

Home Health & Hospice Medicare A Newsline



CAHABA
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BENEFIT
ADMINISTRATORS, LLC

Important Information from Cahaba Government Benefit Administrators®, LLC (Cahaba)

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com















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Cahaba Learning Corner 16

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Key for Icons:



Home Health Providers



Hospice Providers

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News Flash Messages from CMS for Home Health and Hospice Providers

**Flu Season is Upon Us!**

The Centers for Medicare & Medicaid Services (CMS) encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.

**Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program**

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. All bids must be submitted in DBidS, the on-line bidding system, by 9 p.m. prevailing Eastern Time on December 21, 2009; all required hardcopy documents that must be included as part of the bid package must be postmarked by 11:59 p.m. on December 21, 2009. If you are interested in bidding, you must designate one Authorized Official (AO) from those listed on the CMS-855S enrollment form to act as

your AO for registration purposes. The Round 1 Rebid competitive bidding areas (CBAs), product categories, DBidS information, bidder charts, educational materials, complete RFB instructions, and registration information, can all be found at <http://www.dmecompetitivebid.com>, which is the Competitive Bidding Implementation Contractor Web site.

News from CMS for Home Health and Hospice Providers



Further Clarification of Instructions on Using 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: SE0928

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: 6426

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

In CR 6426, CMS instructed providers that it must utilize the CAS segment in the 837I when submitting MSP claims to their Medicare contractor. CR 6426 also informed providers that they cannot submit MSP claims using direct data entry (DDE) since the DDE process does not support the CAS segment adjustments as found in the 837. CR 6426 elicited questions from providers that CMS is addressing in this Special Edition (SE) article.

CAUTION – What You Need to Know

CMS wants providers, who normally submit claims via DDE, to know that they **may use the PC-Ace product Pro32 free billing software** which has MSP billing capabilities including the required CAS segment to identify CAS segment adjustments. However, providers **may use any 837 billing software deemed warranted to submit MSP claims.**

GO – What You Need to Do

In addition to submitting MSP claims with the CAS segments via the billing software, MSP adjustments should be submitted for MSP claims that were originally submitted via DDE on and prior to October 4, 2009, using the 837 transaction and billing software as noted above. DDE MSP adjustment claims will not be accepted. See the “Background” and “Additional Information” sections of this article for further details regarding these changes.

Background

As stated in CR 6426, MSP provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is Obligated to Accept as Payment in Full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

CR 6426 reminded you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

As already mentioned, you may use the PC-Ace product Pro32 free billing software which has MSP billing capabilities including the required CAS segment to identify CAS segment adjustments. However, providers may use any 837 billing software deemed warranted to submit MSP claims. Check the Web site of your Medicare contractor for more details on billing software that they have available for you. You can find their Web site address at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

Note from Cahaba: Go to Cahaba's [EDI Software Downloads / Instructions](#) Web page for information about the PC-Ace produce Pro32 free billing software. If you have questions, contact our Electronic Data Interchange (EDI) Services department at (866) 839-2441.

NOTE: This article does not alter the credit balance reporting process.

Additional Information

If you have questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Phone Us" to call the Provider Contact Center.

You can find the MLN Matters® article related to CR 6426 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf> on the CMS Web site.

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Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters[®] Number: MM6716

Related CR Release Date: November 2, 2009

Related CR Transmittal #: R589OTN

Related Change Request (CR) #: 6716

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Provider Types Affected

This article is for suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs), Medicare administrative contractors (MACs) and/or durable medical equipment Medicare administrative contractors (DME MACs)) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6716, which provides instructions on continuing the payment policy for general maintenance and servicing of certain oxygen equipment after the 36-month rental cap, as established in calendar year (CY) 2009, for dates of service through June 30, 2010. See the “Key Points” section of this article for specific payment instructions.

Background

Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36 month rental cap. Section 144(b)(1) of the MIPPA, provides for payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap if the Secretary of the Department of Health and Human Services determines that such payments are reasonable and necessary. Initial instructions relating to the maintenance and servicing payments for oxygen concentrators and transfilling equipment for CY 2009 were issued in Transmittal 497, CR 6509, dated May 22, 2009. The MLN Matters[®] article for this CR is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf> on the CMS Web site. CR 6716 provides instructions on the continuation of these maintenance and servicing payments in CY 2010 for dates of service through June 30, 2010.

As indicated in Transmittal 497 (CR 6509), CMS determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made no more often than every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases). In CY 2009, the allowed payment amount for each visit is equal to the 2009 fee for code K0739, multiplied by 2, for the state in which the in-home visit takes place. Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392 and/or K0738 along with the MS modifier in order to bill and receive payment for these maintenance and servicing visits.

For example, if the supplier visits a beneficiary’s home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392 MS on the claim and the allowed payment amount would be equal to the lesser of the supplier’s actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary’s home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary’s home to provide the periodic maintenance and servicing for a portable concentrator (E1392), payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

For example, if maintenance and servicing is billed for a column I code, additional payment for the maintenance and servicing of any of the column II codes will not be made.

Column I	Column II
E1390 MS	E1391 MS, E1392 MS
E1391 MS	E1390 MS, E1392 MS
E1392 MS	E1390 MS, E1391 MS, K0738 MS
K0738 MS	E1392 MS

For CY 2010, CMS has determined that it is reasonable and necessary to continue the existing payments and payment methodology, as described above and in Transmittal 497 (CR 6509), for maintenance and servicing of certain oxygen equipment for dates of service through June 30, 2010. For dates of service from January 1, 2010, through June 30, 2010, the allowed payment amount for each visit is equal to 2 units of the 2010 fee for code K0739, for the state in which the in-home visit takes place.

Key Points of CR 6716

- Medicare contractors will pay claims with dates of service from July 1, 2009, through June 30, 2010, for maintenance and servicing for oxygen concentrators no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with one of the following HCPCS codes and modifiers:
 - E1390MS;
 - E1391MS; or
 - E1392MS.
- In addition to payment for maintenance and servicing for stationary oxygen concentrators (HCPCS codes E1390 or E1391 Medicare contractors will pay claims with dates of service from July 1, 2009, through June 30, 2010, for maintenance and servicing for portable oxygen transfilling equipment (HCPCS code K0738) no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with the HCPCS modifier MS.
- Medicare contractors will not pay for maintenance and servicing of both a portable oxygen concentrator (E1392MS) and portable oxygen transfilling equipment (K0738MS).
- For the oxygen equipment codes E1390, E1391, E1392, and K0738, billed with the modifier “MS”, Medicare contractors will make maintenance and servicing payments for covered services equal to the lesser of the supplier’s actual charge or 2 units of K0739 every 6 months.
- Medicare contractors will deny claims for maintenance and servicing of oxygen equipment when billed with the HCPCS codes E0424, E0439, E0431, E0434, E1405 or E1406 and the “MS” modifier.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

The official instruction, CR 6717, issued to your RHHI, MAC, DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R589OTN.pdf> on the CMS Web site.

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Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Round One Rebid Implementation--Phase 8B: Oxygen Modality

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: MM6692

Related CR Release Date: November 6, 2009

Related CR Transmittal #: R593 OTN

Related Change Request (CR) #: 6692

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

Provider Types Affected

Suppliers submitting claims to Medicare regional home health intermediaries (RHHIs) or durable medical equipment Medicare administrative contractors (DME MACs) for stationary or portable oxygen equipment provided to Medicare beneficiaries need to be aware of this article.

Provider Action Needed

CMS issued CR 6692 to announce changes in the way grandfathered oxygen competitive bid claims are processed following a change in stationary or portable equipment modality under Round One of the DMEPOS Competitive Bidding Program. RHHIs and DME MACs are required to apply a single 36-month cap for stationary oxygen equipment and a separate single 36-month cap for portable oxygen equipment regardless of how many different HCPCS codes are billed for a beneficiary during the rental period. See the “**Background**” and “**Key Points**” sections below and make certain your billing staff is aware of these changes.

Background

The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173)

which amended section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Part B.

Section 1847(a)(4) of the Act requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary establish a grandfathering process by which rental agreements for those covered items and supply arrangements with oxygen suppliers entered into before the start of a competitive bidding program may be continued. This grandfathering provision provides the beneficiary the choice of receiving a grandfathered item from a grandfathered supplier or a contract supplier. Unless the beneficiary elects to change suppliers, the rental agreements and supply arrangements for grandfathered items last for the duration of a beneficiary's medical need or for the items reasonable useful lifetime. In the case of oxygen and oxygen equipment, a change in stationary or portable oxygen equipment modality during the 36-month period does not start a new 36-month rental period and does not, in and of itself, terminate a supplier's role as a grandfathered supplier of oxygen and oxygen equipment.

Key Points of CR 6692

- For stationary oxygen systems **codes E0424, E0439, E1390, E1391, E1405, and E1406**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for a stationary oxygen system to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing stationary oxygen and oxygen equipment to a beneficiary residing in a CBA for whom it had furnished such stationary oxygen and oxygen equipment prior to the start of the competitive bidding program.
- For portable oxygen equipment **codes E0431, E0434, E1392, and K0738**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for portable oxygen equipment to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing portable oxygen and oxygen equipment to a beneficiary residing in a CBA for whom it had furnished such portable oxygen and oxygen equipment prior to the start of the competitive bidding program.
- Previously CMS instructed that non-contract suppliers of stationary and portable oxygen equipment **may continue to provide their equipment to their existing beneficiaries, if the beneficiary agrees to the arrangement**. CMS also instructed that, if a non-contract supplier does not want to continue to provide oxygen equipment to its existing beneficiaries at the bid amount, the beneficiary must obtain the item from a contract supplier. If a beneficiary no longer rents a grandfathered item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers), a maximum of 45 rental payments may be made for portable oxygen equipment and up to 45 payments may be made for stationary oxygen equipment.
- In situations where a beneficiary in a CBA is receiving oxygen services via portable and/or stationary oxygen equipment prior to competitive bidding and the beneficiary's oxygen equipment and suppliers are not grandfathered (because the previous supplier chose not to be grandfathered or the beneficiary chose not to stay with that supplier), Medicare will allow for a minimum of 10 monthly rental payments to be paid to the contract supplier for any modality of portable and/or stationary oxygen equipment. In such cases, the beneficiary is liable for the co-payments for any additional payments made to the contract supplier.

Additional Information

If you have questions, refer to the “[Contact Us](#)” page of our Web site and select “Phone Us” to call the Provider Contact Center or contact your Medicare DME MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

The official instruction, CR 6692, issued to your Medicare RHHI or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R593OTN.pdf> on the CMS Web site.

For an overview of the DMEPOS competitive bidding program you may go to <http://www.dmecompetitivebid.com> on the Internet.

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Annual Clotting Factor Furnishing Fee Update

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: MM6673

Related CR Release Date: October 16, 2009

Related CR Transmittal #: R1829

Related Change Request (CR) #: 6673

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Provider Types Affected

This article is for providers billing Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of blood clotting factors to Medicare beneficiaries.

What You Need to Know

CR 6673, from which this article is taken, announces that for calendar year (CY) 2010, the blood clotting factor furnishing fee of \$0.170 per international unit (I.U.) is added to the payment limit for a blood clotting factor that is not included on the Average Sales Price (ASP) or Not Otherwise Classified (NOC) files.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Section 303(e)(1) added section 1842(o)(5)(C) to the Social Security Act (the Act) which requires that, beginning January 1, 2005, a furnishing fee be paid for items and services associated with the administration of blood clotting factors.

It further specifies that for CY 2006 (and subsequent years) this furnishing fee will be equal to the fee for the previous year, increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The blood clotting furnishing factors for years 2005-2010 are displayed in the following table:

Blood Clotting Factor Furnishing Fee	
Furnishing Fee	Calendar Year
\$0.170 per I.U.	2010
\$0.164 per I.U.	2009
\$0.158 per I.U.	2008
\$0.152 per I.U.	2007
\$0.146 per I.U.	2006
\$0.140 per I.U.	2005

Previously, CMS included the clotting factor furnishing fee in the payment limit for Healthcare Common Procedure Coding System (HCPCS) code J7197 “Antithrombin III (human), per I.U.”. This code does not describe a hemophilia clotting factor, and therefore the payment limit for it should not include the clotting factor furnishing fee. Thus, CR 6673 provides further clarification that the payment limit for J7197 does not include the clotting factor furnishing fee and Medicare will not make separate payment for the clotting factor furnishing fee for J7197.

Additional Information

You can find more information about the blood clotting furnishing factor by going to CR 6673, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1829CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Phone Us” to call the Provider Contact Center.

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Changes to Cahaba's E-mail Notification Service Subscription Process

Cahaba recently implemented changes that simplify the process in which providers subscribe to our e-mail notification service (Listserv). New members simply provide their name, city, state, zip code, e-mail address, and an optional password. In addition, they can select from 4 different lists to subscribe to:

- J10 Part A News
- J10 Part B News
- Home Health News
- Hospice News

Once you are a member, you can edit your profile to:

- unsubscribe from all lists
- subscribe to additional lists
- update your e-mail address
- change your name or address information
- change what Cahaba lists you are subscribed to.

Already a Member?

If you enrolled to Cahaba's Listserv prior to November 1, 2009, you will continue to receive messages. You do not need to re-subscribe. However, depending on the selections you made on the subscription form when you originally enrolled, you may receive messages from more than one Cahaba list. To change the list you are subscribed to, access the "[Edit Your E-mail Notification Service Member Profile](#)" Web page and edit your profile.



Postpayment On-site Reviews

A postpayment review is one of the activities performed by our Medical Review staff and is a comprehensive review of individual beneficiary medical records. This review of records may be conducted either on-site at your facility or may be done in our Medical Review department. Please be aware that if the review is done on-site at your facility, the Medicare Medical Review staff person who visits your facility must show your staff a photo identification indicating their affiliation with Cahaba. Verifying proper identification is important before allowing access to your patient's medical records.

For additional information about postpayment reviews, refer to §3.6.2 in Chapter 3 of the *Medicare Program Integrity Manual*, Publication 100-8. This manual can be found on the CMS Web site at: <http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf>



Availability of the Provider Contact Center (PCC)

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). Listed below is the date and time the home health and hospice PCC (1-877-299-4500 and 1-866-539-5592) will be closed for training. We will continue to notify you of future CSR training dates in the *Home Health & Hospice Medicare A Newslines*.

CSR Training Date	Time
December 3, 2009	8:30—10:30 a.m. Central Time (CT)
January 5, 2010	8:30—10:30 a.m. CT



System Availability During the Christmas Holiday

While we celebrate the Christmas holiday with our families, our office will be closed on Thursday and Friday, December 24 and 25, 2009. Our data center has informed us that FISS will not be available December 25, 2009. In addition, FISS will not cycle December 24 and 25, 2009, which means that claims will not be sent to the Common Working File (CWF) either night. Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on December 24 and 25, 2009. However, the **Interactive Voice Response (IVR) unit will be available to providers to check beneficiary eligibility or the status of claims.**

News from Cahaba for Home Health Providers



Diagnosis Codes on Home Health Claims For Services Unrelated to a Hospice Election

It has come to our attention that home health agencies (HHAs) are inappropriately including diagnosis codes that are related to a hospice beneficiary's terminal illness as the **primary** diagnosis on their claims when the HHA is providing services to the beneficiary that are unrelated to the terminal illness.

As a reminder, the diagnosis codes that are submitted on home health claims must originate with the physician, and be based on the patient's condition. The primary diagnosis must be the chief reason for

home health care. According to the OASIS User’s Manual ([Chapter 8, page 8.45](#)), “Secondary diagnoses in M0240 are defined as ‘all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care.’ In general, M0240 should include not only conditions actively addressed in the patient’s plan of care but also any co-morbidity affecting the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.” It may, therefore, be appropriate for HHAs to use the diagnosis for the terminal illness as a secondary diagnosis when caring for a hospice beneficiary.

When a beneficiary elects the Medicare hospice benefit, they waive all rights to Medicare payments for the duration of their hospice election for services related to the treatment of the terminal condition for which hospice was elected (or a related condition). This means that all services related to the terminal condition must be provided/billed by the hospice provider while the beneficiary has elected the Medicare hospice benefit.

Beneficiaries can continue to receive medical care from other health care providers for illnesses unrelated to the terminal diagnosis. In order to do this, it may be necessary for your HHA to contact the hospice to ensure that the services, which your HHA anticipates providing, are unrelated to the terminal illness.

To determine whether the beneficiary has elected the hospice benefit and whether this election impacts your dates of service, Cahaba encourages HHAs to review ELGH page 9 or ELGA page 2 at the time of admission **and** prior to submitting any billing transactions to Medicare. Access the [Checking Beneficiary Eligibility](#) section of the *FISS Reference Guide* for more information about the ELGA/ELGH screens.

NOTE: The provider number for the hospice facility providing services to a Medicare beneficiary can be viewed on ELGH page 9 in the “PROVIDER NO” field. A listing of hospice provider numbers and their contact information is available at http://www.cms.hhs.gov/CostReports/05_Hospice.asp To access the listing, you will need to click on the link to the zip file, “Hospice Provider ID Information” that is located underneath the “Frequent Reports” header in the “Downloads” section of the Web page. If the hospice contact information is not available using this resource, please contact the Provider Contact Center at (877) 299-4500 for assistance.

If your HHA provides services to hospice patients that are unrelated to their terminal diagnosis, ensure condition code “07” is entered in FL 18-28 of the CMS-1450 claim form. Enter this in the first available COND CODES field on FISS Page 01. Condition code “07” can **only** be used when the services are unrelated to the terminal diagnosis; any other use of condition code “07” may be considered abusive.

In addition, when condition code “07” is used, HHAs should ensure that diagnosis codes related to the terminal illness **do not** appear as the **primary** diagnosis on their Requests for Anticipated Payment (RAPs), final claims, or other Medicare billing transactions.

Please ensure that your staff is aware of this billing reminder.



Summary of Changes in the Home Health Physician Certification Requirements

CMS recently released the final rule for the Home Health Prospective Payment System; Rate Update for Calendar Year 2010. Included in that final rule are changes in the physician certification requirement when the beneficiary is receiving management and evaluation of the care plan services provided by a registered nurse [<http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>]. This article summarizes these changes, which are effective for initial certification/recertifications as of January 1, 2010.

The Code of Federal Regulations (CFR) Title 42 Part 424 – Conditions for Medicare Payment, and Section 424.22, Requirements for Home Health Services, has been revised to add the following requirements to the certification/recertification process:

- The physician must include a brief narrative describing the clinical justification of the need for a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's plan of care due to the patient's underlying condition or complications.
 - If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.
 - If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign and date immediately following the narrative in the addendum.
- The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required.

The final rule updates several areas applying to home health agencies and may be found at: <http://edocket.access.gpo.gov/2009/pdf/E9-26503.pdf>



Review of Home Health Recertification Claims with a Primary Diagnosis of Alzheimer's Disease

As a result of the continuing analysis of errors related to the widespread review topic 5THCC from July 1, 2009, through September 30, 2009, Cahaba will be continuing the widespread review of claims under the home health prospective payment system (HH PPS). The topic code for this ongoing review will remain 5THCC and will continue to select non-start of care claims with a primary diagnosis of Alzheimer's disease. The most problematic issue identified was that the documentation for the skilled nurse visits did not support medical necessity. To be covered as skilled nursing services, the services must require the skills of a nurse, and must be reasonable and necessary to the treatment of the patient's illness or injury. Observation and assessment of the patient's condition are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires a skilled nurse to identify and evaluate the patient's need for possible modification in the patient's Plan of Care (POC) until the patient's treatment regimen is essentially stabilized. Indications such as abnormal/fluctuating vital signs, weight changes, or edema and respiratory changes may justify further observation and assessment. Where these indications are such that it is likely

that skilled observation and assessment will result in changes to the treatment of the patient, the services would be covered. Observation and assessment by a nurse is not reasonable and necessary where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

The second reason for denial was related to the POC. Please ensure your agency is documenting clearly the complete order, including frequency, duration, discipline and modalities prior to providing services. The POC and all service orders must be signed before submitting the final claim. If the physician does not clearly date his/her signature, the home health agency will document a "received" date on the order to clearly indicate the written order was obtained prior to submission. For additional references, refer to the [Medicare Benefit Policy Manual \(CMS Pub. 100-02\), Ch. 7](#) and/or the [OASIS Implementation Manual, Chapter 8](#).

News from Cahaba for Hospice Providers



Widespread Hospice Edit Continues to Find Errors

Each quarter, Medical Review evaluates the current edits to ensure they are continuing to be effective in selecting the most vulnerable claims. Last quarter, from July 1 - September 30, 2009, one of the widespread hospice edits reviewed was 5011T, which had a denial rate of nearly 63 percent. This edit selects claims where the length of service is greater than 240 days, and the primary hospice diagnosis is 294.8 - Organic Brain Syndrome (OBS). This edit was initiated in 2007, and remains a problem for providers consistently with the top denial reason of "Six-month terminal prognosis not supported in the documentation."

Patients with OBS may be appropriate for hospice, but it is the hospice agency's responsibility to ensure the documentation supports the six month prognosis. Review the following for guidance to ensure sufficient documentation.

- Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy is six months or less.
- Utilization of the [Hospice Local Coverage Determination \(LCD\)](#) can be helpful in coverage decisions and documentation of symptoms to support the terminal prognosis.
- The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.
- The regulations also state that the record includes all services, whether furnished directly or under arrangements made by the hospice.
- Hospice benefit periods are unlimited as long as the above remains true and documentation of disease progression is evident.
- Generally, a beneficiary will show decline from one certification period to the next; however, this may not be the case for some beneficiary whose condition may not run the normal course of decline and remain temporarily unchanged. **It should still remain clear that the beneficiary has a six month prognosis in the medical record.**

- Documentation notes from multiple disciplines involved in the care of the client should demonstrate a picture of the beneficiary's terminal progression. Avoid vague statements such as “slow decline” or “disease progressing” that do not clearly support the terminal progression requirements; the more objective the documentation, the better.

Please ensure that all of your hospice staff has a working knowledge of the Hospice LCD and continue to consistently support the need for hospice services in their documentation to avoid this denial reason for the continuing widespread edit. The Hospice LCD “Hospice – Determining Terminal Status” can be accessed from the Centers for Medicare & Medicaid Services (CMS) Web site, via the Cahaba’s [“Active Local Coverage Determinations”](#) Web page.

December 2009 Education Events

To register for educational events, go to the “[Calendar of Educational Events](#)” page on our Web site. Select the event title for registration instructions.

➤ “[Navigating the Medicare Resources Sea](#)” Webinar

Date: December 3, 2009

Time: 12:00 – 2:00 p.m. Central Time

Registration Deadline: November 30, 2009

Intended Audience: This event is intended for home health and hospice providers and their staff who have less than 25 full-time employees, or who are new or have staff new to Medicare. However, all providers are welcome to attend.

Description: This Webinar will provide Medicare resources that are available on the Cahaba GBA and the Centers for Medicare & Medicaid Services (CMS) Web sites, as well as self-service technologies.

➤ “[Minimize Your Time in the Medicare Question Check-Out Aisle Ask-the-Contractor Teleconference \(ACT\)](#)”

Date: December 10, 2009

Time: 1:00 – 2:00 p.m. Central Time

Registration Deadline: November 30, 2009

Intended Audience: Home health and hospice provider staff, including administrators and billers.

Description: This ACT will identify common Medicare questions and provide access to resources to assist in resolving issues. An overview of CMS requirements for handling provider-submitted questions will also be provided.

➤ “[Clinicians: Home Health Lunch & Learn: Avoiding the Number One Denial](#)” Webinar

Date: December 16, 2009

Time: 12:00 – 1:00 p.m. Central Time

Registration Deadline: December 13, 2009

Intended Audience: Home health clinicians, quality improvement, directors and administration.

Description: This webinar will review the top denial of home health claims in the past year and provide insights on how to avoid this denial.

➤ **“Clinicians: Hospice Lunch & Learn: Avoiding the Number One Denial”** Webinar

Date: December 17, 2009

Time: 12:00 – 1:00 p.m. Central Time

Registration Deadline: December 14, 2009

Intended Audience: Hospice clinicians, quality improvement, directors and administration.

Description: This webinar will review the top denial of hospice claims in the past year and provide insights on how to avoid this denial.

➤ **“Online Courses”** are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Advanced Hospice Billing	Learn about advanced hospice billing topics.
Appeals Process	Learn about the Medicare appeals process.
Basics of ICD-9-CM Coding for Home Health Clinicians	Learn the basics ICD-9-CM coding.
Beginner Hospice Billing	Learn the basics of hospice billing.
Beginner Home Health Billing	Learn the basics of home health billing.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Medicare Coding (Insight into)	Learn the basics about Medicare coding.
Medicare Cost Report (Introduction to)	Learn the basics about the Medicare Cost Report
Medical Review (Getting a view of)	Learn the basics of the Medical review process.
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.

➤ **“Online Courses”** (Continued)

Course Title	Description
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment	Learn about provider enrollment and how to apply.
Verifying Beneficiary Eligibility	Learn how to identify various eligibility information by using ELGA and ELGH.

Please note these courses were designed specifically for providers served by Cahaba. You can find additional national courses under the [Medicare Learning Network](#).

- **Didn't find what you were looking for?** [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated.

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