# Home Health Coalition Q & A

**To: Home Health Coalition Members**
**From: Jurisdiction 11 (J11) Palmetto GBA Provider Outreach and Education**
**Date: June 6, 2011**
**Location: Airport Sheraton – Charlotte, North Carolina**
**Time: 10 a.m.**
**Number: (866) 206-0131**
**Pass code: 657840#**

**Attachment A: Appeals Report**
**Attachment B: Snapshot Report**
**Attachment C: Data Report Descriptions and Reports**
**Attachment D: Palmetto GBA Electronic Data Interchange (EDI) Updates**
**Attachment E: ANSI 5010 Updates**

**Face-to-Face:**

1) Is the Home Health agency accountable for the content of the physician's Face-To-Face Encounter documentation related to:
   a. Reason for the need for Home Health services
   b. Homebound status (In many cases physicians are not well versed on the Centers for Medicare & Medicaid Services (CMS') regulations and guidance regarding this matter)

   **Yes, the face-to-face encounter is a requirement for the initial certification for home health care under Medicare and is a condition for payment. Ultimately the home health claim can be denied for missing or incomplete documentation of the face-to-face encounter, so the home health agency has a vested interest in assuring the documentation is present and complete in the medical record.**

2) Is the Home Health agency responsible to require the physician to correct an already completed Face-To-Face encounter or will the Centers for Medicare & Medicaid Services (CMS) consider a good faith effort?

   *Clarification received from the home health coalition is as follows: the question is referring to a face-to-Face encounter that has been performed and the physician has documented it. However, when the documentation was received by the agency, the form was not completely filled out or it was filled out incorrectly. They are asking, will the agency then need to go back to the doctor to get the form filled out correctly or will the auditor look at it & say well they tried & showed a "good faith effort" so that is good enough to meet the requirement.*

**The home health agency should assure the documentation of the face-to-face encounter meets the Medicare requirements for certification. If the documentation is incomplete, the home health agency should contact the physician to request complete documentation of the encounter to place into the medical record.**

3) Is the Centers for Medicare & Medicaid Services (CMS) enforcing compliance that the Face-to-Face encounter took place within the time frame or with the content of the documentation? What role will Palmetto GBA play in enforcing these requirements?

   **As of April 1, 2011, CMS is enforcing both the time frame in which the face-to-face encounter took place, as well as the required documentation of the face-to-face encounter. Palmetto GBA will enforce this through the normal medical review process. If the medical records do not contain sufficient evidence of the face-to-face, the claim will be denied.**

4) Does the Centers for Medicare & Medicaid Services (CMS) require a Face-To-Face to be done on patients that have Medicare as their secondary payer?

   **Yes, the face-to-face encounter should be completed as part of the certification requirements for home health care under Medicare if the claim is going to be submitted to Medicare for payment consideration.**

5) If an agency had a form that the physician filled out would the following information on the Face-To-Face form meet the Centers for Medicare & Medicaid Services (CMS) requirements?

   a. Patient name
   b. Date of Birth (DOB)
   c. Date of Face-To-Face encounter (last MD visit)
   d. Clinical Findings (narrative provided by physician)
   e. Check Boxes that stated the following:
   f. I certify that:

      i. ___the above named patient is under my care and that I, or a nurse practitioner or physician's assistant working with me had a Face-To-Face encounter that meets the physician Face-To-Face encounter requirements with this patient on the above date.
      ii. ___the encounter with the patient was, in whole or in part, for the medical condition listed above, which is the primary reason for home health.
      iii. ___Home health services are medically necessary
      iv. ___This patient is homebound, (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons; bedbound not required). Medicare Benefit Policy manual Ch. 7, Section 30).

v. ___Based on my findings narrated above, the following services are medically necessary home health services (check all that apply):
   1. ___Nursing ___Physical Therapy
   2. ___Occupational Therapy ___Speech Language Pathology

vi. Physician Signature and Date _____

**Palmetto GBA cannot endorse or approve forms/formats. It would be the provider's responsibility to ensure all required elements are included. In the example listed above, it should be noted that the "clinical findings" in the narrative section must support the beneficiary's homebound status and need for skilled care. Also, when using a form with boxes or fields that must be checked, if one or more of these areas are not checked the entire form may not be acceptable. Providers may want to include "prompts" that will encourage or remind physician's to include necessary information such as:**

- **beneficiary is homebound because_____**
- **beneficiary is in need of skilled care because _____**

**The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 7, Section 30.5.1.1 states, "2. Encounter Documentation Requirements: The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services."**

6) What is going to happen if we service a patient for which we have no Face-To-Face encounter and we bill? How will Palmetto GBA know agencies didn't have a Face-To-Face encounter?

**Palmetto GBA will know the face-to-face encounter did not occur if the claim is reviewed and the documentation for the face-to-face encounter is not present in the medical record.**

7) When does Palmetto GBA expect to receive the Centers for Medicare & Medicaid Services (CMS) billing instructions (change request) for the Medicare and Qualified therapy visits?

**Change Request 7374, which provides the updates to the therapy visits, was issued May 6, 2011.**

8) If the Face-To-Face physician encounter does not occur within 30 days of the start of care, but does occur on, for example, day 35, does the agency have to adjust the start of care date until then or does the original start of care date stand?

**If the face-to-face encounter does not occur within the required time frame, the claim should not be billed as the Face-To-Face encounter is a requirement for certification for home health care services under Medicare.**

9) Which HHABN do you use when you have to discharge (D/C) a patient because the Face-To-Face encounter has not occurred?

**The HHABN, Form CMS-R-296 has been revised. Mandatory use of the revised HHABN by home health agencies began on April 1, 2011. All HHABNs with the expiration date of August 31, 2009, that are issued on and after April 1, 2011 will be considered invalid.**

**References: www.cms.gov/BNI/03_HHABN.asp**

- **Links to the revised form and instructions for the form**
- **CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 40.3.5, Section 60**

10) It was my understanding that you could use the HHABN if you were unable to get the Face-To-Face encounter and had to discharge the patient, is this correct?

**HHABN Option 2 must be used if a Home Health Agency (HHA) has initiated home health services and chooses to terminate services for administrative reasons such as lack of a face-to-face encounter. HHABN Option 2 is a change of care notice and has no bearing on financial liability. The HHA is required to provide the specific reason on the HHABN that termination is due to the failure to meet the face-to-face encounter requirements. HHAs should recognize that they are responsible for providing information to Medicare beneficiaries prior to the start of care.**

**Reference: CMS Home Health Face-to-Face FAQs. Answer ID: 10481**

**Therapy Reassessments:**

1) Has there been any clarification regarding what to do if the 30 day reassessment is missed due to patient cancelling appointment? (e.g., Agency planned to go and 30 day was due, but patient cancelled appointment and next available time to visit was day 32) Hence, not the agency's fault.

**The regulations state that at least every 30 days a qualified therapist must provide the needed therapy service and functionally reassess the patient in accordance with Code of Federal Regulations, 42 CFR, Part 409.44(c)(2)(i)(A). Palmetto GBA has not received any additional instructions or clarifications.**

2) If the agency misses the therapy threshold, do they just hold billing and do not bill visits in between until the re-evaluation (13th/19th visits) are completed or should they do it differently?

   **The visits provided between the time the re-evaluation was due and the time the actual re-evaluation was conducted are not covered and therefore should not be submitted on the claim. Therapy would be covered again for the visit(s) which occurs *after* the qualified therapist(s) completes all the assessment, objective measurement and documentation requirements.**

   **Reference: CMS Therapy Questions and Answers document #12, which can be found at www.cms.gov/center/hha.asp**

3) What is Palmetto GBA's expectation and reasons for denial related to therapy? We have been hearing that other intermediaries are denying claims with Muscle Mass Testing of 4/5 or greater indicating it is endurance and not strengthening and also denying claims for ambulation/gait of greater than 100-150 ft. for same reason that endurance is not considered skilled and medically necessary.

   **Although Palmetto GBA cannot comment on another contractor's coverage determination, we would expect providers to utilize the CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 7, Home Health Services when determining a patient's appropriateness for therapy services under the Medicare Home Health (HH) benefit. Providers can also reference the Local Coverage Determination (LCD) for Physical Therapy for Home Health (L31542) at: www.PalmettoGBA.com/HHH/lcd.**

   **To be covered, the skilled services must be reasonable and necessary to the treatment of the patient's illness or injury. Additionally, the qualified therapist must complete the assessment/measurement/documentation requirements and determine if the measurement results reveal progress toward therapy goals. Assessments should be based on physician orders, accepted practice and state and national accrediting guidelines.**

   **Documentation should always clearly support the need for skilled therapy services necessary to the treatment of the patient's illness or injury within the context of the patient's UNIQUE medical condition.**

4) A patient with a right humeral fracture has both Physical Therapy (PT) and Occupational Therapy (OT) on the plan of care. After 2 OT visits, OT places the patient on hold due to physician limiting right upper extremity movements for 2 weeks. Meanwhile, PT continues treating patient and performs the 13th visit re-assessment. At visit 16, OT resumes visits, after the physician removes the restriction on movement of the right upper extremity. Because the OT did not complete a re-assessment by the 13th visit are the OT and PT visits after the 13th visit billable?

**If a patient is receiving more than one type of therapy, all therapists must perform respective assessments close to but no later than the 13th or 19th visit. Therapists should visit patients as ordered in the patient's plan of care. CMS has provided flexibility for multiple-discipline therapy cases when documented exceptional circumstances exist. In multiple-discipline therapy cases, the visit can occur close to the 13th and 19th visits. If no visit is ordered for one discipline, the visit prior to the 13th visit would satisfy the requirement.**

**Reference: CMS Therapy Questions and Answers document #7 and #15, which is available at www.cms.gov/center/hha.asp**

**With scenarios such as this, the visits would most likely be covered. However, physician orders should be detailed and the therapist's documentation should clearly explain the patient's condition during this time. Occupational therapists should remember they are still responsible for the 30-day assessment visit.**

**G-Codes:**

1) We are to bill in 15 minute increments. Will Palmetto GBA payments differ on the basis of the units billed? In other words, does Palmetto GBA plan to pay by number of units billed?

   **Billing in 15 minute increments will not change how Home Health (HH) claims are reimbursed. Home health providers will continue to receive payments for HH claims based on the Home Health Prospective Payment System (HH PPS).**

**OASIS and Flu Vaccine:**

1) How does OASIS questions MM7234 affect Home Health Agencies (HHAs) when billing the flu vaccine since they are cost based reimbursed for this service? (Questions are on the Palmetto GBA Web site, but none of them specifically relate to the OASIS question)

   **OASIS questions should be directed to your state OASIS coordinator.**

**Accreditation:**

1) Once an agency is accredited for home care by an authorized accrediting body, I have been told there is a delay of 4 to 6 months to receive your provider number to bill Medicare. Is there any process we can utilize to shorten this time?

   **The State Survey and/or accrediting body process is commenced after Palmetto GBA completes processing CMS Form 855. After the survey/accreditation process is completed the paperwork is sent to the CMS Regional Office which has final approval authority to grant program eligibility. Palmetto GBA does not have a role in the processing timeline between the accreditation process and issuance of the provider number.**

**Payment Issues Related to the Change in Reimbursement Rates at the Beginning of the Calendar Year (CY):**

1) Our agency experienced payment glitches (underpayments & overpayments) for dates of service 4/1/10-12/31/10 that appeared on Remittance Advices (RAs) dated 1/3/11 thru 1/20/11. Palmetto GBA has stated via telephone that glitches occurred during their update to 2011 Prospective Payment System (PPS) rates but has not posted a fix date on the "claims issues" homepage. Palmetto GBA instructions by phone to the provider are "do nothing....Palmetto GBA will correct." Is there a projected time frame in which these payment glitches will be resolved?

   **The CY 2011 update to the HH PPS Pricer program, which was implemented January 3, 2011, contained incorrect wage index values for certain Core-Based Statistical Areas (CBSAs). As a result, HH PPS claims paid on or after January 3, 2011, with one of the affected CBSAs and with dates of service between April 1, 2010, and December 31, 2010, were paid incorrectly. The CMS released a revised HH PPS Pricer program on January 20, 2011, to correct this problem. The updated HH PPS Pricer was installed February 7, 2011. Claims affected by this issue continue to be adjusted. There are numerous adjustments underway for a variety of reasons. We appreciate your patience.**

2) (Similar to question #1 in this category) - Every year in January when the new rates go into effect, we receive payments based on the prior year rates for about 2 weeks. The payment is eventually adjusted, but this makes it very difficult for our accounts receivable department to post cash. They have difficulty identifying the cause of the payment variances. Why can't Palmetto GBA ensure that the rates are correct from the beginning?

   **Annual and periodic updates to the HH Pricer are governed by CMS.**

**Medical Necessity:**

1) How is medical necessity determined when there are only symptom codes on the OASIS, but Physical Therapy (PT) and Occupational Therapy (OT) are ordered? What documentation is needed on the nursing admission to justify the need for therapy?

   **Medical necessity of services is determined by a review of the entire record. The PT and OT evaluation documentation as well as each visit note would need to support the need for skilled care.**

2) What documentation is needed to justify the need for skilled care on admission? Does "needs teaching on meds" justify a need?

   **Simply "needs teaching on meds" would not necessarily support a need for skilled care. The beneficiary's level of consciousness or level of understanding, type of medication and length of time on a particular medication are some of the factors that would need to be considered when evaluating the medical necessity of skilled care such as teaching on new or changed medications.**

3) In order to prove medical necessity for diabetic patients, is the patient's inability to administer his own insulin to be included on each Skilled Nurse (SN) progress note or just once a week?

   **Palmetto GBA does not dictate the frequency by which a provider must document a beneficiary's ability to administer insulin. It must be evident within the documentation that the beneficiary was unable to administer their own insulin during the entire period billed. The beneficiary's condition should be re-evaluated on a regular basis and the provider should develop internal processes regarding the frequency and content of documentation.**

**Partial Episode Payments (PEPs):**

1) What do agencies do when they try and follow the rules and discharge when there is no further need and/or patient has met their maximum potential and/or are chronic. Then another agency picks the patient up and PEPs the first agency? This question was asked at a Palmetto GBA webinar and the response from Palmetto GBA was to report them. If this is the avenue to take, what is the process of reporting and follow up?

   **When a beneficiary has been discharged and readmitted to another home health agency, during the same 60 day episode, the claim from the first agency is automatically PEPd. A beneficiary may be readmitted to home health care by another agency during the same 60 day episode so long as the beneficiary qualifies for home health care coverage. The reference for this information is in the CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 7, Section 10.8.**

   **The response to the question asked during the April 12, 2011, Ask-the-Contractor Teleconference (ACT) regarding the reporting of the event pertains to the first agency's concern that the second agency was providing services that were not appropriate. It was explained to the provider that if they had reason to believe and documentation to support that another agency was providing services inappropriately they should report the issue to the Medicare Fraud hotline, appropriate state agency, or to Palmetto GBA. Providers reporting suspected inappropriate activities to Palmetto GBA should submit a written inquiry to:**

**Palmetto GBA**
**J11 HHH PCC**
**Mail Code: AG-620**
**P.O. Box 100238**
**Columbia, SC 29202-3238**

**The inquiry should include a statement to explain their allegations of potential inappropriate activity as well as the name of the provider submitting the inquiry as well as the provider number, NPI, and the last five digits of the Tax ID. When Palmetto GBA receives the inquiry, the information will be reviewed and referred to the appropriate entity, if applicable.**

**Once the issue is reported, the reporting provider may or may not be contacted.**

**Medicare Secondary Payer (MSP):**

1) Providers are struggling with getting MSP claims transmitted correctly and are receiving frequent returns. Is there a specific training session just for MSP claims or does Palmetto GBA plan to hold one in the future?

   **Palmetto GBA is in the process of updating the MSP online training. The training will be set this quarter. As soon as a date has been set, the education event will be posted under the Learning and Education session of Palmetto GBA's Web site. Providers who need immediate educational assistance may complete the Provider Outreach and Education Request Form at www.PalmettoGBA.com/HHH. Select "Forms" from the menu in the Top Links box at the left navigation.**

2) Why does the system restrict editing a MSP claim in Direct Data Entry (DDE) like you can with other claims?

   *Clarification from the home health coalition is as follows: In Palmetto GBA's DDE system, corrections and adjustments to normal claims may be done when necessary. No corrections or adjustments are allowed on MSP claims. Examples: condition code needs changed after the claim is submitted electronically, regular claim yes you can change on line, MSP claim no you cannot. The claim submitted was missing units, on a regular claim a line can be added and the claim adjusted on MSP it cannot be. MSP claim gets denied because a condition code needs added, the status needs corrected or the span dates need changed, all can be done on a regular claim in DDE but not for an MSP claim. The result is the Provider must wait than until PGBA denies the claim, the Provider requests the Customer Service Rep to cancel the claim, which takes 30 days, than the Provider can fix and resubmit.*

   **Claim corrections made through DDE are limited to claims which contain no MSP data. This process is a direct result of the implementation of Change Request (CR) 6426, which was issued on June 26, 2009. CR 6426 mandated that MSP claims be submitted with Claim Adjustment Segments (CAS), which are not available in DDE.**

3) What is the best channel that a provider should follow when struggling with getting difficult MSP claims processed?

   **The provider's first point of contact should be the Provider Contact Center (PCC) at (866) 830-3925. If the provider needs education to ensure they are submitting the claims correctly, the provider should submit the Provider Outreach and Education Request Form at www.PalmettoGBA.com/HHH. Select "Forms" in the Top Links box at the left navigation.**

4) Our agency has a patient that was in an auto accident. The benefits have been exhausted and we received a denial from the accident insurance. We bill Palmetto GBA with all of the condition codes and value codes required per their instructions. They deny payment and tell us to contact the Coordination of Benefits (COB) Unit to have the file closed and bill Medicare as primary. We call the COB and they tell us to fax the denial and payment distribution ledger which we have sent to them. We keep checking the Common Working File (CWF) to look for the record to be closed and it is never closed. We called the COB again. We then find out that they do have the information that we faxed to them but are still investigating the situation and have no idea how long it will be to close the MSP record in the CWF. The COB then advises us to bill Medicare conditionally to receive payment. We then called Palmetto GBA and are told the opposite that we must contact the COB and have the record updated. So therefore the claim is almost past the filing time limit and no one will update the CWF file or pay the claim. How do we resolve this situation?"

   **Under the Workers' Compensation, No-fault, Liability MSP guidelines, once the benefits have been exhausted, the COB should be contacted to have the file updated with a term date. Palmetto GBA does not have jurisdiction over the COB and cannot effectuate the MSP records. In addition, although the CWF records reflect a valid MSP segment, the provider should not file conditional claim because the Workers' Compensation, No-fault, Liability plan is no longer an effective primary payer. The provider should file the claim to Medicare as primary. However, Medicare will not pay until the files are appropriately reflected at CWF. The COB may be contacted at (800) 999-1118.**

   **Providers are reminded that the timely filing requirements still apply. Therefore, if a provider is able to determine that the records at CWF will not be updated before the timely filing deadline, a claim should be submitted regardless of whether or not payment can or will be made. In most cases, claims submitted for primary payment when an open MSP segment exists on CWF will be rejected (placed in an "R" status) and can later be adjusted when the MSP segment is updated on CWF.**

**Provider Outreach and Education:**

1) When a Provider submits a written education request for specific training, how long does it take to receive a response from Palmetto GBA?

   **Palmetto GBA typically responds within two to three weeks. When received, the request is assigned to an ombudsman as soon as possible.**

2) Why aren't the Aug. 23, 2010, final Q&A's posted at the Jurisdiction 11 Home Health and Hospice Web site under Coalition Questions?

   **As a result of changes that were made to Palmetto GBA's Web site during the implementation process of the Jurisdiction 11 (J11) Medicare Administrative Contract (MAC), the final Q & As from the August 23, 2010, Home Health Coalition meeting were inadvertently removed. The document has been restored to the Web site and is available at www.PalmettoGBA.com/HHH >Resources >Coalition Q & As.**

**Claims:**

1) When a patient has been labeled as not homebound after a ZPIC audit, how long will it remain? What can change that patient status to homebound from non-homebound?

   **Zoned Program Integrity Contractor (ZPIC) determinations remain in effect until the ZPIC makes a different determination on the beneficiary's status. Providers should consult with the appropriate ZPIC regarding the change in a patient's status.**

2) How many unduplicated auto denials, reason code 5Z42H or 5Z41R, have occurred from July 2010 through March 2011?

   **This information would need to be requested from the appropriate ZPIC. In this instance "5Z4" indicates Health Integrity. The remaining two digits of the reason code depict the exact reason why the claim was denied.**

3) How many reason codes 5Z42H or 5Z41R have been appealed by providers July 2010 through March 2011?

   **To date, Palmetto GBA has received a total of 114 appeals for reason code 5Z42H and four for reason code 5Z41R.**

4) Of the appeals for reason codes 5Z42H or 5Z41R, how many have been paid (i.e. over turned in favor of the provider)?

   **For reason code 5Z42H, of the 114 appeals received 41 have been reversed and paid, 6 have been partially paid and 10 are pending review. For reason code 5Z41R, of the four appeals received, one has been reversed and paid and three are pending review.**

5) Of the appeals for reason codes 5Z42H or 5Z41R, how many have been upheld?

**Of the 114 appeals received for reason code 5Z42H, 52 have been affirmed (payment denied) and 5 were dismissed for late filing. To date, there have been no affirmations (denials) made on the appeals received for reason code 5Z41R.**

6) According to its Web site, TrailBlazer takes about 39 days to process an initial 855A application and about 27 days to process a change of information 855A application. Why does it take PGBA 180 days or more, sometimes a year to process their 855A applications?

**The Palmetto GBA average processing days for 855As for January 1, 2011 through May 31, 2011 was:**
**Initial Enrollments = 53**
**Change of Information = 31**
**Internet PECOS Applications = 46**

**We encourage providers to submit their applications through the Internet PECOS as the processing time is quicker.**

7) We have had something unusual happen with several claims. The claims are paid in full for the amount that matches our agency's calculator and the Centers for Medicare & Medicaid Services (CMS) rates. Without any request from our agency, Palmetto GBA processed a Type of Bill (TOB) 33G and paid us additional money. Money that we did not think was due to us. After that Palmetto GBA issued another TOB 33G, but did not take back the additional funds that were paid to us. We have tried to process a claims adjustment in FSS0, but the claims in question are in "S" status and we cannot file the adjustment claim. What should we do? What will happen if the issue isn't resolved before the timely filing limit?

**XXG adjustments are not manually entered by Palmetto GBA. These adjustments automatically generate in FISS due to replies from the CWF maintainer. Palmetto GBA has no control over why and when XXG adjustments generate.**

**XXG adjustments will generate for various reasons, including the following:**
- **A/B shift adjustments**
- **Partial Episode Payment (PEP) adjustments**
- **Episode sequence adjustments – Those adjustments will result in the provider receiving a higher or lower reimbursement.**

**Providers who experience claims cycling in "S" status and location, should contact the PCC at (866) 830-3925.**

8) Why do 1099's issued by Palmetto GBA not match the actual money received by the home health agency? The detail on the Palmetto GBA issued 1099 shows the deposit and some column which is a debit with an amount (there is no detail for the amounts in the debit column). Palmetto GBA then adds the deposit column to the debit column and reports that as the amount of money the agency received. In 2009 our difference was about $250,000 more than what we deposited. In 2010 our difference was about $150,000 more than what we deposited.

   **Palmetto GBA issues the 1099 forms in accordance with the IRS regulations. IRS regulations require that the amounts be the gross amount that is paid to the provider and not the net. Therefore, if providers have had any adjustments to the check amount, the two would not be the same, and they would need to adjust their income on their taxes when they file. Providers who have additional questions regarding the 1099 forms may contact Tax.Admin@PalmettoGBA.com. Palmetto GBA will produce detailed 1099 reports for the providers who request it as well as the IRS regulation specifics for their review.**

9) Our agency has submitted our Credit Balance Report indicating that there were credit balances. We did not include repayment with the report. We assumed that Palmetto GBA would request repayment. We have not heard anything from Palmetto GBA. What should we do?

   **Providers may direct Credit Balance inquiries to Credit.Balance@PalmettoGBA.com. The addresses for submitting the quarterly provider Medicare credit balance report (MCBR) have changed with Palmetto GBA's transitioning to the J11 Home Health and Hospice MAC (J11 HHH MAC). Home Health and Hospice provider should submit their MCBRs to:**

   **Palmetto GBA**
   **Attn: Credit Balance Reporting**
   **P.O. Box 100277**
   **Columbia, SC 29202-0277**

   **OR**

   **Palmetto GBA**
   **Credit Balance Reporting**
   **2300 Springdale Drive**
   **Building One**
   **Camden, SC 29020**

**In addition, the CMS does allow for MCBRs to be accepted under facsimile. Home health and hospice providers may fax their inquiries to:**

**MCBR Receipts**
**Attn: Credit Balance Reporting**
**(803) 419-3277**

**It is not necessary to both send a facsimile and mail an original. Please ensure that all fields are accurately completed to avoid rejection of the quarterly MCBR.**
**J11 South Carolina Part A/J11 HHH – Effective Date: January 25, 2011**

10) When will Centers for Medicare & Medicaid Services (CMS) update the Common Working File (CWF) to show all Hospice benefit periods for a Medicare Hospice Beneficiary?

**Palmetto GBA is unaware if or when CMS will update the CWF to reflect all benefit periods for Medicare Hospice Beneficiaries. As a reminder, Palmetto GBA's Online Provider Services (OPS) system is available to provider to access a beneficiary's eligibility records. In addition, Palmetto GBA recently updated our connectivity to the HIPAA Eligibility Transaction System (HETS) and stability has improved greatly. The HETS 270/271 system allows date requests up to 27 months in the past. To learn more about the features of the OPS, please visit www.PalmettoGBA.com/HHH.**

11) Recent communication from the Centers for Medicare and Medicaid Services [Change Request (CR) 7228 and MLN Matters Article MM7228] relate to the auto denial of claims submitted with a GZ Modifier. The information presented indicates that Medicare contractors have been given guidance that they have discretion to automatically deny claims submitted by both institutional and professional providers billed with a GZ modifier. The GZ modifier indicates that an Advance Beneficiary Notice (ABN) was not issued to the beneficiary and signified that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. This will apply to claims with dates of service on or after July 1, 2011. It also indicates that the Medicare contractor will not perform complex medical review on any claim line item(s) submitted with the GZ modifier. Can you provide an example(s) of when a home health provider would utilize the GZ modifier?

**Currently, there are no examples available.**

12) Do you use Home Health Advance Beneficiary Notice (HHABN) every time you discharge (D/C) the patient from nursing?

Re: HHABN. If a discipline [e.g., Physical Therapy (PT)] D/C's according to the Plan of Care (POC) and another discipline [e.g., Registered Nursing (RN)] continues, I believe an HHABN is NOT required. Only if the D/C is a reduction [does not follow the POC] in service. Am I correct?

**HHABN notices must be issued whenever home health coverage is reduced or discontinued. The notices are issued to beneficiaries receiving the home health benefit for notification of potential financial liability and/or when the POC changes. Based on the information provided in the first scenario, an HHABN would be needed as it appears the POC has changed.**

**In the second scenario, issuance of an HHABN would not be necessary.**
**References:**

- **www.cms.gov/BNI/03_HHABN.asp**
  - **Links to the revised form and instructions for the form**
- **CMS IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 30, Section 40.3.5, Section 60**

| Home Health Reversal Rate | 1st Quarter 2011 |
|---|---|

| | | | | Quarter | |
|---|---|---|---|---|---|
| | | | | Total | Percent |
| **Redetermination Cases** | Jan | Feb | Mar | | |
| Affirmed | 271 | 14 | 91 | 376 | 30% |
| Dismissed | 316 | 30 | 117 | 463 | 36% |
| Reversed (Partial or Complete) | 282 | 30 | 119 | 431 | 34% |
| **Total Cases** | **869** | **74** | **327** | **1270** | 100% |
| | | | | | |
| **QIC Cases** | Jan | Feb | Mar | | |
| Affirmed | 39 | 0 | 1 | 40 | 16% |
| Dismissed | 100 | 1 | 7 | 108 | 44% |
| Reversed (Partial or Complete) | 74 | 10 | 14 | 98 | 40% |
| **Total Cases** | **213** | **11** | **22** | **246** | 100% |
| | | | | | |
| **ALJ Cases** | Jan | Feb | Mar | | |
| Affirmed | 41 | 10 | 17 | 68 | 28% |
| Dismissed | 52 | 20 | 19 | 91 | 37% |
| Reversed (Partial or Complete) | 73 | 0 | 12 | 85 | 35% |
| **Total Cases** | **166** | **30** | **48** | **244** | 100% |

**Totals by State**

| State | Redeterminations | | | | QIC | | | ALJ | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Autodeny | Affirmed | Dismissed | Reversed | Affirmed | Dismissed | Reversed | Affirmed | Dismissed | Reversed |
| AL | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| AR | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| FL | 21 | 600 | 54 | 194 | 155 | 11 | 18 | 13 | 1 | 3 |
| GA | 0 | 5 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| IL | 2 | 24 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 |
| IN | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| KY | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 |
| LA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MS | 0 | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 0 |
| NC | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| NM | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OH | 0 | 70 | 1 | 14 | 0 | 0 | 0 | 0 | 0 | 0 |
| OK | 7 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 |
| SC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| TN | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| TX | 2 | 163 | 16 | 106 | 49 | 0 | 4 | 0 | 0 | 0 |
| | | | | | | | | | | |
| | | | | | | | | | | |

# Snapshot of Palmetto GBA Performance Measures:

**January – April 2011**
**Jurisdiction 11 Home Health and Hospice Medicare Administrative Contractor**
**J11 HHH MAC**

**Claims Processing**

- All Claims Processed in 30 days
  - CMS Standard: 95 percent
  - Palmetto GBA performance: 99.9 percent
  - ***Metric Exceeded***

**Claims processed:** 3,812,192 (Includes SC Part A and RHHI)

**Dollars paid:** $**5,687,327,388.92** (Includes Part A and RHHI)

**Appeals** (includes SC Part A and HHH)

- Redeterminations Completed in 60 days
  - CMS Standard: 100 percent
  - Palmetto GBA performance: 97 percent
  - ***Metric Not Met***

**Provider Contact Center (PCC)**
**Average Speed of Answer (ASA)**

- The ASA is the average time, in seconds, that all calls waited before being connected to a CSR.
  - CMS Standard: < 60 seconds
  - Palmetto GBA performance: **38** seconds
  - ***Metric Exceeded***

- PCC Written Inquiries Completed within 45 business days of the date of receipt
  - CMS Standard: ≤ 45 business days
  - Palmetto GBA performance: 100 percent
  - **Metric Met**

**Medical Review (MR)**

- Medical Review Timeliness in 60 days
  - CMS Standard: 100 percent
  - Palmetto GBA performance: 100 percent
  - ***Metric Met***

**Provider Enrollment** (includes SC Part A and HHH)

- 855 A Change of Information

**Percent Completed within 60 days**

- CMS Standard: 80 percent
- Palmetto GBA performance: 88.1percent
- ***Metric Exceeded***

**Percent Completed within 90 days**

- CMS Standard: 90 percent
- Palmetto GBA performance: 95.6 percent
- ***Metric Exceeded***

**Percent Completed within 120 days**

- CMS Standard: 95 percent
- Palmetto GBA performance: 97.9 percent
- ***Metric Exceeded***

**ATTACHMENT C**

Home Health PPS Claims Analysis
Report 1: Auto-Denied Claims Information
Number of Claims and Denied Charges by State
Reporting Period: January 2011 - March 2011*

| State | Type | Denial Code | Denial Description | Claims | Denied Charges | # of Providers |
|---|---|---|---|---|---|---|
| Alabama | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 4 | 8,052.66 | 2 |
| Arkansas | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Florida | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 72 | 339,566.59 | 30 |
| Georgia | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 73 | 132,345.32 | 4 |
| Illinois | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 98 | 273,787.93 | 5 |
| Indiana | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Kentucky | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Louisiana | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Mississippi | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| New Mexico | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| North Carolina | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 1 | 7,466.70 | 1 |
| Ohio | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Oklahoma | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 12 | 42,093.15 | 3 |
| South Carolina | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | | | |
| Tennessee | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 1 | 292.63 | 1 |
| Texas | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 15 | 33,320.10 | 12 |
| Other | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 1 | | 1 |
| All States | Home Health | 56900 | Auto Deny - Requested Records Not Submitted | 277 | 836,925.08 | 59 |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011

Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 2: Visits per Beneficiary by Discipline (2-Digit Revenue Code Group)
Paid Dates: January 2011 - March 2011*

**ATTACHMENT C**

| | Visits per Beneficiary by Discipline Type | | | | | |
|---|---|---|---|---|---|---|
| **State** | **42X** | **43X** | **44X** | **55X** | **56X** | **57X** |
| Alabama | 10.20 | 7.18 | 6.97 | 10.28 | 1.75 | 11.98 |
| Arkansas | 10.50 | 6.58 | 7.48 | 11.93 | 1.56 | 15.86 |
| Florida | 11.59 | 7.13 | 6.88 | 17.29 | 1.60 | 17.68 |
| Georgia | 9.67 | 6.06 | 6.27 | 11.18 | 1.65 | 11.63 |
| Illinois | 10.61 | 5.91 | 6.57 | 10.79 | 1.38 | 13.89 |
| Indiana | 10.40 | 6.30 | 5.93 | 10.82 | 1.85 | 15.40 |
| Kentucky | 9.87 | 6.73 | 6.76 | 10.20 | 1.56 | 14.47 |
| Louisiana | 10.77 | 7.57 | 7.67 | 12.41 | 1.63 | 20.61 |
| Mississippi | 11.98 | 8.09 | 8.81 | 11.20 | 1.45 | 16.76 |
| New Mexico | 9.70 | 5.94 | 6.50 | 11.82 | 1.63 | 16.01 |
| North Carolina | 9.29 | 5.52 | 7.17 | 9.69 | 1.55 | 11.48 |
| Ohio | 9.32 | 5.68 | 6.58 | 11.98 | 1.63 | 18.64 |
| Oklahoma | 12.62 | 7.22 | 7.83 | 14.51 | 1.70 | 19.18 |
| South Carolina | 9.77 | 6.42 | 6.20 | 9.95 | 2.13 | 10.01 |
| Tennessee | 13.00 | 7.81 | 7.77 | 11.61 | 1.92 | 15.19 |
| Texas | 12.30 | 7.96 | 8.31 | 15.93 | 1.60 | 21.78 |
| Other | 8.77 | 5.66 | 6.08 | 10.52 | 1.75 | 19.82 |

*Based on the final adjudication of the claim as of April 4, 2011; excludes RAPs

Source of Report: Palmetto GBA Medicare Statistical Analysis Department (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 3: Claim Statistics by State and MSA Status
Paid Dates: January 2011 - March 2011*

**ATTACHMENT C**

| State | MSA Status | Episodes per Beneficiary | Visits per Episode | % LUPAs | % Outliers |
|---|---|---|---|---|---|
| Alabama | MSA | 1.32 | 16.28 | 9.27% | 0.28% |
| | Non-MSA | 1.00 | 20.50 | 0.00% | 0.00% |
| Arkansas | MSA | 1.29 | 17.60 | 8.87% | 1.36% |
| | Non-MSA | 1.33 | 21.00 | 0.00% | 0.00% |
| Florida | MSA | 1.25 | 22.80 | 6.71% | 7.78% |
| | Non-MSA | 1.21 | 22.18 | 5.85% | 8.51% |
| Georgia | MSA | 1.26 | 16.75 | 10.87% | 1.15% |
| | Non-MSA | 1.34 | 14.13 | 10.64% | 0.00% |
| Illinois | MSA | 1.30 | 14.63 | 7.41% | 0.27% |
| | Non-MSA | 1.36 | 15.67 | 4.82% | 0.00% |
| Indiana | MSA | 1.24 | 18.96 | 9.92% | 1.21% |
| | Non-MSA | 1.22 | 14.36 | 0.00% | 0.00% |
| Kentucky | MSA | 1.29 | 16.25 | 12.26% | 0.75% |
| | Non-MSA | 1.55 | 11.32 | 19.35% | 0.00% |
| Louisiana | MSA | 1.46 | 16.36 | 5.26% | 0.84% |
| | Non-MSA | 1.79 | 17.36 | 0.00% | 0.00% |
| Mississippi | MSA | 1.40 | 15.48 | 6.76% | 0.19% |
| | Non-MSA | 1.55 | 17.29 | 23.53% | 0.00% |
| New Mexico | MSA | 1.29 | 17.21 | 9.43% | 1.30% |
| | Non-MSA | 1.50 | 17.67 | 8.33% | 0.00% |
| North Carolina | MSA | 1.21 | 14.66 | 17.04% | 0.69% |
| | Non-MSA | 1.18 | 8.31 | 38.46% | 0.00% |
| Ohio | MSA | 1.25 | 17.95 | 11.26% | 3.10% |
| | Non-MSA | 1.28 | 17.06 | 6.25% | 3.13% |
| Oklahoma | MSA | 1.40 | 19.31 | 5.81% | 2.51% |
| | Non-MSA | 1.18 | 13.80 | 5.00% | 0.00% |
| South Carolina | MSA | 1.20 | 15.80 | 12.29% | 0.43% |
| | Non-MSA | 1.00 | 7.00 | 0.00% | 0.00% |
| Tennessee | MSA | 1.36 | 18.18 | 8.37% | 0.61% |
| | Non-MSA | 1.25 | 18.60 | 0.00% | 0.00% |
| Texas | MSA | 1.44 | 18.43 | 5.19% | 3.50% |
| | Non-MSA | 1.36 | 17.45 | 3.61% | 0.60% |
| Other | MSA | 1.19 | 15.91 | 13.18% | 1.01% |
| | Non-MSA | 1.64 | 17.39 | 17.39% | 8.70% |
| All States | MSA | 1.33 | 18.07 | 7.72% | 2.78% |
| | Non-MSA | 1.32 | 17.73 | 7.06% | 2.88% |

*Based on the final adjudication of the claim as of April 4, 2011; excludes RAPs
Source of Report: Palmetto GBA Medicare Statistical Analysis Department (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 4: Claim Statistics by State
Paid Dates: January 2011 - March 2011*

**ATTACHMENT C**

| State | Episodes per Beneficiary | Visits per Episode | % LUPAs | % Outliers |
|---|---|---|---|---|
| Alabama | 1.32 | 16.28 | 9.27% | 0.28% |
| Arkansas | 1.29 | 17.60 | 8.87% | 1.36% |
| Florida | 1.25 | 22.80 | 6.71% | 7.78% |
| Georgia | 1.26 | 16.75 | 10.87% | 1.15% |
| Illinois | 1.30 | 14.64 | 7.41% | 0.27% |
| Indiana | 1.24 | 18.95 | 9.92% | 1.21% |
| Kentucky | 1.29 | 16.25 | 12.27% | 0.75% |
| Louisiana | 1.46 | 16.36 | 5.26% | 0.84% |
| Mississippi | 1.40 | 15.48 | 6.76% | 0.19% |
| New Mexico | 1.29 | 17.21 | 9.42% | 1.30% |
| North Carolina | 1.21 | 14.66 | 17.05% | 0.69% |
| Ohio | 1.25 | 17.95 | 11.26% | 3.10% |
| Oklahoma | 1.40 | 19.30 | 5.81% | 2.51% |
| South Carolina | 1.20 | 15.80 | 12.29% | 0.43% |
| Tennessee | 1.36 | 18.18 | 8.36% | 0.61% |
| Texas | 1.44 | 18.42 | 5.19% | 3.50% |
| Other | 1.19 | 15.91 | 13.18% | 1.02% |
| All States | 1.00 | 18.07 | 7.72% | 2.78% |

*Based on the final adjudication of the claim as of April 4, 2011; excludes RAPs
Source of Report: Palmetto GBA Medicare Statistical Analysis Department (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 5: Reviewed and Denied Information
Number of Claims and Charges by Denial Code and State
Reporting Period: January 2011 - March 2011*

**ATTACHMENT C**

| State | Type | Denial Code | Denial Description | Claims | Submitted Charges | Denied Charges |
|---|---|---|---|---|---|---|
| Alabama | APPROVAL | NONE | NONE | 8 | $21,787.65 | $0.00 |
| Alabama | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 4 | $8,052.66 | $8,052.66 |
| Alabama | DENIAL | 5A031 | Skilled Observation Not Needed From Start of Care | 1 | $1,825.92 | $1,825.92 |
| Alabama | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 1 | $2,014.45 | $2,014.45 |
| Alabama | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 2 | $3,840.37 | $3,840.37 |
| Alabama | DENIAL | 5F012 | Physician's Plan of Care and/or Certification Present - Signed but Not Dated | 2 | $3,295.44 | $3,295.44 |
| Alabama | DENIAL | 5T070 | Visits/Supplies/DME Billed Not Documented/Not Documented As Used | 1 | $6,416.41 | $4,466.35 |
| Arkansas | APPROVAL | NONE | NONE | 2 | $4,715.32 | $0.00 |
| Arkansas | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 1 | $3,212.96 | $3,212.96 |
| Arkansas | DENIAL | 5FT10 | Doc Does Not Support Homebound Status | 1 | $1,275.50 | $1,275.50 |
| Florida | APPROVAL | NONE | NONE | 556 | $1,686,825.77 | $0.00 |
| Florida | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 72 | $339,566.59 | $339,566.59 |
| Florida | DENIAL | 5A031 | Skilled Observation Not Needed From Start of Care | 2 | $4,416.65 | $4,416.65 |
| Florida | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 11 | $23,869.79 | $23,527.00 |
| Florida | DENIAL | 5A301 | Info Provided Does Not Support the M/N for Therapy Services | 2 | $10,684.47 | $7,555.97 |
| Florida | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 12 | $25,953.70 | $25,953.70 |
| Florida | DENIAL | 5AE39 | SN No Documentation to Exempt From Endpoint - Insulin Administration | 1 | $1,680.42 | $1,680.42 |
| Florida | DENIAL | 5AT39 | SN No Endpoint to Daily (Realistic or Unrealistic) | 4 | $9,710.53 | $7,679.94 |
| Florida | DENIAL | 5AT49 | SN Single Visit (No Other Qualifying Service) | 1 | $3,759.44 | $3,759.44 |
| Florida | DENIAL | 5AT5J | SN And/or HHA Services Over 28/35 Hour Limit | 2 | $16,279.95 | $10,552.81 |
| Florida | DENIAL | 5AU39 | Valid Endpoint Given, But Not Realistic | 1 | $2,525.59 | $2,525.59 |
| Florida | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 23 | $106,820.68 | $16,992.05 |
| Florida | DENIAL | 5CHG2 | MR HIPPS Code Change/Provider Billed Higher Category Than OASIS MO Items Total | 2 | $4,511.84 | $569.64 |
| Florida | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 7 | $40,952.27 | $7,472.91 |
| Florida | DENIAL | 5DOW4 | Partial Denial Resulting in a LUPA | 1 | $8,169.59 | $7,712.53 |
| Florida | DENIAL | 5F011 | Certification Not Signed Timely | 3 | $9,584.27 | $9,584.27 |
| Florida | DENIAL | 5F012 | Physician's Plan of Care and/or Certification Present - Signed but Not Dated | 22 | $81,876.23 | $81,876.23 |
| Florida | DENIAL | 5F013 | Physician's Plan of Care and/or Certification Present - Signed but Dated Untimely | 10 | $23,305.80 | $23,305.80 |
| Florida | DENIAL | 5F023 | No Plan of Care or Certification | 8 | $27,056.72 | $27,056.72 |
| Florida | DENIAL | 5F031 | Skilled Observation Not Needed From Start of Care | 6 | $12,803.26 | $12,803.26 |
| Florida | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 3 | $5,352.64 | $5,352.64 |
| Florida | DENIAL | 5F078 | Incomplete Physician's Orders | 1 | $115.05 | $115.05 |
| Florida | DENIAL | 5FE39 | SN No Documentation to Exempt From Endpoint - Insulin Administration | 8 | $20,464.23 | $20,464.23 |
| Florida | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 48 | $206,102.79 | $206,102.79 |
| Florida | DENIAL | 5FT10 | Doc Does Not Support Homebound Status | 3 | $7,065.88 | $7,065.88 |
| Florida | DENIAL | 5FT39 | SN No Endpoint to Daily (Realistic or Unrealistic) | 3 | $7,393.66 | $7,393.66 |
| Florida | DENIAL | 5FT5J | SN And/or HHA Services Over 28/35 Hour Limit | 1 | $2,525.59 | $2,525.59 |
| Florida | DENIAL | 5FU39 | Valid Endpoint Given, But Not Realistic | 2 | $4,782.99 | $4,782.99 |
| Florida | DENIAL | 5NOHB | Edit to Deny Beneficiary's that are not Homebound | 4 | | |
| Florida | DENIAL | 5T013 | Physician's Plan of Care and/or Certification Present - Signed but Dated Untimely | 1 | $5,256.28 | $5,256.28 |
| Florida | DENIAL | 5T070 | Visits/Supplies/DME Billed Not Documented/Not Documented As Used | 2 | $4,519.15 | $0.00 |
| Florida | DENIAL | 5T071 | Services Billed Were More Than Ordered | 47 | $183,560.86 | $50,448.53 |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011

Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 5: Reviewed and Denied Information
Number of Claims and Charges by Denial Code and State
Reporting Period: January 2011 - March 2011*

**ATTACHMENT C**

| State | Type | Denial Code | Denial Description | Claims | Submitted Charges | Denied Charges |
|---|---|---|---|---|---|---|
| Florida | DENIAL | 5T072 | No Physician's Orders for Services | 4 | $16,433.45 | $12,635.12 |
| Florida | DENIAL | 5T073 | Orders Not Signed &/or Dated Timely (VOs) | 8 | $46,608.19 | $22,583.39 |
| Florida | DENIAL | 5T074 | No Qualifying Service Present | 1 | $3,759.44 | $3,759.44 |
| Florida | DENIAL | 5T075 | Post Dated Orders Submitted | 1 | $7,555.97 | $7,555.97 |
| Florida | DENIAL | 5T078 | Incomplete Physician's Orders | 7 | $43,304.78 | $35,281.87 |
| Florida | DENIAL | 5T099 | Billing Error | 10 | $24,782.38 | $5,350.45 |
| Florida | DENIAL | 5TDSD | Dependent Services Denied (Qualifying Service Denied Technically) | 1 | $2,781.70 | $2,781.70 |
| Florida | DENIAL | 5Z7D1 | 5Z7D1 | 3 | $11,250.54 | $5,994.26 |
| Georgia | APPROVAL | NONE | NONE | 11 | $41,452.93 | $0.00 |
| Georgia | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 73 | $132,345.32 | $132,345.32 |
| Georgia | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 1 | | |
| Georgia | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 1 | $4,532.02 | $1,076.65 |
| Georgia | DENIAL | 5F011 | Certification Not Signed Timely | 1 | $2,028.63 | $2,028.63 |
| Georgia | DENIAL | 5F023 | No Plan of Care or Certification | 1 | $7,481.37 | $7,481.37 |
| Georgia | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 3 | $6,919.42 | $6,919.42 |
| Georgia | DENIAL | 5T073 | Orders Not Signed &/or Dated Timely (VOs) | 1 | $4,665.99 | $2,163.71 |
| Georgia | DENIAL | 5T078 | Incomplete Physician's Orders | 1 | $4,532.02 | $1,076.65 |
| Georgia | DENIAL | 5T099 | Billing Error | 2 | $13,153.03 | $0.00 |
| Illinois | APPROVAL | NONE | NONE | 33 | $87,249.36 | $0.00 |
| Illinois | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 98 | $273,787.93 | $273,787.93 |
| Illinois | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 14 | $36,045.66 | $5,056.25 |
| Illinois | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 2 | $12,322.48 | $4,271.77 |
| Illinois | DENIAL | 5DOW4 | Partial Denial Resulting in a LUPA | 1 | $2,543.81 | $1,994.98 |
| Illinois | DENIAL | 5F013 | Physician's Plan of Care and/or Certification Present - Signed but Dated Untimely | 1 | $2,767.25 | $2,767.25 |
| Illinois | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 2 | $4,290.02 | $4,290.02 |
| Illinois | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 4 | $11,982.25 | $11,982.25 |
| Illinois | DENIAL | 5T071 | Services Billed Were More Than Ordered | 3 | $11,625.23 | $4,341.74 |
| Illinois | DENIAL | 5T078 | Incomplete Physician's Orders | 1 | $8,410.47 | $2,746.14 |
| Indiana | APPROVAL | NONE | NONE | 59 | $191,343.47 | $0.00 |
| Indiana | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 2 | $6,018.50 | $6,018.50 |
| Indiana | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 2 | $6,018.50 | $6,018.50 |
| Indiana | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 3 | $9,880.35 | $864.52 |
| Indiana | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 6 | $27,768.72 | $8,589.21 |
| Indiana | DENIAL | 5F011 | Certification Not Signed Timely | 1 | $6,397.74 | $6,397.74 |
| Indiana | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 3 | $4,156.60 | $4,156.60 |
| Indiana | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 1 | $3,689.71 | $3,689.71 |
| Indiana | DENIAL | 5T071 | Services Billed Were More Than Ordered | 4 | $18,757.93 | $4,179.66 |
| Indiana | DENIAL | 5T078 | Incomplete Physician's Orders | 3 | $12,887.49 | $8,286.25 |
| Kentucky | APPROVAL | NONE | NONE | 2 | $7,475.45 | $0.00 |
| Louisiana | APPROVAL | NONE | NONE | 8 | $24,225.12 | $0.00 |
| Louisiana | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 2 | $3,761.30 | $3,761.30 |
| Louisiana | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 2 | $3,761.30 | $3,761.30 |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011

Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 5: Reviewed and Denied Information
Number of Claims and Charges by Denial Code and State
Reporting Period: January 2011 - March 2011*

**ATTACHMENT C**

| State | Type | Denial Code | Denial Description | Claims | Submitted Charges | Denied Charges |
|---|---|---|---|---|---|---|
| Louisiana | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 1 | $2,597.17 | $489.38 |
| Louisiana | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 1 | $1,546.80 | $1,546.80 |
| Mississippi | APPROVAL | NONE | NONE | 48 | $138,077.51 | $0.00 |
| Mississippi | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 4 | $6,784.31 | $6,598.99 |
| Mississippi | DENIAL | 5A301 | Info Provided Does Not Support the M/N for Therapy Services | 6 | $31,372.45 | $20,363.20 |
| Mississippi | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 1 | $2,356.47 | $2,356.47 |
| Mississippi | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 4 | $17,047.30 | $2,543.53 |
| Mississippi | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 7 | $36,884.31 | $21,572.44 |
| Mississippi | DENIAL | 5DOW4 | Partial Denial Resulting in a LUPA | 2 | $3,355.47 | $2,789.32 |
| Mississippi | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 5 | $7,934.00 | $7,934.00 |
| Mississippi | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 2 | $3,886.26 | $3,886.26 |
| Mississippi | DENIAL | 5FT15 | Frequency of Non Medical Absences | 1 | $1,973.05 | $1,973.05 |
| Mississippi | DENIAL | 5T071 | Services Billed Were More Than Ordered | 6 | $21,266.90 | $5,733.33 |
| Mississippi | DENIAL | 5T074 | No Qualifying Service Present | 1 | $1,628.88 | $1,628.88 |
| Mississippi | DENIAL | 5T078 | Incomplete Physician's Orders | 1 | $1,846.29 | $1,465.46 |
| North Carolina | APPROVAL | NONE | NONE | 4 | $15,183.61 | $0.00 |
| North Carolina | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 1 | $7,466.70 | $7,466.70 |
| Ohio | APPROVAL | NONE | NONE | 14 | $30,268.32 | $0.00 |
| Ohio | DENIAL | 5CHG2 | MR HIPPS Code Change/Provider Billed Higher Category Than OASIS MO Items Total | 1 | $2,340.18 | $37.57 |
| Ohio | DENIAL | 5F011 | Certification Not Signed Timely | 1 | $1,586.95 | $1,586.95 |
| Oklahoma | APPROVAL | NONE | NONE | 24 | $53,281.13 | $0.00 |
| Oklahoma | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 12 | $42,093.15 | $42,093.15 |
| Oklahoma | DENIAL | 5AT39 | SN No Endpoint to Daily (Realistic or Unrealistic) | 1 | $11,368.83 | $7,004.22 |
| Oklahoma | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 4 | $12,571.37 | $1,325.34 |
| Oklahoma | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 1 | $11,368.83 | $7,004.22 |
| Oklahoma | DENIAL | 5F023 | No Plan of Care or Certification | 1 | $6,059.63 | $6,059.63 |
| Oklahoma | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 5 | $8,390.21 | $8,390.21 |
| Oklahoma | DENIAL | 5FT10 | Doc Does Not Support Homebound Status | 1 | $190.70 | $190.70 |
| Oklahoma | DENIAL | 5T070 | Visits/Supplies/DME Billed Not Documented/Not Documented As Used | 1 | $11,368.83 | $7,004.22 |
| Oklahoma | DENIAL | 5T071 | Services Billed Were More Than Ordered | 2 | $8,166.21 | $1,469.71 |
| Oklahoma | DENIAL | 5T072 | No Physician's Orders for Services | 1 | $11,368.83 | $7,004.22 |
| Oklahoma | DENIAL | 5T078 | Incomplete Physician's Orders | 1 | $3,109.80 | $1,145.69 |
| South Carolina | APPROVAL | NONE | NONE | 4 | $9,968.41 | $0.00 |
| South Carolina | DENIAL | 5F011 | Certification Not Signed Timely | 1 | $2,265.13 | $2,265.13 |
| Tennessee | APPROVAL | NONE | NONE | 12 | $39,719.14 | $0.00 |
| Tennessee | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 1 | $292.63 | $292.63 |
| Tennessee | DENIAL | 5A031 | Skilled Observation Not Needed From Start of Care | 1 | $1,434.52 | $1,434.52 |
| Tennessee | DENIAL | 5A301 | Info Provided Does Not Support the M/N for Therapy Services | 1 | $4,360.14 | $2,839.71 |
| Tennessee | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 1 | $1,434.52 | $1,434.52 |
| Tennessee | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 2 | $9,241.17 | $1,577.18 |
| Tennessee | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 1 | $4,360.14 | $2,839.71 |
| Tennessee | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 1 | $386.93 | $386.93 |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011

Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 5: Reviewed and Denied Information
Number of Claims and Charges by Denial Code and State
Reporting Period: January 2011 - March 2011*

**ATTACHMENT C**

| State | Type | Denial Code | Denial Description | Claims | Submitted Charges | Denied Charges |
|---|---|---|---|---|---|---|
| Tennessee | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 3 | $6,919.43 | $6,919.43 |
| Texas | APPROVAL | NONE | NONE | 98 | $238,731.31 | $0.00 |
| Texas | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 15 | $33,320.10 | $33,320.10 |
| Texas | DENIAL | 5A031 | Skilled Observation Not Needed From Start of Care | 4 | $8,439.73 | $8,439.73 |
| Texas | DENIAL | 5A041 | Info Provided Does Not Support the M/N for This Service | 19 | $32,835.95 | $32,188.41 |
| Texas | DENIAL | 5ADSD | Dependent Services Denied (Qualifying Service Denied Medically) | 14 | $24,442.87 | $24,442.87 |
| Texas | DENIAL | 5AU39 | Valid Endpoint Given, But Not Realistic | 2 | $10,295.06 | $5,902.61 |
| Texas | DENIAL | 5CHG1 | MR HIPPS Code Change/Doc Contradicts MO Item(s) | 12 | $25,822.98 | $5,450.93 |
| Texas | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 4 | $19,846.96 | $8,925.52 |
| Texas | DENIAL | 5DOW4 | Partial Denial Resulting in a LUPA | 3 | $5,188.01 | $4,372.00 |
| Texas | DENIAL | 5F011 | Certification Not Signed Timely | 1 | $2,252.69 | $2,252.69 |
| Texas | DENIAL | 5F013 | Physician's Plan of Care and/or Certification Present - Signed but Dated Untimely | 3 | $8,813.27 | $8,813.27 |
| Texas | DENIAL | 5F023 | No Plan of Care or Certification | 2 | $7,852.48 | $7,852.48 |
| Texas | DENIAL | 5F031 | Skilled Observation Not Needed From Start of Care | 1 | $2,277.35 | $2,277.35 |
| Texas | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 9 | $17,143.51 | $17,143.51 |
| Texas | DENIAL | 5FNOA | Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted | 4 | $22,606.07 | $22,606.07 |
| Texas | DENIAL | 5T070 | Visits/Supplies/DME Billed Not Documented/Not Documented As Used | 1 | $378.49 | $185.95 |
| Texas | DENIAL | 5T071 | Services Billed Were More Than Ordered | 9 | $25,689.05 | $16,229.76 |
| Texas | DENIAL | 5T072 | No Physician's Orders for Services | 1 | $4,365.55 | $3,224.03 |
| Texas | DENIAL | 5T073 | Orders Not Signed &/or Dated Timely (VOs) | 3 | $16,890.75 | $8,792.71 |
| Texas | DENIAL | 5T078 | Incomplete Physician's Orders | 2 | $4,319.61 | $4,200.90 |
| Other | APPROVAL | NONE | NONE | 7 | $20,189.07 | $0.00 |
| Other | DENIAL | 56900 | Auto Deny - Requested Records not Submitted | 1 | | |
| Other | DENIAL | 5CHG3 | MR HIPPS Code Change Due to Partial Denial of Therapy | 1 | $6,813.98 | $433.71 |
| Other | DENIAL | 5F013 | Physician's Plan of Care and/or Certification Present - Signed but Dated Untimely | 1 | $2,400.80 | $2,400.80 |
| Other | DENIAL | 5F041 | Info Provided Does Not Support the M/N for This Service | 3 | $7,205.74 | $7,205.74 |
| Other | DENIAL | 5FT10 | Doc Does Not Support Homebound Status | 1 | $2,666.94 | $2,666.94 |
| Other | DENIAL | 5T071 | Services Billed Were More Than Ordered | 1 | $6,813.98 | $433.71 |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011

Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

Home Health PPS Claims Analysis
Report 6: Claim and Charge Denial Rate for Reviewed Claims by State
Reporting Period: January 2011 - March 2011*

**ATTACHMENT C**

| State | Claim Denial Rate | Charge Denial Rate |
|---|---|---|
| Alabama | 52.94% | 49.74% |
| Arkansas | 50.00% | 48.77% |
| Florida | 63.94% | 33.51% |
| Georgia | 89.08% | 70.51% |
| Illinois | 78.85% | 69.01% |
| Indiana | 21.33% | 16.80% |
| Kentucky | 0.00% | 0.00% |
| Louisiana | 38.46% | 26.63% |
| Mississippi | 35.14% | 28.73% |
| North Carolina | 20.00% | 32.97% |
| Ohio | 12.50% | 4.75% |
| Oklahoma | 51.02% | 49.45% |
| South Carolina | 20.00% | 18.52% |
| Tennessee | 42.86% | 26.01% |
| Texas | 83.96% | 42.35% |
| Other | 50.00% | 28.51% |
| All States | 67.11% | 38.05% |

*January 2011 - March 2011 includes paid dates January 5, 2011 to April 4, 2011
Medically reviewed claims only; excludes demands
Source of Report: Palmetto GBA MSAD (HH Coalition Reports)
Run Date: 04/21/2011

**ATTACHMENT D**

# Palmetto GBA – Electronic Data Interchange (EDI) Updates
# Home Health Coalition
# June 6, 2011

It is time for our DDE ID certification. EDI Operations is in the process of mailing out the DDE ID recertification letters for the period of July through December 2010. We will post an article to our web site notifying everyone that the letters have been mailed out. It is imperative that DDE IDs are certified and mailed back in. Failure to certify DDE IDs will result in the IDs being deleted per CMS security guidelines.

**ATTACHMENT E**

Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

## ANSI 5010

The Centers for Medicare and Medicaid Services (CMS) is underway with implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0.

**Current Dates of Implementation**

- Effective Date of the regulation: **March 17, 2009**
- Begin testing 5010 production claims: **January 1, 2011**
- Begin testing ERRATA 5010 production claims: **April 4, 2011**
- Begin submitting 5010 ERRATA production claims: **April 4, 2011**
- Last day to submit 4010A1 production claims: **December 31, 2011**
- ICD-10 Cut-over: **October 1, 2013**

## New 5010 Reports

TA1 Interchange Acknowledgement produced **only** when interchange(ISA-IEA) rejects
Functional Acknowledgement 997 is being replaced by 999
Claims Acknowledgement 277CA(Claims Acknowledgement) will replace proprietary error reporting (GPNet Response Report) and will contain a claim number.

To see examples of all new reports, please visit the ANSI 5010 section of our Web site.

## ANSI 5010 Section on Web Site

An ANSI 5010 section has been established under the EDI Section of each contract on our Web site. All EDI related ANSI 5010 information will be posted here. Our Web site is **www.palmettogba.com/HHH/edi**

## 5010 Testing Procedures

External testing for providers has begun. For specific instructions on how and when to test, please visit your contract section of the Web site.

## Keep Up to Date on Version 5010 and ICD-10

CMS Web site:
**www.cms.gov/Version5010andD0/**

Education resources: **www.cms.gov/Version5010andD0/40 Educational Resources.asp**

Transaction and Code Set Standards:
**www.cms.gov/TransactionCodeSetsStands**

Medicare Fee-for-Service(FFS) 5010 –D.0:
**www.cms.gov/MFFS5010D0**
Implementation guides (TR3-Technical Review Type 3):
**www.x12.org** or **www.wpc-edi.com**

## What Should I Do to Prepare

Contact your software vendor to find out when you will get your upgrade
Contact your billing service or clearinghouse to find out when they are going to begin submitting 5010
Ask your vendor, billing service, or clearinghouse if they are going to provide user friendly ANSI 5010 Reports
Sign up for our listserv to get ANSI 5010 information
Determine what you will need to do at your site to switch
Plan your switch well in advance of the December 31, 2011 deadline

## Contractor Readiness

Continuing to test internally daily
Attending calls with CMS and other contractors daily
Working with external testers, including vendors, large clearinghouses and billing services
Hosting webinars and special events on ANSI 5010
Educating on ANSI 5010 at every event

## Upcoming Events

National Testing Day – Palmetto GBA on June 15, 2011 from 9 a.m. to 4 p.m. ET

Troubleshooting with your Contractor – Palmetto GBA Webinar on July 20, 2011 at 1 to 3 pm. ET

## Contact Us

Technology Support Center: **(866) 749-4301**
Hours of Operation: **8 a.m. to 5 p.m. ET**