Medicare at 50
The Golden Years
2015 Home Health Workshop Series
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• Statistics
  ▪ Length of stay
  ▪ Disbursement

• Review Findings
  ▪ Comprehensive Error Rate Testing (CERT)
  ▪ Medical Review

• Diabetes and the Home Health (HH) Benefit
Objectives

- Discuss Palmetto GBA data and explain the significance.
- Discuss methodology to reduce improper payments.
- Discuss requirements and expectations for the Home Health Diabetes benefit.
Length of Stay and Other Data
<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013 (Preliminary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes</td>
<td>6,833,669</td>
<td>6,821,459</td>
<td>6,727,875</td>
<td>6,660,631</td>
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<tr>
<td>Beneficiaries receiving at least 1</td>
<td>3,431,696</td>
<td>3,449,231</td>
<td>3,446,122</td>
<td>3,432,571</td>
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<tr>
<td>episode (HH users)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A and/or B FFS beneficiaries</td>
<td>36,818,078</td>
<td>37,686,526</td>
<td>38,224,640</td>
<td>38,501,512</td>
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<tr>
<td>HH users as a percentage of Part A</td>
<td>0.19</td>
<td>0.19</td>
<td>0.18</td>
<td>0.17</td>
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<tr>
<td>and/or B FFS beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHAs providing at least 1 episode</td>
<td>10,916</td>
<td>11,446</td>
<td>11,746</td>
<td>11,820</td>
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</table>
## Average Costs per Visit and Average Number of Visits for a 60-Day Episode

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2012 Average Costs per Visit</th>
<th>2013 Average Number of Visits</th>
<th>2013 Estimated Cost per Episode</th>
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<tbody>
<tr>
<td>Skilled Nursing (SN)</td>
<td>$130.49</td>
<td>9.30</td>
<td>$1,241.47</td>
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<tr>
<td>Home Health Aide</td>
<td>$61.62</td>
<td>2.42</td>
<td>$152.55</td>
</tr>
<tr>
<td>Physical Therapy (PT)</td>
<td>$160.03</td>
<td>4.99</td>
<td>$816.92</td>
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<tr>
<td>Occupational Therapy (OT)</td>
<td>$157.78</td>
<td>1.20</td>
<td>$193.69</td>
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<tr>
<td>Speech –Language Pathology (SLP)</td>
<td>$172.08</td>
<td>0.24</td>
<td>$42.25</td>
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<tr>
<td>Medical Social Services</td>
<td>$210.36</td>
<td>0.14</td>
<td>$30.13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>N/A</strong></td>
<td><strong>3.05</strong></td>
<td><strong>$2,477.01</strong></td>
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</tbody>
</table>

FY 2012 Medicare cost report data and 2013 Medicare claims data from the standard analytic.
### Percentage Of Home Health Visits By HCPCS Code CY 2012

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Type of Visit</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0154</td>
<td>Direct skilled services provided by a RN/LPN</td>
<td>67.6</td>
</tr>
<tr>
<td>G0162</td>
<td>Skilled services by a RN for management and evaluation of the plan of care</td>
<td>1.5</td>
</tr>
<tr>
<td>G0163</td>
<td>Skilled services of a RN/LPN for the observation and assessment of the patient’s Condition</td>
<td>10.5</td>
</tr>
<tr>
<td>G0164</td>
<td>Skilled services of a RN/LPN, in the training and/or education of a patient or family member</td>
<td>20.4</td>
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</tbody>
</table>

Source: CY 2012 Medicare claims data for episodes ending on or before December 31, 2012
HH Episodes Per Beneficiaries CY 2012

The map shows the distribution of HH episodes per beneficiaries across different states in CY 2012, with varying numbers ranging from 0.03 to 0.40. The colors indicate different ranges:
- Light blue for 0.03 to 0.08
- Light green for 0.09 to 0.11
- Medium blue for 0.12 to 0.14
- Dark blue for 0.14 to 0.18
- Deep blue for 0.19 to 0.40
## High Usage States

<table>
<thead>
<tr>
<th>Year</th>
<th>TX</th>
<th>FL</th>
<th>OK</th>
<th>MS</th>
<th>LA</th>
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</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,127,852</td>
<td>689,183</td>
<td>208,555</td>
<td>153,169</td>
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<tr>
<td>2011</td>
<td>1,107,605</td>
<td>701,426</td>
<td>203,112</td>
<td>153,983</td>
<td>249,479</td>
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<td>2012</td>
<td>1,054,244</td>
<td>691,255</td>
<td>196,887</td>
<td>148,516</td>
<td>230,115</td>
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</table>

**Number of Episodes**

<table>
<thead>
<tr>
<th>Year</th>
<th>TX</th>
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<th>LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>336,844</td>
<td>355,181</td>
<td>68,440</td>
<td>55,132</td>
<td>77,976</td>
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<tr>
<td>2011</td>
<td>363,474</td>
<td>388,900</td>
<td>67,218</td>
<td>55,818</td>
<td>77,677</td>
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<tr>
<td>2012</td>
<td>350,803</td>
<td>354,838</td>
<td>65,948</td>
<td>55,438</td>
<td>74,755</td>
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**Beneficiaries Receiving at Least One Episode**
### Part A and/or B Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
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<th>MS</th>
<th>LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2,500,237</td>
<td>2,422,141</td>
<td>533,792</td>
<td>465,497</td>
<td>544,555</td>
</tr>
<tr>
<td>2011</td>
<td>2,597,406</td>
<td>2,454,124</td>
<td>549,687</td>
<td>476,497</td>
<td>561,531</td>
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<tr>
<td>2012</td>
<td>2,604,458</td>
<td>2,451,790</td>
<td>558,500</td>
<td>480,218</td>
<td>568,483</td>
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### Episodes per Part A and/or B Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
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<th>LA</th>
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</thead>
<tbody>
<tr>
<td>2010</td>
<td>.045</td>
<td>0.28</td>
<td>0.39</td>
<td>0.33</td>
<td>0.47</td>
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<tr>
<td>2011</td>
<td>0.43</td>
<td>0.29</td>
<td>0.37</td>
<td>0.32</td>
<td>0.44</td>
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<tr>
<td>2012</td>
<td>0.40</td>
<td>0.28</td>
<td>0.35</td>
<td>0.31</td>
<td>0.40</td>
</tr>
</tbody>
</table>
## High Usage States

<table>
<thead>
<tr>
<th>Year</th>
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<th>FL</th>
<th>OK</th>
<th>MS</th>
<th>LA</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>13.47</td>
<td>14.47</td>
<td>11.81</td>
<td>11.54</td>
<td>13.15</td>
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### Home Health Users as a Percentage of Part A and/or Part B Beneficiaries

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<thead>
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<th>Year</th>
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<th>OK</th>
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</thead>
<tbody>
<tr>
<td>2010</td>
<td>2,352</td>
<td>1,348</td>
<td>240</td>
<td>53</td>
<td>213</td>
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<tr>
<td>2011</td>
<td>2,472</td>
<td>1,426</td>
<td>252</td>
<td>51</td>
<td>216</td>
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<tr>
<td>2012</td>
<td>2,549</td>
<td>1,430</td>
<td>254</td>
<td>48</td>
<td>213</td>
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</table>

### Providers Providing at Least One Episode
Mean LOS and Disbursement Greater than State Average

- Oklahoma
- Louisiana
- Texas
- Mississippi
Oklahoma

- This state had the highest mean length of stay at 454.3 days.
- Disbursement per beneficiary of $4,668.00.
- Total claim count over 100,000.
Louisiana

- This state had the second highest mean length of stay at 431.8 days.
- Disbursement per beneficiary of $4,511.00.
- Total claim count over 109,000.
Texas

- This state had the third highest mean length of stay at 421.4 days.
- Disbursement per beneficiary of $4,972.00.
- Total claim count over 517,000.
Mississippi

- This state had the fourth highest mean length of stay at 293.3 days.
- Disbursement per beneficiary of $4,196.00.
- Total claim count over 71,000.
## Billing by Revenue Code

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</thead>
<tbody>
<tr>
<td>32x</td>
<td>PT</td>
<td>9,544,326</td>
<td>8,964,276</td>
<td>6,231,145</td>
<td>6,719</td>
<td>1,420</td>
<td>765,894</td>
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<td>12</td>
<td>13</td>
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<tr>
<td>32x Total</td>
<td>PT</td>
<td>9,544,326</td>
<td>8,964,276</td>
<td>6,231,145</td>
<td>6,719</td>
<td>1,420</td>
<td>765,894</td>
<td>12</td>
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<td>13</td>
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<tr>
<td>32x</td>
<td>OT</td>
<td>2,262,850</td>
<td>2,112,980</td>
<td>1,354,482</td>
<td>5,482</td>
<td>413</td>
<td>321,029</td>
<td>7</td>
<td>7</td>
<td>8</td>
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<tr>
<td>32x Total</td>
<td>OT</td>
<td>2,262,850</td>
<td>2,112,980</td>
<td>1,354,482</td>
<td>5,482</td>
<td>413</td>
<td>321,029</td>
<td>7</td>
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<tr>
<td>32x</td>
<td>SLP</td>
<td>514,549</td>
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<td>303,757</td>
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<td>133</td>
<td>67,850</td>
<td>8</td>
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<tr>
<td>32x Total</td>
<td>SLP</td>
<td>514,549</td>
<td>461,168</td>
<td>303,757</td>
<td>3,865</td>
<td>133</td>
<td>67,850</td>
<td>8</td>
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<td>32x</td>
<td>SLP</td>
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<td>33x</td>
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<td>33x Total</td>
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<td>21,995</td>
<td>171,698</td>
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<td>36,373</td>
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<tr>
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<td>4,219</td>
<td>36,373</td>
<td>182,312</td>
<td>418</td>
<td>10</td>
<td>560</td>
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## Billing by Revenue Code

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<td><strong>Total</strong></td>
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<tr>
<td><strong>TOTAL</strong></td>
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<td><strong>Total</strong></td>
<td>Aide</td>
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<td><strong>TOTAL</strong></td>
<td>20,270</td>
<td>19,877</td>
<td>14,526</td>
<td>768,931</td>
<td>585</td>
<td>1,671</td>
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</tbody>
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*August 2015 Palmetto GBA, a CMS-Contracted Medicare Administrative Contractor (MAC) 19*
## State Billing

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<td></td>
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<td>7,054</td>
<td>$717,320</td>
<td>1,151,240</td>
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<tr>
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<td>2,344</td>
<td>$12,192</td>
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<td>$3,361</td>
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</tbody>
</table>

August 2015

Palmetto GBA - A CMS-Contracted Medicare Administrative Contractor (MAC)
Making All Of The Puzzle Pieces Fit Together

What are we trying to accomplish?
The Health Information Supply Chain (HISC)

Step 1: Medicare beneficiary and provider encounter

Step 2: Coding and billing of claim

Step 3: Processing of claim by Palmetto GBA and use of information by CMS
Examples of ‘Links’ in the Chain

- Referral
- Screening
- Admission
- Certification
- Face-to-Face (F2F) Encounter Documentation
- Plan of Care (POC)
- Patient Visit(s)
- Documentation of Visit(s)
- Coding
- Billing
Eliminate Improper Payments

Improper Payment Examples:

• Payment to an ineligible recipient.
• Payment for an ineligible service.
• Any duplicate payment.
• Payment for services not received.
• Payment for an incorrect amount.
## Top MR Denials All States

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th>Number of Claims</th>
<th>Percentage of Claims Denied</th>
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<tr>
<td>1</td>
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<td>2</td>
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<td>3</td>
<td>5CHG3</td>
<td>MR HIPPS Code Change Due to Partial Denial of Therapy</td>
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<td>4</td>
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## CERT Errors vs. Medical Review Denials

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<tr>
<th>CERT Error</th>
<th>Insufficient Documentation</th>
<th>Medical Necessity</th>
<th>No Documentation Submitted</th>
<th>Incorrect Coding</th>
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</table>
| CERT Sub-Error | • Home Health- Face-to-Face evaluation in Home Health physician certification  
• Home Health-MD certification/recertification  
• Home Health-Orders  
• Home Health-Plan of care  
• Home Health-Oasis not in repository/medical record  
• Pt A/B General-No signature log or attestation submitted  
• Illegible identifier.  
• Therapy recertification | • Home Health-Progress notes supporting billed DOS by specific SNV, HHA, LCSW, PT, OT, SLP specialist  
• Therapy-Progress notes to support billed therapy services  
• Medically unnecessary service or treatment | • No documentation submitted | • Documentation submitted does not adequately describe the service defined by the CPT code, HPCS code, or HCPCS modifier billed |
| Palmetto GBA Medical Review | • Plan of care and or certification denials  
• Face-to-Face denials  
• Denial related to orders  
• Services Billed Were More Than Ordered  
• Signature denials | • Info Provided  
• Does Not Support the Medical Necessity for This Service  
• Therapy medical necessity  
• Homebound denials | • Auto Deny - Requested Records not Submitted | • Unable to Determine Medical Necessity of HIPPS Code Billed as appropriate Oasis Not Submitted  
• Medical Review HIPPS Code Change Due to Partial Denial of Therapy  
• Medical Review HIPPS Code Change/Doc Contradicts M Item(s)  
• MR down code |
Palmetto GBA Denials by State
## Denials by State

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<tr>
<th>Denial Code</th>
<th>Denial Description</th>
<th>Claims</th>
<th>Denied Charges</th>
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Palmetto GBA Denials by HIPPS Code
<table>
<thead>
<tr>
<th>HIPPS Code</th>
<th>Region(s)</th>
<th>Claims Reviewed</th>
<th>Claims Denied</th>
<th>Dollars Denied</th>
<th>CDR%</th>
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<td>HIPPS Code</td>
<td>Region(s)</td>
<td>Claims Reviewed</td>
<td>Claims Denied</td>
<td>Dollars Denied</td>
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<td><strong>2,610</strong></td>
<td><strong>$6,651,445.64</strong></td>
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Medical Review Denials
Face-to-Face (F2F)
Certification
Plan of Care (POC)
Records Not Submitted
Medical Necessity
Therapy Requirements
To be eligible for Medicare HH services, a patient must:

- Be confined to the home.
- Need skilled services.
- Be under the care of a physician.
- Receive services under a POC established and reviewed by a physician.
- Have had a F2F encounter with a physician or allowed non-physician practitioner (NPP).

Care must be furnished by or under arrangements made by a participating HHA.
The patient must be in need of one of the following:

- SN care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable; or
- PT; or
- SLP services; or
- Continuing OT services (the first OT service, which is a dependent service, is covered only when preceded by an intermittent SN care service, PT service, or SLP service as required by law).
CMS does not require a specific form for format for the certification as long as the five certification requirements outlined in 42 Code of Federal Regulations (CFR) §424.22(a)(1) are met.

- The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians should complete the certification when the POC is established, or as soon as possible thereafter. Therefore, it is not acceptable for HHAs to wait until the end of a 60-day episode of care to obtain a completed certification.
The certifying physician must certify that:

1. The patient needs intermittent SN care, PT, and/or SLP.
2. The patient is confined to the home.
3. A POC has been or will be established and has been or will be periodically reviewed by a physician.
4. Services were or will be furnished while the individual was or is under the care of a physician.
5. Face-to-Face (F2F) Encounter:

- Occurred no more than 90 days prior to the HH start of care date or within 30 days of the start of the HH care,
- Was related to the primary reason the patient requires HH services, and
- Was performed by a physician or allowed NPP.
- The certifying physician must document the date of the encounter.
To qualify for HH services, the beneficiary must meet the need for intermittent SN services, PT or SLP.

Describe what nursing, PT or SLP would be doing in the home.
Skilled Nursing

- Teaching/training.
- Observation and assessment.
- Complex care plan management.
- Administration of certain medications.
- Tube feedings.
- Wound care, catheters and ostomy care.
- NG and tracheostomy aspiration care.
- Psychiatric evaluation and therapy.
- Rehabilitation nursing.

MLN Matters® Number: SE1405
Skilled Therapy Services

- PT, OT, SLP services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition.
Skilled Therapy Services

• Assuming all other eligibility and coverage requirements have been met, one of the following three (3) conditions must be met for therapy services to be covered:
  ▪ Restore patient function.
  ▪ Design or establish a maintenance program.
  ▪ Perform maintenance therapy.

MLN Matters® Number: SE1405
Supporting Documentation

Documentation that substantiates the patient’s:

1. Need for the skilled services.
2. Homebound status.
3. Occurred within the required timeframe.
4. Was related to the primary reason the patient requires HH services.
5. Was performed by an allowed provider type.
Per the regulations at 42 CFR 424.229(b)(2), the recertification must:

- Be signed and dated by the physician who reviews the POC.
- Indicate the continuing need for skilled services.
- Estimate how much longer the skilled services will be required.
The F2F encounter requirement is applicable for all episodes initiated with the completion of a Start-of-Care OASIS assessment, which is considered a certification, not a re-certification.

F2F encounter documentation should be submitted with all records submitted for review (regardless of what episode it is), including appeals.
Clinical Findings

- This also includes documenting the date of the encounter and including an explanation of why the clinical findings of such encounter support that the patient is homebound (as defined in sections 1835(a) and 1814(a) of the Act) and in need of either intermittent skilled nursing services or therapy services as defined in § 409.42(c).

- The documentation must be clearly titled and dated and the documentation must be signed by the certifying physician.
The goal of the Affordable Care Act (ACA) provision is to achieve greater physician accountability in certifying a patient’s eligibility and in establishing a patient’s POC.

This goal is better achieved if the F2F encounter occurs close to the start of HH care, increasing the likelihood that the clinical conditions exhibited by the patient during the encounter are related to the primary reason the patient needs HH care.
Four Questions to Ask

• What is the structural impairment?
• What is the functional impairment?
• What is the activity limitation?
• How do the skills of a nurse or therapist address the specific structural/functional impairments and activity limitations cited in steps 1–3?
Plan of Care (POC)/Certification Denials

- Physician's POC and/or Certification Present - Signed but Not Dated.
- Physician's POC and/or Certification Present - No Signature.
- No POC or Certification.
The services billed were not covered because the HHA did not have the POC established and approved by a physician, as required by Medicare, included in the medical records submitted for review and/or the service(s) billed were not covered because the documentation submitted did not include the physician’s signed certification or recertification.
Plan of Care (POC)/Certification Documentation

- Ensure that the appropriate POC is included and that it is legibly signed and dated by the physician prior to billing.
- A POC refers to the medical treatment plan established by the treating physician with the assistance of the HH skilled professional.
Plan of Care (POC) Contents

The POC contains:

- All pertinent diagnoses
- Patient’s mental status
- Types of services
- Supplies
- Equipment frequency of visits to be made
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments, safety measures to protect against injury
- Instructions for timely discharge or referral
- Any additional items the HHA or physician chooses to include
Medical records were not received in response to an Additional Documentation Request (ADR) in the required time frame; therefore, we were unable to determine medical necessity.
Submitting Records

- Monitor your claim status on Direct Data Entry (DDE). If the claim is in status/location SB6001, the claim has been selected for review and records must be submitted.

- Aim for responding 30 days of the ADR date. The ADR date is in the upper left corner of the ADR request. The record will auto deny on day 46.

- Submit medical records as soon as the ADR is received.
Submitting Records

• Attach a copy of the ADR request to each individual claim.
• If responding to multiple ADRs, separate each response and attach a copy of the ADR to each individual set of medical records.
• Ensure each set of medical records is bound securely so the submitted documentation is not detached or lost.
• Do not mail packages C.O.D.; we cannot accept them.
This claim was fully or partially denied because the clinical documentation submitted for review did not support the medical necessity of the skilled services billed.

Submitted documentation may have indicated there was no longer a reasonable potential for change in the medical condition.

Sufficient time had been allowed for teaching or observation of response to treatment.
Supporting Medical Necessity

• Submit all documentation related to the services rendered and billed to Medicare which supports the medical necessity of the services.
  ▪ A legible signature is required on all documentation necessary to support orders and medical necessity.
• Use the most appropriate ICD-9-CM codes to identify the beneficiary’s medical diagnosis/diagnoses.
Supporting Medical Necessity

Services may include, but are not limited to, the following:

- New onset or acute exacerbation of diagnosis (Include documentation to support signs and symptoms and the date of the new onset or acute exacerbation).

- New and/or changed prescription medications - New medications: those the beneficiary has not taken recently, i.e., within the last 30 days. Changed medications: those, which have a change in dosage, frequency, or route of administration within the last 60 days.

- Hospitalizations (include date and reason).

- Acute change in condition (Be specific and include changes in treatment plan as a result of changes in medical condition, e.g., physician contact, medication changes).

- Changes in caregiver status or an unstable caregiving situation (e.g., involvement of many services or community resources, unsafe or unclean environment which interferes with putting the plan into action).
Services may include, but are not limited to, the following:

- Complicating factors (i.e., simple wound care on lower extremity for a beneficiary with diabetic peripheral angiopathy).
- Inherent complexity of services; therefore, the services can be safely and effectively provided only by a skilled professional.
- Lack of knowledge or understanding of the beneficiary’s care, which requires initial skilled teaching and training of a beneficiary, the beneficiary’s family or caregiver on how to manage the beneficiary’s treatment regime.
- Reinforcement of previous teaching when there is a change in the beneficiary’s physical location (i.e., discharged from hospital to home).
- Any type of re-teaching due to a significant change in a procedure, the beneficiary’s medical condition, when the beneficiary’s caregiver is not properly carrying out the task, or other reasons which may require skilled re-teaching and training activities.
The need for a nurse to administer an injection of a self-injectable medication such as insulin or Calcimar. Clinical documentation needs to indicate:

- Beneficiary’s inability to self-inject and the non-availability of a willing/able caregiver.
- Appropriate diagnosis to warrant administration of the medication.
- Laboratory results (if required to meet Medicare criteria).
- Dosage of the medication.

The need for foley/suprapubic catheter changes and/or assessment/instruction regarding complications.

The need for gastrostomy tube changes and/or assessment/instruction regarding complications.

The need for administration of IM/IV medications based on medical necessity, supporting diagnosis, and accepted standards of medical practice.
• Dressing changes for complicated wound care including documentation (at least weekly) of wound location, size, depth, drainage, and complaints of pain.
• The need for management and evaluation of a complex care plan. Answering “yes” to the following questions may be helpful in determining this need:
  ▪ Is the patient at high risk for hospitalization or exacerbation of a health problem if the plan of care is not implemented properly (e.g., multiple medical problems or diagnosis, limitations in activities of daily living or mental status, cultural barriers, history of repeated hospitalizations)?
  ▪ Does the patient have a complex unskilled care plan (e.g., many medications, treatments, use of complex or multiple pieces of equipment, unusual variety of supplies)?
  ▪ Is there an unstable caregiving situation (e.g., involvement of many services or community resources, unsafe or unclean environment that interferes with putting the plan into action)?
  ▪ Does it require the skills of a registered nurse or a qualified therapist to ensure safe and appropriate implementation of the POC?
Therapy Requirements

• Be specific and effective treatment for the beneficiary’s medical condition.
• Be reasonable and necessary for treatment of the beneficiary’s medical condition, including amount, frequency and duration of services.
• Expectation that the beneficiary’s condition will improve in a reasonable and generally predictable period of time.
• Necessary to establish a safe and effective maintenance program.
On all record submitted for review, include:

- Initial therapy evaluation.
- All 30 day reassessments.
The Guide to Physical Therapist Practice identifies a “goal” as a remediation of impairments and uses the term “outcomes” for “minimization of functional limitation, optimization of health status, prevention of disability, and optimization of patient/client satisfaction.”
Why Do We Need Goals?

• Help in planning the treatment to meet specific needs and functional limitations identified during the evaluation of the patient.
• Assist in the prioritization of treatment.
• Communicate the expected result for the therapeutic outcome.

Preparing For Goal Writing

• Be sure that you have identified a deficit or functional limitation in your evaluation and/or POC.

http://fl.eqhs.org/Portals/1/Goal%20Writing%20for%20Therapy%20Provider%20with%20Final%20AHCA%20edits%202013%202012.pdf
Considerations in Developing a Measurable Goal

• # of Repetitions
  ▪ (10 reps x 3 sets)

• Timed Tests
  ▪ (supine to stand in 45 secs.)

• # Trials
  ▪ (2/5,3/5,2/3)
SMART Goals

• Specific/Significant.
• Measurable/meaningful (i.e., with metrics/criteria of mastery.
• Achievable/Action-Oriented.
• Realistic/Relevant.
• Timely/Trackable.

ASHA: Writing measurable goals and objectives adapted from Hamilton County Educational Services Center Smart Sheet, Chalfant and McGraw 4/2004.
To identify functional goals with patients, the following steps to be useful:

- Determine the patient’s desired outcome of therapy.
- Develop an understanding of the patient’s self-care, work, and leisure activities and the environments in which these activities occur.
- Establish goals with the patient that relate to the desired outcomes. If patients cannot express their needs, family members or significant others may do so for them.

Physical Therapy Tips

- Identification of the person (patient or caregiver).
- Description of the movement or activity.
- A connection of the movement/activity to a specific function.
- Specific conditions in which the activity will be performed.
- Factors for measuring the outcome.
- Time frame for achieving the goal.

Physical Therapy National Goal Writing Source: APTA: Defensible Documentation for Patient/Client Management: Components of Documentation within the Patient/Client Model (2011)
Elements of a Goal

1. Who
2. Will do what
3. Under what conditions
4. How well
5. By when

• “Who” will almost always the patient.
• The goals should never be written as “the therapist will do....”.
• The behavioral statement must reflect the beneficiary performance.
• Caregivers may be involved in the beneficiary’s care, but they are not the focus of the goal.
• Activity the beneficiary will perform.
• Activity should be observable, repeatable and have a definite beginning and end.
• Statements like “the patient will get stronger” and “the patient will show improvement” are poorly written.
Under What Conditions

• Condition under which the beneficiary’s goal achievement is measured.
• May be environmental factors such as stairs or grassy surfaces.
• May be beneficiary factors such as “with a cane”.
Describes the assistance needed:

- Maximum assistance.
- Moderate assistance.
- Minimal assistance.
- Totally independent.
• Target date to achieve the goal.
• Goals should be short or long term.
• The goals do not necessarily need to be labeled with the words short and long, but the goals should be written in a manner where there are measurable time frames that indicate whether they are short or long.
• There is no set time frame that defines short versus long.
• Short-term goals focus on the primary diagnosis and set the direction for day-to-day intervention.
• Long-term goals encompass the total patient condition and set the direction for discharge planning.
• Goals must be attainable within a certain time frame.
• Each goal should include a statement indicating a time estimate for reaching the goal.
Long Term Goals

- Long Term Goals (LTGs) state the “final product” to be achieved by physical therapy intervention.

LTGs may require revision if:

- Pt.’s condition changes and will not allow progression to the functional level set.
- Pt.’s condition changes and allows progression beyond that level originally set.
- Time span is no longer appropriate and need to be revised.

Examples of Physical Therapy Goals

• Long Term Goal (in 6 weeks):
  - The patient will walk 25 feet from the family room to the kitchen with one hand held at dinner time 5/7 days per week.

• Short Term Goals (in 3 weeks):
  - The patient will transition to standing from the floor through half-kneeling with supervision 4/5 trials for 3 consecutive treatment sessions.
  - The patient will sit unsupported in short-leg sitting for 3 minutes to enable upright activities.

http://fl.eqhs.org/Portals/1/Goal%20Writing%20for%20Therapy%20Provider%20with%20Final%20AHCA%20edits%202013%202012.pdf
Examples of Physical Therapy Goals

• Long Term Goal
  ▪ The patient will increase the range of motion of the cervical spine from less than 50% of expected range to full active range of motion in all directions while sitting in 5/5 consecutive therapy visits within 10 weeks.

• Short Term Goals
  ▪ The mother will demonstrate the home exercise program for cervical spine ROM on the child with 100% accuracy during 2 consecutive therapy visits within 1 month.
  ▪ The patient will maintain the head in midline independently while sitting for 30 seconds 4/5 trials for 3 consecutive treatment sessions within 2 months.
Examples of Speech Goals

• Long Term Goal (in 8 weeks):
  ▪ The patient will increase the use of expressive vocabulary from 0-25 words with familiar listeners in familiar settings, to communicate a variety of pragmatic functions with minimal prompts 80% of opportunities in 4/5 consecutive sessions.

• Short Term Goals (in 4 weeks):
  ▪ With multisensory cueing, the patient will imitate 5 signs/gestures/or word approximations to request, protest, or greet familiar listeners in structured therapy settings 80% of opportunities in 4/5 consecutive sessions.
  ▪ With fading prompts, the patient will use 10 signs/gestures/or word approximations to request, protest, greet, and answer yes/no questions during structured therapy sessions 80% of opportunities in 4/5 consecutive sessions.

http://fl.eqhs.org/Portals/1/Goal%20Writing%20for%20Therapy%20Provider%20with%20Final%20AHCA%20edits%20%202013%201%202012.pdf
Examples of Speech Goals

- Long Term Goal (In 10 weeks):
  - The patient will increase speech intelligibility of 3-4 word phrases from less than 50% in known contexts with known listeners to 80% in unfamiliar contexts with unfamiliar listeners.

- Short Term Goals (in 4 weeks):
  - With multisensory cueing, the patient will identify minimal pairs targeting initial consonant deletion, final consonant deletion, and fronting from field of 2 with 80% accuracy in 4/5 consecutive sessions.
  - With fading prompts, the patient will produce targeted initial consonants (i.e., /m/, /n/, /h/, and /w/) in words with 75% accuracy in 4/5 consecutive sessions.
Examples of Occupational Therapy Goals

- **Long Term Goal (in 8 weeks):**
  - The patient will advance from following a 1 step verbal direction to a 3 step verbal direction, independently, 100% of trials, to improve sequencing and memory recall skills used in functional daily routines.

- **Short Term Goals (in 5 weeks):**
  - The patient will follow a 2 step written direction to pick up toys and place them in the appropriate storage bins with no more than 2 verbal cues for 2/3 trials.
  - The patient will follow a 3 step verbal direction to fold, sort, and put away laundry with no more than 1 verbal cue for 3/3 trials.

http://fl.eqhs.org/Portals/1/Goal%20Writing%20for%20Therapy%20Provider%20with%20Final%20AHCA%20edits%2020%201%2013%20.pdf
Medical Necessity

• A good way to assess the medical necessity of each goal is to ask “What difference does performing this activity mean to the beneficiary?”

• The documentation of the beneficiary encounter should relate back to the goals.
RUMBA

• Relevant: functional goals and achievement
• Understandable: legible and avoid jargon
• Measurable: includes frequency and duration, how long it occurred or how many times
• Behavioral: measurable occurrences
• Achievable: reasonable

Is This A Good Goal?

- Mr. Johnson will walk 4.6 m (15 ft) from his bed to the bathroom with a standard walker, bearing weight as tolerated on his right leg, with standby assistance of one for potential loss of balance by [date].
• Mr. Johnson will retrieve his mail, walking 61 m (200 ft) with a straight cane down 5 steps on his front porch, crossing the lawn to his mailbox, and going back to the house by [date].
Is This A Good Goal?

- Mr. Johnson will dress in 10 minutes, using a stable chair to sit on or for standing support as needed by [date].
• Increase R elbow extension AROM to within 10 degrees of full extension (measurable) within 2 weeks (time frame) to improve pt.’s ability to reach into overhead cabinets at home (functional terms).

CERT Reviews
• Beneficiary has chronic hypertension.
• Beneficiary has a primary diagnosis of HTN & is being seen 1-2x weekly by the SN for education and monitoring of disease process and teaching medications.
• She has been open to home health receiving skilled nurse visits for over a year with HTN as the primary, or secondary diagnosis for all but 2 episodes during this time.
• During this episode, there is documentation of communication with the physician on three days regarding elevated B/P which is documented as taken prior to beneficiary taking medication.
• There was no documentation of any new orders, or changes in treatment or medicines.
Beneficiary has chronic hypertension; she is quite stable.
No changes in meds or treatment; no significant risk of exacerbations.
There was no documentation of any new orders, or changes in treatment or medicines.
Beneficiary has remained stable and there has been ample time for teaching.
Submitted documentation does not support the medical necessity of HH services billed.
• Primary diagnosis has been 781.2, abnormal gait, since the episode started a year ago & she has been receiving both skilled nursing and physical therapy services since that time.
• Documented patient therapy goals are to increase functional strength, mobility and endurance.
• PT documents she lives alone, ambulates with a cane or a walker and is able to safely manage the equipment.
• She is able to tolerate 30 minutes of treatment.
• SN provides weekly visits for teaching on disease processes, long standing medications and energy conservation.
• She [beneficiary] complained of dizziness at times however this has been an ongoing problem and her physician is aware.
• There is no medical necessity for this HH episode.
• Beneficiary is stable; minimal risk of exacerbation of condition.
• No change in treatment; issues are chronic; HEP established some time ago.
• Home health services are not reasonable & necessary for this beneficiary open to home health for almost three years.
• Beneficiary has chronic, stable appearing conditions and there has been ample time to render teaching.
The F2F encounter documentation for encounter:

- Documented as clinical findings is 'HTN, OA, Colon CA ASHD – SN needed for observation, assessment, monitor med compliance'.
- Homebound status is documented as 'Due to joint pain caused by OA patient mobility is limited as tolerated'.
Face-to-Face (F2F) Evaluation is Inadequate

- There is insufficient documentation to support the billed HH episode.
- The F2F encounter documentation for encounter lacks a narrative of clinical findings which supports homebound status.
The Health Insurance Prospective Payment System (HIPPS) Code 4BGK1 is based on an incorrect value entered for M1610 – Urinary Incontinence or Urinary Catheter Presence.

Clinician marked 1 – Patient is incontinent, however documented Foley inserted 5/2/12.

Nurses' home visit notes support the patient has a catheter.
Incorrect Coding

• Received from tech stop the corrected OASIS with the value “2” entered for M1610.
• When changing the value from “1” to “2” the HIPPS Code generated is 4BGK2.
• This beneficiary with hypertension, diabetes, and renal failure was hospitalized multiple times prior to and during the billed episode.

• Of note, there were no covered HHA services documented for date of services, which would make the claim a LUPA if payable.

• The submitted visit note documented vital signs and nurse notification only. Submitted with the claim included copies of the POC, recertification OASIS document, and copies of the SN and HHA visit notes for the episode.
Insufficient Documentation
Home Health (HH)-Plan of Care (POC)

- Missing a copy of the HH POC which has been signed and dated by the physician and received by the home health provider prior to claim submission.
- Documentation is insufficient to support this claim per Medicare guidelines.
• Billed for HH skilled nursing (SN) services for the home health episode.

• Submitted documentation included copies of the physician-signed POC and F2F encounter documents.

• SN services were reasonable and necessary for this beneficiary with invasive bladder cancer and a stage II pressure ulcer.
OASIS was missing.

No signed SN visit note was sent by the provider to support authentication of records for that date of service.

No electronic signature protocol was submitted to support electronic authentication of the records.
This checklist is available on Palmetto GBA’s website and is provided as a reminder of what to include when responding to an ADR.

**Plan of Care and Certification**

- Signed and dated prior to billing the end of episode claim.
- Physician orders not included on the Plan of Care must be signed and dated prior to billing the final claim to Medicare.
- Signature log or attestation of signature is illegible.

**Face-to-Face Encounter**

- Includes clinical findings to support the need for skilled services.
- Includes documentation to support homebound status.
Documentation of services rendered

- Documentation to determine medical necessity of all services billed and to support the Health Insurance Prospective Payment System (HIPPS) code (or level of payment) billed.
- In/out time for nurse and aide visits.
- Projected endpoint to daily skilled nurse visits.
- Documentation for all PRN (as needed) visits, including dates, reason for the PRN visits, outcome of visits and orders for services must be included.
- Any other pertinent documentation that may be needed to establish medical necessity (e.g., date of hospitalization, medication changes, laboratory values, physician contacts/visits, etc.).
- Submit documentation denoting treatment week, when different from calendar week.
- Submit Advance Beneficiary Notice (ABN) if applicable.
Itemized supply list if billed:

- Include the quantity and cost of each item
- Physician orders signed and dated prior to billing the end of episode claim to cover all supplies billed
- Total charges billed (revenue code 270) should equal total charges listed on itemized supply list
Home Health (HH) Plans of Care (POCs): Monitoring Glucose Control in the Medicare Home Health (HH) Population with Type II Diabetes Mellitus
• HH policy regarding coverage for the sole purpose of insulin injections is limited to patients that are physically or mentally unable to self-inject and there is no other person who is able and willing to inject the patient.

• The OIG concluded in August 2013 that some previously covered home health visits for the sole purpose of insulin injections were unnecessary because the patient was physically and mentally able to self-inject.

Medicare Coverage Benefit Policy Manual (Pub.100–02), Section 40.1.2.4.B.2 “Insulin Injections”
Levinson, Daniel R. Management Implication Report 12–0011, Unnecessary Home Health Care for Diabetic Patients
What is Diabetes?

- Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces.
- Insulin is a hormone that regulates blood sugar.
- Hyperglycemia, or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body's systems, especially the nerves and blood vessels.

Diabetes Fact sheet. World Health Organization, reviewed October 2013
Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria:

- Fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;
- 2-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or
- Random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.
Type 1 diabetes (previously known as insulin-dependent, juvenile or childhood-onset) is characterized by deficient insulin production and requires daily administration of insulin.
Type 2 Diabetes (formerly called non-insulin-dependent or adult-onset) results from the body’s ineffective use of insulin.
Diabetes Mellitus Diagnosis Coding

- Diabetes – Category 250
- Fourth digit – presence of any associated complication
- Fifth digit – type of diabetes (type 1 or type 2) and uncontrolled or controlled
4th Digit Coding

- Metabolic
- Chronic
- Renal, eye, neurology, and vascular
- Identified by fourth digit 250.X
  - 4th digits 1 to 3 cover metabolic complications
  - 4th digits 4 to 8 identify chronic or body system complications
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<thead>
<tr>
<th>5th digit</th>
<th>Type</th>
<th>Uncontrolled or Not Stated as Uncontrolled</th>
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<tbody>
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<td>0</td>
<td>Type 2 Unspecified</td>
<td>Not stated as uncontrolled</td>
</tr>
<tr>
<td>1</td>
<td>Type 1 Juvenile type</td>
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<tr>
<td>2</td>
<td>Type 2 Unspecified</td>
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</tr>
<tr>
<td>3</td>
<td>Type 1 Juvenile type</td>
<td>Uncontrolled</td>
</tr>
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</table>
Secondary Diabetes Mellitus

• Codes under category 249, secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus.

• Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).
• In 2012, 29.1 million Americans, or 9.3 percent of the population, had diabetes.
• In 2010 the figures were 25.8 million and 8.3 percent. The prevalence rate for adults age 20 and older in 2012 was 12.3 percent, compared to 11.3 percent in 2010.

Prevalence in Seniors

- The percentage of Americans age 65 and older remains high, at 25.9 percent, or 11.8 million seniors (diagnosed and undiagnosed).
- The rate was 26.9 percent in 2010.

New Cases: The incidence of diabetes in 2012 was 1.7 million new diagnoses/year; in 2010 it was 1.9 million.
State Breakdown by County
<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>32x Home Health</td>
<td>250 Diabetes Mellitus</td>
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<td>$523,046,464</td>
<td>$515,467,953</td>
<td>$543,045,711</td>
<td>6,334</td>
<td>$82,578</td>
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<td>$4,281</td>
<td>$4,285</td>
<td>45,013</td>
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<tr>
<td>32x Home Health</td>
<td>250 Diabetes Mellitus</td>
<td>TOTAL</td>
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<td>$3,615</td>
<td>$3,262</td>
<td>$3,299</td>
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</table>

August 2015

Palmetto GBA - A CMS-Contracted Medicare Administrative Contractor (MAC)
## Covered Charge For Insulin Injection By Provider State 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Covered Charge</th>
<th>Percent Covered</th>
<th>Average Shots per Day</th>
<th>HICN Count</th>
<th>Claim Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
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</table>

August 2015

Palmetto GBA - A CMS-Contracted Medicare Administrative Contractor (MAC)
<table>
<thead>
<tr>
<th>State</th>
<th>Covered Charge</th>
<th>Percentage Covered</th>
<th>Average Shots per day</th>
<th>HICN Count</th>
<th>Claim Count</th>
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<td>867</td>
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According to the Centers for Disease Control (CDC) and Prevention, the number of persons with Type 2 diabetes in the United States will more than triple by 2050 from the current estimate of 26 million.

Diabetes can affect many parts of the body and is associated with serious complications, such as heart disease and stroke, blindness, kidney failure, and lower-limb amputation.


http://www.hopediabetescenter.us/Images/ComplicationsofDiabetes.png
Complications/Comorbid Conditions

Hypoglycemia:

• Hunger
• Nervousness
• Shakiness
• Perspiration
• Dizziness or light-headedness
• Sleepiness
• Confusion
• **Hyperglycemia**: too much glucose in the blood

• **Hypertension**: a condition present when blood flows through the blood vessels with a force greater than normal.

• **Dyslipidemia**: In 2009–2012, of adults aged 18 years or older with diagnosed diabetes, 65 percent had blood LDL cholesterol greater than or equal to 100 mg/dl milligrams.
Comorbid Conditions

- Nonalcoholic Fatty Liver Disease (NAFLD)
- Cardiovascular Disease
- Kidney Disease
- Obesity

Medical Directors Institute for the National Association on managed Care physicians
Secondary Conditions

- Peripheral Neuropathy
- Skin Conditions
- Eye Conditions
Skin Conditions

• Bacterial Infections
• Fungal Infections
• Itching
• Acanthosis Nigricans
• Diabetic Dermopathy
• Necrobiosis Lipoidica Diabeticorum
• Eruptive Xanthomatosis
• Digital Sclerosis
• Disseminated Granuloma Annulare
Bacterial Infections

Several kinds of bacterial infections occur in people with diabetes:

- Styes (infections of the glands of the eyelid)
- Boils
- Folliculitis (infections of the hair follicles)
- Carbuncles (deep infections of the skin and the tissue underneath)
- Infections around the nails

http://www.diabetesandrelatedhealthissues.com/cellulitis.html
Fungal Infections

- The culprit in fungal infections of people with diabetes is often Candida albicans.
- This yeast-like fungus can create itchy rashes of moist, red areas surrounded by tiny blisters and scales.
- These infections often occur in warm, moist folds of the skin.
- Problem areas are under the breasts, around the nails, between fingers and toes, in the corners of the mouth, under the foreskin (in uncircumcised men), and in the armpits and groin.

Acanthosis Nigricans

• Acanthosis Nigricans is a condition in which tan or brown raised areas appear on the sides of the neck, armpits and groin.

• Sometimes they also occur on the hands, elbows and knees.

http://www.aocd.org/resource/resmgr/ddb_high/acanthosis_nigricans_1_high.jpg
• Diabetes can cause changes in the small blood vessels that carry blood to and from all parts of the body.
• The three main types of blood vessels are arteries, veins and capillaries.
• These changes can cause skin problems called diabetic dermopathy.
• Dermopathy often looks like light brown, scaly patches. These patches may be oval or circular.
• Some people mistake them for age spots.
• This disorder most often occurs on the front of both legs. The patches do not hurt, open up, or itch.

Diabetic Dermopathy

Necrobiosis Lipoidica Diabeticorum (NLD) causes spots similar to diabetic dermopathy, but they are fewer, larger, and deeper.

NLD often starts as a dull, red, raised area.

After a while, it looks like a shiny scar with a violet border.

The blood vessels under the skin may become easier to see.

Sometimes NLD is itchy and painful.

Sometimes the spots crack open.

Condition where skin on the fingers, toes as well as hands turn waxy, thick and tight. A stiffness of the joints of the finger can also occur.
Eruptive xanthomatosis — firm, yellow, pea-like skin growths.
The bumps have a red halo around them and may itch.
They’re usually found on the backs of hands, feet, arms, and buttocks.

Biophoto Associates/Photo Researchers, Inc.
In disseminated granuloma annulare, the person has sharply defined ring- or arc-shaped raised areas on the skin. These rashes occur most often on parts of the body far from the trunk (for example, the fingers or ears). Sometimes the raised areas occur on the trunk. They can be red, red-brown, or skin-colored.

last edited March 31, 2014
Foot Complications of the Feet

- Damaged blood vessels.
- Damaged nerves in the feet.
- Decreased ability to fight infection.
- Foot injuries remain unnoticed and infection sets in.

Neuropathy

• Nerve damage.
• About half of all people with diabetes have some form of nerve damage.
• It is more common in those who have had the disease for a number of years and can lead to many kinds of problems.

American Diabetes Association
Peripheral Neuropathy

Diabetic Peripheral Neuropathy

- Healthy tissue
- Diabetes-related metabolic or vascular conditions can cause capillary damage.
- Capillary damage can lead to nerve damage and loss of sensation especially in the extremities.
- Injury due to loss of sensation.
- Loss of sensation and circulation problems result in increased risk of infection, ulcers and gangrene.

http://www.gluxus.com/diabetic-neuropathy/
Nerves carry messages back and forth between the brain and other parts of the body.

Small blood vessels provide nerves with nutrients and oxygen required to survive and function.

High blood glucose damages these small blood vessels that feed the nerves.

When the vessels are damaged, a sufficient supply of nutrients and oxygen no longer reaches the nerve, causing the nerve to become damaged and eventually die.

High blood glucose also damages the outer protective layer of nerves, affecting their ability to transmit signals. This results in incorrect signals being sent to the brain causing chronic pain.

http://www.gluxus.com/diabetic-neuropathy
Peripheral Neuropathy

• Tingling
  ▪ My feet tingle.
  ▪ I feel "pins and needles" in my feet.

• Pain or Increased Sensitivity
  ▪ I have burning, stabbing or shooting pains in my feet.
  ▪ My feet are very sensitive to touch. For example, sometimes it hurts to have the bed covers touch my feet.
  ▪ Sometimes I feel like I have socks or gloves on when I don't.
  ▪ My feet hurt at night.
  ▪ My feet and hands get very cold or very hot.

American Diabetes Association
Last Edited: December 5, 2013
Peripheral Neuropathy

• Numbness or Weakness
  ▪ My feet are numb and feel dead.
  ▪ I don't feel pain in my feet, even when I have blisters or injuries.
  ▪ I can't feel my feet when I'm walking.
  ▪ The muscles in my feet and legs are weak.
  ▪ I'm unsteady when I stand or walk.
  ▪ I have trouble feeling heat or cold in my feet or hands.

• Other
  ▪ It seems like the muscles and bones in my feet have changed shape.
  ▪ I have open sores (also called ulcers) on my feet and legs. These sores heal very slowly.

American Diabetes Association
Last Edited: December 5, 2013
Eye Complications

- Glaucoma
- Cataracts
- Retinopathy
Glaucoma

- When fluid inside the eye does not drain properly from a buildup of pressure inside the eye, it results in another eye problem with diabetes called glaucoma.
- The pressure damages nerves and the vessels in the eye, causing changes in vision.

Cataracts and Diabetes

• A cataract is a clouding or fogging of the normally clear lens of the eye. The lens is what allows us to see and focus on an image just like a camera.

• If you have a cataract, there is a cloudy area in the lens of your eye that results in the inability to focus light, and your vision is impaired.

• Symptoms of this eye problem in diabetes include blurred or glared vision.

http://www.medicinenet.com/diabetes_and_eye_problems/article.htm
• The retina is a group of specialized cells that convert light as it enters though the lens into images.

• The eye nerve or optic nerve transmits visual information to the brain.

• Diabetic retinopathy is one of is due to damage of small vessels and is called a "microvascular complication".

• Kidney disease and nerve damage due to diabetes are also microvascular complications.

http://www.medicinenet.com/diabetes_and_eye_problems/page2.htm#diabetic_retinopathy
Kidney Disease

- Diabetes was listed as the primary cause of kidney failure in 44 percent of all new cases in 2011.
- In 2011, 49,677 people of all ages began treatment for kidney failure due to diabetes.
- In 2011, a total of 228,924 people of all ages with kidney failure due to diabetes were living on chronic dialysis or with a kidney transplant.
Monitoring the Stages Of Kidney Disease

- Microalbuminuria occurs when trace amounts of a protein called albumin begin to leak through the damaged filtering structures of the kidneys. The presence of microalbumin in the urine is often an early warning of kidney disease.

- Proteinuria is the spillage of larger quantities of protein. A standard urinalysis will pick up this spillage (normal is less than 100-150 mg/day, depending on the lab). As damage progresses and protein levels reach about 2000-4000 mg/day, proteinuria is followed by:

  - A rising blood creatinine. Creatinine is a normal breakdown product from muscle which the kidneys cleanse from blood (a normal creatinine is 1.1-1.3 mg/dl or less, depending on the lab). As damaged kidneys have more trouble cleansing the blood, creatinine levels rise. After a gradual buildup, toxins in the blood reach a critical stage (usually at a creatinine level between 3 and 8).

  - Dialysis or a kidney transplant. These technologies replace the severely damaged kidneys in cleansing the blood. Transplant organs are scare and the operations are costly. Dialysis is disruptive to one's lifestyle and can cost $25,000 to $45,000 each year.

Symptoms of End Stage Chronic Kidney Disease

- Fatigue.
- Fluid retention, swelling (edema) of extremities and shortness of breath.
- Urination changes (foamy; dark orange, brown, tea-colored or red if it contains blood; and urinating more or less than normal).
- Kidney pain felt in their back.
- Sleep problems due to muscle cramps or restless legs.
- Nausea and/or vomiting.
- Taste changes - a metallic taste in the mouth.
- Bad breath due to urea buildup in the blood.
- Loss of appetite: People may not feel like eating, and some people report having a metallic taste in their mouth or bad breath.

Symptoms of End Stage Chronic Kidney Disease

- Difficulty in concentrating: Having trouble doing everyday things such as balancing a checkbook or focusing on reading the newspaper can occur.
- Nerve problems: Numbness or tingling in the toes or fingers is a symptom of CKD.
- Making little or no urine.
- Swelling, especially around the eyes and ankles.
- Muscle cramps.
- Tingling in hands or feet.
- Changes in skin color.
- Increased skin pigmentation.

Diabetic Ulcer

http://www.lhsc.on.ca/Health_Professionals/Wound_Care/diabetic.htm
A diabetic ulcer is often related to poorly controlled blood sugar leading to decreased foot sensation and as a result of peripheral neuropathy. Neuropathy can result in unnoticed skin irritation, perhaps from ill-fitting shoes, which may lead to an ulcer. Foot care education and properly fitting shoes are important issues in preventing and resolving diabetic foot ulcers.
Diabetic Ulcer

- Generally appear on the plantar surface of the foot, over the heels, and over the metatarsal heads.
- Dry, warm, cracked, fissured skin, thickened nails.
- Usually no edema is present.
- Minimal to no exudate.
- Wound margins are round with occasional periwound calluses.
- Caused by pressure, secondary to peripheral neuropathy or arterial insufficiency and Poor microvascular circulation, inadequate blood glucose control, and/or lack of sensation.

http://www.lhsc.on.ca/Health_Professionals/Wound_Care/diabetic.htm
Wagner Grade 0

- Pre-ulcerative lesions.
- Healed ulcers.
- Presence of bony deformity.
Wagner Grade 1

- Superficial ulcer.
- No subcutaneous tissue involvement.

Wagner Grade 2

- Penetration through the subcutaneous tissue.
- May expose bone, tendon, ligament of joint capsule.

Wagner Grade 3

- Osteitis
- Abcess
- Osteomyelitis

http://www.naccme.com/program/n-234/page/734/
Wagner Grade 4

Gangrene of digit.

http://www.naccme.com/program/n-234/page/734
Wagner Grade 5

- Gangrene of foot.
- Requires disarticulation.

http://www.circulatorboot.com/casehistory/case8d.jpg
Activity Limitations

Data Source:

- CDC, National Center for Health Statistics, Division of Health Interview Statistics, data from the National Health Interview Survey. Data computed by personnel in CDC's Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion.
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### Percentage of Adults with Diabetes Reporting Limitation in Climbing up 10 Steps, by Age, United States, 1997–2011

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### Percentage of Adults with Diabetes Reporting Limitation in Stooping, Bending, or Kneeling, by Age, United States, 1997–2011

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Percentage of Adults with Diagnosed Diabetes Reporting Any Mobility Limitation, by Age, United States, 1997–2011

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Percentage of Adults with Diagnosed Diabetes Reporting Inability to Do Usual Activities at Least 1 Day in the Past 30 Days, by Age, United States, 1994–2011

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Data Source: Information came from the CDC's Behavioral Risk Factor Surveillance System. The data were computed by CDC's.
Local Coverage Determination (LCD) L35413
Coverage Guidance for Monitoring Glucose Control in the Home

• When a daily medication is required the first-line agent is generally an oral medication, like Metformin, unless there is a contraindication to its use.

• This policy establishes the expectation that for those Medicare beneficiaries requiring medications to achieve long-term control of glucose levels, oral medication shall be considered first-line therapy unless there is a specific contraindication to its use.
Coverage Guidance

- Skilled nurse visits are permitted for the administration of daily insulin injections for the population of Medicare beneficiaries that:
  - Are “either physically or mentally unable to self-inject insulin”
  - There is no other person who is able and willing to inject the beneficiary.
- Reasonable and necessary plans of care must contain sufficient information concerning the identified functional limitations to explain why an individual is physically or mentally unable to self-inject insulin.
- In the absence of another skilled service, failure to include the specific structural or functional impairments, together with the related activity limitations, to support the determination that the individual beneficiary is either physically or mentally unable to self-inject insulin will result in a claim denial.
Evidence-based medicine supports ascertaining glucose control and the risk of secondary conditions, known to occur in individuals with diabetes mellitus, by monitoring glucose and hemoglobin A1c (HbA1c) levels in individuals with diabetes mellitus.

This information, and its communication between the physician and HH agency caring for a given beneficiary, helps ensure that a home health POC is not only patient-centered, but also addresses prognosis - as required by the Medicare Benefit Policy Manual.

Reasonable and necessary HH POC for Medicare beneficiaries with Type II diabetes must therefore include the monitoring and reporting of not only intermittent capillary blood/serum glucose levels but also quarterly (no less often than 120 days) HbA1C levels.
Documentation Requirements

- Patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient.
- The results of the most recent HbA1C.
- Documentation must be legible, relevant and sufficient to justify the services billed.
Coding Guidance

ICD-9 Codes that Support Medical Necessity

250.00  Diabetes Mellitus Without Mention Of Complication, Type 2 Or Unspecified Type, Not Stated As Uncontrolled

250.02  Diabetes Mellitus Without Mention Of Complication, Type 2i Or Unspecified Type, Uncontrolled

250.10  Diabetes With Ketoacidosis, Type 2 Or Unspecified Type, Not Stated As Uncontrolled

250.12  Diabetes With Ketoacidosis, Type 2 Or Unspecified Type, Uncontrolled

250.20  Diabetes With Hyperosmolarity, Type 2i Or Unspecified Type, Not Stated As Uncontrolled

250.22  Diabetes With Hyperosmolarity, Type 2i Or Unspecified Type, Uncontrolled

250.30  Diabetes With Other Coma, Type 2 Or Unspecified Type, Not Stated As Uncontrolled

250.32  Diabetes With Other Coma, Type ii Or Unspecified Type, Uncontrolled

250.40  Diabetes With Renal Manifestations, Type 2 Or Unspecified Type, Not Stated As Uncontrolled

250.42  Diabetes With Renal Manifestations, Type 2 Or Unspecified Type, Uncontrolled

250.50  Diabetes With Ophthalmic Manifestations, Type 2 Or Unspecified Type, Not Stated As Uncontrolled
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• V58.67 Long-term (current) use of insulin, used for insulin requiring diabetes mellitus.

• Documentation must show that patient is on insulin as indicated by the "V" code and must be billed with one of the type 2 diabetes codes.
A group of CMS clinicians and contractor clinicians developed a list of conditions that would support the need for ongoing HH skilled nursing visits for insulin injection assistance for instances where the patient is physically or mentally unable to self-inject and there is no able or willing caregiver to provide assistance.
• 49 percent of HH episodes in a study population did not have a secondary diagnosis from that ICD-9-CM code list on the HH claim that supported that the patient was physically or mentally unable to self-inject.

• When examining only the initial HH episodes of our study population, a study found that 67 percent of initial HH episodes with skilled nursing visits likely for insulin injections did not have a secondary diagnosis on the HH claim that supported that the patient was physically or mentally unable to self-inject.
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<td>887.3</td>
<td>Traumatic amputation of arm and hand, unilateral, at or above elbow, complicated.</td>
<td>V49.66 Above elbow amputation status.</td>
</tr>
<tr>
<td>887.4</td>
<td>Traumatic amputation of arm and hand, unilateral, level not specified, w/o mention of complication.</td>
<td>V49.67 Shoulder amputation status.</td>
</tr>
<tr>
<td>887.5</td>
<td>Traumatic amputation of arm and hand, unilateral, level not specified, complicated.</td>
<td>885.0 Traumatic amputation of thumb w/o mention of complication</td>
</tr>
<tr>
<td>887.6</td>
<td>Traumatic amputation of arm and hand, bilateral, any level, w/o mention of complication.</td>
<td>885.1 Traumatic amputation of thumb w/ mention of complication.</td>
</tr>
<tr>
<td>887.7</td>
<td>Traumatic amputation of arm and hand, bilateral, any level, complicated.</td>
<td>886.0 Traumatic amputation of other fingers w/o mention of complication.</td>
</tr>
</tbody>
</table>

**V Codes:**
- V49.59 Arthritis of hand.
- V49.60 Arthritis of wrist.
- V49.61 Arthritis of elbow.
- V49.62 Arthritis of shoulder.
- V49.63 Hand Amputation Status.
- V49.64 Wrist Amputation Status.
- V49.65 Below elbow amputation status.
- V49.66 Above elbow amputation status.
- V49.67 Shoulder amputation status.
- V49.70 Other amputation.
- V49.71 Amputation of another body part.
- V49.80 Other specified sites.
- V49.82 Other sites.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>362.01</td>
<td>Background diabetic retinopathy.</td>
<td>366.00</td>
<td>Nonsenile cataract unspecified.</td>
</tr>
<tr>
<td>362.50</td>
<td>Macular degeneration (senile) of retina unspecified.</td>
<td>366.01</td>
<td>Anterior subcapsular polar nonsenile cataract.</td>
</tr>
<tr>
<td>362.51</td>
<td>Nonexudative senile macular degeneration of retina.</td>
<td>366.02</td>
<td>Posterior subcapsular polar nonsenile cataract.</td>
</tr>
<tr>
<td>362.52</td>
<td>Exudative senile macular degeneration of retina.</td>
<td>366.04</td>
<td>Nuclear nonsenile cataract.</td>
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<tr>
<td>362.53</td>
<td>Cystoid macular degeneration of retina.</td>
<td>366.09</td>
<td>Other and combined forms of nonsenile cataract.</td>
</tr>
<tr>
<td>362.54</td>
<td>Macular cyst hole or pseudohole of retina.</td>
<td>366.10</td>
<td>Senile cataract unspecified.</td>
</tr>
<tr>
<td>362.55</td>
<td>Toxic maculopathy of retina.</td>
<td>366.11</td>
<td>Pseudo exfoliation of lens capsule.</td>
</tr>
<tr>
<td>362.56</td>
<td>Macular puckering of retina.</td>
<td>366.12</td>
<td>Incipient senile cataract.</td>
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<tr>
<td>362.57</td>
<td>Drusen degenerative) of retina.</td>
<td>366.13</td>
<td>Anterior subcapsular polar senile cataract.</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>366.14</td>
<td>Posterior subcapsular polar senile cataract.</td>
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<tr>
<td>366.15</td>
<td>Cortical senile cataract.</td>
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<tr>
<td>366.16</td>
<td>Senile nuclear sclerosis.</td>
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<tr>
<td>366.17</td>
<td>Total or mature cataract.</td>
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<tr>
<td>366.18</td>
<td>Hypermature cataract.</td>
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<tr>
<td>366.19</td>
<td>Other and combined forms of senile cataract.</td>
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<tr>
<td>366.20</td>
<td>Traumatic cataract Unspecified.</td>
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<tr>
<td>366.21</td>
<td>Localized traumatic opacities.</td>
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<tr>
<td>366.22</td>
<td>Total traumatic cataract.</td>
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<tr>
<td>366.23</td>
<td>Partially resolved traumatic cataract.</td>
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<td>366.8</td>
<td>Other cataract.</td>
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<td>366.9</td>
<td>Unspecified cataract.</td>
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<td>366.41</td>
<td>Diabetic cataract.</td>
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<tr>
<td>366.42</td>
<td>Tetanic cataract.</td>
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<tr>
<td>366.43</td>
<td>Myotonic cataract.</td>
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<tr>
<td>366.44</td>
<td>Cataract associated with other syndromes.</td>
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<td>366.45</td>
<td>Toxic cataract.</td>
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<td>366.46</td>
<td>Cataract associated with radiation and other physical influences.</td>
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<td>366.50</td>
<td>After-cataract unspecified.</td>
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<tr>
<td>369.00</td>
<td>Impairment level not further specified.</td>
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<tr>
<td>369.01</td>
<td>Better eye: total vision impairment; lesser eye: total vision impairment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.10</td>
<td>Moderate or severe impairment, better eye, impairment level not further specified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.11</td>
<td>Better eye: severe vision impairment; lesser eye: blind not further specified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.13</td>
<td>Better eye: severe vision impairment; lesser eye: near-total vision impairment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.14</td>
<td>Better eye: severe vision impairment; lesser eye: profound vision impairment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.15</td>
<td>Better eye: moderate vision impairment; lesser eye: blind not further specified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369.16</td>
<td>Better eye: moderate vision impairment; lesser eye: total vision impairment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICD-9-CM Diagnosis Codes That Indicate a Potential Inability To Self-Inject Insulin: Vision

369.17  Better eye: moderate vision impairment; lesser eye: near-total vision impairment.
369.18  Better eye: moderate vision impairment; lesser eye: profound vision impairment.
369.20  Moderate to severe impairment; Low vision both eyes not otherwise specified.
369.21  Better eye: severe vision impairment; lesser eye: impairment not further specified.
369.22  Better eye: severe vision impairment; lesser eye: severe vision impairment.
369.23  Better eye: moderate vision impairment; lesser eye: impairment not further specified.
369.24  Better eye: moderate vision impairment; lesser eye: severe vision impairment.
369.25  Better eye: moderate vision impairment; lesser eye: moderate vision impairment.
369.3   Unqualified visual loss both eyes.
369.4   Legal blindness as defined in U.S.A.
377.75  Cortical blindness.
379.21  Vitreous degeneration.
379.23  Vitreous hemorrhage. Cognitive/Behavioral:
290.0   Senile dementia uncomplicated.
290.3   Senile dementia with delirium.
290.40  Vascular dementia, uncomplicated.
290.41  Vascular dementia, with delirium.
290.42  Vascular dementia, with delusions.
290.43  Vascular dementia, with depressed mood.
294.11  Dementia in conditions classified elsewhere with behavioral disturbance.
294.21  Dementia, unspecified, with behavioral disturbance.
300.29  Other isolated or specific phobias.
331.0   Alzheimer's disease.
331.11  Pick's disease.
331.19  Other frontotemporal dementia.
331.2   Senile degeneration of brain.
331.82  Dementia with lewy bodies.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>715.11</td>
<td>Osteoarthrosis localized primary involving shoulder region.</td>
</tr>
<tr>
<td>715.21</td>
<td>Osteoarthrosis localized secondary involving shoulder region.</td>
</tr>
<tr>
<td>715.31</td>
<td>Osteoarthrosis localized not specified whether primary or secondary involving shoulder region.</td>
</tr>
<tr>
<td>715.91</td>
<td>Osteoarthrosis unspecified whether generalized or localized involving shoulder region.</td>
</tr>
<tr>
<td>715.12</td>
<td>Osteoarthrosis localized primary involving upper arm.</td>
</tr>
<tr>
<td>715.22</td>
<td>Osteoarthrosis localized secondary involving upper arm.</td>
</tr>
<tr>
<td>715.32</td>
<td>Osteoarthrosis localized not specified whether primary or secondary involving upper arm.</td>
</tr>
<tr>
<td>715.92</td>
<td>Osteoarthrosis unspecified whether generalized or localized involving upper arm.</td>
</tr>
<tr>
<td>715.13</td>
<td>Osteoarthrosis localized primary involving forearm.</td>
</tr>
<tr>
<td>715.23</td>
<td>Osteoarthrosis localized secondary involving forearm.</td>
</tr>
<tr>
<td>715.33</td>
<td>Osteoarthrosis localized not specified whether primary or secondary involving forearm.</td>
</tr>
<tr>
<td>715.93</td>
<td>Osteoarthrosis unspecified whether generalized or localized involving forearm.</td>
</tr>
<tr>
<td>715.94</td>
<td>Osteoarthrosis unspecified whether generalized or localized involving hand.</td>
</tr>
<tr>
<td>716.51</td>
<td>Unspecified polyarthropathy or polyarthritis involving shoulder region.</td>
</tr>
<tr>
<td>716.52</td>
<td>Unspecified polyarthropathy or polyarthritis involving upper arm.</td>
</tr>
<tr>
<td>716.53</td>
<td>Unspecified polyarthropathy or polyarthritis involving forearm.</td>
</tr>
<tr>
<td>716.54</td>
<td>Unspecified polyarthropathy or polyarthritis involving hand</td>
</tr>
</tbody>
</table>
ICD-9-CM Diagnosis Codes That Indicate a Potential Inability To Self-Inject Insulin: Arthritis

716.61 Unspecified monoarthritis involving shoulder region.
716.62 Unspecified monoarthritis involving upper arm.
716.63 Unspecified monoarthritis involving forearm.
716.64 Unspecified monoarthritis involving hand.
716.81 Other specified arthropathy involving shoulder region.
716.82 Other specified arthropathy involving upper arm.
716.83 Other specified arthropathy involving forearm.
716.84 Other specified arthropathy involving hand.
716.91 Unspecified arthropathy involving shoulder region.
716.92 Unspecified arthropathy involving upper arm.
716.93 Unspecified arthropathy involving forearm.
716.94 Unspecified arthropathy involving hand.
716.01 Kaschin-Beck disease shoulder region.
716.02 Kaschin-Beck disease upper arm.
716.04 Kaschin-Beck disease forearm.
716.04 Kaschin-beck disease involving hand.
719.81 Other specified disorders of joint of shoulder region.
719.82 Other specified disorders of upper arm joint.
719.83 Other specified disorders of joint, forearm.
719.84 Other specified disorders of joint, hand.
718.41 Contracture of joint of shoulder region.
718.42 Contracture of joint, upper arm.
718.43 Contracture of joint, forearm.
718.44 Contracture of hand joint.
714.0 Rheumatoid arthritis.
<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>332.0</td>
<td>Paralysis agitans (Parkinson's)</td>
</tr>
<tr>
<td>332.1</td>
<td>Secondary parkinsonism</td>
</tr>
<tr>
<td>333.1</td>
<td>Essential and other specified forms of tremor</td>
</tr>
<tr>
<td>736.05</td>
<td>Wrist drop (acquired)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>438.21</td>
<td>Hemiplegia affecting dominant side.</td>
</tr>
<tr>
<td>438.22</td>
<td>Hemiplegia affecting non-dominant side.</td>
</tr>
<tr>
<td>342.01</td>
<td>Flaccid hemiplegia and hemiparesis affecting dominant side.</td>
</tr>
<tr>
<td>342.02</td>
<td>Flaccid hemiplegia and hemiparesis affecting non-dominant side.</td>
</tr>
<tr>
<td>342.11</td>
<td>Spastic hemiplegia and hemiparesis affecting dominant side.</td>
</tr>
<tr>
<td>342.12</td>
<td>Spastic hemiplegia and hemiparesis affecting non-dominant side.</td>
</tr>
<tr>
<td>438.31</td>
<td>Monoplegia of upper limb affecting dominant side.</td>
</tr>
<tr>
<td>438.32</td>
<td>Monoplegia of upper limb affecting non-dominant side.</td>
</tr>
<tr>
<td>343.3</td>
<td>Congenital monoplegia</td>
</tr>
<tr>
<td>344.41</td>
<td>Monoplegia of upper limb affecting dominant side.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>
Questions?
Medicare at 50
The Golden Years!

2015 Home Health (HH) Workshop Series
Agenda

• Medicare Program Changes
  ▪ Discuss Changes in the FY 2015 Home Health (HH) Final Rule

• Principal Diagnosis Coding
  ▪ Explain Principal Diagnosis coding
    • Manifestation vs. Etiology Diagnosis Coding

• Data Analysis
  ▪ Discuss Data Analysis Reports and Top Reason Codes and Resolutions Steps for:
    • Appeals
    • Provider Contact Center (PCC)
    • Claims

• Tying It All Together
  ▪ Define and Discuss Solid Performance focusing on the DMAIC Methodology to Identify Areas for Improvement

• Resources
  ▪ Identify and Review Web Resources
Medicare Program Changes

Overview of the FY 2015 HH Final Rule
• The Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2015 HH Final Rule on, November 6, 2014.

• The Final Rule (CMS-1611-F) updates Medicare’s HH Prospective Payment System (PPS) payment rates and wage index for CY 2015.
  ▪ These regulations became effective on January 1, 2015.

• Continues the phase-out of the wage index budget neutrality adjustment factor (BNAF).
What Other Changes are in the Final Rule?

The Final Rule also provides updates on:

- HH PPS case-mix weights.
- Second year of the four-year phase-in of the rebasing adjustments (as required by Section 3131(a) of the Affordable Care Act).
- Payments to home health agencies (HHAs) are estimated to decrease by approximately 0.30 percent, or -$60 million in CY 2015.
Additional Changes

• This rule also:
  - Simplifies the Face-to-Face (F2F) encounter regulatory requirements.
  - Revises the HH quality reporting program requirements.
  - Simplifies the therapy reassessment timeframes.
  - Revises the Speech-Language Pathology (SLP) personnel qualifications, and
  - Limits the reviewability of the civil monetary penalty provisions.
Lastly, the Final Rule:

- Provides guidance on Medicare coverage of insulin injections under the HH PPS.
- Provides further information on the delay in the implementation of the International Classification of Diseases, 10th Revision Clinical Modification (ICD-10-CM).
- Provides direction on an HH value-based purchasing (HH VBP) model.
Where do I go if I Need More Information?

- Palmetto GBA hosts Quarterly Updates Webcast in March, June, October and December.
  - Check the calendar on Palmetto GBA’s Event Registration Portal.
- The requirements in the Final Rule are implemented at the Medicare contractor level when CMS issues one or more Change Requests (CRs).
- Until CMS issues the CR(s), Medicare contractors have limited information for educational purposes.
- Register for Palmetto GBA’s and CMS’ email updates to keep abreast of program changes, updates, and scheduled events.
Other Program Changes Impacting 2015 Claims

Change Request 8813
Issued August 1, 2014
Principal Diagnosis Coding
Principal Diagnosis Coding Instructions

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Coding Guidelines require you to report diagnosis coding on your HH claim.

- The principal diagnosis reported on the claim shall be the diagnosis most related to the current HH plan of care (POC).
The coding guidelines state that when the provider has established, or confirmed, a related definitive diagnosis, codes listed under the classification of Symptoms, Signs, and Ill-defined Conditions are not to be used as principal diagnoses.
An analysis of Outcome Assessment and Information Set (OASIS) records and claims for CY 2011 revealed that some agencies were not complying with the coding guidelines when reporting the primary diagnosis, in particular with regards to certain codes that require the underlying condition be sequenced first followed by the manifestation.
HH providers may not report diagnoses codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines and that require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.
What Does All This Mean?

- Effective with dates of service (DOS) on or after January 1, 2015:
  - HHA’s shall not submit manifestation codes as the primary diagnosis.
  - HH Requests for Anticipated Payments (RAP’s) and claims submitted with manifestation codes as the principal diagnosis, will be Returned to the Provider (RTP).
Manifestation Codes
Format of ICD-9-CM Manual

- Volume 1 – Tabular list of diseases and injuries.
- Volume 2 – Alphabetic index of diseases and injuries.
- Volume 3 – Tabular and Alphabetic.
Coding Conventions

- In Alpha Index.
- List underlying code first.
- Manifestation code in brackets [ ].
- In Tabular Listing.
- Instructional information.
- Code underlying condition first.
- Sequencing rule.
• Etiology is telling you what the patient has wrong with them.

• Manifestation tells you how the etiology is presenting.

• Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and therefore should not be used as a primary diagnosis.

ICD-9-CM vs ICD-10-CM

• Slanted brackets, [ ], are used in the ICD-9-CM Index to Diseases to identify manifestation codes.

• In the ICD-10-CM Index to Diseases and Injuries, square brackets, [ ], are used to identify manifestation codes.

http://www.monroecollege.edu/AcademicResources/ebooks/1111540586_lores_ch03.pdf
Example: Index to Diseases

- 277.39 – “Neuritis, amyloid, any site” is the primary code.

- 357.4 – “Polyneuropathy in other diseases classified elsewhere”, appears in slanted brackets and is reported as a secondary code.

http://www.monroecollege.edu/AcademicResources/ebooks/1111540586_lores_ch03.pdf
# ICD-9 – Index to Diseases

## Nephrosis, nephrotic

<table>
<thead>
<tr>
<th>Nephrosis, nephrotic — continued</th>
<th>Neuralgia, neuralgic — see also Neuritis</th>
<th>Neurilemmosarcoma (M9560/3) — see Neurofibrosarcoma</th>
<th>Neuritis — see also Neuralgia — continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>diabetic — continued</td>
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<tr>
<td>due to secondary diabetes</td>
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<tr>
<td>249.4</td>
<td></td>
<td></td>
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<tr>
<td>Finnish type (congenital)</td>
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<td>hemoglobinuric — see Nephritis</td>
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<tr>
<td>amylodiach 277.39 [581.8]</td>
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<td>diabetes mellitus 250.1</td>
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<td>due to secondary diabetes</td>
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<td>249.4</td>
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<td>epidemic hemorrhalgi</td>
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<td>malaria 084.9 [581.81]</td>
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<tr>
<td>polyarteritis 446.0 [581.81]</td>
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<td>systemic lupus erythe</td>
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<td>710.0</td>
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<td>ischemic — see Nephrosis</td>
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<td>lipoid 581.3</td>
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<td>lower nephron — see Nephritis</td>
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<td>lupoid 710.0 [581.81]</td>
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<td>lupus 710.0 [581.81]</td>
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<tr>
<td>malarial 084.9 [581.81]</td>
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<td>minimal change 581.3</td>
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<td>necrotizing — see Nephrotic</td>
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<td>osmotic (sucrose) 588.89</td>
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<td>polyarteritic 446.0 [581.81]</td>
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<td>radiation 581.9</td>
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<td>Thalamic 353.1</td>
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<td>median thenar 354.1</td>
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<td>metatarsal 355.6</td>
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<td>cortical 353.8</td>
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<tr>
<td>chest (wall) 353.8</td>
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<tr>
<td>costal region 353.8</td>
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<tr>
<td>specified nerve NEC — see Disorder, nerve spinal (nerve) 355.9</td>
<td></td>
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</tbody>
</table>
• Verify codes 277.39 and 357.4 in the Tabular List of Diseases.
  ▪ Note the description for code 277.39 does not instruct you to assign code 357.4.
  ▪ Description for code 357.4 is italicized and states, “Code first underlying disease, as” with a listing that includes “Amyloidosis (277.30 – 277.39)”.

• Report code 277.39 followed by code 357.4 on the claim.

http://www.monroecollege.edu/AcademicResources/ebooks/1111540586_lores_ch03.pdf
Always verify code in tabular list.
ICD-9 Tabular List

357.4 Polyneuropathy in other diseases classified elsewhere

Code first underlying disease, as:

- amyloidosis (277.30-277.39)
- beriberi (265.0)
- chronic uremia (585.9)
- deficiency of B vitamins (266.0-266.9)
- diphtheria (032.0-032.9)
- hypoglycemia (251.2)
- pellagra (265.2)
- porphyria (277.1)
- sarcoidosis (135)
- uremia NOS (586)

AHA: 4Q,'02, 47; 2Q,'98, 12

357.81 Chronic inflammatory demyelinating polyneuritis

DEF: Inflammation of peripheral nerves resulting in destruction of myelin sheath; associated with diabetes mellitus, dysproteinemia, renal failure and malnutrition; symptoms include tingling, numbness, burning pain, diminished tendon reflexes, weakness, of lower extremities.
HH Appeals Data
## HH Appeals Data
### Top Reason Codes

<table>
<thead>
<tr>
<th>Reason Code (RC)</th>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7CONB</td>
<td>Recovery Auditor (RA) claim adjustment. Please refer to the RA review result letter for adjustment details.</td>
<td>4,992</td>
</tr>
<tr>
<td>5FF2F</td>
<td>F2F encounter requirements not met</td>
<td>3,892</td>
</tr>
<tr>
<td>7CONF</td>
<td>RA claim adjustment. Line level denial due to duplicate payment.</td>
<td>980</td>
</tr>
</tbody>
</table>
Redetermination Decisions

7CONB – 4,992
- 88% Unfavorable
- 9% Favorable
- 1% Partially Unfavorable
- 3% Dismissed

5FF2F – 3,892
- 83% Unfavorable
- 9% Favorable
- 3% Partially Unfavorable
- 4% Dismissed

7CONF – 980
- 66% Unfavorable
- 30% Favorable
- 2% Partially Unfavorable
- 3% Dismissed
How do I Appeal a Denial?

• When appealing, ensure that the request includes all denial reasons applied to the claim.
  ▪ Some claims will contain line item specific denials and others will contain one reason code for the entire claim.

• Documentation submitted with the appeal should:
  ▪ Support the patient’s need for services rendered.
  ▪ Contain information that addresses all reasons for denial.
  ▪ Include all required admission and continuing care documents [e.g., POC, physician narrative statement, F2F, etc.].
Under Palmetto GBA’s medical review process:

- The documentation submitted in response to the Additional Documentation Request (ADR) is reviewed in its entirety.
- For provider-specific and service-specific medical review edits, a Claim Review Decision and Education letter is mailed to the provider.
  - Letter includes Redetermination: 1st Level Appeal form, which is pre-populated with:
    - Provider Name
    - Provider Address
    - Patient Name
    - Health Insurance Claim (HIC) Number
    - Claim Number
    - Claim Date(s) of Service
MR Claim Review Decision and Education

NAME OF PROVIDER
PROVIDER ADDRESS
CITY, STATE ZIP

Beneficiary Name: XXXXXXXX
Medicare Beneficiary: XXXXXXXX
Date of Service: From: 00/00/0000 To: 00/00/0000
Claim: 000000000000AAA
xFlow DCN: 000000000000000

Dear Provider,

You are receiving this letter for educational purposes. Your claim was medically reviewed via an Additional Development Request (ADR) and denied because errors listed below for J11 Part A services for Edit ID XXXX.

The Granular Error Denial table details the primary reason for the denial. The Granular Error Education table provides additional information.

<table>
<thead>
<tr>
<th>Granular Error Denial</th>
<th>Denial Code and Description</th>
</tr>
</thead>
</table>

For educational information regarding the above denials, please refer to the Palmetto GBA website as follows:

- www.PalmettoGBA.com/Medicare
- Choose the appropriate contract type (J11 MAC Home Health and Hospice, or J11 Part A MAC - NC, SC, VA, WV)
- In the "SEARCH HELP" box, enter a key word(s) associated with the denial reason (e.g. face to face), hit Enter
- This will bring up any articles or education related to that topic
When a claim is reviewed and either fully or partially denied, detailed remarks can be viewed on claim page 4 in DDE after the review is completed. Any errors or deficiencies identified during the review process will be entered on this page.
Providers also have the option to submit their appeals through the Online Provider Services (OPS) application. Use the secure message option to select the Redetermination Request Form.

- The form is pre-populated with the provider information.
- Complete the other fields.
- Documentation is submitted using the attachment feature.
  - Unlimited attachments can be submitted.
  - Attachments must be a pdf document.
  - Each attachment can be up to 40 megabytes.
  - Maximum of 150 megabytes.
Why was My Claim Denied With RC 7CONB?

- This reason code means that the claim was adjusted based on a review done by the Recovery Auditor (RA) and an improper payment was identified.
- Palmetto GBA is required to adjust the claim as instructed by the RA.
  - The RA decision letter for complex reviews provides the explanation of the reason for the improper payment.
• Claim for DOS 05/18 – 06/15 was initially paid.

• Recovery Auditor (RA) selected claim for review approximately two and a half years after the paid date.

• Claim adjusted for denial as requested by the RA.
Request for redetermination submitted on time.

Documentation submitted with request included:

- Valid POC.
- Valid F2F encounter documentation.
- Skilled nursing visits supported based on:
  - Open wound large right toe (skilled nursing required for dressing changes).
  - Coumadin dosage changes.
  - Patient INR monitoring.

Redetermination Decision

- The denial initiated by the Recovery Auditor (RA) was “reversed.”
- The claim was adjusted again to allow payment for all services billed.
- No further action needed.
• Claim with DOS 05/07 – 07/05 was initially paid.
• Recovery Auditor (RA) selected claim for review approximately two years after the initial paid date.
• Claim was adjusted for denial as requested by the RA.
RC 7CONB – Unfavorable Example
Redetermination Information

Request for redetermination submitted on time.

Documentation submitted with request included:

- **POC** – No noted deficiencies.
- **F2F Documentation** - sufficient physician narrative of the beneficiary specific-clinical conditions as seen during the encounter and how they supported homebound status not documented.
- **Other documentation** – did not support patient’s homebound status; documentation indicated that the patient was independent with activities of daily living and able to administer his medications without assistance, which did not establish specific impairments that required a skilled need.

Redetermination Decision

- Denial was “affirmed”.
- Redetermination decision letter mailed that explained the details of the decision and further appeal the rights.
## RC 7CONB – Unfavorable Example

### What to do Now?

| Is there a F2F encounter document with the physician narrative, and supporting homebound documentation that existed prior to billing the claim? |
|---|---|
| **Yes?** | **No?** |
| • Proceed to the next step in the appeals process, which is a Reconsideration by the Qualified Independent Contractor (QIC).  
• Submit all required documentation with the request, especially the F2F encounter documentation with physician narrative and homebound documentation.  
• This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. | • Documentation that did not exist prior to billing cannot be added and/or backdated.  
• No payment can be made on the claim. |
• Claim for DOS 09/06 – 11/04 was initially paid.
• Recovery Auditor (RA) selected claim for review approximately one year after the paid date.
• Claim adjusted for denial as requested by the RA.
RC 7CONB – Partially Favorable Example
Redetermination Information

Request for redetermination received on time.

Documentation submitted with the request included:

- **POC** – supported the patient’s home bound status and the need for two skilled nursing visits as billed and included orders for physical therapy (PT) evaluation visit, but did not provide the expected outcome or goals.

- **Additional physician orders** – PT evaluation documentation with additional orders and complete goals were included, but were not counter signed and dated by the physician.

Redetermination Decision

- The denial for the two skilled nursing visits initially billed was reversed, and the claim was adjusted to allow payment.
- Denial for PT visits was affirmed.
- Since only two nursing visits were allowed for payment, the episode was changed to a Low Utilization Payment Adjustment (LUPA) episode, which generated a change in the Health Insurance Prospective Payment System (HIPPS) code initially billed; thus partial payment was allowed for this episode.
| Did valid documentation for PT visits with physician signed and dated order for the additional services existed before the claim was filed? |
|---|---|
| **Yes?** | **No?** |
| • Proceed to the next step in the appeals process, which is a Reconsideration by the QIC.  
• Submit all required documentation with the request, especially the documentation supporting the additional PT visits ordered with the physician’s signed and dated signature.  
• This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. | • Documentation that did not exist prior to billing cannot be added and/or backdated.  
• No payment can be made on the claim. |
RC 7CONB – Dismissal Example
Initial Denial Details

- DOS on claim 04/19 through 05/03.
- Claim adjusted on 03/24 (two years after initial payment made) as requested by the Recovery Auditor (RA).
- Adjusted claim finalized on 03/31, which is the date of the Remittance Advice.
• Redetermination requests must be submitted within 120 days of the date of the Remittance Advice or demand letter.

• For this example, the request for a redetermination was due to Palmetto GBA no later than 07/31.

• The request was received on 08/07, and dismissed due to late filing.
Timely filing requirements can be extended if good cause is established.

Examples of good cause are:

- Incorrect or incomplete information about claim or subject was furnished to provider by official sources (CMS, the contractor, or the Social Security Administration).
- Unavoidable circumstances that prevented the provider from timely filing a request.
  - Ex: Major floods, fires, tornados, and other natural catastrophes.
  - NOTE: Failure of a billing company or other entity retained by the provider to submit a request on time does not constitute good cause.
If good cause exists for filing the request late, resubmit the request and ensure that the request includes documentation to support the provider’s position as to why the request is being submitted late.

Any “State of Disaster” proclamations made by the president or state governors are automatically established as good cause (e.g., areas where hurricanes or tornados, etc.).
• The claim was medically reviewed and the reviewer determined that the required F2F encounter documentation was missing/incomplete/untimely.
  ▪ Physician certification is deemed invalid when F2F requirements are not met.
  ▪ The exact reason for a F2F denial will vary from claim to claim.
  ▪ Denial explanations can be viewed in the remarks on claim page 4 of DDE.
• DOS 04/01 – 05/30:
  - Claim selected for review through Palmetto GBA’s ADR process.
  - Denial issued on 07/11.
  - Review results determined claim should be denied because:
    • F2F encounter document did not contain sufficient information of the clinical findings to support the patient’s homebound status and need for skilled services.
RC 5FF2F – Favorable Example
Redetermination Information

Request for redetermination submitted on time.

Documentation submitted with request included:

- Valid POC.
- Valid HH certification.
- F2F encounter with documentation that supported patient’s homebound status and need for skilled nursing visits due to arthritis of the knee that buckles, history of falls, and the patient has to ambulate with a cane outside of the home.

Redetermination Decision

- Denial of claim reversed and claim adjusted for payment of services billed.
- No further action needed.
• DOS on claim are 03/17 – 05/12.
  ▪ Claim selected for medical review through Palmetto GBA’s ADR process.
  ▪ Initial denial of the claim applied on 07/22.
  ▪ Initial review found:
    • F2F documentation did not include clinical findings to support patient’s homebound status.
    • The reviewer also found that the documentation did state the therapy goals in objective and measurable terms with expected date(s) of accomplishment.
    • Projected thirteen (13) therapy visits, but only six (6) were billed.
RC 5FF2F – Unfavorable Example
Redetermination Information

Request for redetermination submitted on time.

Documentation submitted with request included:

- **F2F documentation** – did not include a sufficient physician narrative of the beneficiary’s specific clinical conditions that supported the patient’s homebound status.
- **PT** – expectation of when/how goals would be met was not included.

Redetermination Decision

- Denial was “affirmed”.
- Redetermination decision letter mailed that explained the details of the decision and further appeal the rights.
## RC 5FF2F – Unfavorable Example
### What to do Now?

Is there a F2F encounter document with the physician narrative to support homebound status and therapy goals expected that existed prior to billing the claim?

<table>
<thead>
<tr>
<th>Yes?</th>
<th>No?</th>
</tr>
</thead>
</table>
| • Proceed to the next step in the appeals process, which is a Reconsideration by the QIC.  
• Submit all required documentation with the request, especially the F2F encounter documentation with physician narrative that supports homebound status and therapy documentation.  
• This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. | • Documentation that did not exist prior to billing cannot be added and/or backdated.  
• No payment can be made on the claim. |
• DOS 04/12 – 05/17, which is the second episode in a sequence of episodes.
  • Admission date for this patient was 02/11.
  ▪ Claim selected for review through ADR process.
  ▪ Claim fully denied on 09/19 because:
    • F2F encounter document was missing from the medical documentation submitted for this home health claim.
    • The F2F encounter is a requirement for admission to HH care. When this requirement is not met, initial and all subsequent episodes are subject to payment denial even if the claim for a previous episode processed and paid because it was not reviewed.
    • Review also revealed that there were twelve (12) therapy visits projected, but only ten (10) were billed which would have resulted in a change in HIPPS code.
**Redetermination request received on time.**

**Documentation submitted with request included:**

- **F2F Documentation** – valid from start of care (SOC).
- **POC** – valid and supported patient’s need for skilled nursing visits and PT.
- **OASIS** – projected therapy visits were twelve (12), but only ten (10) were billed.

**Redetermination Decision**

- Denial Skilled nursing and PT visits initially denied was reversed, and the claim was adjusted to allow payment for those visits.
- Total number of therapy visits projected in OASIS was twelve (12), but only ten (10) were billed.
- The HIPPS code generated from the OASIS was correct. However, only ten (10) therapy visits were billed, thus changing the threshold of therapy visits, which changes the payable HIPPS code.
- The HIPPS code change from 1BGP1 to 1BGN1 is considered a down code, thus resulting in a “partial payment”. 
RC 5FF2F – Partially Favorable Example
What to do Now?

### Do you disagree with the decision to down code the HIPPS code?

<table>
<thead>
<tr>
<th>Yes?</th>
<th>No?</th>
</tr>
</thead>
</table>
| • Proceed to the next step in the appeals process, which is a Reconsideration by the QIC.  
• Explain in the request the reason for the disagreement, documentation that existed prior to billing the claim that supports the additional therapy visits that were not billed (e.g., corrected UB-04 with additional therapy visits and clinical documentation to support that visits were made and were medically reasonable and necessary), and any other documentation to support services billed.  
• This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. | No further action is needed |
RC 5FF2F – Dismissal Example

Initial Denial Details

- DOS are 02/17 – 03/14.
- Claim received on 04/17 and selected for review through the ADR process.
- Response to ADR received on 05/16.
- Review decision made on 06/02 to deny payment on claim because the F2F documentation did not provide adequate information to support the need for skilled services and clinical findings to support the patient’s homebound status.
Redetermination request received on 07/29 but was not signed and/or dated.

- When submitting a request for a redetermination by Fax or Mail, providers may use the Redetermination Request Form found on Palmetto GBA’s website or provide a cover letter that contains all of the elements on the form.
- The form or letter must be signed and dated by the individual in the agency who is authorized to submit the request.
- If the request form or letter is not signed, the request will be dismissed.
• If time permits, the request for a redetermination may be resubmitted.
  ▪ Request for a redetermination must be submitted within 120 days of the date of the remittance advice.
  ▪ In this scenario, a request for a redetermination had to be submitted no later than 10/02.
  ▪ The provider did resubmit the request for a redetermination, which was received on 08/08.

• A redetermination decision was made and the provider notified of the decision.
Why was My Claim Denied With RC 7CONF?

- This RC is applied to a claim that has been adjusted due to a decision made by the Recovery Auditor (RA).
- The denial is applied at the line level when the RA has determined that payment for services billed on one or more specific dates were paid in error.
• Palmetto GBA initially paid claim for all services billed from 01/06 – 01/12.

• RA selected the claim for review three (3) years after the initial payment was made and determined that ten (10) of the fourteen (14) nursing visits billed were paid in error.
  ▪ Palmetto GBA adjusts paid claims when directed to do so by the Recovery Auditor (RA).
  ▪ The RA decision letter for complex reviews provides the explanation as to the exact reason for the denial.
RC 7CONF – Favorable Example
Redetermination Information

Request for redetermination submitted on time.

Documentation submitted with request included:

- **POC** – supported patient’s homebound status based on need for assistance of another individual and/or walker to ambulate due to shortness of breath with moderate exertion.
- **Physician’s order** – supported beneficiary’s medical condition for uncontrolled blood pressure, which was elevated upon admission, resulting in the need for skilled nursing services for observation and assessment and educating care giver.

Redetermination Decision

- Denial was “reversed”.
- No Further action needed.
• Payment for all services billed for DOS 10/04 – 10/12.
• Claim selected by Recovery Auditor (RA) for review approximately one (1) year after initial payment was made.
• Six (6) skilled nursing service visits billed for DOS 10/04, 10/05, 10/06, 10/09, 10/10, and 10/12.
• RA decision to deny two (2) skilled nursing visits (10/10 and 10/12).
• Claim was adjusted on 01/27 (one (1) year and one (1) month after the initial payment was made).
  - Palmetto GBA adjusts paid claims when directed to do so by the RA.
  - The RA decision letter for complex reviews provides the explanation as to the exact reason for the denial.
RC 7CONF – Unfavorable Example
Redetermination Information

Request for redetermination submitted on time.

Documentation submitted with request included:

- **POC** – did provide supporting documentation to establish patient’s homebound status.
- **F2F Documentation** - sufficient physician narrative of the beneficiary specific-clinical conditions as seen during the encounter and how they supported homebound status not documented.
- **Other Documentation** – indicated that patient was independent of activities of daily living, including medication administration.

Redetermination Decision

- Denial was “affirmed”.
- Redetermination decision letter mailed that explained the details of the decision and further appeal the rights.
RC 7CONF – Unfavorable Example
What to do Now?

| Is there a F2F encounter document with the physician narrative, and supporting homebound documentation that existed prior to billing the claim? |
|---|---|
| **Yes?** | **No?** |
| - Proceed to the next step in the appeals process, which is a Reconsideration by the QIC. | - Documentation that did not exist prior to billing cannot be added and/or backdated. |
| - Submit all required documentation with the request, especially the F2F encounter documentation with physician narrative and homebound documentation. | - No payment can be made on the claim. |
| - This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. |
Claim for DOS 03/23 – 05/18 initially paid for all services billed (ten (10) skilled nursing visits).

Claim selected for review by the Recovery Auditor (RA) three (3) years after initial payment was made.

RA review resulted in denial of seven (7) of the ten (10) skilled nursing visits (DOS 04/05 – 05/18).

Palmetto GBA adjusted the claim as directed by the RA.
RC 7CONF – Partially Favorable Example
Redetermination Information

Request for Redetermination received on time.

Documentation received with the request included:

- POC and/or other documentation – supported two (2) of the seven (7) nursing visits (04/07 and 04/13) denied by the Recovery Auditor (RA) observation and assessment for a three-week period because beneficiary had hypertension and antihypertensive medication change.

Redetermination decision

- Denial for remaining nursing visits “affirmed” because the documentation submitted did not support patient’s homebound status; documentation indicated that the patient was independent with activities of daily living and able to administer his medications without assistance, which did not establish specific impairments that required a continued skilled nursing.
- Redetermination decision letter mailed that explained the details of the decision and further appeal the rights.
### Is there documentation that existed prior to billing the claim to support the beneficiary’s homebound status for the nursing visits denied?

<table>
<thead>
<tr>
<th>Yes?</th>
<th>No?</th>
</tr>
</thead>
</table>
| • Proceed to the next step in the appeals process, which is a Reconsideration by the QIC.  
• Submit all required documentation with the request, especially the documentation to support the beneficiary’s homebound status for the nursing visits that were denied.  
• This is a new and independent review, and Palmetto GBA does not forward the medical records to the QIC. | • Documentation that did not exist prior to billing cannot be added and/or backdated.  
• No payment can be made on the claim. |
Claim for DOS 03/16 – 05/14 initially processed and paid.

Claim selected by Recovery Auditor (RA) for review approximately two (2) and a half years after the initial payment date.

Claim was adjusted as directed by the RA on 01/06 (two (2) and a half years after the initial paid date).

Adjusted claim finalized on 01/15, which is the date of the remittance advice.
Redetermination requests must be submitted within 120 days of the date of the remittance advice or demand letter.

For this example, the request should have been received by Palmetto GBA no later than 05/15.

The request was not received until 07/11, and dismissed due to late filing.
• If good cause exists for filing the request late, resubmit the request and ensure that the request includes documentation to support the provider’s position as to why the request is being submitted late.
HH PCC Data
## PCC Data – Top RC’s for Provider Inquiries

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>39011</td>
<td>Claim was not submitted on time.</td>
<td>1,938</td>
</tr>
<tr>
<td>38107</td>
<td>No Request for Anticipated Payment (RAP) found.</td>
<td>1,568</td>
</tr>
<tr>
<td>37186</td>
<td>Claim has been approved for payment.</td>
<td>1,436</td>
</tr>
</tbody>
</table>
How Many Inquiries did the PCC Receive?

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Total Inquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>39011</td>
<td>2,018</td>
</tr>
<tr>
<td>38107</td>
<td>1,624</td>
</tr>
<tr>
<td>37186</td>
<td>1,436</td>
</tr>
</tbody>
</table>
What Does RC 39011 Mean?

• Timely filing requirements not met.
  ▪ Claims filed on the CMS 1450 (UB-04) claim form, must be filed within twelve (12) calendar months from the “Through” date on the claim.
    • Timely filing for Requests for Anticipated Payment (RAPs) is determined based upon whether or not the final claim would be considered timely when submitted.
      ▪ **Example:** From date on the RAP is 01/01. The calculated end date of the episode is 03/01. The RAP is submitted on 02/28 the following year. The calculated end date of the episode is 03/01, so the RAP would be accepted because it is anticipated that the final claim would still be submitted within the timely filing requirements.
  ▪ Timely filing requirements may be extended if “good cause” exists.
    • Examples of good cause are:
      ▪ Administrative error (error or misrepresentation of an employee, Medicare contractor).
      ▪ Retroactive Medicare entitlement: this applies only if all Medicare admission requirements were completed when the patient was admitted to HH care.

Resources: [CMS IOM, Publication 100-04, Chapter 1, Section 70.7](#) Palmetto GBA’s Timely Filing Job Aid
Can I Appeal a Timely Filing “Denial”?

- Timely filing rejections are not considered a “denial” and cannot be appealed.

- If provider disagrees with the timely filing rejection, a written request may be submitted for review to determine if the time limit can be extended.
  - Request must include:
    - Patient name, address, Medicare Number.
    - Provider, name and address as it is in the provider enrollment file.
    - Provider Transaction Access Number (PTAN), which is the six-digit number assigned to the provider for billing privileges.
    - Provider NPI, and
    - A detailed explanation as to why the timely filing requirement should be extended.

- Note: RAPs that reject for timely filing cannot be adjusted or changed. Providers must submit the final claim and request the timely filing extension (if applicable) on the final claim after it has rejected for timely filing.
Where do I Send My Request to Extend the Timely Filing Requirement?

- Providers that submit claims to Palmetto GBA should send their written inquiries for an extension of the timely filing requirements either:
  - **By Mail:** Palmetto GBA  
    HHH PCC  
    Mail Code: AG-840  
    P. O. Box 100238  
    Columbia, SC 20202-3238
  
  OR

  - **By Fax:** 803-462-2217

See Palmetto GBA’s [Timely Filing Job Aid](#) and [Checklist for Timely Filing Extension Due To Error or Misrepresentation](#)
Inquiry Example: 39011
Episode dates 05/22 – 07/20

1. Inquiry received requesting that timely filing be waived on the RAP.

2. Request denied because RAPs do not count as a “claim” and cannot be adjusted or otherwise modified once processed.

3. Follow-up inquiry for assistance with timely filing edit on the final claim.

4. Prior to the receiving the inquiry, Palmetto GBA had received a billing dispute request, which had not yet been processed. After receiving the inquiry, the billing dispute request was processed and the issue was resolved. As a result, a timely filing extension was granted, the final claim was adjusted and processed for payment.
Timeline of Events

Initial RAP for 05/22 received on 06/05, which was within fifteen (15) days of the start date of episode. The RAP processed and finalized, but a “Z” no pay indicator was applied, so no payment was made.

Beneficiary’s Medicare eligibility records at that time the RAP was initially submitted showed Medicare as the secondary payer; thus no payment was made on the RAP.

On 09/26, the RAP auto-canceled because the final claim was not submitted.

Final claim must be submitted within the greater of 60 days of the date the RAP paid/finalized (P B9997) or 120 days from the SOC date. Otherwise, the RAP will auto-cancel.

In this example, the final claim should have been submitted no later than 09/18 (120 days from the SOC was greater than the date the RAP processed).

On 03/03 (the following year), the RAP was resubmitted and rejected with reason code C7080.

RC C7080 = the DOS on the claim overlap a hospital inpatient stay.

Patient’s Medicare eligibility records showed that an inpatient hospital bill with DOS 05/01 – 05/30 had been paid between the time the initial RAP auto-canceled and the new RAP was submitted.
Timeline of Events Continued

RAP was submitted four additional dates RTP’d each time with RC C7080.

Subsequent RAP Submission Dates 05/12, 05/16, 06/17 and 06/24 (keep in mind that these dates are all the calendar year following the actual start date of the episode in question).

After the last RAP returned to provider (RTP’d), the provider submitted a billing dispute request to resolve the overlapping DOS on the inpatient hospital bill. The billing dispute was resolved, and the claim for the inpatient services was canceled. The RAP was submitted again on 10/08 and processed, but it rejected for timely filing.

Final claim successfully submitted on 01/22, but was rejected because the timely filing period had passed.

On 02/09, the provider’s requested an extension of the timely filing requirement, which was granted and the final claim was adjusted to process for payment consideration.
Could This Have Been Resolved Sooner?

- The answer to this question is **YES**!
- Submit the final claim on time.
- If the RAP auto-cancels as it did in this case, resubmit the RAP as soon as possible.
  - Track the status of your RAPs and claims.
- When the RAP is resubmitted, ensure that it finalizes (PB9997).
- If the RAP RTPs or is rejected, take the necessary steps to resolve the rejection before attempting to resubmit the RAP.
When the RAP rejects with RC C7080, do the following:

1. Verify that the patient was not in the hospital on the start date of the episode by:
   a. Reviewing the patient’s chart.
   b. Viewing the eligibility records in DDE or OPS.
      i. If the patient was in the hospital, no payment can be made.
      ii. If the patient was not in the hospital, contact the hospital to request that the inpatient claim be corrected or canceled.
      iii. If the hospital refuses, is unwilling to cooperate or does not make the correction to the claim within an acceptable amount of time, submit a request to the Medicare contractor to resolve the billing dispute.

Note: There is no standard that defines what an acceptable amount of time is. The agency should have a process in place to determine how long they should wait before requesting assistance from the contractor.
Using the DDE Inquiries Menu 01, providers can access information that is stored in the beneficiary’s eligibility files when it is available.

For inpatient stays in a hospital or a Skilled Nursing Facility (SNF), select option 10 from the inquiries menu in DDE.

MAP1751 will display, and if any inpatient claims have been filed, the inpatient stay dates will display on this screen.

Under the “Current Benefit Period Data” heading, the beginning and ending dates of the most current inpatient stay in either a hospital or a SNF are displayed when applicable in:
- FIRST BILL DT = The beginning date of an inpatient benefit period.
- LST BILL DT = The ending date of an inpatient benefit period.
 Viewing Inpatient Data in DDE

<table>
<thead>
<tr>
<th>HIC</th>
<th>CURR XREF HIC</th>
<th>PREV XREF HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSFER HIC</td>
<td>C-IND</td>
<td>LTR DAYS</td>
</tr>
<tr>
<td>LN</td>
<td>FN</td>
<td>MI</td>
</tr>
<tr>
<td>DOB</td>
<td>DOD</td>
<td></td>
</tr>
<tr>
<td>ADDRESS: 1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

**CURRENT ENTITLEMENT**

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>BENEFIT PERIOD DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRST BILL DT</td>
<td>LST BILL DT</td>
</tr>
<tr>
<td>SNF FULL DAYS</td>
<td>SNF PART DAYS</td>
</tr>
<tr>
<td>INP DED REMAIN</td>
<td></td>
</tr>
<tr>
<td>HSP FULL DAYS</td>
<td>HSP PART DAYS</td>
</tr>
<tr>
<td>BLD DED PNTS</td>
<td></td>
</tr>
</tbody>
</table>

**PSYCHIATRIC**

| PSY DAYS REMAIN | PRE PHY DAYS USED | PSY DIS DT | INTRM DT IND |

Please enter data - HIC, LN, FN, SEX, and DOB. Press PF3-EXIT PF8-NEXT PAGE.
Viewing Inpatient Data in OPS

Inpatient Days Remaining By Spell

<table>
<thead>
<tr>
<th>DOEBA</th>
<th>DOLBA</th>
<th>Full Inpatient Days</th>
<th>Full Inpatient Copay Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/12/2013</td>
<td>04/25/2013</td>
<td>47</td>
<td>30</td>
</tr>
<tr>
<td>07/13/2011</td>
<td>10/04/2011</td>
<td>31</td>
<td>30</td>
</tr>
</tbody>
</table>

SNF Days Remaining by Spell

<table>
<thead>
<tr>
<th>DOEBA</th>
<th>DOLBA</th>
<th>Full SNF Days</th>
<th>Full SNF Copay Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/12/2013</td>
<td>04/25/2013</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>07/13/2011</td>
<td>10/04/2011</td>
<td>0</td>
<td>45</td>
</tr>
</tbody>
</table>
How do I Submit A Request to Resolve a Billing Dispute?

- Palmetto GBA has a **Billing Dispute Resolution Request Form** to assist providers that submit their claims to us.

- Before submitting the request:
  - An attempt to resolve the matter with the other entity must have been made and documented.
  - The form is not required, but the letter or other documentation submitted to request assistance must contain the information provided on the form.
  - The request must be for dates of service that are still within the timely filing period.
• A HH final claim type of bill (TOB) 329 has been submitted; however a processed matching RAP (TOB 322) cannot be found for one of the following reasons:
  - No RAP was submitted.
  - The RAP auto-canceled (TOB 328) because the final claim was not received timely.
    • Final claim must be submitted within the greater of 60 days from the date the RAP paid or 120 days of the SOC date.
  - The submitted RAP is in status/location (S/LOC) of T B9997 or R B9997.
  - Key information on the final claim (329 TOB) does not match the RAP:
    • Statement from date.
    • Admission date.
    • First 4 positions of the HIPPS code.
    • Line item DOS for the HIPPS code (0023 revenue line date).
    • Provider number.
The RAP and Final Claim Process

RAP is submitted as a 322 type of bill (TOB).

Final claim processes and moves to the P B9997 status and location.

RAP processes and moves to a P B9997 Status and location. Payment on the RAP is made at 60% of the episodic payment for the initial episode and 50% for all subsequent episodes.

The remaining amount due for the episode is paid. The actual amount paid is the episodic payment amount less the amount paid on the RAP.

Final claim is submitted with TOB 329.
Final Claim Submission Errors

- **Final Claim Submitted Errors**
  - **Final Claim submitted timely but information does not match the RAP, claim edits with reason code 38107.**
  - **Final claim submitted without resubmitting the RAP edits with reason code 38107.**
  - **Final claim submitted without correcting and resubmitting the RAP, claim edits with reason code 38107.**
  - **Final claim is corrected with information that matches the RAP and resubmitted.**
  - **Information on the RAP was submitted incorrectly: Cancel the RAP (TOB 328). When cancel RAP processes, resubmit the RAP allow to finalize (S/L P B 9997) and resubmit the final claim.**

- **Final Claim Submission Errors**
  - **Final claim submitted without resubmitting the RAP edits with reason code 38107.**

**RAP Submitted with TOB 322 (Should be at the beginning of the episode).**

- **RAP processes, moves to status and location P B9997.**
- **RAP returns for correction (RTP).**

**RAP auto-cancels because final claim not submitted timely.**
• Claim returned with reason code 38107 because the RAP auto-canceled. Provider was advised to resubmit the RAP
  ▪ The RAP has to be resubmitted before rebilling the final claim
What Could Have Been Done to Resolve This?

- Checking the status of the RAP before billing the final claim.

- The status of the RAP can be checked using the DDE system, OPS, or the Interactive Voice Response (IVR) unit.

- Since the RAP auto-canceled, resubmit the RAP, allow it to process, and then submit (F9 in DDE) the claim.
  - Ensure that all information on the final claim is correct before resubmitting.
Resources to Assist With Resolving RC 38107

- **Resources:**
  - The [Home Health Basics Training Modules](#) on Palmetto GBA’s website contain detailed instructions for billing HH claims to Medicare.
  - The [Claim Submission Error Help](#) tool contains detailed information about RC 38107.
  - The CMS [Internet Only Manuals](#) (IOMs), Publications 100-02, Chapter 7 and 100-04, Chapter 10, contain billing and documentation requirements.
What Does RC 37186 Mean?

- The claim was approved for payment.
- Payment made on the claim is made in accordance with the home health prospective payment system (HH PPS).
• Inquiry received on 12/18 to verify claim for episode with dates of service 06/03 – 07/22 processed.

• PCC staff confirmed that claim paid on 10/21.
Timeline of Events

- RAP for episode start date 06/03 received on 06/10.
  - RAP processed and paid on 06/20.

- Final Claim for episode dates 06/03 – 08/01 received on 08/06.
  - Final claim processed and paid on 08/20.

- Cancellation claim for episode received on 08/28.
  - Cancellation claim processed on 09/05. The entire episode was removed from the Common Working File (CWF).
Timeline of Events Continued

Received another final claim on 09/05 with episode dates of 06/03 – 07/22.

- Claim RTP’d with RC 38107 because the cancellation claim had removed the entire episode from the CWF. A new RAP should have been submitted after the cancellation claim processed.

New RAP received on 09/19.

- RAP processed and paid on 09/28.

Final claim with episode dates of 06/03 – 07/22 received on 10/03.

- Claim processed and paid on 10/21.
Was a Telephone Call Really Necessary?

- The answer to the question, in general, is **No!**
- Providers can check the status of their claims in DDE or in OPS.
- Providers also receive a remittance advice for all claims that are fully processed.
  - Fully processed means that either full or partial payment has been made (P B9997), the claim has been rejected (R B9997) or denied (D B9997), but posted to the CWF.
- In this instance, the provider could have adjusted the final claim to change the dates and, if needed, other information.
- The only time it is necessary to actually cancel a claim is when the episode start date was submitted incorrectly on the RAP or when the claim should never have been submitted.
HH Claims Data
<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>38107</td>
<td>HH claim submitted and matching RAP not found.</td>
<td>177,389</td>
</tr>
<tr>
<td>38055</td>
<td>HH claim submitted as Medicare primary and contains exact service dates corresponding to a previously submitted claim for the same provider with at least one matching revenue code.</td>
<td>29,478</td>
</tr>
<tr>
<td>38158</td>
<td>HH duplicate claim of one that is suspended or denied.</td>
<td>29,386</td>
</tr>
</tbody>
</table>
Total Number of RTP Claims

- Total Count: 173,389
- Reason Code 38107: 29,478
- Reason Code 38158: 29,386
• RAP submitted/received on 02/07.
• Payment on RAP made 02/14.
• SOC Date 01/30.
• Final claim should have been submitted no later than 05/30.
• Final claim initially submitted on 03/05, but RTP’d with RC 31790 and was not corrected until 12/18.
RC 38107 – Claim Resolution Steps

- In this scenario, the final claim was received on time, but returned for correction and was not resubmitted before the RAP auto-canceled.
- Resubmit the RAP.
- Resubmit the final claim after the RAP moves to P B9997 status and location.
  - Double check to ensure that all information on the final claim matches the RAP.
# DDE Status/Location Codes

<table>
<thead>
<tr>
<th>Status</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>The claim is completely processed (either fully or partially paid).</td>
</tr>
<tr>
<td>D</td>
<td>The claim is completely processed and was denied.</td>
</tr>
<tr>
<td>R</td>
<td>The claim is completely processed and was rejected.</td>
</tr>
</tbody>
</table>
| S      | The claim is still in process.  
  **Note:** *[no provider intervention can be made other than responding to ADR if applicable]*. |
| T      | The claim has been RTP for correction. |
| I      | The Intermediary has either inactivated OR specially processed your claim.  
*RTPs more than 60 days old and suppressed claims are moved to an “I B9997” status for 3 years then purged.* |
• The claim submitted contains the exact service dates corresponding to a previously submitted claim for the same provider with at least one (1) matching revenue code.
  ▪ This is essentially a duplicate claim error.
  ▪ One (1) or more of the dates of service on the claim overlap with a claim that has already been submitted and processed with the same date(s), or
  ▪ The final claim was submitted and not allowed to finalize before it was resubmitted.

**Note:** This is one of several top reason codes that indicates that a duplicate claim has been received in the Medicare claims system.
RC 38055 – Claim Example

- Episode dates = 03/03 – 05/01.
- RAP submitted/received on time, processed and did not auto-cancel.
- Final claim submitted/received on 10/29 and 11/06.
- The first claim received was still processing and in a suspense status when the second claim was received.
- The system doesn’t know which claim to process, so the first claim rejects with RC 38055.
- In this scenario, the second claim returned with RC 38107 and 38158; the first claim received had already alerted the system that the final claim was submitted against the RAP, so this claim could not process either.
- The RAP also auto-canceled on 01/13 because a valid final claim was not received timely.
How to Resolve RC 38055

• Monitor the status of the claim in DDE, OPS or through the IVR.

• Claims in a suspense (“S”) status are being processed and do not need to be resubmitted.

• Before submitting another final claim, check to make sure that another final claim has not already processed (P B9997, D B9997 or R B9997) and posted to the CWF.
  - If so, then adjust the final claim to make the necessary correction if possible (claims denied due to medical necessity cannot be adjusted).

• If, as in this scenario, the final claim never posted to CWF, check to be sure that the RAP has not auto-canceled before resubmitting the final claim.
  - If RAP has not auto-canceled, resubmit the final claim.
  - If RAP has auto-canceled, resubmit the RAP, allow it to finalize then resubmit the final claim.
• The claim is a duplicate of a paid, suspended or denied home health claim and contains the same:
  ▪ Provider number.
  ▪ Health Insurance Claim (HIC) number.
  ▪ Revenue code and line item DOS, but without a cancel date.

Note: This is one of several top reason codes that indicates that a duplicate claim has been received in the Medicare claims system.
• Episode dates = 05/07 to 05/23.
• RAP submitted and processed.
• Final claim initially submitted/received on 06/04, but RTP’d with RC 31091 on 06/05.
• The claim was retransmitted on 07/16 but RTP’d with RC 38158 because a new final claim was submitted/received on 07/15 and already in process when this claim was retransmitted.
• Checking the status of claims before attempting to submit a new claim or correct and retransmit an existing claim will help prevent this type of error.
How to Resolve RC 38158

- Always check the S/LOC of submitted claims before attempting to resubmit, correct or adjust.
  - The original claim paid (P B9997).
    - If changes need to be made to the original paid claim, it can either be adjusted or canceled (cancelling a claim should only be done if absolutely necessary).
  - The original claim denied (D B9997).
    - The claim has been denied by medical review.
    - A claim that has been denied may only be appealed.
    - Do not submit another claim.
  - The original claim suspended (S BXXXX).
    - Check the reason code on this claim for additional information.
    - Any further inquiries on the suspended claim should be directed to the PCC at 855-696-0705.
    - Do not submit another claim for one that is suspended.
The following are available on Palmetto GBA’s website at www.PalmettoGBA.com/hhh:

- Job aid [Claim Status and Location Hints and Tips](#).
- Job Aid - [Appeals, Adjustments and The D9 Claim Change Reason (Condition) Code And Cancelling a Claim](#).
- [Claim Submission Error Help](#).
- [Claims Payment Issues Log](#).
Tying It All Together
DMAIC

- **Define**: clearly articulating the business problem, goal, potential resources, project scope and high-level project timeline.

- **Measure**: documenting the current process, validating how it is measured, and assessing baseline performance.

- **Analyze**: isolate the top causes, list and prioritize potential causes of the problem, and prioritize classes and subclasses of errors, and target interventions.

- **Improve**: fully understanding the top causes identified in the Analyze phase, with the intent of either controlling or eliminating those causes to achieve breakthrough performance.

- **Control**: Sustaining the changes made to guarantee lasting results.

[Link](http://www.dmaictools.com/wp-content/uploads/2009/05/Six-Sigma-DMAIC-Methodology.png)
Palmetto GBA Actions – Define

- Research the CMS design requirements for addressing the potential or observed vulnerabilities.
- Design requirements are typically contained in Medicare statute, regulation, manual/National Coverage Decision (NCD) instruction, or Local Coverage Determination (LCD).
- Communicate them to providers.
Palmetto GBA Actions – Measure

• Determine the relevant metrics that will be used to track improvement for providers selected for medical review.

• All error classes undergoing medical record audits will have impact severity risk maps constructed.
Palmetto GBA uses a procedure that determines the inherent level of risk of an error-class based on a combination of financial risk and National or local audit experience.

“Dollars at risk”.

“Estimated error dollars” – the product of dollars at risk and either the locally corresponding Charge Denial Rate (CDR) measured by Palmetto GBA’s PCA process or the corresponding Claims Payment Error Rate (CPER) measured and reported Nationally by the CERT Contractor – are subjected to a weighting procedure that determines an “a priori risk score”.
• Conduct medical review to validate problem(s).
• Prioritize classes and subclasses of errors, and target interventions.
• Notify providers of results.
• Continued medical review.
• One-on-one education via telephone conferences.
• Educational articles.
• Webcasts.
• LCDs.
• Social media.
  ▪ The [Going Beyond Diagnosis (GBD) blog](#), and
  ▪ Twitter account: @BeyondDx.
• Utilize statistical process control methods to identify recurrent problems with providers that have experienced denials via the Progressive Corrective Action (PCA) process.

• Prevent new problems by systematically sampling new providers for known error-classes within their specialty/service type.
Online Provider Services (OPS)

OPS
Explore The Possibilities!
A Suite of eServices!

Claim Status
Eligibility
Remittances Online
Financial Information: Payment Floor, Last Three Checks Paid
Appeals – Redetermination Request Form
Medical Review ADR Response Form

eChecks
eOffset Request Form
Online Provider Services (OPS)

- Placeholder for OPS video
Secure Forms and Messaging

Welcome to secure forms. You can now submit forms to Palmetto GBA securely through OPS. You may attach up to five PDF attachments to each form. Each attachment can be up to 5MB in size. The forms and attachments are automatically entered into our workflow. This makes form processing more efficient and cost effective.

To begin, please select an answer to the questions from the drop-down selections below. Based upon the answer given for each of the questions, the available form(s) will appear at the bottom of this box. At this time, only Appeals forms are available.

Select a Topic: Appeals

Select a Type: First level appeal on a Medicare Claim

Is your appeal late? (over 120 days for a redetermination or over 365 days for a reopening): No

Redetermination: 1st Level Appeal (AP-J11-B-1000)
Secure Forms and Messaging

Select a Topic: Appeals

Select a Type: First level appeal on a Medicare Claim

Is your appeal late? (over 120 days for a redetermination or over 365 days for a reopening): No

Redetermination: 1st Level Appeal (AP-J11-B-1000)
Owe Medicare Money?

Request an immediate offset to repay your overpayment or request a that all future demanded overpayments are set for immediate offset.
Owe Medicare Money?

Use eChecks to repay Medicare
Refund your overpayments electronically through OPS >>

Make electronic check payments, for demanded or voluntary payments with no additional processing or transaction fees.
Other eServices in OPS

Respond to ADRs
Submit Appeals

- Unlimited attachments.
- Each attachment can be up to 40 Megabytes.
- Total file size for all attachments is 150 Megabytes.
Navigating Palmetto GBA’s Website

- Placeholder for web navigation video
How do I Access Palmetto GBA’s Website?

Palmetto GBA’s HH and Hospice Website URL Is:

www.PalmettoGBA.com/hhh
How do I Contact Palmetto GBA?

- Register For Updates.
- Email Us Questions.
- Contact Us By Telephone.
What Social Media Does Palmetto GBA Have?

- Try Our Blog
- Face Book
- Twitter
- LinkedIn
- YouTube
Palmetto GBA Website
Self Service Tools & Left Navigation

- From Acronym/Terminology Index to Tools and Calculators, find the resources that will assist you with your needs.
- Direct link to ICD-10 information.

- This option provides educational resources such as the Event Registration Portal that houses Palmetto GBA’s event schedule.

- Claims Processing Issues Log (CPIL)
- Forms
- ICD-10 Website
- Job Aids
- Workshops

Self Service Tools
Learning and Education
Most Frequently Viewed Topics
CMS Website

CMS Website

- www.cms.gov

Medicare

- This section provides information specific to the Medicare Program from General Information to Special Topics. Each section on this page has options to select that will take you to the information you need.

Regulations & Guidance

- The CMS IOMs, Paper-Based Manuals, and Transmittals, MLN Matters Articles® as well as a number of other resources are available in this section.

Outreach & Education

- This section has a number of options that will assist you with educational needs. Earn continuing education credits for completing certain educational sessions, or find tools that you can use to help your agency/facility or others.
Questions????