 01/12/1941
Address: 500 Main St., Pampa TX 79102

Sign off status: Completed

Example 3 – Part 1 of 2

Progress Notes

Patient: Roger, Buck
DOB: 08/13/1925
Address: 344 Happy Lane, Texarkana, MD 13485

Subjective:

CC:

CC:

Weakness

HPI:

Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregivers are present with him for the time. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs since his last visit. He has improved in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not used a wheelchair previously. The patient denies any fever, chills, cough, chest pain, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.

ROS:

No weight change, positive for weakness, negative for fatigue.

Cardiology:

No chest pain, no palpitations, no dyspnea, no shortness of breath.

Medical History: HTN, hyperlipidemia, Diabetes Mellitus

Medication: ASA 125 mg once a day, 1 tablet 1 tablet once a day, Lipitor 10 mg tablet 1 tablet once a day. Metformin 1000 mg once a day.

Allergies: NKA

Objective:

Vitals: Temp 98.6, BP 130/80, HR 75, RR 12, Wt 200 lb 5' 9” pulse on 98% on room air

Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. MENT: Pupils do not react to light. Heart rate regular and rhythm, lungs clear, BS present. Extremities: Pupils: 2, binoculars, normal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Muscle strength 3/5 in all 4 extremities (normal=5). The patient's gait and gait test was 53 seconds (normal = 10)

Assessment:

Muscle Weakness secondary to deconditioning due to pneumonia

Plan:

1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to use a cane without difficulty. The patient requires a home health PT program for gait training and increased muscle strength to restore the patient's ability to walk in his residence.

Follow Up: Return within 2-3 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:16 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 3) for homebound status.
Example 3 – Part 2 of 2

Problem List*

- Patient: Rogers, Buck
- DOB: 08/13/1925
- Address: 234 Happy Lane, Towson, MD 21245
- 401.1 HTN - 1999
- 272.2 Hyperlipidemia - 1999
- 250.5 Diabetes Mellitus with nephropathy manifestations - 2005
- 369.22 Anemia - 2002 requires caregiver assistance in order to leave the home
- 482.31 Pneumonia - Streplococcus - 2014

In conjunction with the progress note, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

* A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.

Example 4 – Part 1 of 2

AAA HOSPITAL DISCHARGE SUMMARY
DEPARTMENT OF SURGERY

Name: Smith, John
Physician: Dr. San Bose, M.D.
Date of Admission: 04.14.2014
Discharge Date: 06.18.2014

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroscopy.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is a 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain a night that interrupts sleep. Weight did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Surgical knee repair

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 3/325 every 4 hours as needed for pain. Lisinopril 10 mg daily. Lovenox 5mg SQ every 12 hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapy and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation and teaching of Lovenox injections.

PAPER INSTRUCTIONS:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight loss as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bose in two weeks.

Transcribed by: A.M. 04/18/2014
Electronically signed by: San Bose, M.D. 04/18/2014 18:31
For Home Health and Hospice Providers

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:
For Home Health and Hospice Providers

**Fiscal Intermediary Standard System (FISS)**

**Direct Data Entry (DDE) Screen Changes**

The January 2019 quarterly system release, which will be implemented on January 7, 2019, includes changes to the following FISS DDE screens. In addition, the following chapters of the home health and hospice FISS DDE Guide has been updated to reflect these changes.

- **Chapter One: FISS Overview** - [https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_1-fiss_overview.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_1-fiss_overview.pdf)
- **Chapter Three: Inquiry Menu** - [https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf)
- **Chapter Five: Claims Correction** - [https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf)

**Inquiry Menu Screen**

The new selection, "INVOICE NO/DCN TRANS" will be added to the FISS DDE Inquiry Menu (Map 1702) screen. The MLN Matters® article MM10542 ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10542.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10542.pdf)) explains that this option allows providers to use DDE to look up the claims associated with an Accounts Receivable (AR) by using the invoice number.
on the AR to find the Document Control Number (DCN), and then using the DCN to look up the claims.

MAP1702                  CGS J15 MAC - XXX REGION        ACPFA052 MM/DD/YY
XXXXXX                   INQUIRY MENU                  C201135E HH:MM:SS

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**INVOICE NO/DCN TRANS 88**

ENTER MENU SELECTION:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

**Option 88 - MAPHDCN**

Once Option 88 is selected, the MAPHDCN screen displays.

Providers may enter the DCN in the FISS DCN field and press F9 to populate the Invoice Number field. Or, enter the Invoice Number in the Invoice Number field and press F9 to populate the FISS DCN field.

MAPHDCN                  CGS J15 MAC - XXX REGION       ACPFA052 MM/DD/YY
XXXXXX                   MEDICARE PART A             C201135E HH:MM:SS

INVOICE NUMBER/DCN TRANSLATOR

PLEASE ENTER UP TO 5 DCNS ON THE LEFT OR 5 DCNS ON THE RIGHT. PRESS PF9.

THE EQUIVALENT DCNS WILL BE DISPLAYED IN THE OPPOSITE FIELD.

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<tr>
<th>F I S S</th>
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MSG: PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

PF1= PF2= PF3=END PF4= PF5= PF6= 
PF7= PF8= PF9=PROCESS PF10= PF11= PF12= 

**Claim Summary (Option 12)**

The Claim Summary Inquiry screen (MAP 1741) will be updated to include the DCN field.

Providers will need to enter their National Provider Identifier in the NPI field, the patient’s
As mentioned, these changes will be effective on January 7, 2019. For details about FISS DDE, refer to the home health and hospice FISS DDE Guide Web page at https://www.cgsmedicare.com/hhh/education/materials/fiss.html.

For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by January 30, 2019, for the quarter ending December 31, 2018. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.


NOTE: Please do not submit duplicate Credit Balance Reports. To ensure CGS has received your report, consider using the website portal myCGS to submit your report. myCGS provides instant confirmation of receipt and allows you to check the status. Submitting your CBR using certified mail, or other methods that require a signature upon delivery is also an option.

The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

Refer to the Medicare Credit Balance Report (CMS-838) form for complete instructions. However, for additional assistance in completing the form, refer to the “Tips on Completing a Credit Balance Report (Form CMS-838)” Web page at https://www.cgsmedicare.com/hhh/financial/838_form_tips.html on the CGS website.

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below. Do not submit duplicate Credit Balance Reports.
myCGS, secure Web Portal (preferred method): 

myCGS provides instant confirmation of receipt. For details, refer to:

Reports may be faxed to (do not send duplicate faxes):
1.615.664.5987
MCBR Receipts
Attn: Credit Balance Reporting

Regular and Certified Mail:
CGS
Attn: HHH Credit Balance Reporting
PO Box 20014
Nashville, TN 37202

Fed Ex/ UPS/ Overnight Courier:
CGS
J15 Credit Balance Reporting
2 Vantage Way
Nashville, TN 37228

Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

If you are issuing a refund check for a credit balance:

- Send the CMS-838 and a copy of the refund check using one of the options listed above.
- Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:
  CGS - J15 Home Health and Hospice
  PO Box 957124
  St. Louis, MO 63195-7124

If you have general questions related to the Credit Balance report, refer to the CGS Credit Balance Report (Form CMS-838) website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html or call the Provider Contact Center at 1.877.299.4500 (Option 1). If you have questions about withholding, call 1.877.299.4500 and select Option 4.

For Home Health and Hospice Providers
MLN Connects® Weekly News

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

MM10611 Revised: Medicare Cost Report
E-Filing (MCReF)

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10611 Revised  Related Change Request (CR) #: 10611
Related CR Release Date: November 2, 2018  Effective Date: June 12, 2018
Related CR Transmittal #: R2194OTN  Implementation Date: June 12, 2018

Note: This article was revised on November 6, 2018, to reflect revisions to CR10611, issued on October 24 and November 2. The article was revised to extend the MAC portals to be open until January 2, 2019, instead of July 2, 2018. As a result of the revision to the article, providers that wish to electronically submit their MCR must do so using MCReF on or after January 2, 2019, instead of the original date of July 2, 2018. As a result of the November 2 CR revision, an incorrect Web address for new user registration is corrected. In addition, the CR release date, transmittal number, and the Web address for CR10611 are also revised. All other information remains the same.

Provider Types Affected
This MLN Matters Article is intended for cost report staff submitting annual Medicare Cost Reports (MCRs) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10611 informs MACs and providers of the new MCR e-filing (MCReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers’ Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCReF System.

Background
In accordance with Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II (PRM-II) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html), providers that continue to participate in the Medicare Program are required to submit a cost report within 5 months of their cost reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for “no Medicare utilization” cost reports are addressed in PRM-II, Section110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare Cost Report (MCR) Filing and Receipt Process
Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

• Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the Print Image), using CMS-approved MCR vendor software.

• Submit the Worksheet S (Certification Page) signed by an officer or administrator of the provider. A “wet” signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.

• Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare Bad Debt Listing, Interns and Residents Information System data, and so on.
Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for 9 percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR Filing Process

To streamline the MCR filing process, the 2018 Inpatient Prospective Payment System (IPPS) Final Rule allows for an electronic signature on the MCR Worksheet S (Certification Page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCReF system available to Part A providers for electronic transmission (e-Filing) of an MCR package directly to a MAC. A CMS Enterprise Identity Management (EIDM) account is required to use MCReF, which is the same account providers use to order copies of their Provider Statistical and Reimbursement Reports (PS&R).

Upon login, providers will be able to select the Fiscal Year End for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is “receivable” (See Attachment A of CR10611. The Web address of CR10611 is in the Additional Information section of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed “receivable,” the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare Cost Report e-Filing (MCReF) System Access

MCReF will be hosted at the following URL: https://mcref.cms.gov. System access to MCReF will be controlled by the EIDM system, as previously noted. Part A Provider Security Officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.

Providers that are not registered in EIDM, but wish to gain access to MCReF, must register in EIDM and assign an SO for their organization. New user registration is available at https://portal.cms.gov/wps/portal/unauthportal/selfservice/newuserregistration.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCReF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting January 2, 2019, providers that wish to e-file their MCR must use MCReF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of Streamlined MCR Processes

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCRIS) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR Postmarked Date, Received Date, and HCRIS Sent Date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction’s portals or physical mailing addresses.

An MCR submitted through MCReF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.

Providers will receive immediate feedback on whether the MCR is received.

Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;

Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCReF.

MCReF has a simple, straightforward user interface with just one screen.

Reduces provider confusion due to conflicting MAC “receivability” rules.

Additional Information
The official instruction, CR10611, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2194OTN.pdf. A detailed MCReF System Overview is attached to the CR. CMS encourages cost report staff to review this overview.


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

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<td>May 2, 2018</td>
<td>Initial article released.</td>
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For Home Health and Hospice Providers

**MM10854: Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME)**

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters Number: MM10854
Related CR Release Date: November 21, 2018
Related CR Transmittal Number: R2206OTN
Related Change Request (CR) Number: 10854
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Provider Types Affected

This MLN Matters Article is intended for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) who submit claims to the Durable
Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

CR 10854 informs providers that the Centers for Medicare & Medicaid Services (CMS) is implementing a special payment rule and a new Healthcare Common Procedure Coding System (HCPCS) code E0467 for a multi-function ventilator under the frequent and substantial servicing DME payment category. Make certain your billing staffs are aware of these changes.

Background

Under Medicare, ventilators fall under the frequent and substantial servicing DME payment category described in Section 1834(a)(3) of the Social Security Act. Payment for items falling under the frequent and substantial servicing payment category is made on a monthly rental basis until medical necessity ends and includes payment for all related accessories necessary for the effective use of the equipment. Recently, the Food & Drug Administration (FDA) cleared a new type of ventilator that integrates multiple therapies into a single device for ventilator-dependent patients. This new multi-function ventilator can also function as an oxygen concentrator, cough stimulator, aspirator and nebulizer. The multi-function ventilator replaces the multiple stand-alone devices (for example, a separate ventilator, oxygen concentrator, and so forth) that beneficiaries may need over time. CMS added a special payment rule to the regulations at 42 CFR 414.222 to address payment for this new type of multi-function ventilator.

CR 10854 instructs MACs to deny claims that are:

- Submitted on the same claim or that overlap any dates of service for the new multi-function ventilator for same or similar items (for example, oxygen and oxygen equipment, nebulizers and related accessories, aspirators and related accessories, or cough stimulators and related accessories) if furnished on or after the date that the multi-function ventilator is furnished.
- For the new multi-function ventilator when the beneficiary owns any of the same or similar equipment, or has reached the 36-month cap for oxygen equipment, for equipment which has not reached the end of its reasonable useful lifetime.

Effective January 1, 2019, HCPCS code E0467 was established to describe the multi-function ventilator along with a single fee schedule amount under the frequent and substantial servicing payment category. The new multi-function ventilator policy and HCPCS code applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (oxygen concentrator, cough stimulator, suction pump and nebulizer). If a claim is received for the rental of a multi-function ventilator under the HCPCS code E0467, claims for the rental of separate stand-alone devices and related accessories will be denied, if it is billed during a rental month of a paid separate stand-alone rental device and the date of service is on or after that of the separate stand-alone rental device. Only one item may be paid during a rental month and payment will be made for the earliest dated item billed. The separate stand-alone rental devices and accessories that are integrated into the multi-function ventilator or which represent similar equipment used for the same purpose that should be denied if billed in conjunction with the new multi-function ventilator code are:

- Nebulizers and related accessories (HCPCS codes E0565, E0570, E0572, E0585, A4619, A7003, A7004, A7005, A7006, A7007, A7012, A7013, A7014, A7015, A7017, A7525, and E1372)
- Aspirator and related accessories (HCPCS codes E0600, A4216, A4217, A4605, A4624, A4626, A7000, A7001, A7002, and A7047)
• Cough Stimulator, High Frequency Chest Wall Oscillation, Oscillatory Positive Expiratory Pressure and related accessories (HCPCS codes E0482, A7020, E0483, A7025, A7026 and E0484)

• Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RADs) and related accessories (HCPCS codes E0601, E0470, E0471, E0472, A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562)

• Oral appliance (HCPCS code E0486)

• Ventilators (HCPCS codes E0465 and E0466)

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement parts) of beneficiary-owned equipment identified by HCPCS codes E0482, E0565, E0570, E0572, E0585, or E0600 will be denied if the dates of service for the repair service overlaps any dates of service for the multi-function ventilator.

MACs will use the following messages when denying claims submitted with same or similar HCPCS as the HCPCS E0467 multi-function ventilator:

• Claim Adjustment Reason Code (CARC) 151: Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

• Remittance Advice Remark Code (RARC) M3: Equipment is the same or similar to equipment already being used.

• Claim Adjustment Group Code - CO (Contractual Obligation)

Additional Information


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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For Home Health and Hospice Providers

**MM10983:** Common Working File (CWF) Provider Queries National Provider Identifier (NPI) and Submitter Identification (ID) Verification

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters Number: MM10983
Related CR Transmittal Number: R2198OTN
Effective Date: April 1, 2019 for NPI Verification, July 1, 2019 for Submitter ID Verification

Related CR Release Date: November 9, 2018
Related Change Request (CR) Number: 10983
Implementation Date: April 1, 2019 for NPI Verification, July 1, 2019 for Submitter ID Verification
Provider Types Affected
This MLN Matters Article is intended for Medicare Part A providers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10983 announces that the Common Working File (CWF) will require verification of the National Provider Identifier (NPI) and Submitter Identification (ID) similar to the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) when Medicare Part A providers request Medicare beneficiary eligibility and entitlement data via the CWF provider inquiry screens. Make sure your billing staffs are aware of this update.

Background
Medicare Part A providers, clearinghouses and billing agents can request Part A Medicare beneficiary eligibility information from CWF. There are five Part A eligibility queries available through the CWF.

The Centers for Medicare & Medicaid Services (CMS) is directing CWF to modify each Part A eligibility inquiry and establish verification processes similar to those established in HETS. This change will align the verification process for Part A eligibility data across the CMS systems. Thus, with the implementation of this change request, the CWF host will verify the status of the NPI and the Submitter ID against information provided by the Provider Enrollment, Chain and Ownership System (PECOS) and HETS, respectively.

Additional Information
Currently, Medicare Part A providers have access to Medicare beneficiary eligibility and entitlement data through 1) MACs portals, 2) HETS, and/or 3) CWF provider inquiry screens.

With implementation of CR 10983, Medicare Part A providers must have HETS Submitter ID to access CWF provider inquiry screens. All HETS submitters have HETS Submitter IDs issued and maintained by Medicare Customer Assistance Re: Eligibility (MCARE). However, Medicare Part A providers not having HETS Submitter IDs shall either continue to access MACs portals without any changes or establish a Submitter ID with HETS.

Note from CGS: The CWF provider inquiry screens include ELGA and ELGH.


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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<td>November 13, 2018</td>
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For Home Health and Hospice Providers

MM11038: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

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**MLN Matters Number:** MM11038  
**Related CR Release Date:** November 16, 2018  
**Related Change Request (CR) Number:** 11038  
**Effective Date:** April 1, 2019  
**Related CR Transmittal Number:** R4167CP  
**Implementation Date:** April 1, 2019

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**Provider Type Affected**

This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

CR 11038 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and/or PC Print software if they use that software.

**Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. CMS provides CR11038 as a code update notification indicating when updates to CARC and RARC lists are available on the Washington Publishing Company (WPC) website. Medicare’s SSMs must implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date specified in CR 11038, MACs must implement on the date specified on the WPC website at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise, as the WPC website is only updated three times per year and may not match the CMS release schedule. The MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 10620).

**Additional Information**

If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

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### For Home Health and Hospice Providers

**MM11039: Implement Operating Rules - Phase III**

**Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE**

The Centers for Medicare & Medicaid Services (CMS) issued the following *Medicare Learning Network*® (*MLN*) *Matters* article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles)

**MLN Matters® Number:** MM11039  
**Related Change Request (CR) #:** 11039  
**Related CR Release Date:** November 16, 2018  
**Related CR Transmittal #:** R4168CP  
**Effective Date:** April 1, 2019  
**Implementation Date:** April 1, 2019

### Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs and Home Health & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

### Provider Action Needed

CR 11039 instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform use of CARC, RARC and CAGC rule publications. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2019. Make sure that your billing staffs are aware of these changes.

### Background

The Department of Health and Human Services (DHHS) adopted the Phase III (CAQH CORE, EFT, and ERA Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act (ACA).

The Health Insurance Portability and Accountability Act amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

CR 11039 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.
CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2019. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2018. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them. Visit http://www.wpc-edi.com/Reference for CARC and RARC updates and http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/CORE-required_CodeCombos.xlsx?token=_29xvBua for CAQH CORE defined code combination updates.

The Affordable Care Act mandates all health plans, including Medicare, must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

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<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 16, 2018</td>
<td>Initial article released.</td>
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For Home Health and Hospice Providers

National Provider Enrollment Conference — March 2019

CMS will hold a National Provider Enrollment Conference on March 12 and 13, 2019 at the Nashville Music City Center. Take advantage of this opportunity to interact directly with CMS and Medicare Administrative Contractor provider enrollment experts.

Nashville, Tennessee

- Tuesday, March 12, 2019, from 8:00 a.m. to 5:00 p.m. CT
- Wednesday, March 13, 2019, from 8:30 a.m. to 5:00 p.m. CT

Register at https://www.palmgba.com/events/NPEC2019/ and learn more about this conference.

For Home Health and Hospice Providers

Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the
opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Tuesday, January 1, 2019, New Year’s Day</td>
<td>Office Closed</td>
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<tr>
<td>Thursday, January 10, 2019</td>
<td>PCC Closed 8:00 – 10:00 a.m. Central Time</td>
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<tr>
<td>Monday, January 21, 2019, Martin Luther King, Jr.’s Birthday</td>
<td>Office Closed</td>
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The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For Additional Information, go to https://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the webpage.


For Home Health and Hospice Providers

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, refer to the CMS.gov Email Updates Web page at https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/EmailUpdates.html to subscribe. Refer to the CMS Quarterly Provider Update at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html for Additional Information.
For Home Health and Hospice Providers

SE18016: A Prescriber’s Guide to the New Medicare Part D Opioid Overutilization Policies for 2019

The Centers for Medicare & Medicaid Services (CMS) issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE18016
Related Change Request (CR) #: N/A
Related CR Release Date: November 01, 2018
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters Special Edition Article is intended for physicians and other prescribers who prescribe opioid medications to patients with a Medicare Part D prescription drug benefit.

Background
The Centers for Medicare & Medicaid Services (CMS) understands the magnitude of our nation’s opioid epidemic and its impact on communities. Opioid medications are effective at treating certain types of pain, but have serious risks such as increasing tolerance, addiction, overdose, and death. Given the scope of the crisis, CMS published a roadmap in June 2018 outlining our efforts to address this issue. The roadmap (https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf) details our three-pronged approach to combating the opioid epidemic going forward: 1) prevention of new cases of opioid use disorder (OUD); 2) treatment of patients who have already become dependent on or addicted to opioids; and 3) utilization of data from across the country to better target prevention and treatment activities. Through our 2019 Medicare Part D opioid overutilization initiatives, CMS seeks to strengthen and broaden our partnership with providers to address the opioid crisis.

What Providers Need to Know
CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019. These policies involve further partnership with providers and prescription drug plans. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. Medicare prescription drug plans can assist providers by alerting them about unusual utilization patterns in prescription claims.

The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy, and drug management programs to better coordinate care when chronic high-risk opioid use is present.

Real-Time Safety Alerts at the Time of Dispensing
Part D plans commonly implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. These alerts are typically for drug-drug interactions, therapeutic duplication, or a potentially incorrect drug dosage (for example, doses above the maximum dosing in the Food and Drug Administration (FDA)-approved labeling).

Specific to prescription opioids, beginning in January 2019, Medicare Part D plans will employ the following new safety alerts at the pharmacy:

- **7 day supply limit for opioid naïve patients:** Part D plans are expected to implement a hard safety edit to limit initial dispensing to a supply of 7 days or less. A hard safety edit stops the pharmacy from processing a prescription until an override is entered or authorized by the plan. This policy will affect Medicare patients who have not filled an opioid prescription recently (for example, within the past 60 days) when
they present a prescription at the pharmacy for an opioid pain medication for greater than a 7 day supply.

CMS’ goal with this policy is to reduce the potential for chronic opioid misuse through closer management of opioid naïve patients. Clinical evidence cited by the Centers for Disease Control and Prevention (CDC) found that opioid use for acute pain is associated with long-term opioid use and that a greater amount of early opioid exposure is associated with greater risk for long-term use. Recommendation 6 of the CDC Guideline states that opioids prescribed for acute pain should be limited to 3 days or fewer, and that more than a 7 day supply is rarely necessary. Limiting the amount dispensed with the first opioid prescription may reduce the risk of patients developing a future dependency or overuse of these drugs.

A pharmacist can dispense partial quantities of an opioid prescription consistent with state and federal regulations. However, if a prescriber believes that an opioid naïve patient will need more than a 7 day supply initially, the provider can proactively request a coverage determination on behalf of the patient attesting to the medical need for a supply greater than 7 days. Additionally, if a provider assesses upon re-evaluation that a patient will need additional opioid therapy, subsequent prescriptions will not be subject to the 7 day supply limit, as the patient will no longer be considered opioid naïve.

• **Opioid care coordination alert:** This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME. Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. It is the prescriber who writes the prescription that triggers the alert who will be contacted by the pharmacy even if that prescription itself is below the 90 MME threshold.

This safety alert includes a 90 MME threshold for identifying potentially high risk patients who may benefit from closer monitoring and care coordination. 90 MME is cited in the CDC Guideline as the level above which prescribers should generally avoid. This is not a prescribing limit. In reviewing the alert, the pharmacist may need to consult with the prescriber to confirm medical need for the higher MME. The pharmacist can then indicate that the prescriber was consulted so the prescription claim can pay.

The care coordination safety alert is a proactive step to give prescribers more information, and if warranted, to encourage prescribers to emphasize opioid overdose risk and prevention with their patients, especially if the patient is receiving prescription opioids from multiple prescribers or pharmacies.

**Drug Management Programs**

The Comprehensive Addiction and Recovery Act of 2016 included provisions that give Part D plans important new tools to use in 2019 to address opioid overutilization. To implement this law, CMS adopted a regulation so that Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be “frequently abused drugs” for patients who are considered to be at-risk for prescription drug abuse. Limiting access means that the patient might only be able to obtain these medications from a specified prescriber or pharmacy. For 2019, CMS has identified opioids and benzodiazepines as frequently abused drugs.

The goal of drug management programs is better care coordination for safer use. Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies. Therefore, these are patients who could potentially abuse or misuse prescription opioids. One of the key components of a drug management program is prescriber involvement in case management.

1 See [https://www.cdc.gov/drugoverdose/prescribing/guideline.html](https://www.cdc.gov/drugoverdose/prescribing/guideline.html).
If a provider prescribes opioids or benzodiazepines for a patient who is identified as a potential at-risk patient, the Part D plan will contact the provider to review the patient’s total utilization pattern of frequently abused drugs. The plan will ask the prescriber:

- Are the prescription opioid medications appropriate, medically necessary, and safe for the patient’s medical condition and treatment;
- Is the patient at-risk for misusing or abusing opioids and benzodiazepines; and
- Would one of the drug management program tools help the prescriber better manage their patient’s prescription drug use?

The potential tools include:

1. **Patient-specific point of sale (POS) claim edit:** This is an individualized POS edit for the specific patient. It limits the amount of frequently abused drugs that may be dispensed to the patient. This limitation could be a restriction on all frequently abused drugs or limitations to specific drugs and/or specific amounts, which the plan will determine on a case by case basis as a result of their review. The plan will make every effort to obtain a prescriber’s agreement for this limitation, but is authorized to implement it if no prescriber responds to the plan’s attempts at contacting the prescriber through case management.

2. **Pharmacy limitation (also known as “pharmacy lock-in”):** This limitation will require the patient to obtain prescriptions for frequently abused drugs at a certain pharmacy(ies). Before implementing this limitation, the plan must verify with a prescriber that the patient is at-risk, but is not required to obtain a prescriber’s agreement to the limitation. Patients can choose which pharmacy(ies) they prefer to use and may update those preferences as needed.

3. **Prescriber limitation (also known as “prescriber lock-in”):** A limitation that will require the patient to obtain their prescriptions for frequently abused drugs from a certain prescriber(s). The plan must obtain the prescriber’s agreement to be a prescriber and confirm the prescriber’s selection for this limitation. Patients can choose which prescribers(s) they prefer to use and may update those preferences as needed.

After the Medicare drug plan conducts case management with prescribers, and before the plan implements a tool, the plan will notify the patient in writing that coverage of opioid and/or benzodiazepine medication(s) will be limited, or if the patient must obtain these prescriptions from certain prescriber(s) or pharmacy(ies). Plans are required to make reasonable efforts to send the prescriber a copy of the notice sent to the patient. The prescriber and patient will have the opportunity to provide a response to this written notice and the requested information to the Part D plan within 30 days.

After this 30 day time period, if the Part D plan determines based on its review that the patient is at-risk and implements a limitation, it must send the patient a second written notice confirming the specific limitation and its duration. The initial limitation period could be for a maximum of 12 months and extend to an additional 12 months. Alternatively, if the plan determines that the patient is not at-risk, it must send a written notice confirming that a coverage limitation will not be implemented after all.

**Provider Action**

*Why are there new Medicare Part D opioid overutilization policies for 2019?*

The opioid epidemic is a top priority at CMS. We are working with multiple stakeholders to find ways to reduce the negative impacts of the opioid epidemic on the general public. These new Medicare Part D opioid overutilization policies encourage interdisciplinary collaboration as well as care coordination among Part D plans, pharmacies, prescribers, and patients in improving opioid utilization management, preventing opioid misuse, reducing serious adverse risks, and promoting safer prescribing practices.
Are any patients exempt from the new opioid safety alert and drug management program policies?

CMS recognizes that a “one size fits all” approach does not take into account different circumstances related to opioid use. All of the approaches are tailored to address the distinct populations of Medicare Part D prescription opioid users. Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions.

CMS would like to remind providers that access to medication-assisted treatment (MAT) such as buprenorphine will not be impacted by these initiatives. CMS recognizes the importance for patients who are on MAT drugs to continue therapy without disruption.

Will the pharmacy call the provider every time a patient has an opioid prescription that reaches or exceeds 90 MME for the care coordination safety alert?

No. The provider will be initially contacted by the pharmacist if a patient presents to the pharmacy with a prescription that reaches a cumulative threshold of 90 MME or greater across all of the patient’s opioid prescriptions and triggers the alert at the pharmacy. Once a pharmacist consults with a prescriber on a patient’s prescription for a plan year, the pharmacist does not have to consult with the prescriber on every opioid prescription written for the same patient after that unless the plan implements further restrictions. For example, Part D plans also have the option to set an additional alert that stops a prescription from being filled at the pharmacy if the opioid threshold reaches 200 MME or greater and may additionally include prescriber and pharmacy counts.

Why is the provider contacted by the pharmacy for only certain patients?

Prescribers may be contacted by the pharmacy for only some Medicare patients but not for all, depending on which Part D plan the patient is enrolled in because the plan sponsor has the flexibility to modify the care coordination safety alert parameters. A plan sponsor may customize this alert so that it would be triggered based on the patient’s total number of opioid prescribers and/or opioid dispensing pharmacies specified in the care coordination safety alert.

What is the provider’s role for a patient in the Medicare Part D drug management program?

If a patient is identified as being potentially at-risk for prescription drug abuse by his or her Part D plan, the plan will initiate case management. As part of the case management process, the Part D plan will contact the patient’s providers who prescribed opioids and benzodiazepines for clinical information needed to make a decision on whether a patient is at-risk and should have his or her access to frequently abused drugs limited through one of the available tools. The provider’s role is to respond to the Part D plan if and when they contact the provider for further information about a patient’s prescription use history.

How can the provider help his or her patient if their prescription triggers an opioid safety alert, such as the 7 day supply alert for opioid naïve patients or the care coordination alert?

If one of these opioid safety alerts is triggered and the prescription cannot be filled as written or cannot be resolved at the pharmacy, the pharmacist should provide a written copy of the standardized CMS pharmacy notice, “Medicare Prescription Drug Coverage and Your Rights” (https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/yourrightsfactsheet.pdf) to the patient.

The patient, the patient’s representative, or the physician or other prescriber, on the patient’s behalf, has the right to request a coverage determination for a drug(s) subject to the alert, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid (for example, after a surgical procedure).

The timeframe for an expedited coverage determination request applies when the prescriber indicates, or the plan decides, that applying the standard timeframe may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function. CMS
generally expects coverage determinations related to any opioid safety alerts to meet the criteria for expedited review. If the request meets the criteria for an expedited review by the plan, the plan must make its decision and notify the patient as expeditiously as their health condition requires, but no later than 24 hours after receipt of the request.

**Would the patient or the provider be able to request an appeal if the Part D plan determines a patient to be an at-risk patient under the drug management program?**

A patient, a patient’s representative, or the physician or other prescriber may request an appeal within 60 calendar days from the date of the second written notice, notifying the patient that he or she has been identified as an at-risk patient. At-risk determinations are subject to the existing Part D benefit appeals process. If the patient or the physician or other prescriber disagrees with the at-risk determination, the patient, the patient’s representative, or the physician or other prescriber may request a redetermination and a change to the limitations can be made as a result of an appeal. The party may request an expedited or standard redetermination under 42 CFR § 423.580. The standard timeframe for notification of a redetermination made by the plan is as expeditiously as the patient’s health condition requires, but no later than 7 days from receipt of the request. The plan must notify the patient of its decision on an expedited redetermination as expeditiously as the patient’s health condition requires, but no later than 72 hours from receipt of the request. In addition to the right to appeal an at-risk determination, the patient has the right to request a coverage determination, as explained in the previous response.

**How else can a provider prepare for the new 2019 Medicare Part D overutilization policies?**

Many patients have difficulty understanding the risk of using opioids and may underestimate their chances of overdosing. Providers may want to discuss the risks of an accidental overdose or having an adverse reaction to opioids since these risks are not necessarily associated with misuse.

As the new opioid safety alerts are implemented in 2019, on-going communication among the pharmacist, the Part D plan, and the prescriber will be critical. Physicians and other prescribers can protect their patients’ access to medically necessary drugs by responding to pharmacists’ or plan sponsors’ telephone calls or case management notices. Providers will also want to initiate coverage determinations or exceptions, when clinically appropriate. To avoid a prescription being rejected at the pharmacy, prescribers may proactively request a coverage determination in advance of prescribing an opioid prescription if the prescriber has assessed that the patient will need the full quantity written (for example a plan may not be aware a patient is exempt based on a new exclusion such as cancer). Additionally, to resolve opioid safety alerts expeditiously and avoid withdrawal or disruption of therapy, CMS encourages prescribers to respond to pharmacists’ outreach in a timely manner and give the appropriate training to on-call prescribers when necessary.

**Additional Information**

- For additional information regarding the CDC Guideline for Prescribing Opioids for Chronic Pain, please visit [https://www.cdc.gov/drugoverdose/prescribing/guideline.html](https://www.cdc.gov/drugoverdose/prescribing/guideline.html).
For Home Health and Hospice Providers

SE18025: Medicare Fee-for-Service (FFS) Response to the 2018 California Wildfires

The Centers for Medicare & Medicaid Services (CMS) issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE18025
Related CR Release Date: November 15, 2018
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the 2018 wildfires in the State of California.

Provider Information Available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the 2018 Wildfires, a major disaster exists in the State of California. On November 13, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in the State of California retroactive to November 8, 2018, and authorized waivers and modifications under §1135 of the Social Security Act.

Also on November 13, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to November 8, 2018, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires.

Under Section 1135 or 1812(f) of the Social Security Act, CMS has issued several blanket waivers in the impacted geographical areas of the State of California. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

The most current waiver information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EP/Current-Emergencies/Current-Emergencies-page.html. See the Background section of this article for more details.
Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. CR 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of California from November 8, 2018, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.html. Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html, and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of California. These Q&As are displayed in two files:
   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the State of California.
   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective November 8, 2018, for the State of California.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

   a. Q&As applicable without any Section 1135 or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.
   b. Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf.

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected areas of the State of California. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires in the State of California. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- 42 CFR 483.20: Waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).
Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).
- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto- cancellation date of Requests for Anticipated Payment (RAPs).

Critical Access Hospitals

This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing Acute Care Patients In Excluded Distinct Part Units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of the wildfires in the State of California, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the wildfires in the State of California. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the wildfires.)

Care for Excluded Inpatient Psychiatric Unit

Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of the wildfires in the State of California, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the wildfires. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for Excluded Inpatient Rehabilitation Unit

Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part rehabilitation units that, as a result of the wildfires in the State of California, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the wildfires. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients, and such patients continue to receive intensive rehabilitation services.

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

As a result of the wildfires in the State of California, CMS has determined it is appropriate to issue a blanket waiver to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) where DMEPOS are lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician’s order, and new medical necessity documentation are not required for
replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS were lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the wildfires.


**Medicare Advantage Plan or other Medicare Health Plan Beneficiaries**

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan’s contact information can contact 1.800.MEDICARE (1.800.633.4227) for assistance.

**Replacement Prescription Fills**

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the disaster or emergency.

**Requesting an 1135 Waiver**

Information for requesting an 1135 waiver, when a blanket waiver hasn’t been approved, can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

**Additional Information**

If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

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**For Home Health and Hospice Providers**

**Targeted Probe and Educate Progress Update**

Findings
Medical Review initiated complex review edits for specific providers identified through data analysis demonstrating high risk for improper payment. Education has been offered to providers throughout and upon completion of Round 1 of TPE review. Current Round 1 Home Health and Hospice Results are as follows:

Home Health

Probes completed July 1, 2018 – September 30, 2018

<table>
<thead>
<tr>
<th>Eligibility and Medical Necessity edit 5A000</th>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>121</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>23</td>
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</table>

<table>
<thead>
<tr>
<th>LOS &gt;120 Days edit 5A002</th>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>LOS &gt;180 Days edit 5A003</th>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
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<table>
<thead>
<tr>
<th>No response to ADR edit 5A004</th>
<th>Results</th>
<th>Home Health</th>
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<tbody>
<tr>
<td>Probes Completed</td>
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<tr>
<td>Providers Compliant after Round 1 Completion</td>
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<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>19</td>
<td></td>
</tr>
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</table>

Probes completed October 1, 2017 – September 30, 2018

<table>
<thead>
<tr>
<th>Eligibility and Medical Necessity edit 5A000</th>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>4</td>
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<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>32</td>
<td></td>
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<table>
<thead>
<tr>
<th>LOS &gt;120 Days edit 5A002</th>
<th>Results</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Findings by State

CGS is providing an overview of review findings by state for providers who have completed Round 1.

Home Health Review Decisions by State: July 1, 2018 - September 30, 2018

Home Health Review Decisions by State: October 1, 2017 - September 30, 2018

Risk Category

Risk Category is defined based on end of round provider error rate. The categories are defined as:

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>0-25%</td>
</tr>
<tr>
<td>Moderate</td>
<td>26-50%</td>
</tr>
<tr>
<td>Significant</td>
<td>51-100%</td>
</tr>
</tbody>
</table>
**Top Denial Reasons July 1 2018 – September 30, 2018**

1. Face-to-Face missing/incomplete/untimely
2. Initial certification invalid
3. Medical records were not received
4. Recertification estimate missing/invalid
5. Plan of care missing/invalid

- **FTF Documentation Denials** accounted for approximately 25% of the total Targeted Probe and Educate denials.
  - Actual FTF encounter document not submitted
  - Certifying physician did not document the date of the FTF encounter
  - Community physician was not identified when a physician who would not be following the patient after discharge signed the certification
  - Required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification

Refer to the CGS Home Health Coverage Guidelines Web page at [https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html](https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html) for a variety of resources on the home health FTF encounter.

- **Initial certification invalid** accounted for approximately 13% of the total Targeted Probe and Educate denials.

- **Medical records were not received** accounted for approximately 11% of the total Targeted Probe and Educate denials. Refer to the CGS Medical Review Additional Development Request (ADR) Process Web page at [https://www.cgsmedicare.com/hhh/medreview/adr_process.html](https://www.cgsmedicare.com/hhh/medreview/adr_process.html) for information to ensure that necessary steps are taken to submit documentation timely.


- **Plan of care missing/invalid** accounted for approximately 7% of the total Targeted Probe and Educate denials. Refer to the CGS Physician Orders, Plan of Care and Certification Web page at [https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/1b.html](https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/1b.html) and Home Health Missing/Incomplete/Untimely Plan of Care or Certification Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hpIn-5hord_factsheet.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hpIn-5hord_factsheet.pdf) for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7).

### Hospice

#### Probes completed July 1, 2018 – September 30, 2018

<table>
<thead>
<tr>
<th>LOS with Non-Oncologic Diagnosis edit 5D000</th>
<th>Results</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
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<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR's for Round 1</td>
<td>0</td>
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#### Probes completed October 1, 2017 – September 30, 2018

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<tr>
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Hospice Review Decisions by State: July 1, 2018 - September 30, 2018

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<thead>
<tr>
<th>State</th>
<th>% Approved</th>
<th>% Full Denial</th>
<th>% Partial Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>DE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD</td>
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Hospice Review Decisions by State: October 1, 2017 - September 30, 2018

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<td></td>
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<td></td>
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Hospice Risk Category: July 1, 2018 - September 30, 2018

Hospice Risk Category: October 1, 2017 - September 30, 2018

Top Denial Reasons July 1 2018 – September 30, 2018

1. Terminal prognosis not supported
2. MD services not medically necessary
   - Terminal prognosis not supported accounted for approximately 96% of the total Targeted Probe and Educate denials.
     Refer to the CGS Hospice Denial Fact Sheet—Six-Month Terminal Prognosis Not Supported Web page at https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_5pter_factsheet.pdf for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9).
   - MD services not medically necessary accounted for approximately 4% of the total Targeted Probe and Educate denials.
     Refer to the CGS Billing Hospice Physician and Nurse Practitioner (NP) Services Web page at https://www.cgsmedicare.com/hhh/education/materials/pdf/physician_and_np.pdf for billing services decision tree and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9).

Education

Providers with a moderate to high error rate will be offered an individualized education session where each claim found in error will be discussed and any questions will be answered. CGS offers education sessions via webinar, Web-based presentation, or traditional teleconferences. Other methods may also be available. Providers may also submit questions or request education via the home health and hospice TPE email box at J15HHPROBEANDEDUCATION@CGSADMIN.COM.
Next Steps

Providers found to be non-compliant at the completion of Round 1 will advance to Round 2 of TPE at least 45 days from completion of the 1:1 post probe education call date. CGS offers education at any time for providers. Providers do not have to be identified for TPE to request education. CGS encourages providers to request education and conduct self-monitoring based on our posted Medical Review Activity Log at https://www.cgsmedicare.com/hhh/medreview/activitylog.html and using tools such as Comparative Billing Reports (CBRs) (https://www.cgsmedicare.com/hhh/education/materials/pdf/mycgs_comparative_billing_reports_hhh.pdf) offered through our Web portal.

References


For Home Health and Hospice Providers

Upcoming Educational Events

The CGS Provider Outreach and Education (POE) department offers educational events through webinars and teleconferences throughout the year. Registration for these events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/HHH_Report.asp. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.

If you have a topic that you would like the CGS POE department to present, send us your suggestion to J15_HHH_Education@cgsadmin.com.

For Home Health and Hospice Providers

Updated 2019 Amount in Controversy (AIC) for Administrative Law Judge Hearings or Federal District Court Appeals

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare contractors of the update to the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) or Federal District Court appeal rights beginning January 1, 2019.

- The amount remaining in controversy requirement for ALJ hearing requests made on or before December 31, 2018, is $160. **This amount will remain at $160 for ALJ hearing requests filed on or after January 1, 2019.**
The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2018 is $1,600. This amount will increase to $1,630 for appeals to Federal District Court filed on or after January 1, 2019.

Please share this with your appropriate staff.

For Home Health and Hospice Providers

Voluntary Refunds – Calendar Year 2018

As you know, providers may at times receive incorrect payment (e.g., for services/items not covered, erroneously billed, etc.). When this happens, a refund should be sent to the contractor. Otherwise, an overpayment, which is a debt due to the Medicare program, will be established when the error is identified.

Medicare expects providers to exercise care when billing and accepting payment, and also expects that providers will promptly bring incorrect payments to the carrier’s attention. These submissions acknowledge your awareness of this expectation and confirm a measure of compliance. However, please be aware that the CMS Online Manual, Publication 100-08, Chapter 4, Section 4.16 states:

The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Thank you for your efforts to work in cooperation with CGS Administrators, LLC to ensure proper and appropriate delivery of Medicare benefits. If you have any questions, please contact our office at one of the following numbers.

<table>
<thead>
<tr>
<th>CGS Jurisdictions</th>
<th>States</th>
<th>Customer Service Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction 15 Providers</td>
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</tr>
<tr>
<td>Part A</td>
<td>KY &amp; OH</td>
<td>1.866.590.6703</td>
</tr>
<tr>
<td>Part B</td>
<td>KY &amp; OH</td>
<td>1.866.276.9558</td>
</tr>
<tr>
<td>Home Health &amp; Hospice</td>
<td>CO, DC, DE, IA, KS, MD, MO, MT, ND, NE, PA, SD, UT, VA, WV, &amp; WY</td>
<td>1.877.299.4500</td>
</tr>
<tr>
<td>Jurisdiction B DME Suppliers</td>
<td>IL, IN, KY, MI, MN, OH, &amp; WI</td>
<td>1.866.590.6727</td>
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<tr>
<td>Jurisdiction C DME Suppliers</td>
<td>AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VA, VI, &amp; WV</td>
<td>1.866.270.4909</td>
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