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Orientation to Home Health and Hospice Medicare

12/1/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach and Education Home Health and Hospice Team

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POE Manager

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Disclaimer

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Define the role of the Medicare Administrative Contractor (MAC)
- Provide a basic description of federal Medicare contractors
- Understand the role of Provider Outreach and Education
- Explain the role of the provider in safeguarding the Medicare trust fund against fraud, waste and abuse
- Provide information regarding Targeted Probe and Educate, as well as how to respond to an Additional Documentation Request
- Provide a basic understanding of the appeals process
- Deliver information regarding NGSConnex
- Offer NGS and CMS references, resources and job aids

Agenda

- Medicare Contractors
  - Medicare Administrative Contractors (MACs)
    - National Government Services (NGS)
      - NGS Provider Outreach and Education (POE)
      - NGS POE Offerings and Opportunities
      - NGS Self-Service Tools and Resources
- Other Medicare Contractors

Agenda (cont.)

- Safeguarding the Medicare Program
  - Fraud
  - Waste
  - Abuse
- Additional Documentation Request (ADR)
- Targeted Probe and Educate
- Preparing and Submitting Medical Record Documentation
- CMS and NGS HH+H References and Resources
- Wrap Up Question and Answer Period

Medicare Administrative Contractors (MACs)

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MACs

- Private Health Care Insurer
- Awarded Geographic Jurisdiction
- Process Medicare Claims
- Medicare Fee-for-Service (FFS) Beneficiaries

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MACs

- The Centers for Medicare & Medicaid Services relies on a network of contracted companies to serve as the primary operational contact between the Medicare fee-for-service program and health care providers enrolled in the program.

MAC Duties

- Provider Enrollment
- Claims Processing
- Claims Payment
- Medical Record Review
- Provider Audit & Reimbursement
- Provider Inquiry Response
- Provider Education
- First Level Appeals: Redeterminations

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MAC Responsibilities

Medical Review

Provider Audit & Reimbursement

Provider Enrollment

Claim Re-openings & First Level Appeals

Claims Processing & Payment

Provider Inquiry Response

Provider Education

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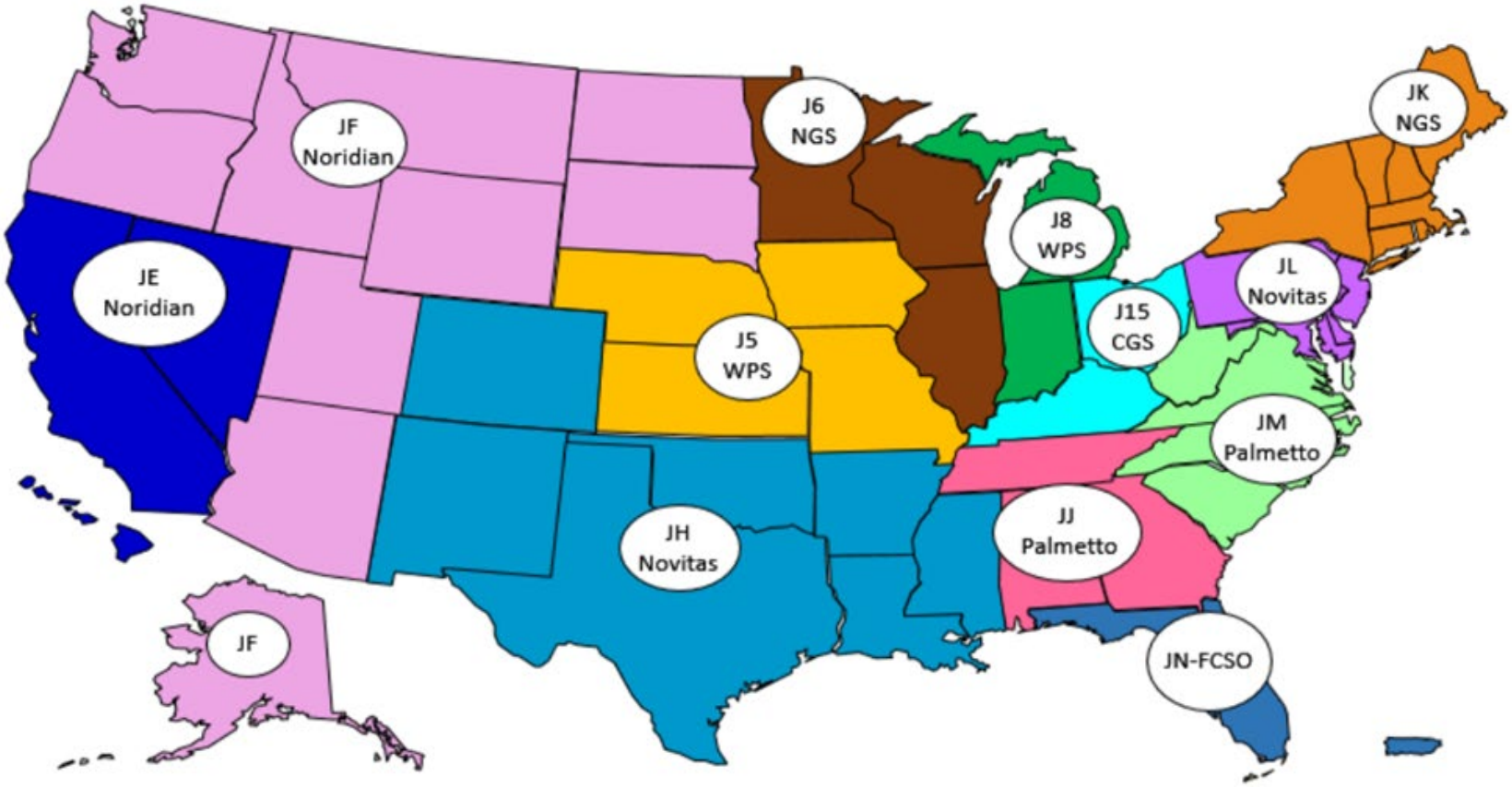
MACs - Parts A/B



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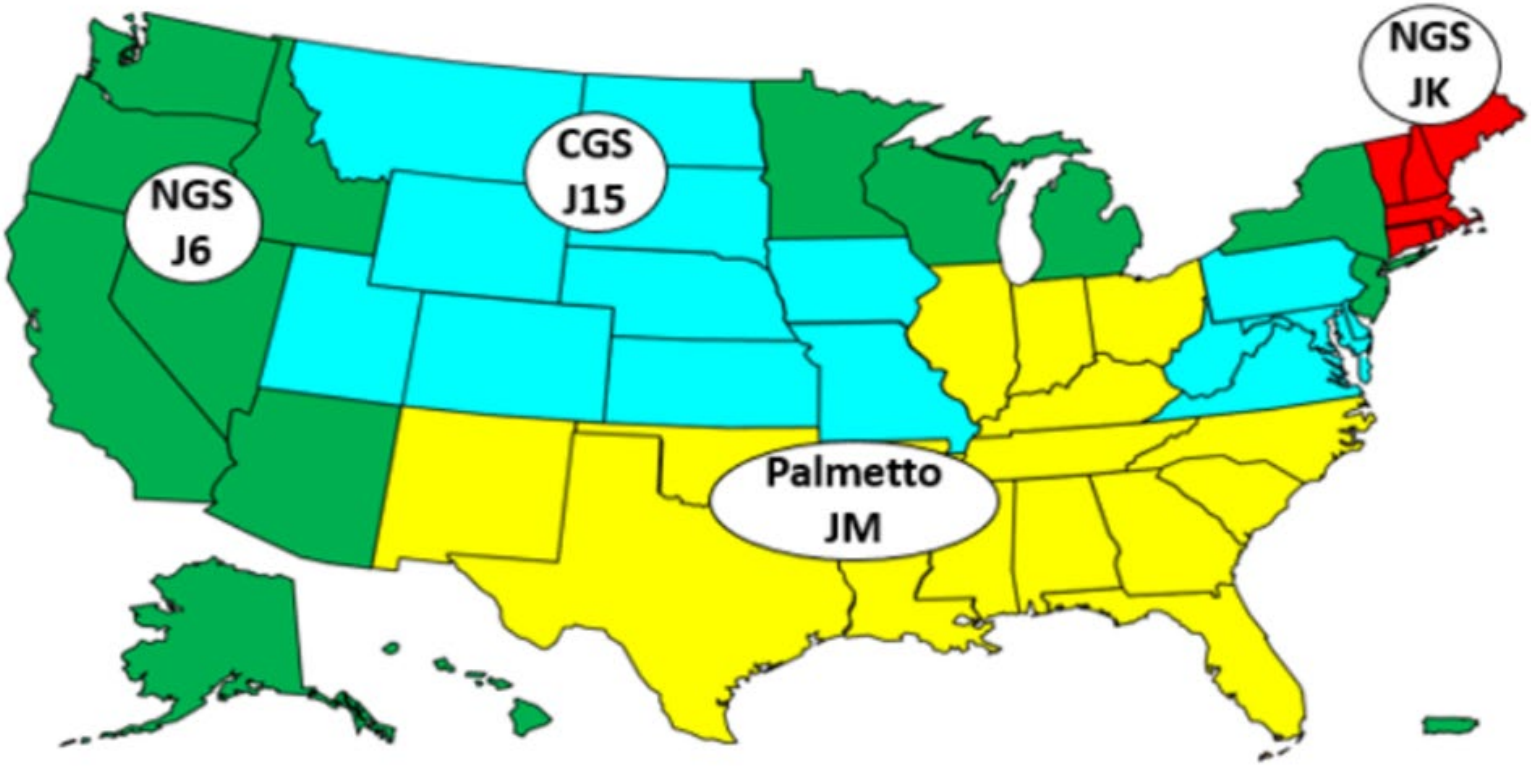
Home Health and Hospice MACs



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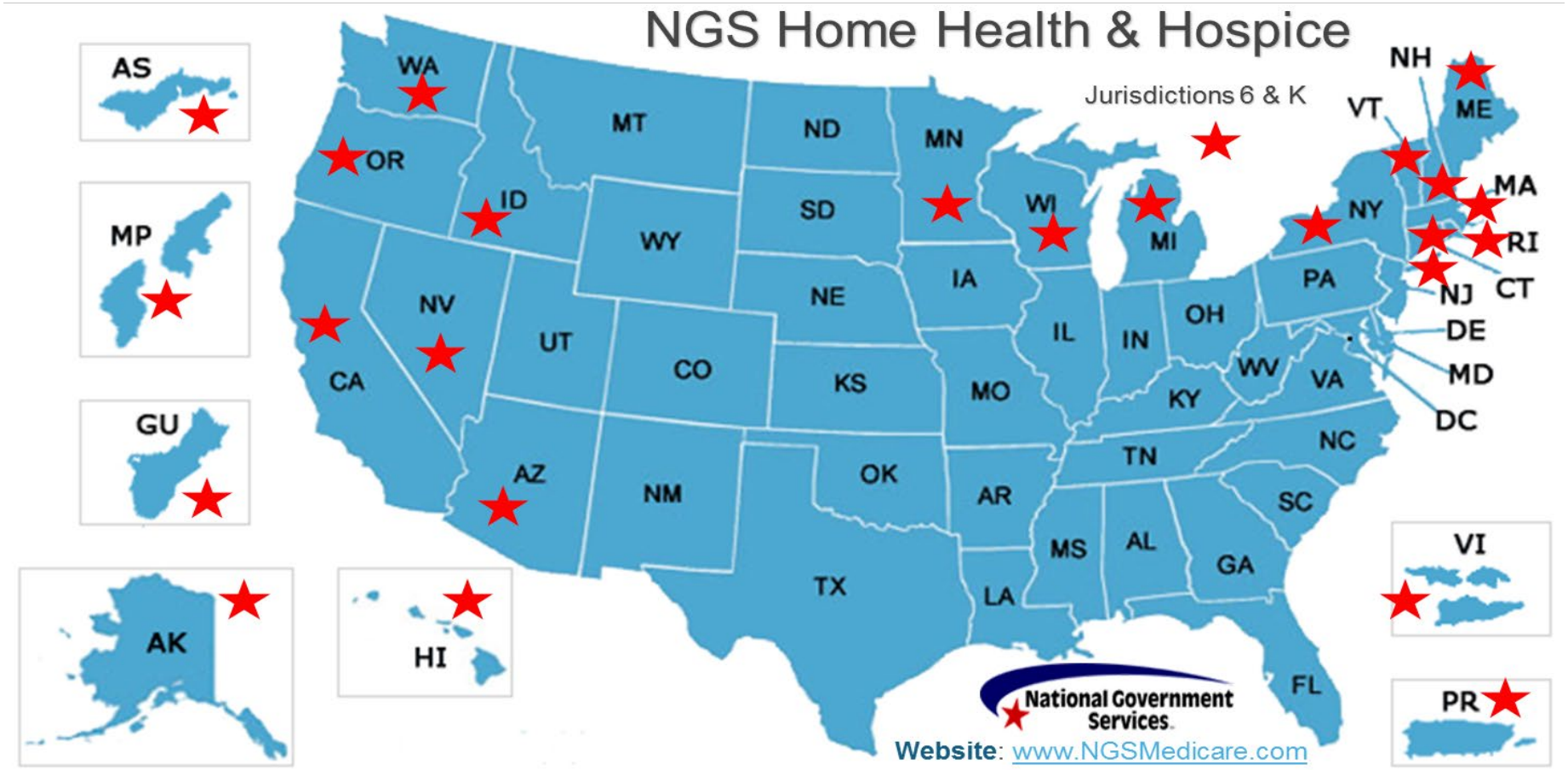
National Government Services (NGS)

NGS States and Territories



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NGS Jurisdictions

J6 Part A & B	J6 HHH	JK Part A & B	JK HHH
WI, MN, IL	AK, Samoa, AZ, CA, Guam, HI, ID, NV, NJ, NY, Mariana Islands, MI, MN, OR, PR, US VI, WI	CT, ME, MA, NH, NY, RI, VT	MA, RI, CT, NH, VT, ME
2.5+ Million Beneficiaries	12+ Million Beneficiaries	4+ Million Beneficiaries	2+ Million Beneficiaries
75,000 Physicians	**Approx 3K+ Home Health Agencies**	100,000 Physicians	**450+ Home Health Agencies**
450+ Hospitals	**1500+ Hospice Agencies**		**150+ Hospice Agencies**

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NGS Demographics

Serves over 27 million people with Medicare in 20 states & five US territories

Serves 240 members of Congress

14,000 Part A providers in 10 states

5,000 home health and hospice providers in 20 states & five US territories

4,500 FQHCs in 44 states, DC & five US territories

Over 416,000 Part B physicians and providers of service in 10 states

Over 228 million Medicare claims processed annually

Administered more than $84 billion from the Medicare trust fund in 2019

Responded to 2.4 million phone & interactive voice response calls

Responded to 59,000 written inquiries

Responded to 250 Congressional inquiries

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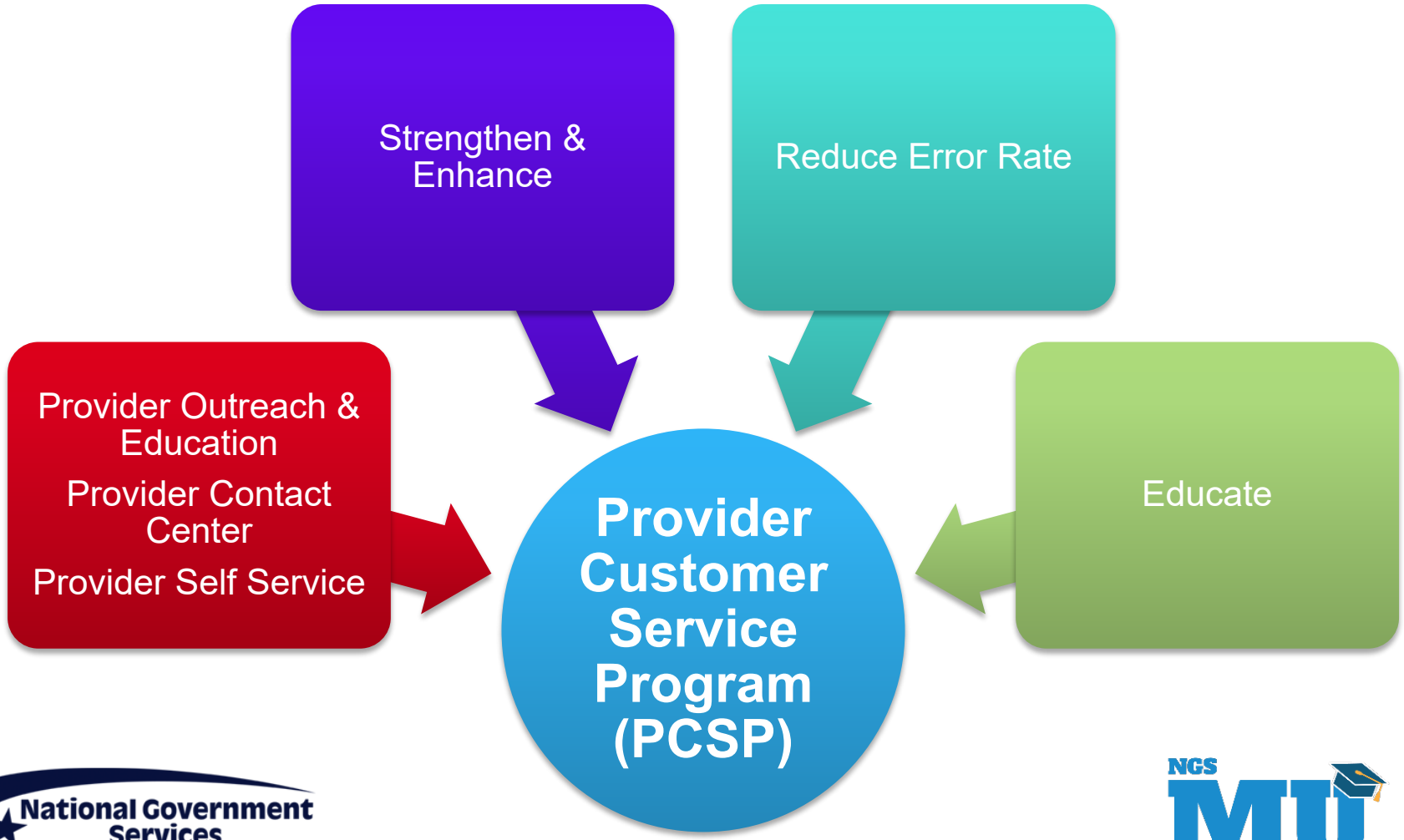
NGS Provider Outreach and Education (POE)

POE Purpose



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POE Internal and External Collaborations

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NGS POE
Offerings and Opportunities

Ask-the-Contractor Teleconferences (ACTs)

- Opportunity for providers to ask questions of any department within NGS
- Opportunity to ask questions live or submit questions prior to each event
- Held twice a year
- Included in the listing of live sessions www.ngsmedicare.com > Events
- Upcoming ACT reminders are sent to all providers who subscribe to NGS email updates

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Provider Outreach and Education Advisory Groups (POE AGs)

- Consists of provider representatives from each jurisdiction
- Offers a forum for providers to propose ideas for education
- **OBJECTIVE:** Offer the most relevant education to the provider community
- Meetings scheduled three times per year
- Meeting schedules and minutes:
  - www.ngsmedicare.com > Education > POE Advisory Group

POE AG Membership

Home health clinical and billing staff from providers within the JK contract jurisdiction:
Billers, billing managers, intake nurses, case managers, clinicians, physicians, allowed practitioners, therapists, staff educators, quality or compliance officers, or any other staff involved in patient care or billing practices

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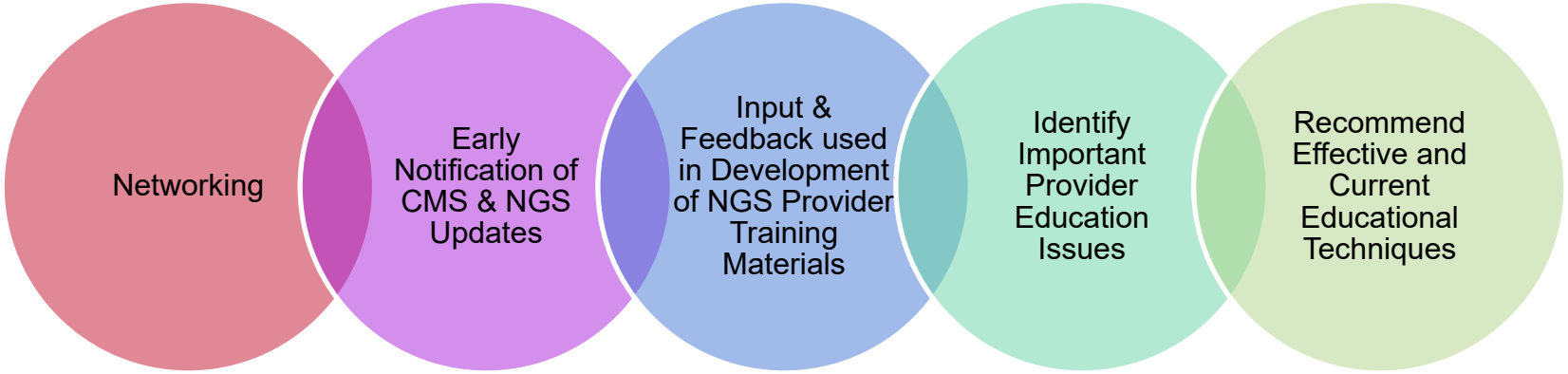
POE AG Membership Benefits



POE

2022 Past Live Virtual Events & NGS Webinars	
January	NGS Webinars: NOA Coffee Break, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service, Understanding the Physician & Non-Physician Practitioner Roles & Responsibilities in Hospice, Hospice Documentation: Supporting the Terminal Illness, Hospice Long Lengths of Stay
February	NGS Webinars: Home Health Billing Basics, NGSConnex Walkthrough, NOA Coffee Break, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service, Live/Virtual Conference: CAHSAH ADR Conference
March	NGS Webinars: Home Health Billing Basics, NGSConnex Walkthrough, NOA Coffee Break, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service
April	NGS Webinars: Home Health Billing Basics, Home Health Billing Lunch & Learn, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service
May	NGS Webinars: Home Health Billing Basics, Home Health Billing Lunch & Learn, Home Health Top Billing Errors, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service, Hospice and the VBID Model
June	NGS Webinars: Home Health Billing Basics, Home Health Billing Lunch & Learn, Orientation to Medicare HHH, Understanding the Levels of Appeal, HH Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service
July	Live/Virtual Conference Series: CHAPCA

POE

2022 Past Live In-Person Events	
March 5 – 9 SD	NHPCO Washington DC
April 19 & 20 SD	OHPCA & WSHPCO Vancouver, WA
April 21 & 22 SD, CS, EM, JW	Data Soft Logic LA, California
May 10 & 11 SD, EM	MHHA Traverse City, MI
May 23 – 26 SD, EM	CAHSAH Rancho Mirage- Palm Springs CA
June 6 – 10 SD, EM	CHAPCA Orange, CA
June 21 – 24 SD, EM	AAHC & AHPCO Phoenix, AZ
July 12 – 15 SD, CS, EM, JW	Data Soft Logic Sacramento, CA

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POE HH+H Articles, Email Updates, Job Aids: January-July 2022

- NOA
- NOA U537F PIA
- Updated NOA QA
- HH+H On Demand Video Library
- HH+H COVID Information
- HH Billing Job Aid
- Hospice VBID Model

POE HH+H Articles, Email Updates, Job Aids: January-July 2022

- HH Transfers
- HH Transfer and Dispute Protocol
- HH Nonphysician Practitioner/MedLearn Matters
- HH Demand Billing
- HH TPL Demand Billing
- MBPM Chapter 7 NP/PA Allowed Practitioners

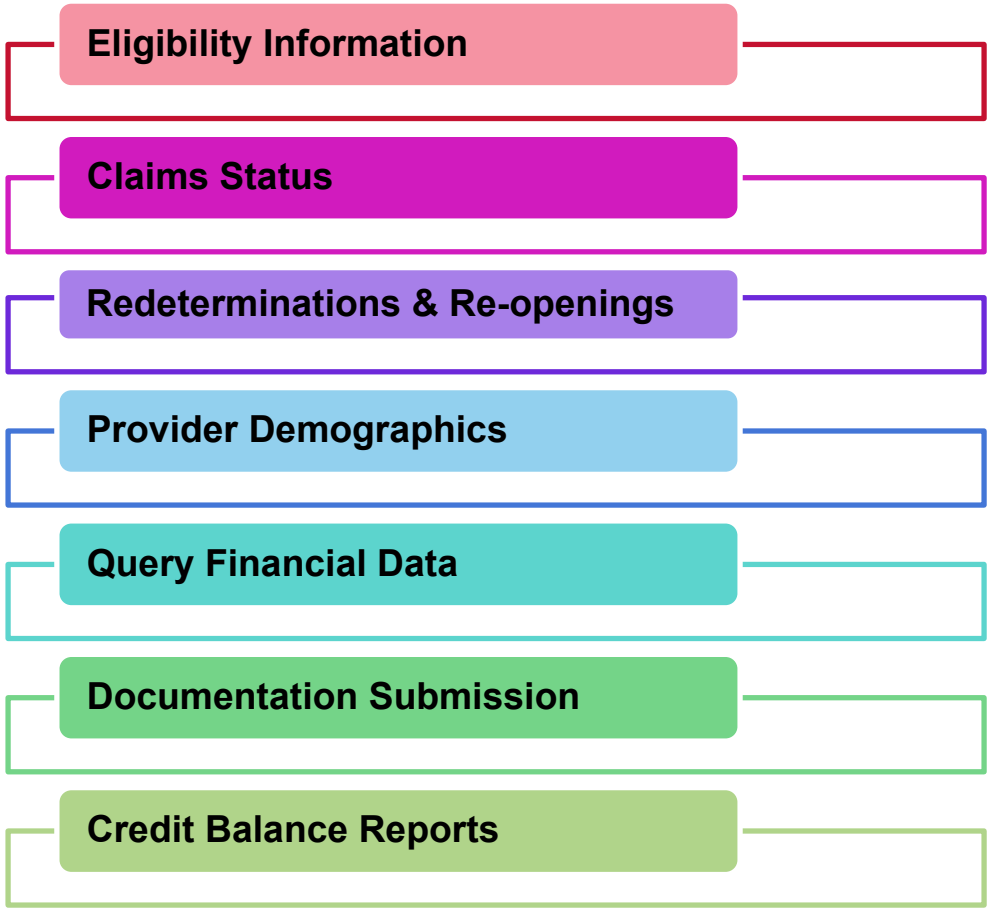
NGS Self-Service Tools and Resources

NGSConnex

- NGSConnex is a free, secure, web-based application developed by NGS just for you!
- NGSConnex provides access to a wide array of self-service functions that save you time and money, such as:
- Obtain beneficiary eligibility information
- Query for your claims status
- Initiate and check the status of redetermination and reopening requests
- View your provider demographic information
- Query for your financial data
- Submit documents for an additional documentation request
- Submit credit balance reports and more!

NGSConnex

- Free, secure, web-based application developed by NGS
- Wide array of self-service functions
- Save providers time and money



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Medicare University (MU)

- Learning Platform
- Variety of Medicare related provider training tools
- Computer-Based-Training (CBT) Courses
- Listing of available CBTs
  - www.ngsmedicare.com > Education > Medicare University Courses

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Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

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Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
  - Topic = **Title of the Presentation**
  - Medicare University Credits (MUCs) = **Number of Credits**
  - Catalog Number = **##########**
  - Participant Code = **##########**
  - For step-by-step instructions on self-reporting please visit the Get Credit for Completed Courses on the NGS website

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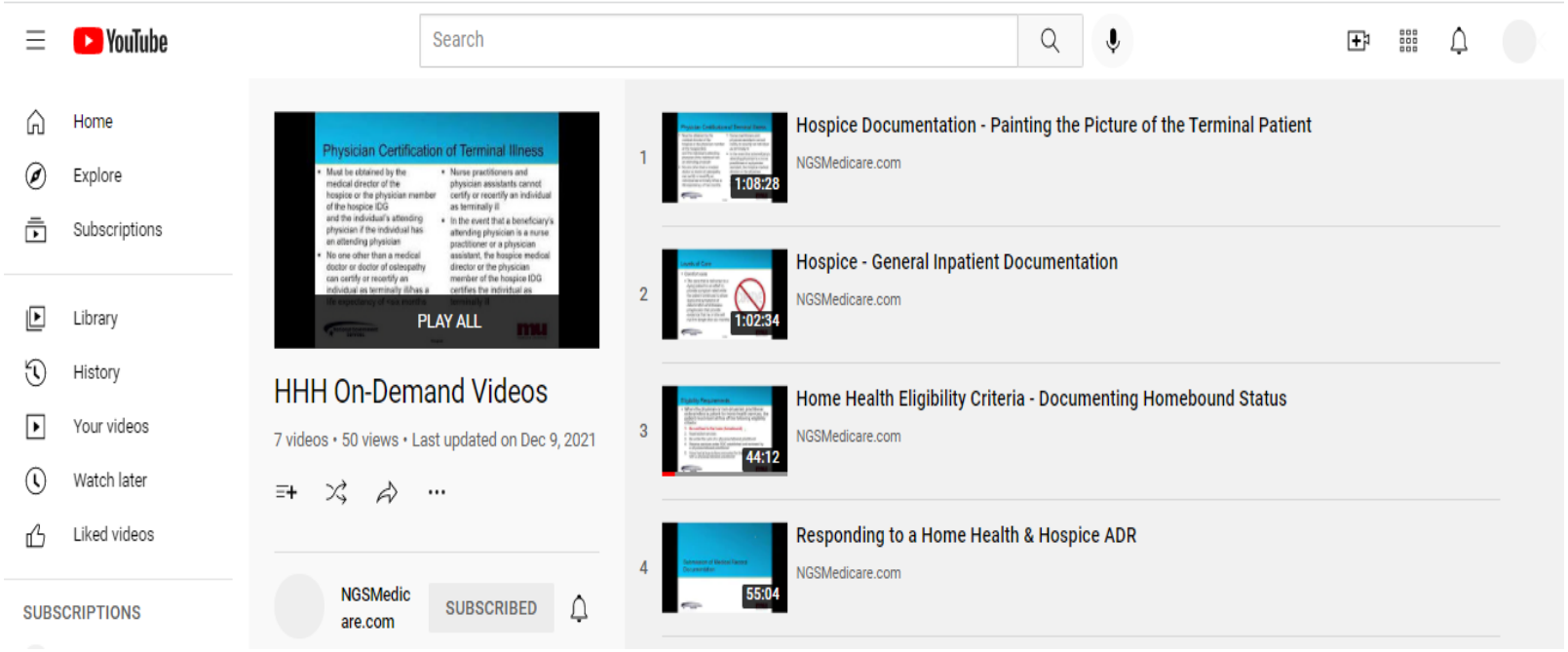
YouTube

Efficient Tutorials

NGSMedicare.com > Apps > YouTube

YouTube

- NGS HHH On-Demand Videos



Provider Outreach and Education Videos

YouTube Videos	On-Demand Video Library
Hospice Clinical Documentation Videos: Hospice Election Statement, Medicare Hospice Election Statement Addendum, Hospice Transfers and Revocations	
Hospice Billing Videos: How to Correct a Date on a Notice of Election, Hospice Levels of Care	Understanding the Levels of Appeal, Lunch and Learn – Home Health Billing Q & A, Home Health Top Billing Errors, Home Health Billing Basics
Home Health Clinical Documentation Videos: HH Benefits & Eligibility Requirements: The Basics, Homebound Status, Need for Skilled Service, Under the Care of a Physician or NPP, The Plan of Care, The Face-to-Face Encounter, Certification & Recertification, Documentation Collaboration	
Home Health Billing Videos: What is an Advance Beneficiary Notice of Noncoverage (ABN), The Issuance of an Advance Beneficiary Notice of Noncoverage, How to Complete the Advance Beneficiary Notice of Noncoverage, What is a Triggering Event for an Advance Beneficiary Notice of Noncoverage	

Twitter

- Twitter: Hundreds of followers!
  - HH+H Related Tweet Topics
    - HH+H On-Demand Educational Video Library Link
    - NHPCO Leadership Conference NGS Attendance
    - HH+H Orientation to Medicare Webinar
    - Summit Early Bird Registration
    - Medicare Mobile News Updates via Text
    - AAHC and AHPCO Annual Conference NGS Attendance
    - CAHSAH Annual Conference NGS Attendance
    - OHPCA and WSHPCO Annual Conference NGS Attendance
  - Other Important Tweets: NGSConnex, Medicare Telehealth, E&M Services, Outpatient Therapy, SNF Consolidated Billing, esMD, eHealth initiative, Think Green, Go Paperless, Medicare Part A virtual conference, Fundamentals of Medicare, Part A Billing, Part B Billing, EDI Enrollment, MOON, Provider Enrollment

Provider Outreach & Education

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Other Medicare Contractors

Unified Program Integrity Contractor

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Unified Program Integrity Contractors (UPIC)

- Combine previously performed functions of the Zone Program Integrity Contractor (ZPIC) and the Program Safeguard Contractor (PSC)

Unified Program Integrity Contractors (UPIC)

- Detect, prevent and proactively deter fraud, waste and abuse within the Medicare Program

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Unified Program Integrity Contractors (UPIC)

- Identify vulnerabilities
- Investigate fraud allegations
- Initiate the appropriate administrative actions to support evidence of fraudulent activity
- Refer any identified improper payments for recoupments to NGS

Unified Program Integrity Contractors (UPIC)

- NGS refers suspected fraud to the UPIC
  - Medical Review
  - Beneficiary Complaints
  - Data Analysis

Unified Program Integrity Contractors (UPIC)

UPIC North East	UPIC Mid West	UPIC South West	UPIC South East	UPIC West
Safeguard Services	**CoventBridge Group**	**Qlarant Integrity Solutions**	**Safeguard Services**	**Qlarant Integrity Solutions**
Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas	Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee, Virgin Islands, Virginia, West Virginia	Alaska, Arizona, American Samoa, California, Guam, Hawaii, Idaho, Montana, Nevada, North Dakota, Northern Marianas Islands, Oregon, South Dakota, Utah, Washington, Wyoming

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Recovery Auditor (RA)

Recovery Auditor (RA)

- Goals:
  - Identify and recover Medicare overpayments and underpayments
- Functions:
  - Detect and correct improper payments
  - Implement actions that will prevent future improper payments

Recovery Auditor (RA)

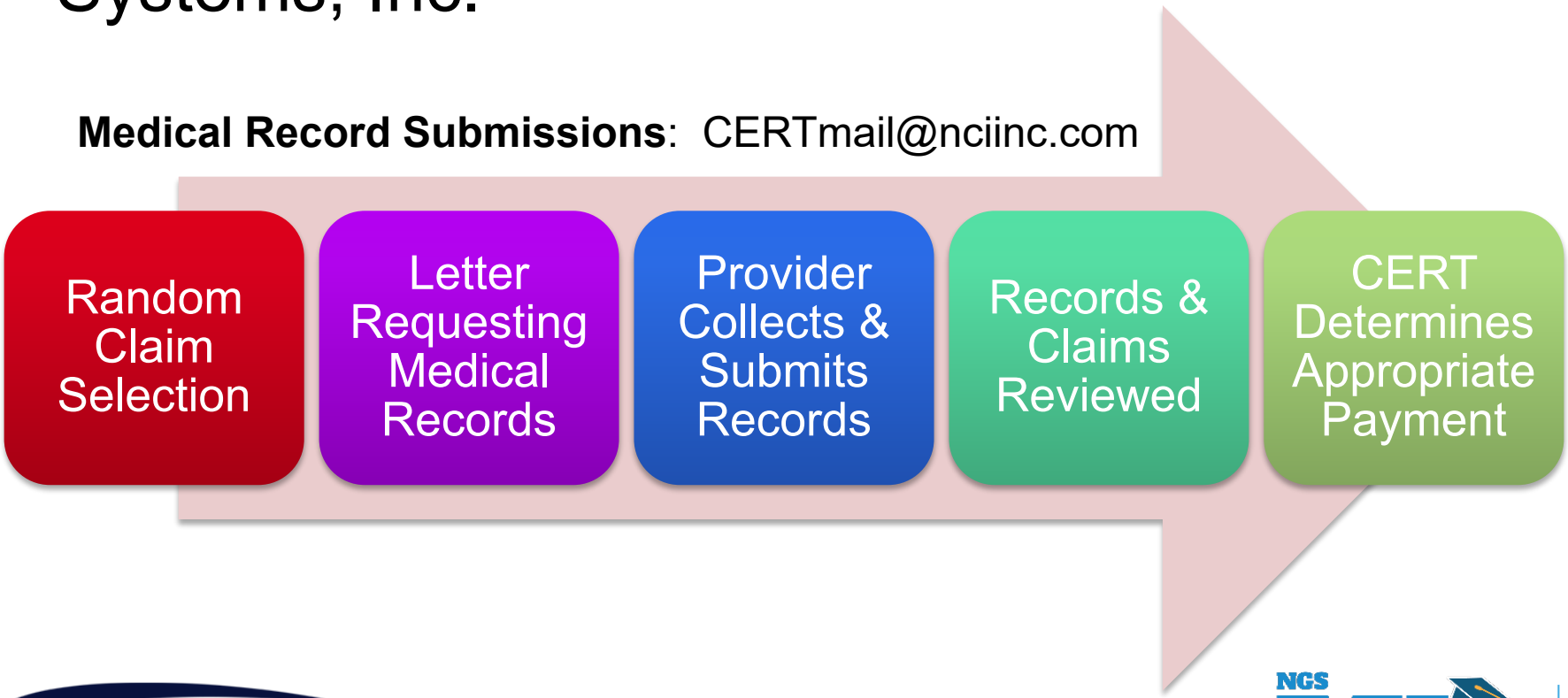
- Home Health and Hospice
- Nationwide
  Performant Recovery
  2751 Southwest Blvd.
  San Angelo, TX 76904
  Toll Free: 866-201-0580
- Email: info@performantrac.com
- Website: www.performantrac.com
- Medicare Fee for Service Recovery Audit Program

Comprehensive Error Rate Testing (CERT)

CERT Contactor

- CERT Review Contractor: NCI Information Systems, Inc.

Medical Record Submissions: CERTmail@nciinc.com



CERT

- CERT Documentation Center
  1510 East Parham Road
  Henrico, Virginia 23228
- Fax: 804-261-8100
- Customer Service: 888-779-7477
- Email: CERTprovider@nciinc.com

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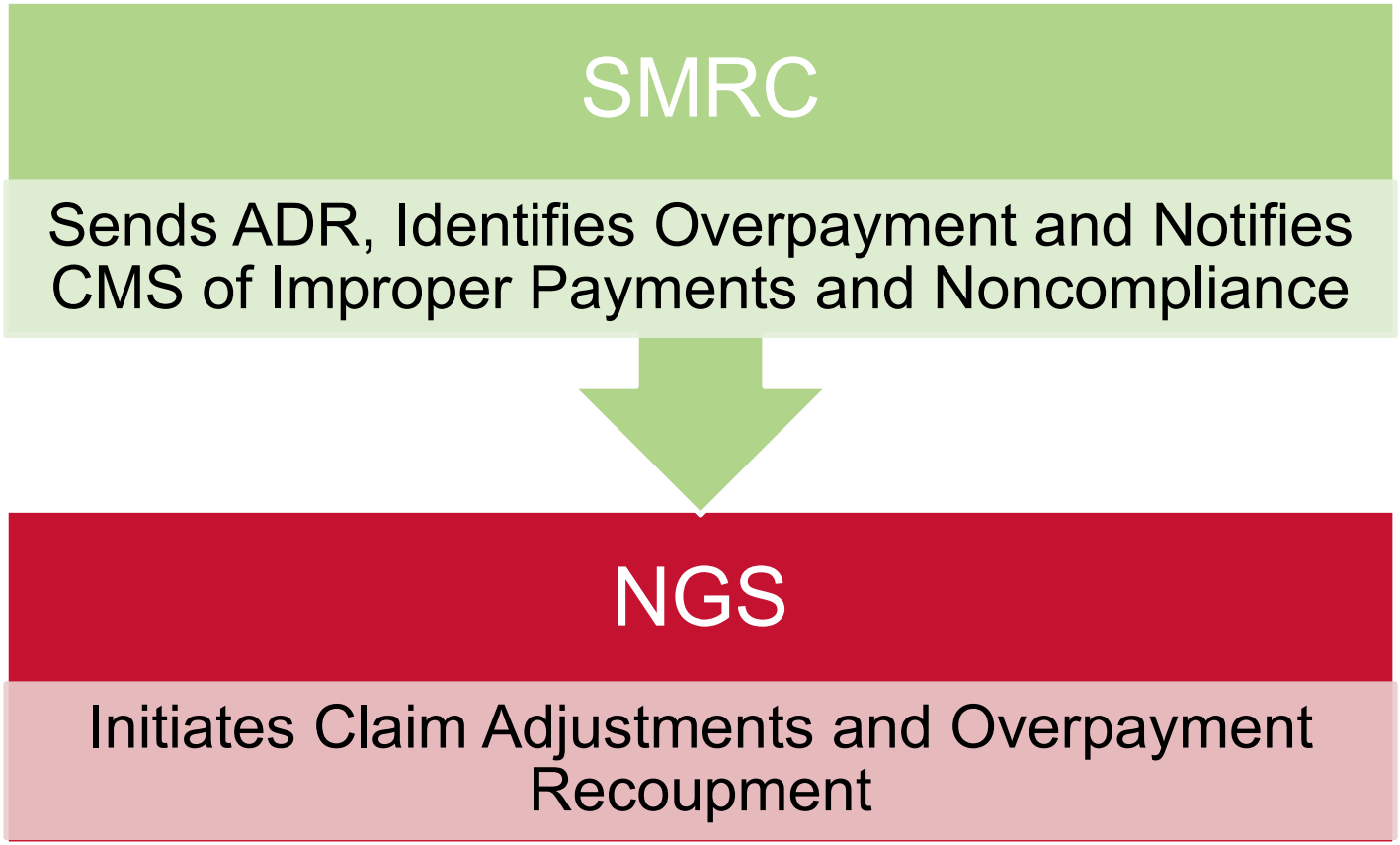
Supplemental Medical Review Contractor (SMRC)

Supplemental Medical Review Contractor (SMRC)

- Lower the improper payment rates and increasing efficiency of medical review functions of the Medicare and Medicaid programs
- Conducts medical review of Part A and B Medicare claims to ensure claims were billed in compliance
- Focus of review includes: vulnerabilities identified by CMS data analysis, CERT or other professional federal oversight agencies

Supplemental Medical Review Contractor (SMRC)



Supplemental Medical Review Contractor (SMRC)

- SMRC
  Noridian Healthcare Solutions, LLC
  Noridian SMRC
  P.O. Box 6711
  Fargo, ND 58108-6711
- Accepts esMD Transactions
- Customer Service: 833-860-4133 (M-F 7:30 a.m.-5:00 p.m. CT)
- Email: SMRCMail@Noridian.com
- Website: https://www.noridiansmrc.com/

Benefits Coordination and Recovery Center (BCRC)

BCRC

- The Medicare Secondary Payer (MSP) program is in place to ensure that Medicare is aware of situations where it should not be the primary, or first, payer of claims
- If a beneficiary has Medicare and other health insurance, Coordination of Benefits (COB) rules decide which entity pays first
- Activities related to the collection, management, and reporting of other insurance coverage for beneficiaries is performed by the BCRC
- Responsible for creation, updates & termination of all Medicare Secondary Payer (MSP) records

BCRC

- Customer Service
  M-F 8:00 a.m.-8:00 p.m. ET
- Telephone: 855-798-2627
- Fax:405-869-3307
- Written Inquiries
  Medicare – Data Collections
  P.O. Box 138897
  Oklahoma City, OK 73113-8897

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Safeguarding the Medicare Program

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Safeguarding the Medicare Program

- Fraud
- Waste
- Abuse

Safeguarding the Medicare Program

FRAUD: The intentional deception or misrepresentation of facts that an individual or organization knows to be false or does not believe to be true and could result in some unauthorized benefit to himself/herself or some other person, or the organization.

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WASTE: Over-utilization of services, or other practices that result in unnecessary costs, taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act, or omission by players with control over or access to government resources.

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Safeguarding the Medicare Program

ABUSE: Actions that are inconsistent with accepted, sound medical, business or fiscal practices. Abuse can be identified when individuals unintentionally follow practices that result in unnecessary Medicare Program costs. Abusive practices may develop into fraud and be prosecuted as such. Abuse directly or indirectly results in unnecessary costs to the program through improper payments.

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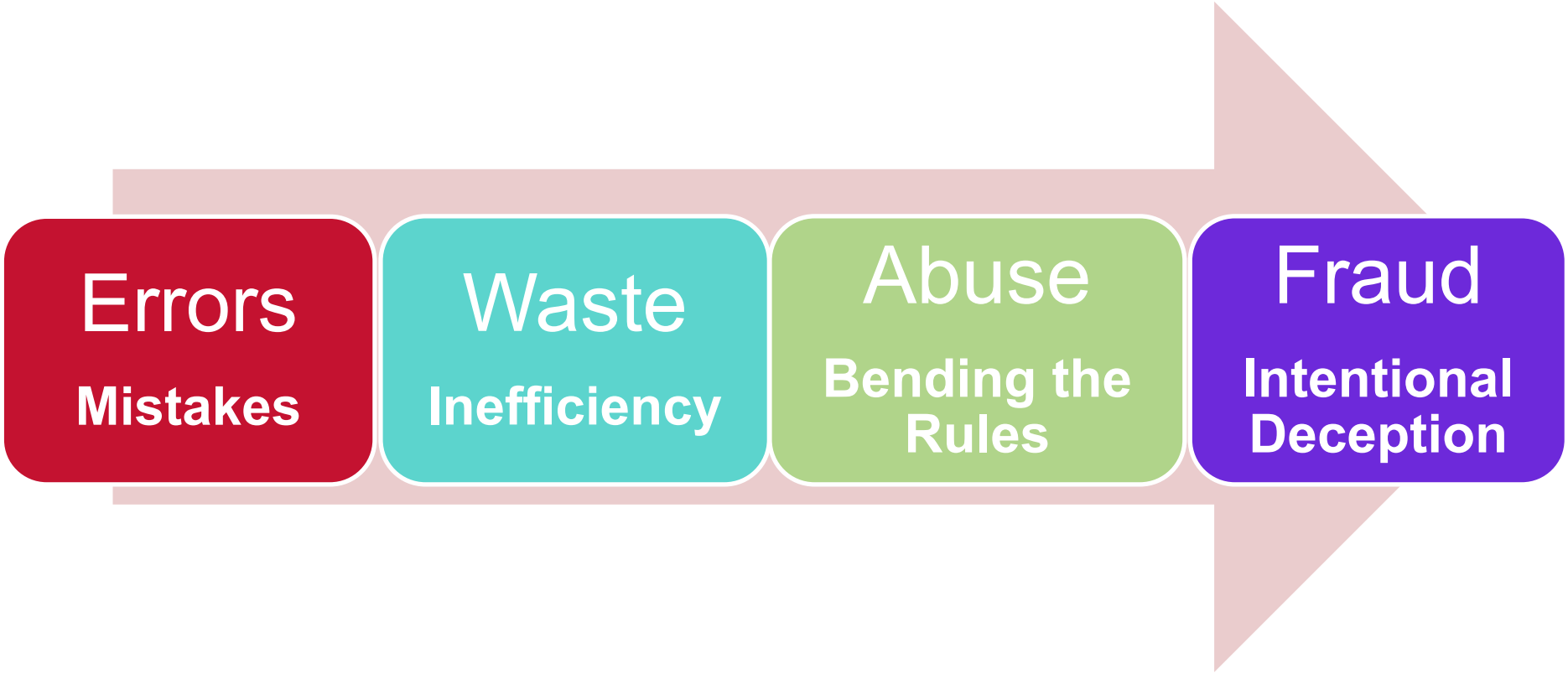
Safeguarding the Medicare Program



Safeguarding the Medicare Program

Helpful Hints

- Staff Education
- Responsibility
- Medical Necessity
- Comprehension Of the Anti-Kickback Statute & Stark Laws
- Report Fraud

Safeguarding the Medicare Program

Report Fraud, Waste & Abuse

By Phone

Health & Human Services Office of the Inspector General

1-800-HHS-TIPS
(1-800-447-8477)
TTY: 1-800-377-4950

Online

Health & Human Services Office of the Inspector General Website

By Fax

Maximum of 10 pages

1-800-223-8164

By Mail

Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

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Additional Documentation Request (ADR)

ADR

- An ADR is a request for documentation to support a Medicare claim
  - It is imperative that providers maintain a process or policy that ensures requested medical record documentation is collected efficiently and appropriately for review
  - Methods or techniques often utilized to ensure proper documentation is collected include
    - Mock Chart
    - Check List
    - Staff Members Assigned to Collect Documentation
    - Staff Members Assigned to Review Documentation Prior to Submission

ADR

System Issues ADR	• Claim suspends to status/location SB 6001 • ADR is sent to provider • Provider has **45 days** to return records to the MAC
Records are NOT received by day 45	• On day 46 the system will deny the claim and move it to S/L DB 9997 • Claim assigned reason code 56900
Wait one week and recheck status/location	• If the records were received the claim will move to S/L SM 5REC • If denial code appears, recheck, call the PCC for assistance, if necessary

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ADR

- Incorporating the methods and techniques mentioned into policies/procedures will assist in ensuring
  - Appropriate documentation is obtained from outside entities
  - Records are reviewed for accuracy by multiple people prior to submission
  - All eligibility criteria have been met
  - All proper documentation is included in the medical record prior to submission
  - Proper claims payment

ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS VIA PAPER, FAX, CD/DVD AND ESMD OMB #0938-0969

PLEASE NOTE:

MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 45 CALENDAR DAYS.

NON-MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 14 CALENDAR DAYS.

Records DUE: 45 Days

ADR

- The ADR provides helpful hints to help appropriate claims payment

MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED.

MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN SIGNATURES, HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD.

ADR

PATIENT IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER SIGNATURE IS NOT CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE, AND THE INITIALS FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT AN ATTESTATION STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE THAT THE MEDICAL NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

PLEASE SUBMIT THE SUPPORTING DOCUMENTATION WITHIN 45 DAYS FROM THE DATE OF THIS NOTICE. THIS DOCUMENTATION MUST BE CLEAR AND LEGIBLE.

Date

Signature

Legibility

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ADR

- The ADR does not provide an all-inclusive list of what should/should not be included for medical record submission
  - **Reminder:** It is important to review the records prior to submission to ensure documentation supports eligibility criteria

Targeted Probe and Educate (TPE)

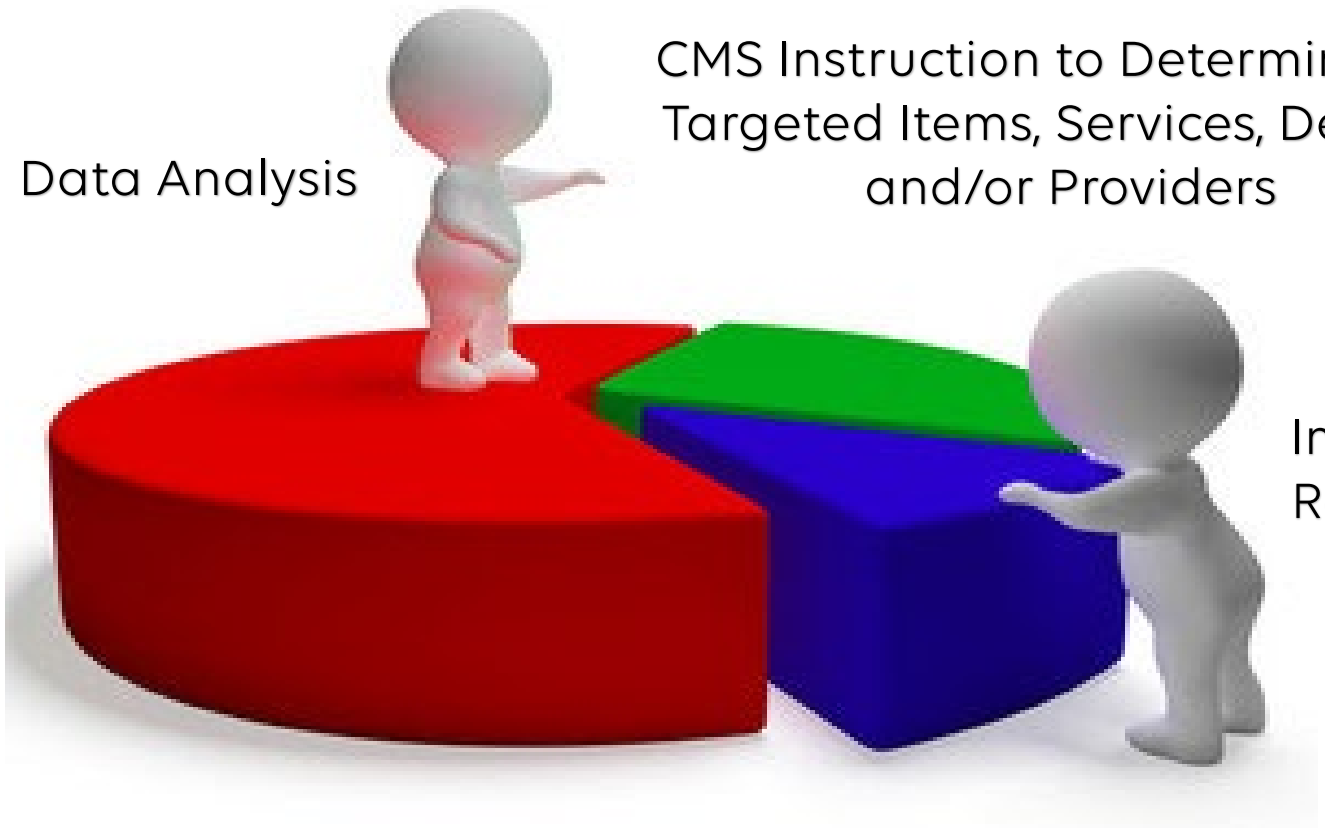
TPE

- CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals
- The goal is to help providers quickly identify and improve errors

TPE

Data Analysis

CMS Instruction to Determine the Targeted Items, Services, Devices and/or Providers



Improper Payment Reduction Strategy

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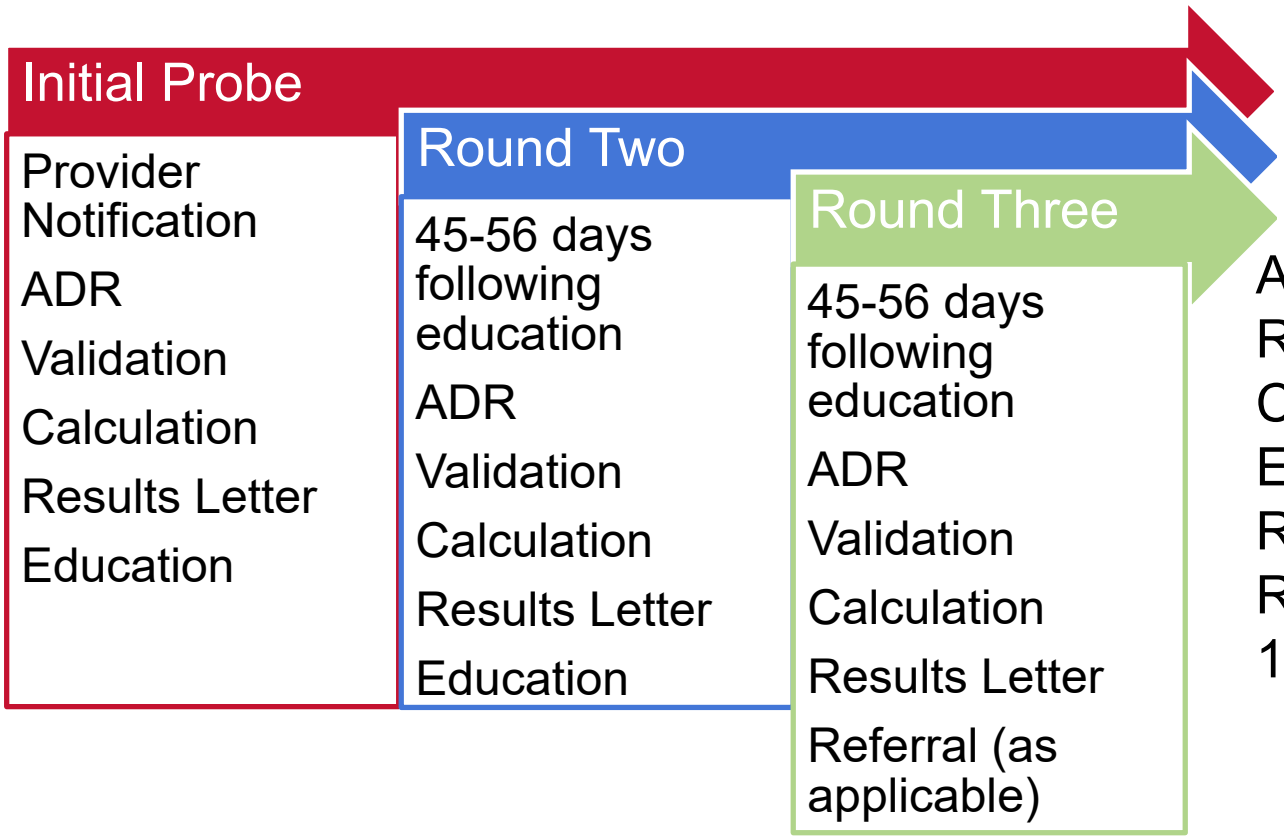
TPE


Trends
Billing Comparisons
Utilization Patterns
Data Analysis

TPE



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Additional Rounds of TPE
Referral for Revocation
Corrective Action
Extrapolation
Referral to UPIC
Referral to RA
100% Pre-Pay Review

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TPE

- CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.
  - The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.
- TPE reviews can be either prepayment or postpayment and involve MACs focusing on specific providers/suppliers that bill a particular item or service.

TPE

- Notice of review includes reason for review
- Request 20 – 40 claims
- Do not send documentation until ADR received for each claim
- ADRs generated via the usual process
- 45 days to respond
- Non-responders could be referred to the RA or UPIC
- Records Reviewed within 30 days of receipt
- Results letter offers 1:1 education

TPE

- Additional Rounds of Review
  - Payment error **>15%**
  - Additional rounds include education with Medical Review staff following each round of review
  - Payment Error Rate
    - Payment/Payment Denied
    - 1,000/500 = 50% PER
  - Claims Error Rate
    - # of Claims/Claim in Error
    - 10 Claims/5 Claims Denied = 50% CER

National Government Services

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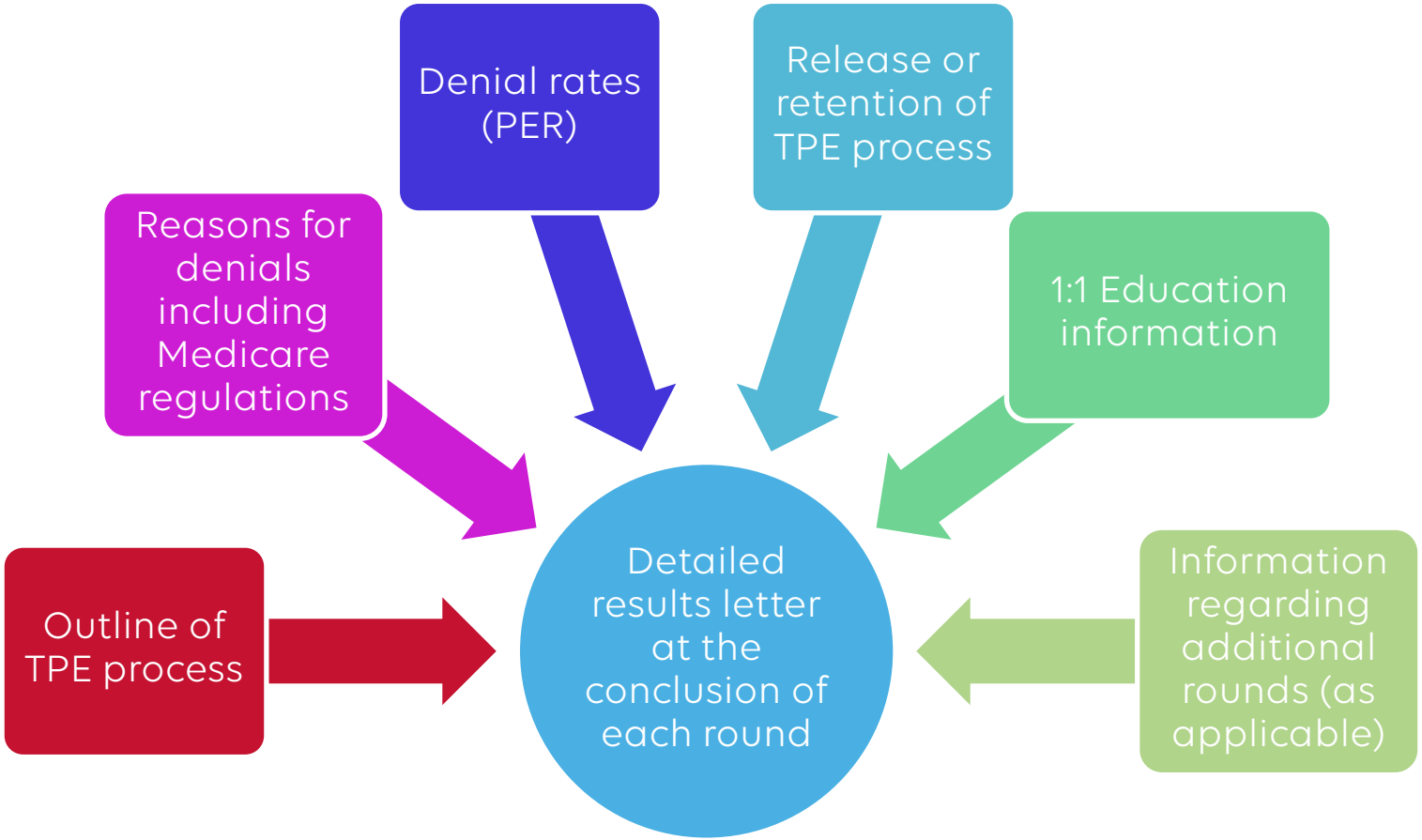
TPE

- Medical Review of Records for:
- Technical Components
  - Physician certification
  - Physician orders
  - Beneficiary election statement
- Eligibility Requirements
  - Medicare coverage guidelines
  - Medical necessity
  - Documentation to support services billed

TPE


Denial rates (PER)
Release or retention of TPE process
Reasons for denials including Medicare regulations
1:1 Education information
Outline of TPE process
Detailed results letter at the conclusion of each round
Information regarding additional rounds (as applicable)

Submission of Medical Record Documentation

Submission of Medical Record Documentation

- Documentation Collaboration
- Sources of documentation that may assist in supporting eligibility criteria include
  - Discharge summary
  - Progress notes
  - History and physical
  - Plan of care
  - Case Management records
  - Discharge Planning documentation
  - Therapy records
  - Face-to-face encounter documentation

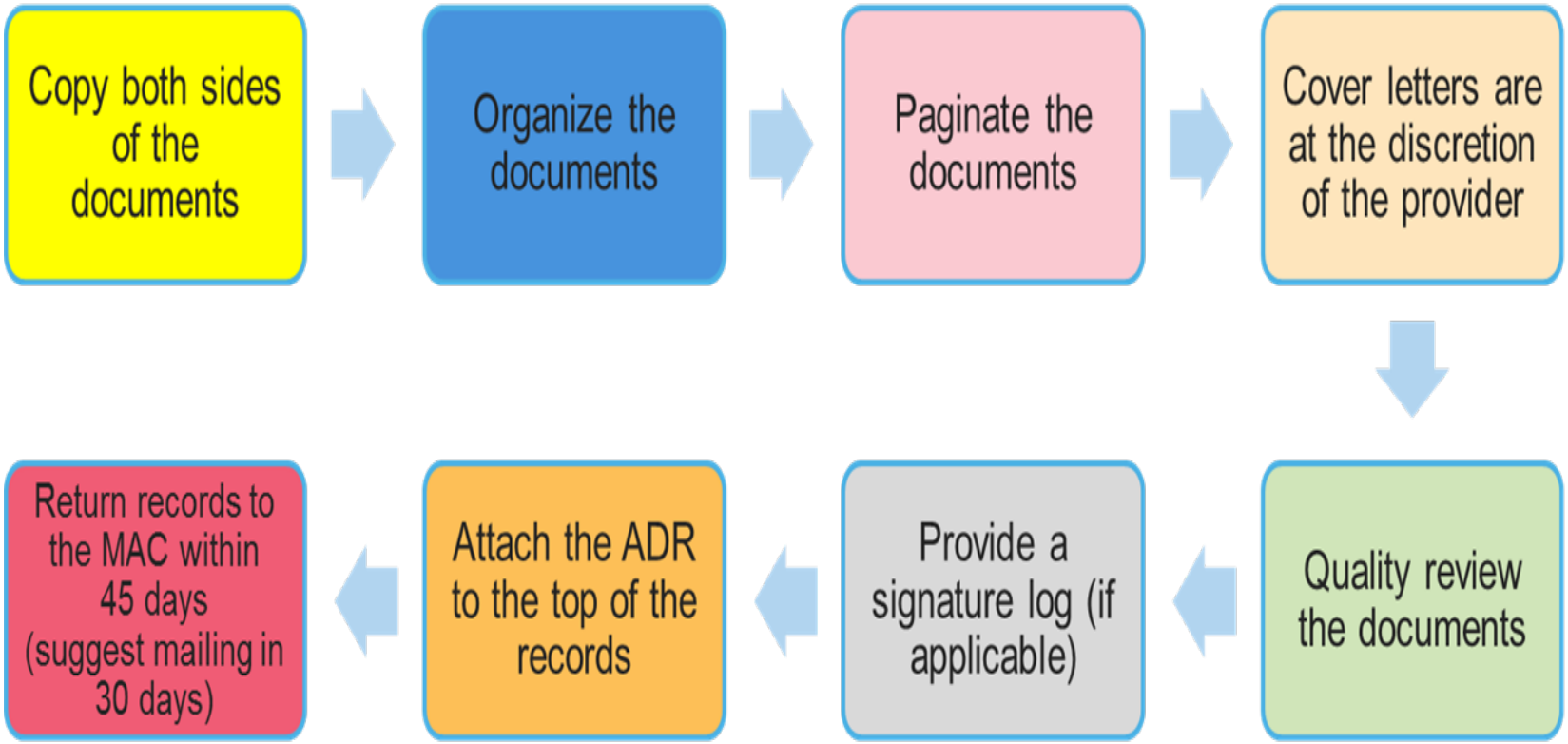
Submission of Medical Record Documentation

- Documentation Preparation
- Prior to submission of documentation, it is imperative that all medical record documentation is completely reviewed to ensure
  - All pages are for the appropriate patient
  - PECOS – Validation for all physicians involved in the patient's care for all DOS in the period of care
  - Appropriate OASIS submission
  - Any and all therapy evaluations and reevaluations are included
  - The patient's name is on each page (front and back where appropriate)
  - The correct dates of service for the claimed period of care
  - Dates and signatures are clear and appropriate
  - Legibility of all handwritten documentation

Submission of Medical Record Documentation

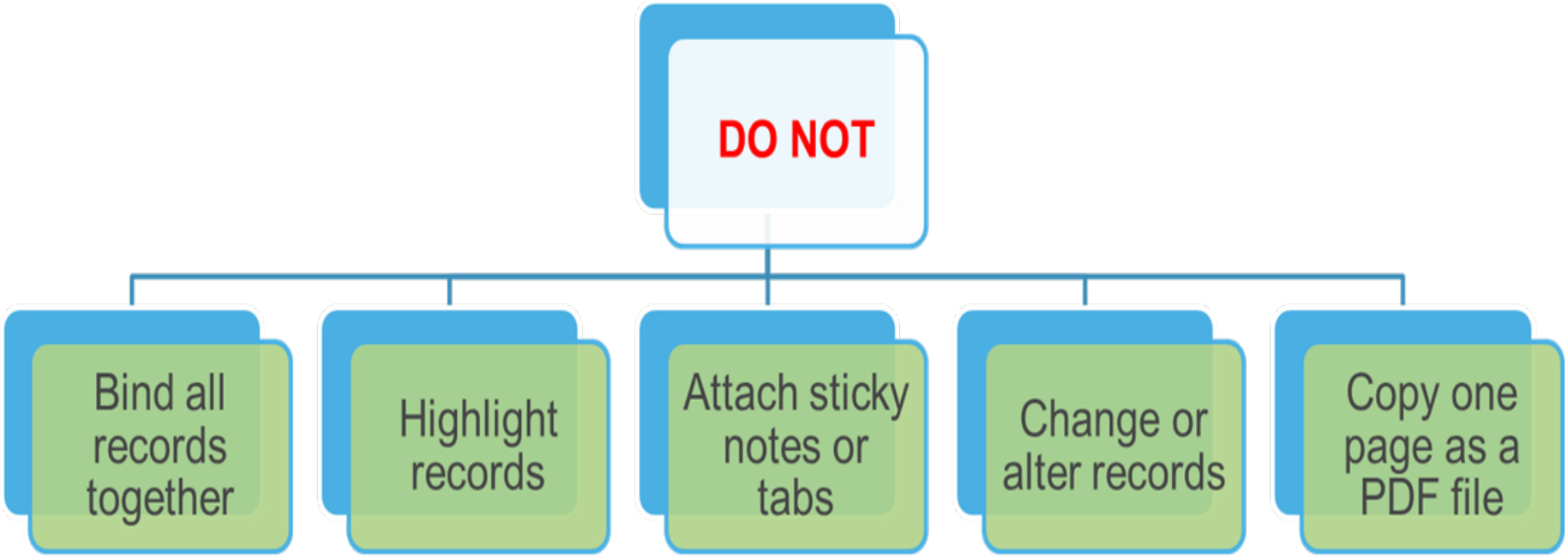
- Documentation Preparation
- Prior to submission of documentation, review all records to ensure
  - Identifiable credentials for each clinician signature
    - Signature sheets as appropriate from agency and referring facility/office
  - Accuracy of documentation
  - All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
  - Pages are not folded over, cut off or crinkled during copying/printing/faxing
  - Highlighter is not utilized
  - ADR is placed on the top of the medical record
  - Reminder: Black ink copies best
  - Provider contact name and telephone number

Submission of Medical Record Documentation



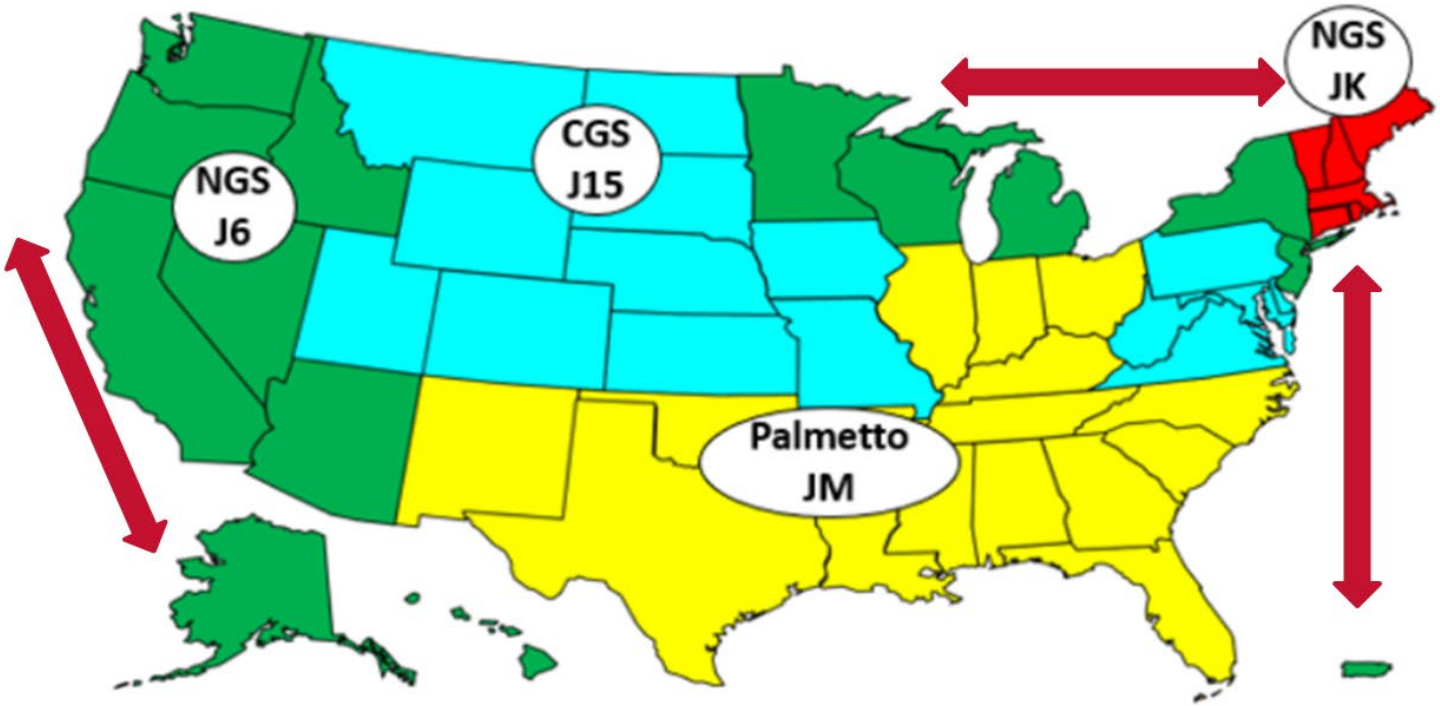
Submission of Medical Record Documentation

Documentation Preparation



Submission of Medical Record Documentation

- HH+H Jurisdictions



Submission of Medical Record Documentation **J6**

NGSConnex

esMD

FedEx

National Government Services Inc.

8115 Knue Rd

Indianapolis, IN 46250

Attn: Mail & Distribution

National Government Services Inc.

PO Box 7108

Indianapolis, IN 46206-6474

FAX: 315.442.4154

Always check www.NGSMedicare.com for the most current information

National Government Services

NGS MU

Submission of Medical Record Documentation **JK**

NGSConnex

esMD

FedEx

National Government Services Inc.

8115 Knue Road
Indianapolis, IN 46250

ATTN: Mail & Distribution

National Government Services Inc.

PO Box 7108
Indianapolis, IN 46207-7108

FAX: 315.442.4390

Always check www.NGSMedicare.com for the most current information

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56900 Denials

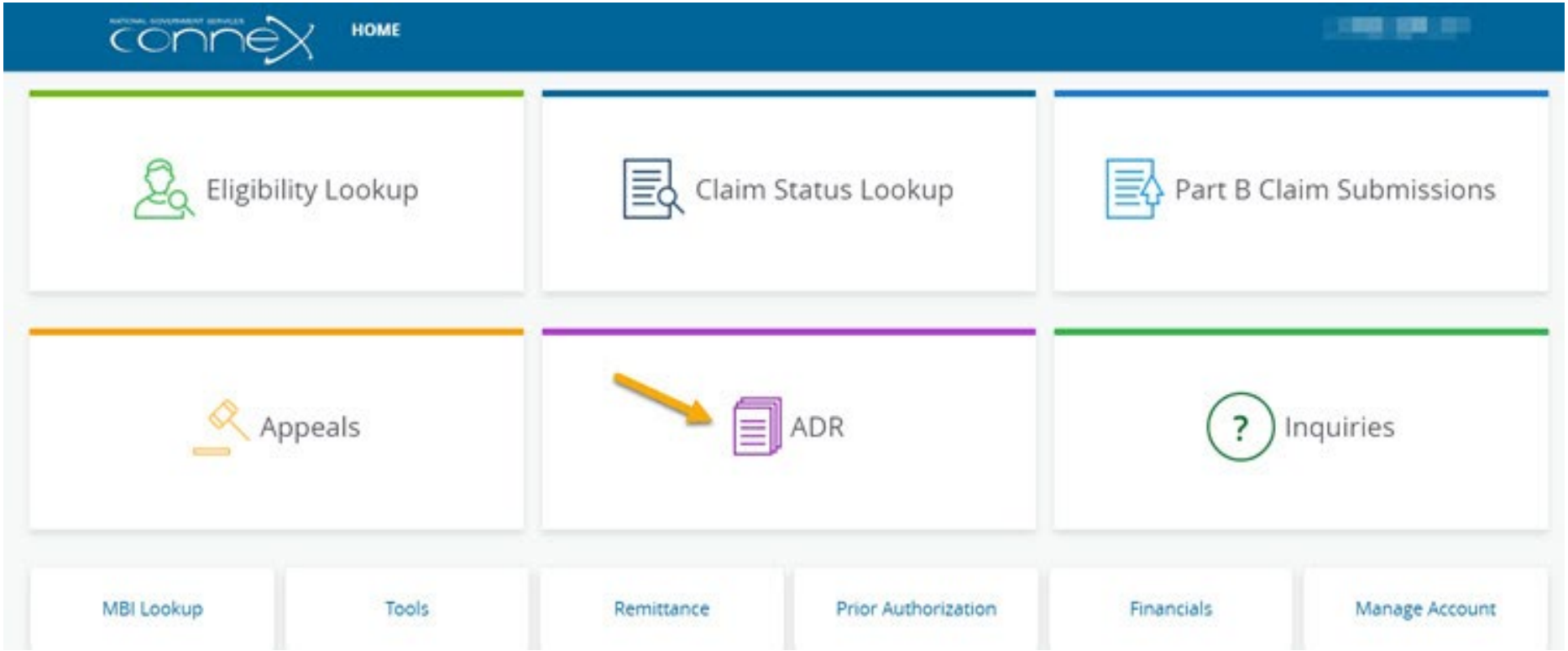
- Records not received

NGSConnex

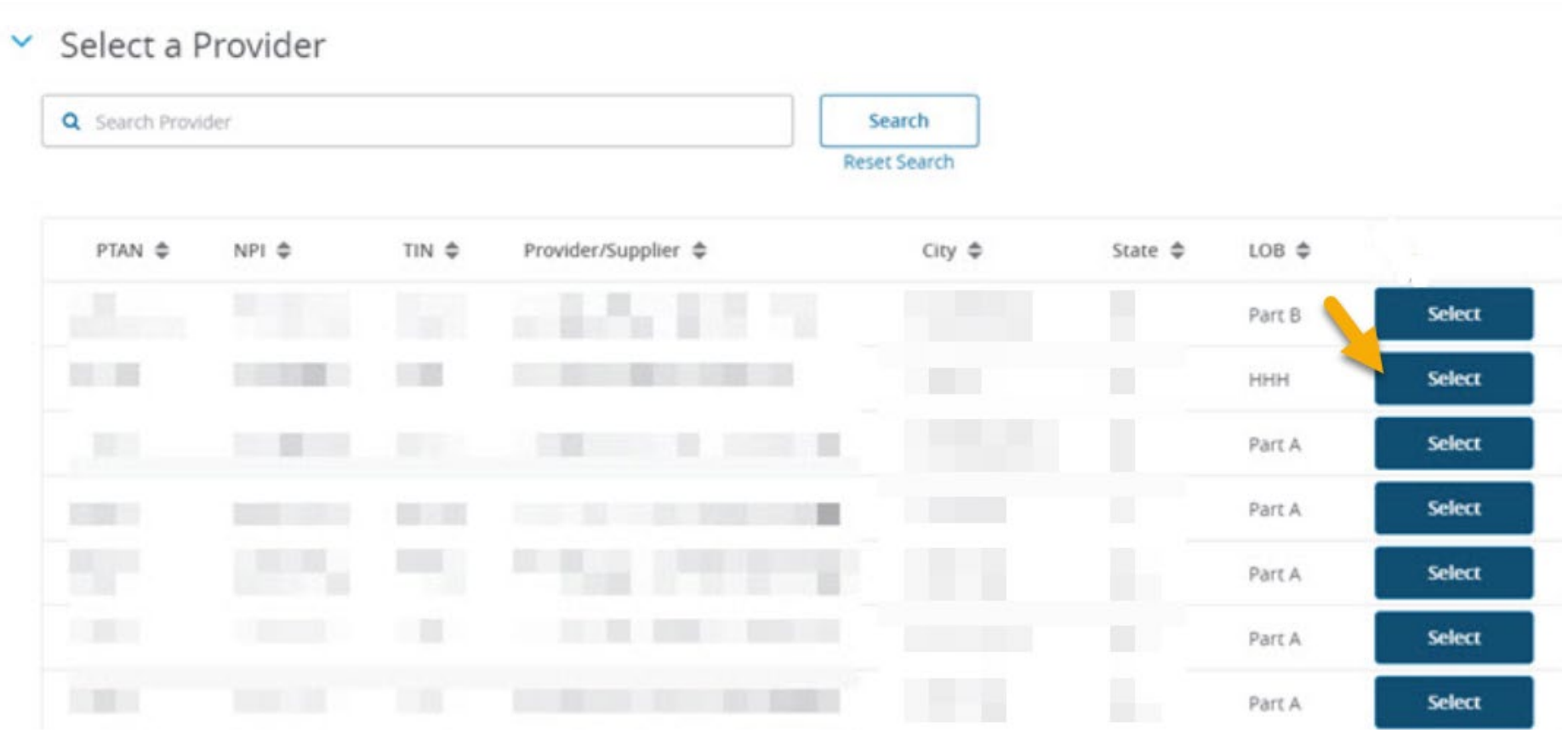
NGSConnex

- NGSConnex is a free, secure, web-based application developed by NGS just for you!
- NGSConnex provides access to a wide array of self-service functions that save you time and money, such as:
- Obtain beneficiary eligibility information
- Query for your claims status
- Initiate and check the status of redetermination and reopening requests
- View your provider demographic information
- Query for your financial data
- Submit documents for an additional documentation request
- Submit credit balance reports and more!

NGSConnex: Homepage



NGSConnex: Select a Provider



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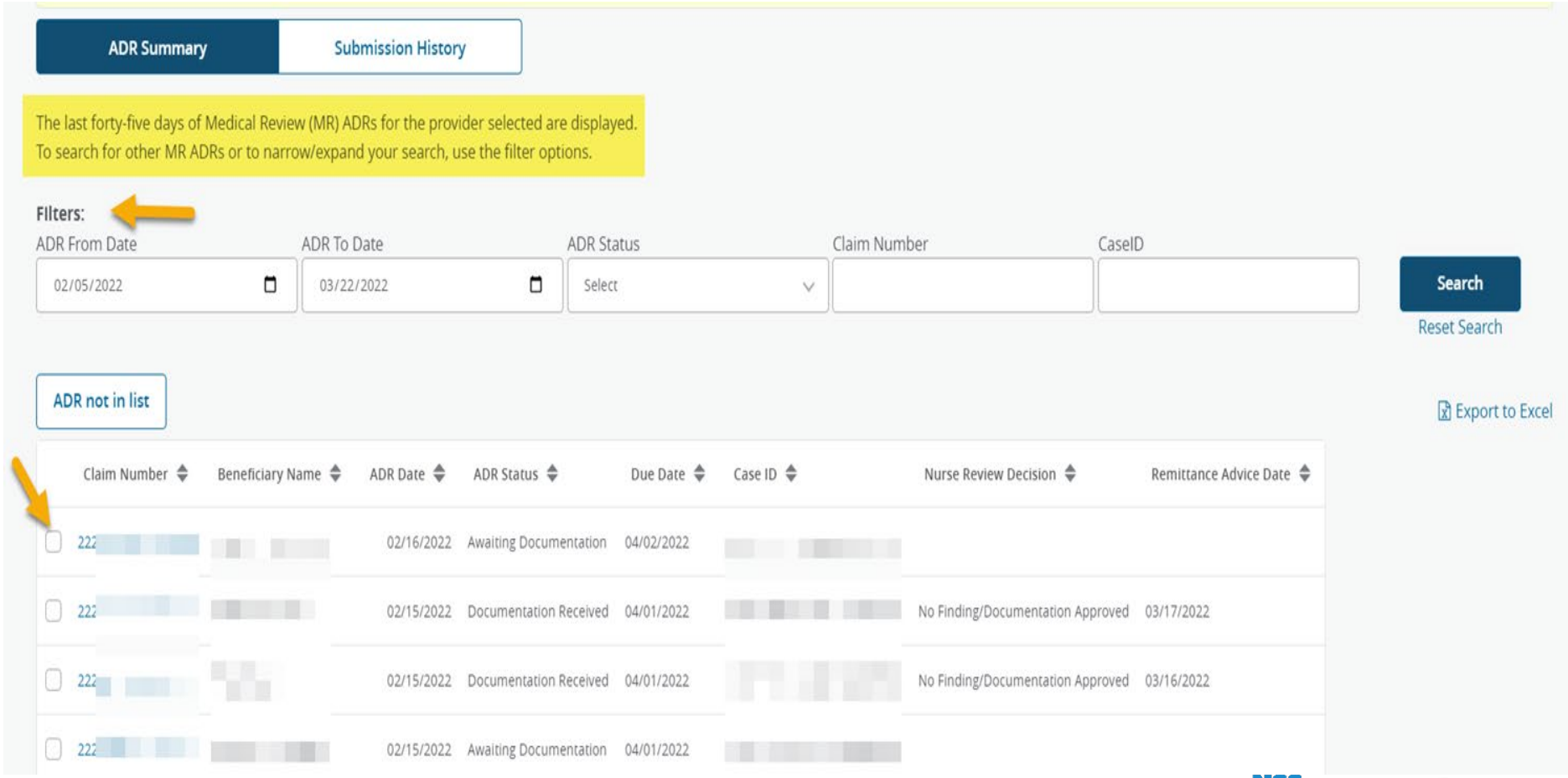
NGSConnex: ADR Summary Panel



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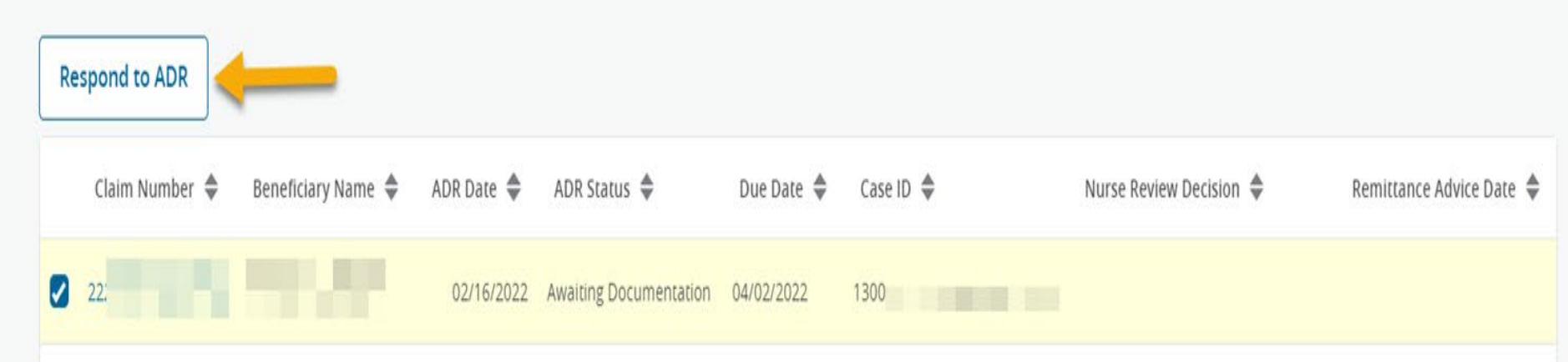
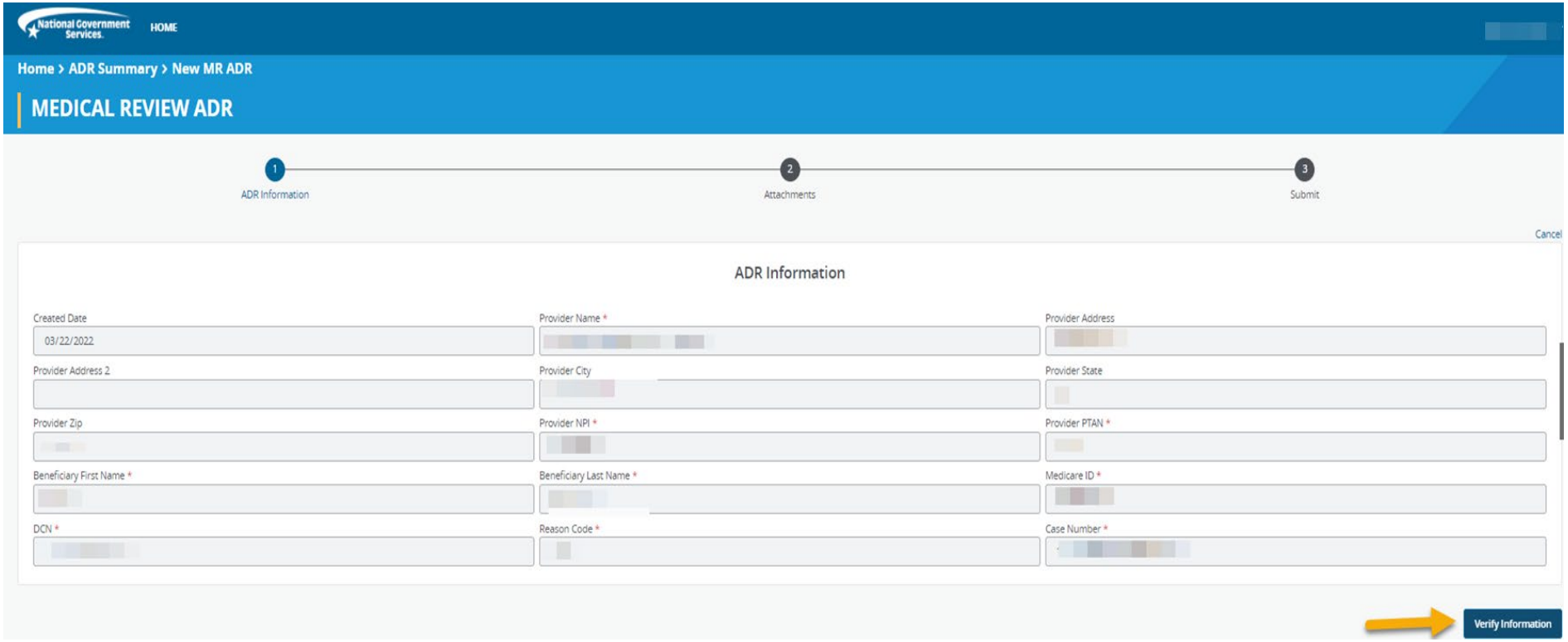
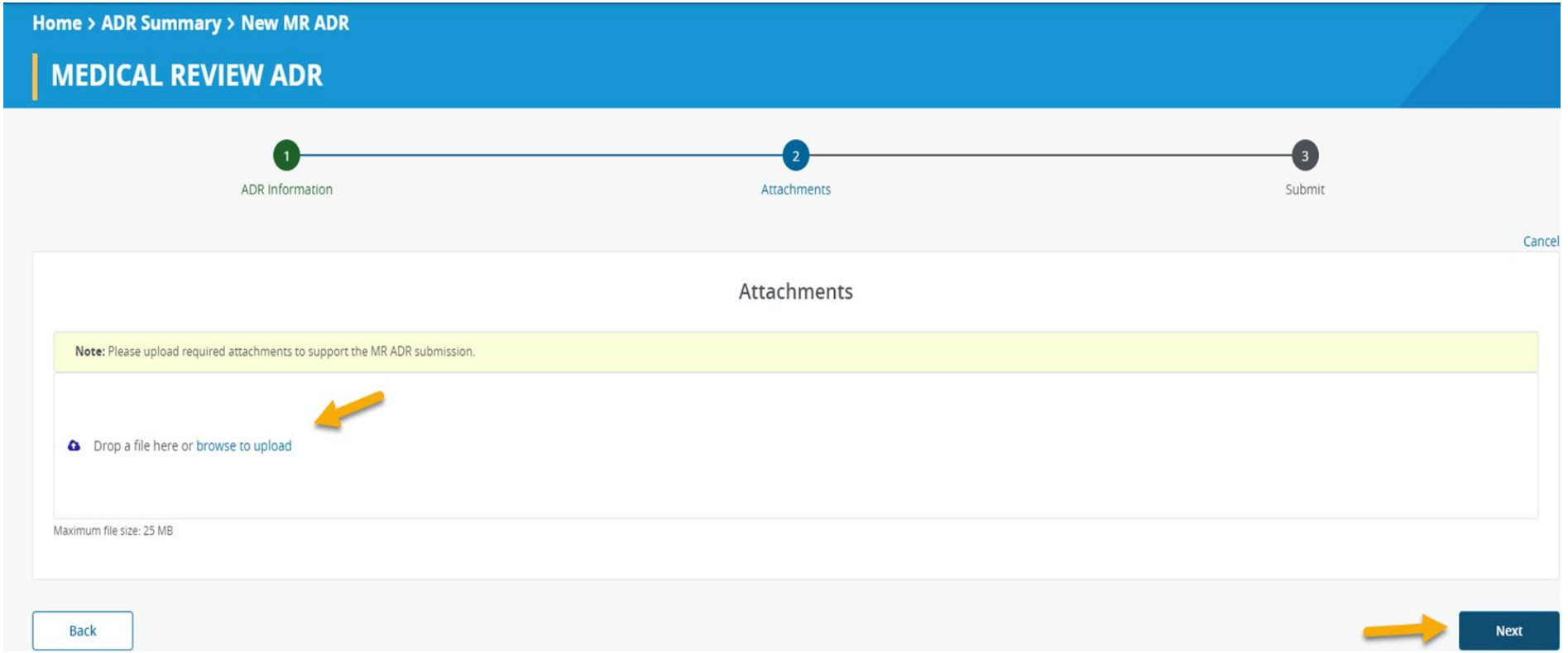
NGSConnex: Respond to an ADR



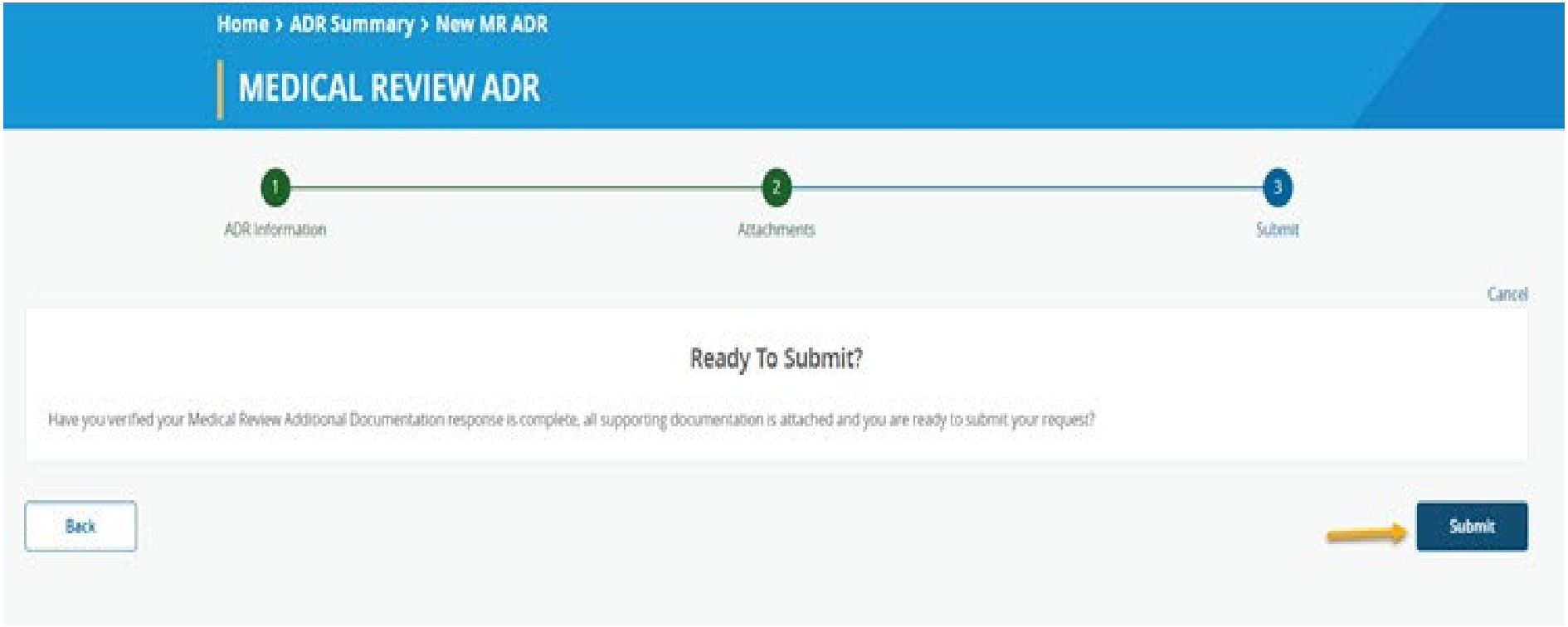
NGSConnex: ADR Information – Step 1



NGSConnex: ADR Information – Step 2

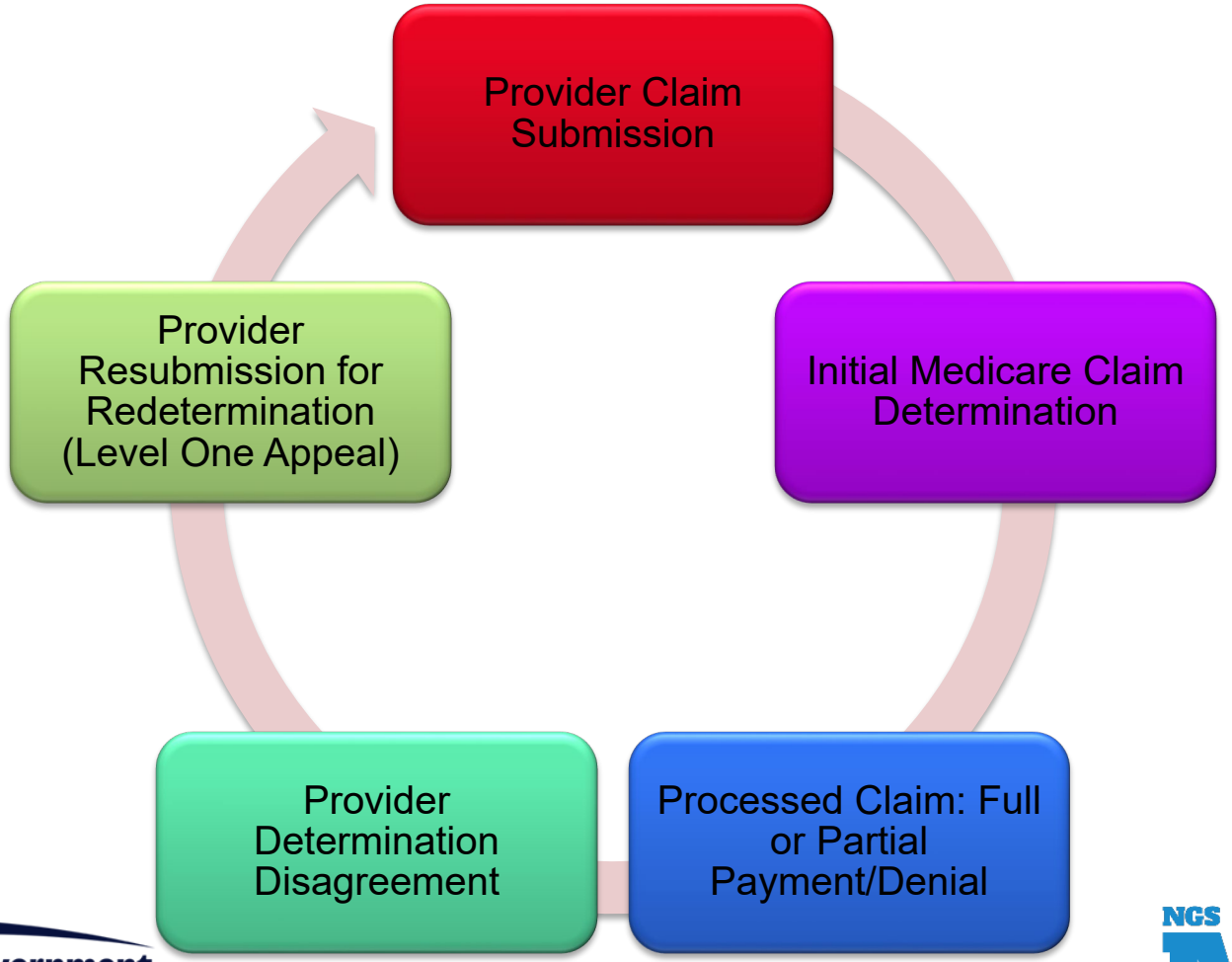


NGSConnex: ADR Information – Step 3



Appeals

What is an Appeal?



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Purpose of an Appeal

- All appeals activities are governed by CMS
  - Ensure correct adjudication of claims
- Providers and beneficiaries have the right to appeal any claim determination made by the MAC

Five Levels of Appeal

Level One Redetermination Medicare Administrative Contractor (MAC)

Level Two Reconsideration Qualified Independent Contractor (QIC)

Level Three Administrative Law Judge (ALJ)

Level Four Medicare Appeals Council Department Appeals Board (DAB)

Level Five US Federal District Court

Level One Appeals

Level One Appeals

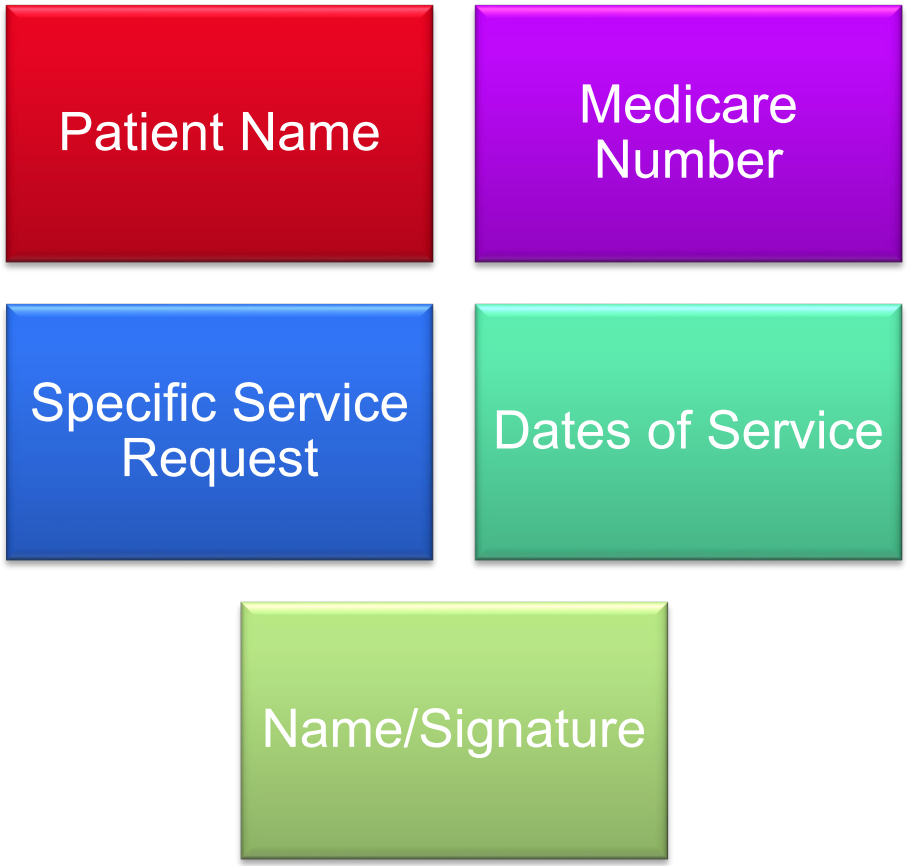
Redetermination – MAC			
Time limit to initiate = 120 days from date of initial determination	Time limit to complete the review = 60 days	Amount in controversy = no minimum amount	How to File: Electronically via NGSConnex or esMD or in writing via Redetermination Form

Level One Appeals

Redetermination – MAC	
Jurisdiction 6	Jurisdiction K
National Government Services Appeals Department P.O. Box 6474 Indianapolis, IN 46206-6474	National Government Services Appeals Department P.O. Box 7111 Indianapolis, IN 46207-7111
Mailing Address for states AK, AZ, CA, HI, ID, MI, MN, NJ, NV, NY, OR, WA, WI, & U.S. Territories	Mailing Address for states CT, MA, ME, NH, RI, VT:

Level One Appeals

- Must include all pertinent information to avoid dismissal of the case
- Previously sent records will automatically be incorporated



Timely Filing

- Federal regulations mandate timely filing of claims within one year of services rendered
- Appeals staff may extend time limit in certain situations called “Conditions that Establish Good Cause”

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Timely Filing

- Conditions that Establish Good Cause
  - Unavoidable Circumstances
    - Provider is not excused from the timely filing rules for the next level of appeal

Timely Filing

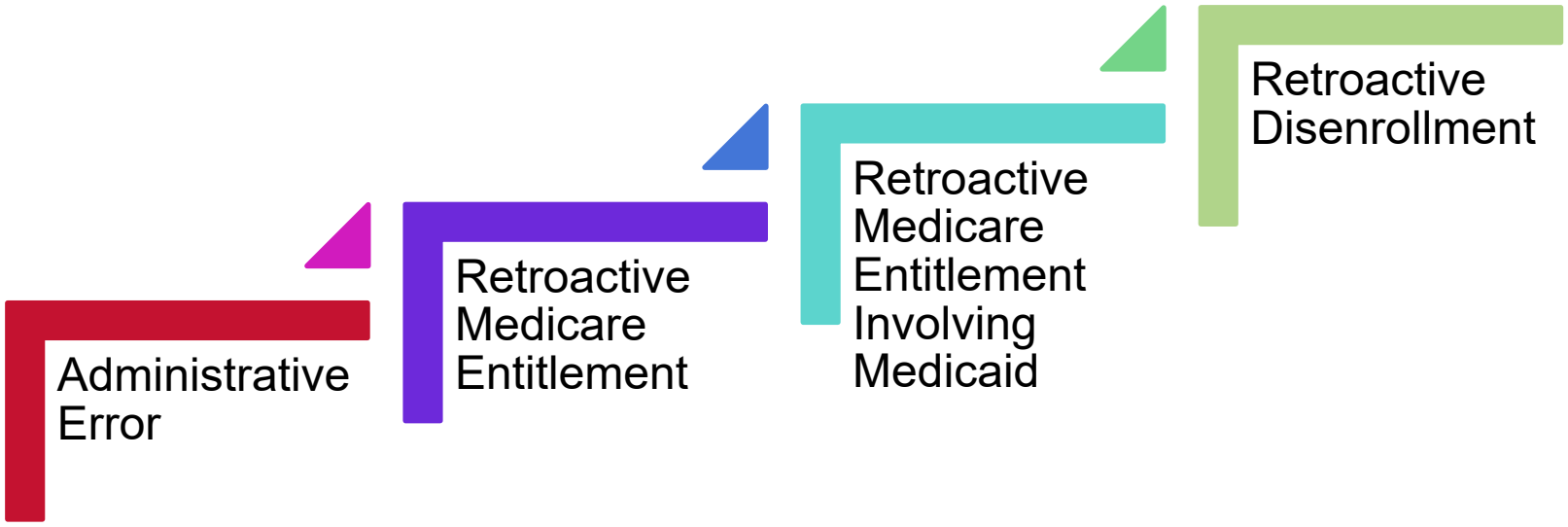
- Conditions that **do not** establish good cause

Timely Filing

- Timely filing for claims is not an appealable determination
  - Once a claim is processed, submitting an adjustment is the only mechanism to bypass timely filing

Timely Filing

Allowable Exceptions



Level Two Appeals

Level Two Appeals

Reconsideration – QIC			
Time limit to initiate = 180 days from date of redetermination denial	Time limit to complete the review = 60 days	Amount in controversy = no minimum amount	How to file: Reconsideration CMS Form 20033

Level Two Appeals

Reconsideration – QIC

Jurisdiction 6	Jurisdiction K
MAXIMUS Federal Services QIC Medicare Part A West 3750 Monroe Ave. Suite 706 Pittsford, NY 14534	**C2C Innovative Solutions, Inc.** QIC Part A East Appeals P.O. Box 45305 Jacksonville, FL 32232-5305

**Request must be made in writing only

Level Three Appeals

Level Three Appeals

Administrative Law Judge Hearing (ALJ)			
Time limit to initiate = 60 days from date of QIC denial	Time limit to complete the review = 90 days	Amount in controversy = minimum $180	How to File: ALJ Form: OMHA-100 Office of Medicare Hearings & Appeals

Level Three Appeals

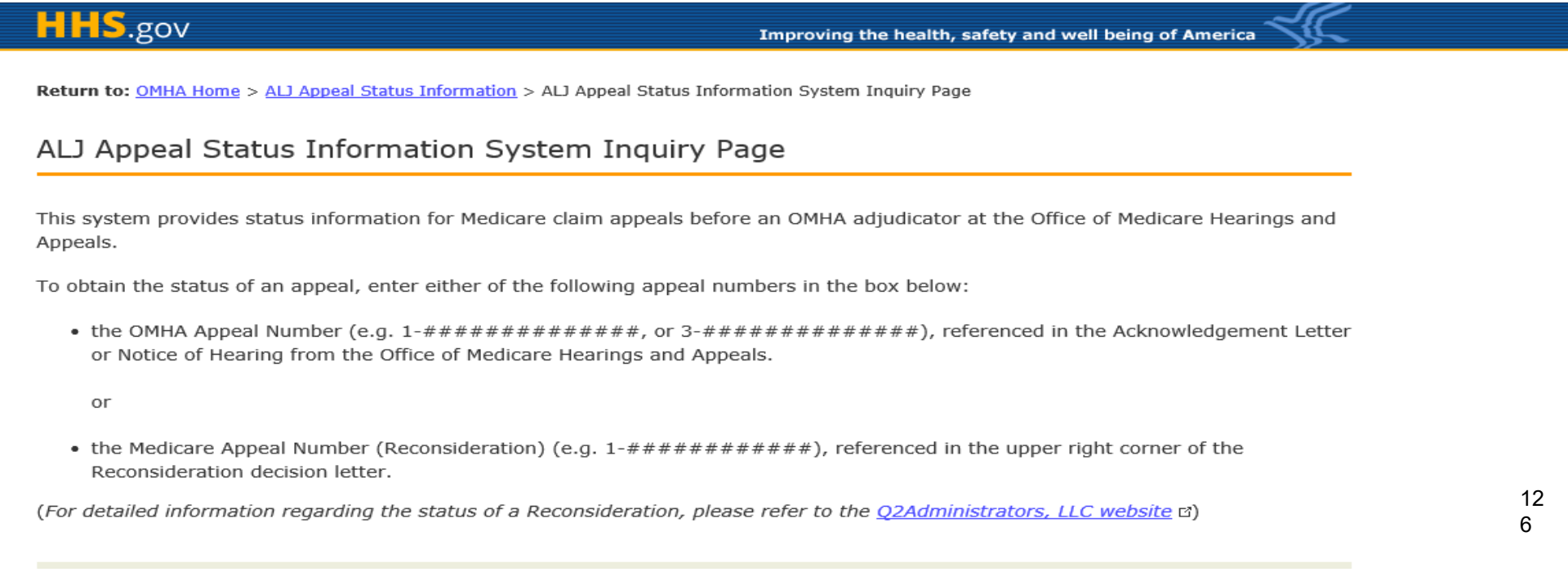
ALJ

OMHA **Central Operations**
1001 Lakeside Avenue, Suite 930
Cleveland, OH 44114-1158
For further assistance call
855-556-8475

OMHA e-Appeal Portal

ALJ Appeal Status Information System: AASIS

- US Department of Health & Human Services Office of Medicare Hearings and Appeals OMHA
  - Check the status of Medicare claim appeals before the ALJ
  - ALJ Appeal Status Information System (AASIS)



HHS.gov Improving the health, safety and well being of America

Return to: OMHA Home > ALJ Appeal Status Information > ALJ Appeal Status Information System Inquiry Page

ALJ Appeal Status Information System Inquiry Page

This system provides status information for Medicare claim appeals before an OMHA adjudicator at the Office of Medicare Hearings and Appeals.

To obtain the status of an appeal, enter either of the following appeal numbers in the box below:

- the OMHA Appeal Number (e.g. 1-##############, or 3-##############), referenced in the Acknowledgement Letter or Notice of Hearing from the Office of Medicare Hearings and Appeals.

  or

- the Medicare Appeal Number (Reconsideration) (e.g. 1-############), referenced in the upper right corner of the Reconsideration decision letter.

(*For detailed information regarding the status of a Reconsideration, please refer to the Q2Administrators, LLC website*)

Level Four Appeals

Level Four Appeals

Medicare Appeals Council Department Appeals Board (DAB)			
Time limit to initiate = 60 days from date of ALJ denial	Time limit to complete the review = 90 days	Amount in controversy = no minimum amount	How to File: Form DAB 101

Level Four Appeals

Medicare Appeals Council
Department Appeals Board (DAB)

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

Fax: 202-565-0227

For further assistance call:
202-565-0100
**Requests must be made in writing or via fax

Level Five Appeals

Level Five Appeal

Federal U.S. District Court

Time limit to initiate = 60 days from date of receipt of DAB denial	Time limit to complete the review:	Amount in controversy = $1760	How to file: In writing, no form necessary. Suggest submission of all other forms for appeals level one through four

Level Five Appeal

U.S. Federal District Court

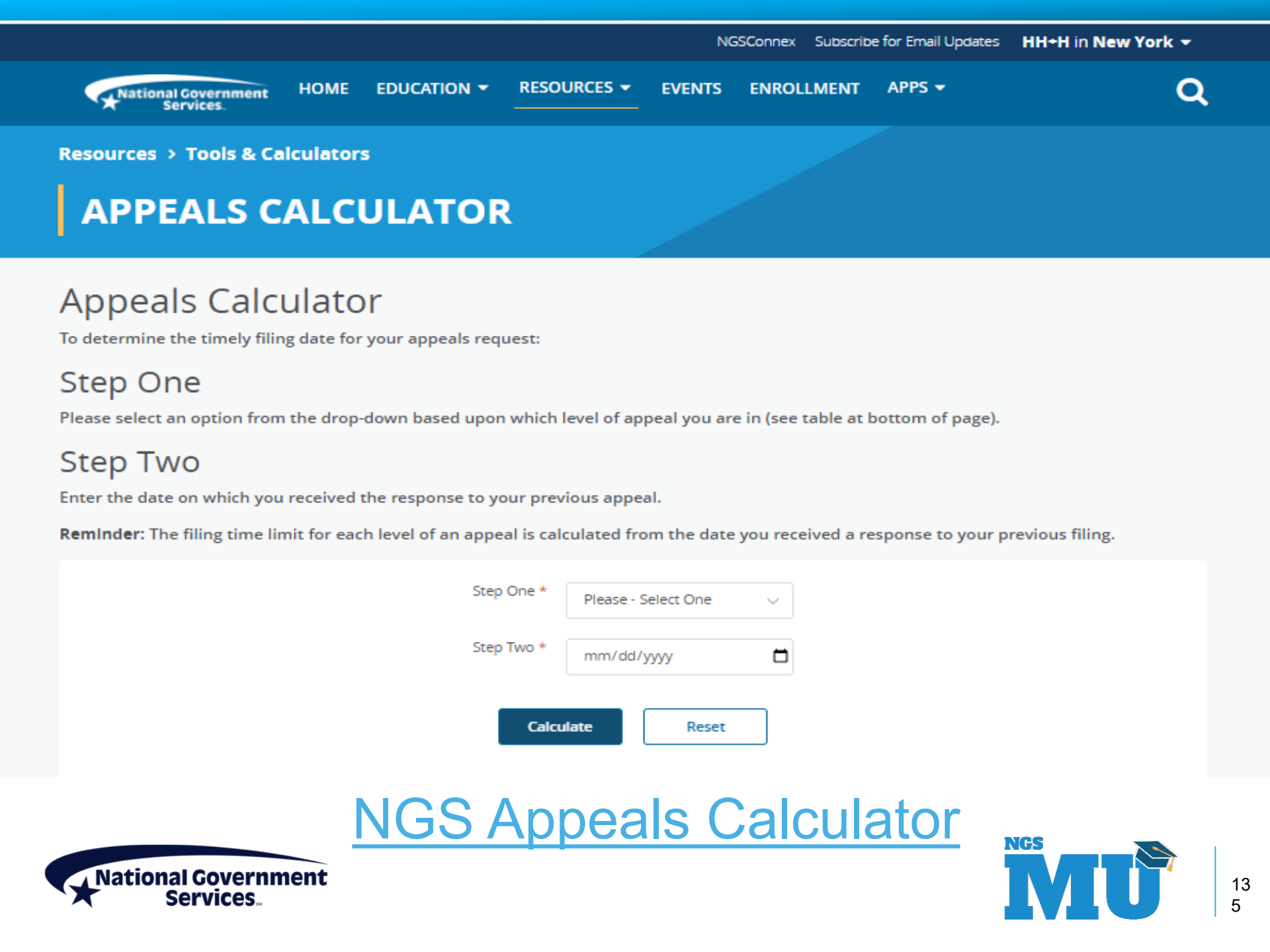
Department of Health and Human Services
General Counsel
200 Independence Avenue, SW
Washington, DC 20201

**Requests must be made in writing only

Appeal
Hints and Reminders

Appeals Overview Chart

Appeal Level	Time Limit For Filing	Monetary Threshold
Redetermination	120 days from date of receipt of RA	None
QIC Reconsideration	180 days from redetermination notice	None
ALJ Hearing	60 days from reconsideration notice	$180
DAB Review	60 days from the ALJ decision	None
Judicial Review	60 days from DAB decision	$1760



NGS Appeals Calculator

National Government Services

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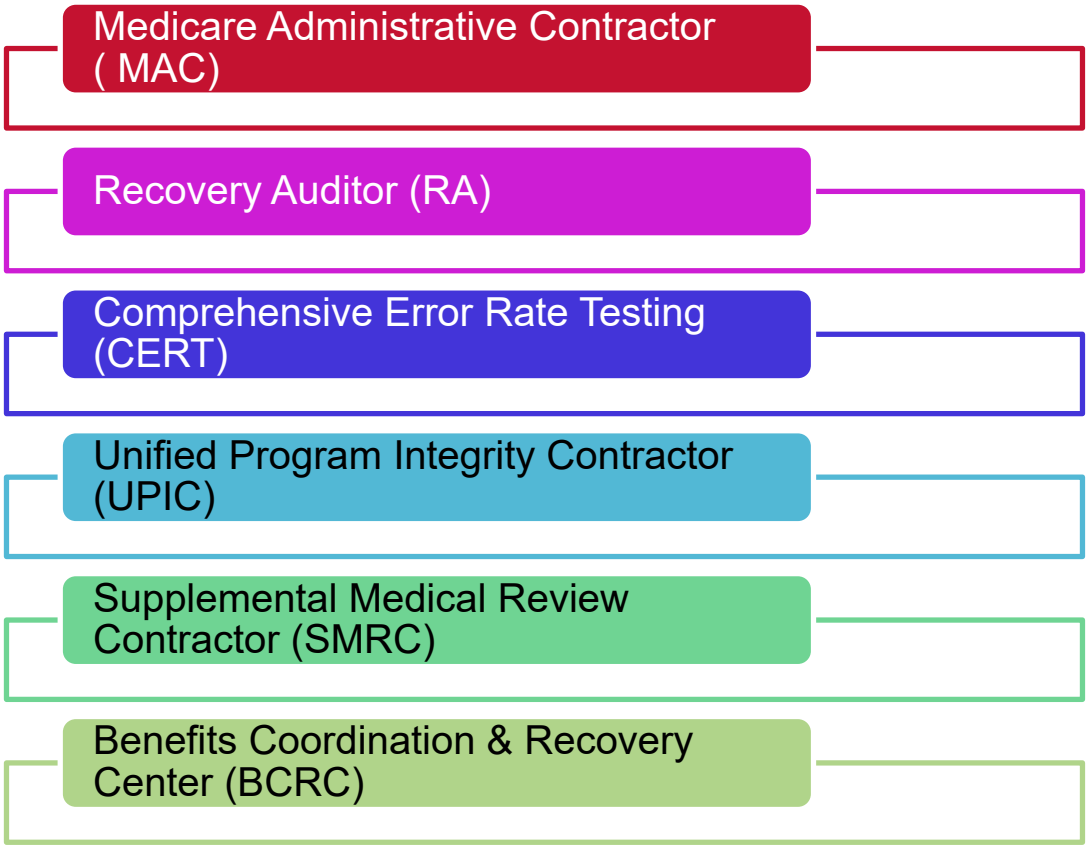
Helpful Hints

- Review reasons for denial
- “Remarks” section of FISS
- Claims determination letter



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Helpful Hints

- Be sure to include the following with your appeal
  - Beneficiary name
  - Medicare number
  - Date of service
  - Requestor name and signature
  - Attachments for additional information
  - All pertinent supporting medical record documentation (signed by a physician)
  - Explanations for delayed requests

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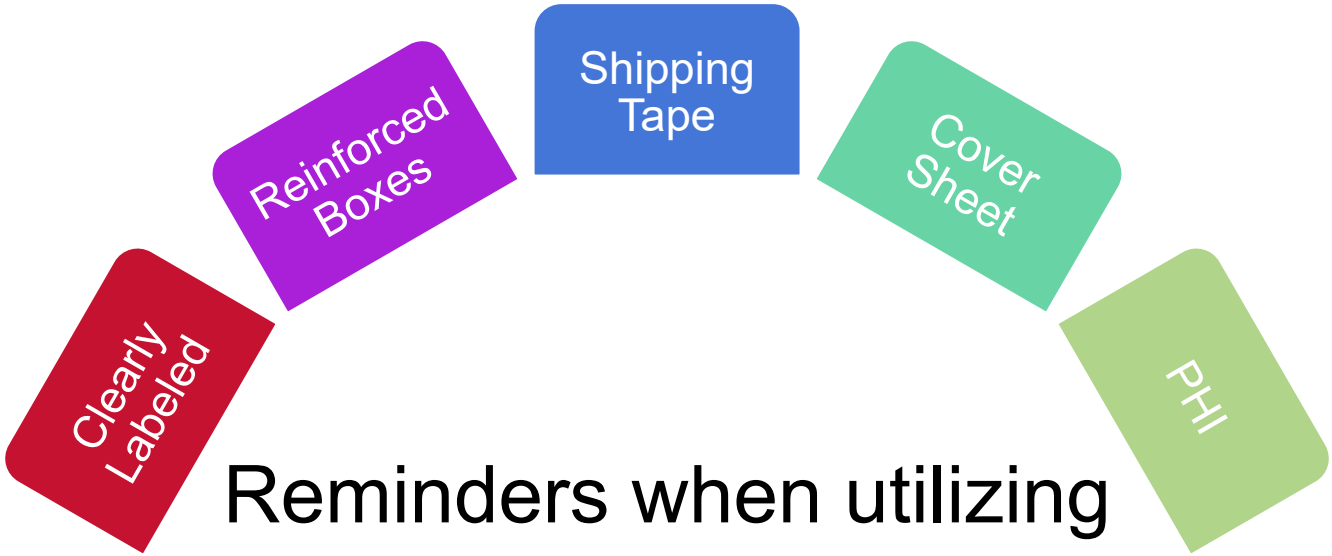
Helpful Hints



Reminders when utilizing USPS, Fed Ex, UPS

Compliance

HIPAA

Health Insurance Portability and Accountability Act

connex

NGSConnex

esMD for Providers and Suppliers

National Government Services

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CMS and NGS
Home Health and Hospice Resources

NGS MU
NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

National Government Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Home Health Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies

CMS Hospice Resources

- Medicare Contractor Beneficiary and Provider Communications Manual
- Medicare Benefit Policy Manual-Hospice
- Medicare Claims Processing Manual-Hospice
- Hospice Code of Federal Regulations
- Model Hospice Election Statement Example
- Model Hospice Election Statement Addendum Example

CMS Home Health & Hospice Resources

- HH PPS web page
- Home Health Agency (HHA) Center
- MLN® Publication, “Home Health Prospective Payment System”
- Hospice Center Webpage
- Hospice Code of Federal Regulations
- The Medicare Learning Network®

NGS References & Resources

- NGS Website
  - Education
  - Home Health and Hospice Topics
    - Billing
    - Documentation

Appeals References and Resources

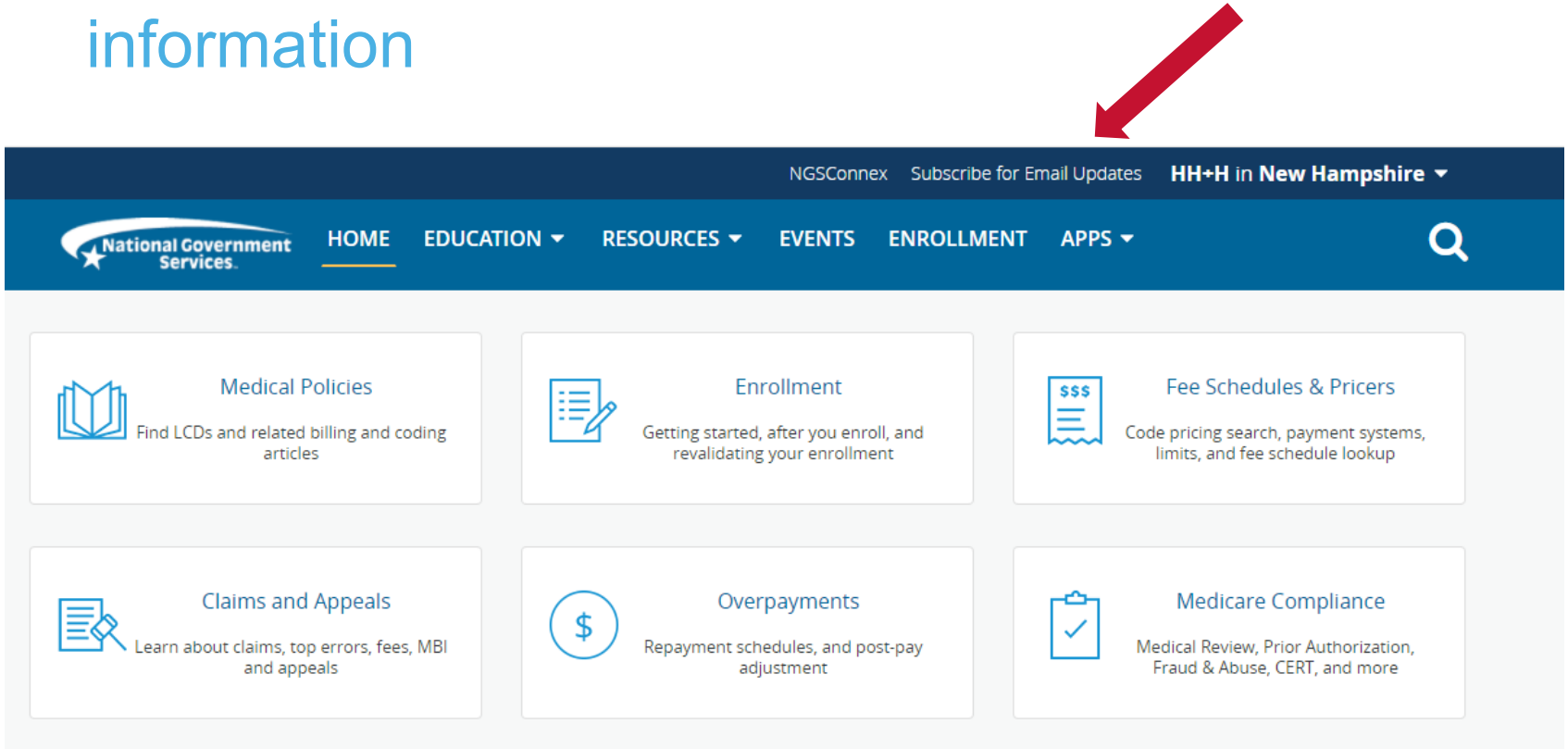
- The Centers for Medicare & Medicaid Services Original Medicare Appeals Portal
- Medicare Claims Processing Manual Chapter 29 – Appeals of Claims Decisions
- Office of Medicare Hearings & Appeals
- National Government Services Appeals Portal
- NGS Appeals Forms Portal

Appeals Forms

- Part A - Reopening Request Form
- Level One Appeal Redetermination
- Level Two Appeal CMS Form 20033
- Level Three Appeal ALJ Form OMHA-100
- Level Four Appeal Form DAB

NGS Email Updates

- Subscribe to receive the latest Medicare information



NGS Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY Contact Information	866-277-7287	Monday-Friday* 8:00 a.m.-4:00 p.m. PT *Closed for training on the 2nd and 4th Friday of the month 9:00 a.m.-1:00 p.m. PT
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-289-0423 TTY Contact Information	866-275-7396	Monday-Friday* 8:00 a.m.-4:00 p.m. ET *Closed for training on the 2nd and 4th Friday of the month. 12:00-4:00 p.m. ET
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-590-6728 TTY Contact Information	866-275-3033	Monday-Friday* 8:00 a.m.-4:00 p.m. CT 9:00 a.m.-5:00 p.m. ET *Closed for training on the 2nd and 4th Friday of the month. 11:00 a.m.-3:00 p.m. CT 12:00-4:00 p.m. ET

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NGS Provider Contact Center Procedures

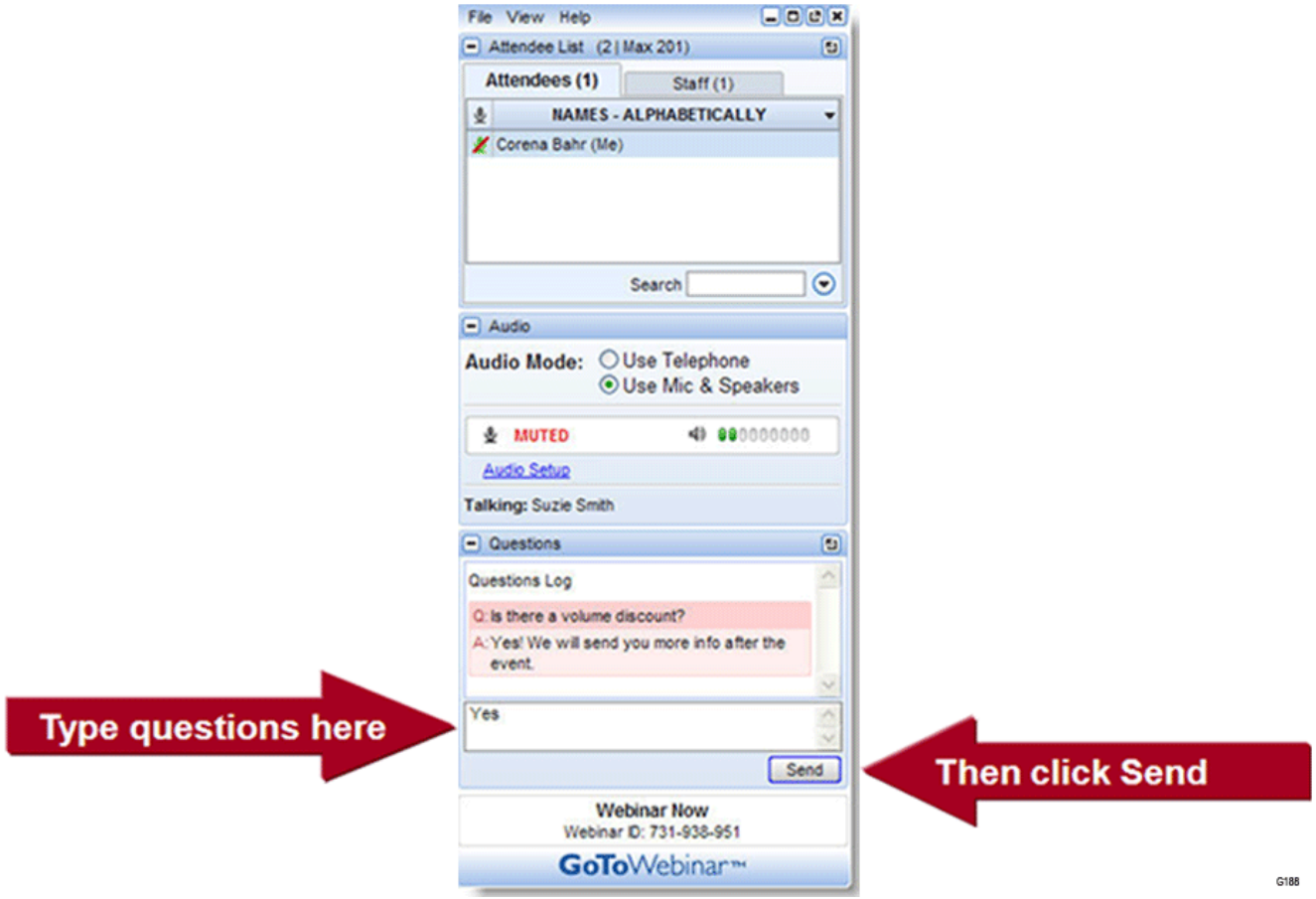
- First option upon contacting the MAC
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

NGS Provider Mailbox

- J6.provider.training@anthem.com

Question and Answer Period

To Ask a Question
Using the Question Box



Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
  - Topic =
  - Medicare University Credits (MUCs) =
  - Catalog Number =
  - Participant Code =
  - For step-by-step instructions on self-reporting please visit the Get Credit for Completed Courses on the NGS website

National Government Services

NGS MU

Thank You!

Any Questions?