MEDICARE CLINICAL & BILLING UPDATES FROM CGS

NEBRASKA HOME CARE ASSOCIATION
2016 WINTER CONFERENCE
SADIE DECKER RN BSN & NYKISHA SCALES
CGS ADMINISTRATORS, LLC
FEBRUARY 19, 2016

HOME HEALTH CLINICAL NEWS

PROBE AND EDUCATE

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PROBE AND EDUCATE

All home health agencies (HHAs) who submit claims for Medicare home health services are included.

Begins with episodes with starts of care on or after August 1, 2015.

PROBE AND EDUCATE

Medical Review will focus on home health claims to determine if requirements are being met for

- certification/recertification
- patient eligibility, and
- medical necessity

5 claims from each home health agency will be reviewed.

After the 5 claims are reviewed by medical review, the home health agency will receive a detailed results letter.

This letter will include directions to request one-on-one telephonic education.

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**PROBE AND EDUCATE**

Providers are **encouraged** to request education. Education will be provided by **appointment**. Education will be provided by a clinician with knowledge of the claims to be discussed.

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**PROBE AND EDUCATE**

One-on-one telephonic education will discuss **claim specific** information including clinical facts and corresponding denial reasons. The HHA has **opportunity** to review claim decisions, ask questions and receive feedback.

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**PROBE AND EDUCATE**

Corrective action plans are based on a HHA specific basis.

**Minor Concern:**

- 0 to 1 errors in the 5 claim sample
- HHA will receive detailed results letter with instructions to request one-on-one education
**PROBE AND EDUCATE**

**Moderate to Major Concern:**
- 2 or more errors in the 5 claim sample
- HHA will receive detailed results letter with instructions to request one-on-one education
- 2nd round of probe and educate reviews

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**RECERTIFICATION**

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**PHYSICIAN RECERTIFICATION**

The physician must include an estimate of how much longer skilled services will be required (preferably a timespan or interval of time)
- As part of the recertification document
- A recertification that does not include this information may result in a claim denial

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**PHYSICIAN RECERTIFICATION**

The achievement of a treatment goal as an estimate of how much longer a patient may need HH services is **not acceptable**.

Unacceptable examples of treatment goals:
- Services will be required until the patient can walk safely
- Services will be required until the ulcer heals

**Acceptable examples of timespan** used to convey how much longer the services will be needed:

- The patient is able to speak more clearly; however, when eating, she tires easily and often misjudges the amount of food she places in her mouth. While improving in this area, she continues to need home health services for **another 60 days to continue self-feeding training and endurance building**.

- The patient can now transfer without assistance; however, he tires very easily and can stand only 5 seconds before he transfers his weight on to the walker. He continues to need home care services **another 4 weeks for strength building**.

**FACE-TO-FACE (FTF) ENCOUNTER**

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FTF DOCUMENTATION:
IMPORTANT REMINDERS

FTF is requirement for Medicare payment
Missing/incomplete documentation results in entire claim being denied
As the billing entity, the home health agency’s (HHA’s) responsibilities include:
• Facilitating and coordinating between patient and physician to ensure FTF occurs timely
• Ensuring all FTF requirements are met
• Ensuring physician’s documentation is complete
• Delaying submission of claim until documentation complete

FACE-TO-FACE

• Face-to-Face (FTF) encounter is required for certifications; rather than initial episodes
  • When a new start of care OASIS assessment completed

FACE-TO-FACE
WHEN?

Certifying physician must document FTF took place within
• 90 days prior to start of care (SOC), or
• 30 days after SOC

Reminder:
• FTF must be related to primary reason for home health admission
• Exceptional circumstance: Patient death before FTF can be performed

The certifying physician (or allowed non-physician provider) must have a face-to-face encounter with the beneficiary before they certify the beneficiary’s eligibility

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FACE-TO-FACE WHEN?

The certifying physician or acute/post acute care physician who took care of the patient just prior to admission; or a non-physician provider working with one of those physicians must have a face-to-face encounter with the beneficiary before they certify the beneficiary’s eligibility.

SUPPORTING DOCUMENTATION

Per Benefit Policy Manual 100-02 Ch. 7 section 30.5.1.2, for SOC effective January 1, 2015, documentation in certifying physician’s medical record and/or acute/post-acute care facility’s medical record:

- Will be used as basis for patient’s home health eligibility
- Must contain information to justify the referral for home health services including:
  - Need for skilled services; and
  - Homebound status

HHAs may send information to the certifying physician:

- Created/generated by HHA
- Other information created/generated by and obtained from the acute/post-acute facility clinicians and staff

The certifying physician may consider and/or use any information sent by the HHA, that has been incorporated into the medical record, as the basis for certification of the patient’s eligibility for home health services.
SUPPORTING DOCUMENTATION

Examples of supporting documentation:

- Face-to-face encounter documentation
- Plan of care
- Start of care (SOC) assessment
- Certification/recertification statement
- Discharge summaries
- History and physical examination (H&P)

SUPPORTING DOCUMENTATION

- Information from the HHA incorporated into the physician’s medical record must not conflict with other medical record entries in certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient
- Information submitted & incorporated from HHAs must be received timely to ensure the certifying physician has all relevant information when making the decision to certify/recertify the patient
- Documentation created or generated by the HHA must be signed/dated by certifying physician to indicate acceptance of documentation into their medical records
- Physician’s dated signature must be on/before the time of claim submission

The physician’s sign-off indicates the physician reviewed, accepted and incorporated the HHA generated documents into the patient’s medical record held by the certifying physician (and/or the acute/post acute care facility).

If the documentation in the medical record is not sufficient to support the need for qualified home health services, there will be no payment

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**SUPPORTING DOCUMENTATION**

Per Benefit Policy Manual 100-02 Ch. 7 section 30.5.1.2., for SOC effective January 1, 2015, documentation in certifying physician’s medical record and/or acute/post-acute care facility’s medical record:

- **Must** be provided to home health agency (HHA) when requested

Home health agencies should obtain **as much documentation** from the physician’s and/or facility’s medical records as necessary to assure **eligibility criteria** has been met

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**SUPPORTING DOCUMENTATION**

Clarification of Ordering and Certifying Documentation Maintenance Requirements


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**SUPPORTING DOCUMENTATION**

Examples of Medical Records HHAs obtain from the certifying physician and/or the acute/post acute care facility:

- Physician or allowable non-physician practitioner (NPP)
- **Face-to-face** encounter documentation
- HHA created **plan of care** (signed and dated)
- HHA created **start of care assessment** (signed and dated)
- **Certification/recertification statement**
- Acute/Post-acute care **discharge summaries**
- **History and physical** examination

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SUPPORTING DOCUMENTATION

Per Benefit Policy Manual 100-02 Ch. 7 section 30.5.1.2, certifying physician and/or acute/post-acute facility medical record (if the patient was directly admitted to home health) for the patient must contain the actual clinical note for the FTF encounter visit that demonstrates that the encounter:

- Occurred within required timeframe;
- Was related to primary reason patient requires home health services
- Was performed by an allowed provider type

PATIENT SCENARIOS

Two most common scenarios:

Scenarios #1

Patient discharged from acute/post-acute facility directly to home health services

- Hospitalist sees patient & performs FTF encounter
- Community physician will follow patient after discharge and certifies HH services
  - HH criteria requires patient to be under care of physician
  - Certifying physician must document the date of the FTF encounter
  - (Benefit Policy Manual 100-02 Ch. 7 §30.5.1)

Scenario #2

Patient admitted to home health, not resulting from acute/post-acute discharge

- Community physician is seeing patient in physician’s office with no hospitalization

PATIENT SCENARIO #1

Scenario #1: Patient discharged from acute/post-acute facility directly to home health services

- Hospitalist sees patient & performs FTF encounter
- Community physician will follow patient after discharge and certifies HH services
  - HH criteria requires patient to be under care of physician
  - Certifying physician must document the date of the FTF encounter
  - (Benefit Policy Manual 100-02 Ch. 7 §30.5.1)
PATIENT SCENARIO #1

Scenario #1: Patient discharged from acute/post-acute facility directly to home health services

• NOTE: If hospitalist performs FTF encounter and also certifies patient for home health, the hospitalist must identify the community physician who will follow the patient

PATIENT SCENARIO #2

Scenario #2: Patient admitted to home health, not resulting from acute/post-acute discharge

• Community physician has in-person visit with patient 90 days before or 30 days after 1st HHA visit (and the in-person visit is related to the reason for home health services)

• Documents FTF encounter in medical record, and certifies patient's eligibility for home health

CR 9119 (TRANSMITTAL 92)

CMS Manual System; Pub 100-01 Medicare General Information, Eligibility, and Entitlement; Change Request 9119


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HOSPICE CLINICAL RESOURCES

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 9)

20.1 - Timing and Content of Certification

“If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician’s signature.”

GENERAL INPATIENT (GIP)


HOSPICE LEVELS OF CARE


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HOSPICE MEDICARE LEVELS OF CARE

Four levels of hospice care based on the needs of the beneficiary

- Routine
- **General inpatient (GIP)**
- Continuous home care (CHC)
- Respite (caregiver related)

GENERAL INPATIENT (GIP)

General inpatient (GIP) is appropriate when the beneficiary’s medical condition warrants a short-term inpatient stay for pain control or other acute or chronic symptom management that cannot be provided in other settings.

- Medication adjustment, observation or other stabilizing treatment
- It is NOT appropriate to use GIP level of care (LOC) where the individual’s caregiver support has broken down unless the coverage requirements of the GIP LOC are otherwise met
- Must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting

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GENERAL INPATIENT (GIP)
Document to show need for GIP
- Pain management requiring skills of nurse
- Aggressive treatment to control pain
- Complicated technical delivery of medication
  - Can include teaching to patient or family for providing delivery
- Frequent evaluation
- Frequent medication adjustment
  - PRN medications

Symptom changes
- Sudden deterioration, requiring skills of nurse
- Uncontrolled nausea/vomiting
- Unmanageable respiratory distress
- Uncontrolled delirium, agitation

Problems identified in GIP documentation:
- A patient in the dying process does NOT make the patient eligible
- Discharge planning days are NOT covered
- An inpatient unit is NOT an automatic step down from the hospital
- Location does NOT determine level of care
GENERAL INPATIENT (GIP)

Examples of inappropriate use of general inpatient level of care seen in medical review:

• For routine admission and care plan formation
• Ongoing assessment of managed symptoms
• No available caregiver for in-home care
• Caregiver relief
• General fall risk and/or supervision need

GENERAL INPATIENT (GIP)

Quantitative Data

• Pain ratings
• Vital signs
• Weights
• Intake and output
• Descriptions and other objective data
• Body language if unable to communicate

GENERAL INPATIENT (GIP)

• A discharge plan should be documented daily for all GIP patients
• Discharge and disposition planning begins before admission
• Medicare does not pay for additional days for discharge plan
CHANGE IN LEVEL OF CARE

Document level of care was provided and level of care it is changing to:

- Date when level of care changed
- Location where care is being provided

Change in patient or caregiver situation that triggered change in level of care

Examples:

- "Patient’s wife is no longer able to provide extensive care in home due to her recent illness."
- "Patient continues to have increased respiratory distress, despite several med changes in the home. Is in need of increased oxygen and inhalation treatments."

RESOURCES

HOME HEALTH CLINICAL RESOURCES

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 7)

Medicare Benefit Policy Manual
Chapter 7 - Home Health Services
Table of Contents
(Rev. 201, 05-11-15)
Transmittals for Chapter 7
1-7 - Home Health Services (Rev. Transmittal October 18, 2013) (01 2014)

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ICD-10 Transition Moves Forward

Types of Errors We Are Seeing

- Invalid ICD-10 codes submitted
- Incorrect diagnosis codes on HH transactions with spanned dates
  - Remember, if episode started prior to 10/1/2015 but ends on 10/1 or later, must be submitted with ICD-10 diagnosis codes
- Transactions containing both ICD-9 and ICD-10 codes

Types of Errors We Are Seeing (continued)

- Reason code 31276 (HH): 329 type of bill (TOB) has through date of service prior to 10/1/2015, and claim contains an ICD-10 diagnosis code
  - Final claims with a TO (or through) date prior to 10/1/2015, must include ICD-9 codes
- Reason code 34926 (Hospice): For TOB 81X & 82X, principal diagnosis code cannot begin with a “V” (for ICD-9) or “Z” (for ICD-10)
- Use of unspecified diagnosis codes as primary diagnosis
HOW DO I FIND VALID ICD-10 CODES?

GEMs = General Equivalence Mappings

- 2016 ICD-10-CM & GEMS,

CONFIRM VALIDITY OF ICD-10 CODES IN FISS

Refer to Ch. 3 of FISS Guide,

1. From the Inquiry Menu, type "2" in the Enter Menu Selection field and press Enter.

WHO DO I CONTACT?

- Start with your Medicare Administrative Contractor (MAC)
- CGS = J15 MAC including HH&H
- Providers can contact ICD-10 Ombudsman at ICD10_Ombudsman@cms.hhs.gov
- All others should contact ICD-10 Coordination Center at ICD10@cms.hhs.gov
- ICD-10: Provider Contacts for Medicare & Medicaid Questions,
  https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf
Q: Since my MAC can’t tell me how to code, how do I submit a coding question?

A: Coding questions may be submitted via http://www.codingclinicadvisor.com/

- Registration required
- Review FAQ sections for details on submitting questions
- Same process was used for ICD-9-CM questions
- Formulate coding question
  - Don’t just ask what is the code for XYZ
- Provide documentation
- Identify if inquiry refers to a certain setting (hospice or home health)
- Be advised, Coding Clinic Advisor cannot answer payment, coverage, or etc. questions

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The CMS ICD-10 Blog

http://blog.cms.gov/2015/10/01/welcome-to-icd-10/

- Monitors transition in real time
- Addresses issues sent to ICD-10 Coordination Center

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CMS Website

Find all of these resources here,

- Latest news
- FAQs
- Fact sheets
- Infographics
- ICD-10 code listings
- GEMs
- CMS training opportunities
  - NEW videos, https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html

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**Change Request 8581**

- “Automation of the Request for Reopening Claims Process,”
- Effective for claims received on/after October 1, 2015
- CR 8581 allows providers to electronically request reopenings of claims
- Reopening
  - Remedial action to change final decision that resulted in overpayment or underpayment, even if decision was correct based on evidence of record

**Change Request 9369**

  - Effective on/after January 1, 2016
  - Change Request creates new codes to distinguish whether Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided hospice or home health services
  - Current single G-code of G0154, “Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting” has been retired
  - Service provided by RN shall be coded as G0299
  - Service provided by LPN shall be coded as G0300

**Medicare Secondary Payer (MSP) Updates**

- CR 8486, Instructions on Utilizing 837 Institutional Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A Claims in Direct Data Entry (DDE) and 837 I 5010 Claims Transactions
  - Implementation Date: January 4, 2016
- Provider Action: Include CAS segment adjustments from primary payers remittance advice on your 837I transaction, DDE, or paper claim when submitting claims to Medicare for secondary payment
- Updates previous MSP instructions outlined in CR 8448 which didn’t allow acceptance of DDE MSP transactions
- MSP claims & adjustments can now be entered via DDE

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RECENT MEDICARE CHANGES
Home Health

CY 2016 HH PPS RATE UPDATE
CR 9406, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016

• Implementation Date: January 4, 2016
• Provider Action: Be informed of updates to 60-day national episode rates, national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, & non-routine medical supply payment amounts for CY 2016

HOME HEALTH QUALITY INITIATIVES
  • Goals
  • Measures
  • Process
  • Reporting Data
  • Manuals
  • Resources
  • Notifications of National Provider Calls/Training

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HOME HEALTH VALUE-BASED PURCHASING (HHVB) MODEL

**What:** Designed to provide incentives to Medicare-certified HHAs who offer higher quality & more efficient care

**When:** January 1, 2016 for 9 states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee & Washington

**Why:** Supports greater quality & care efficiency

**How:** Payment adjustment to HHAs for services based on quality of care, not just quantity

**Provider Action for HHAs in the 9 HHVB model states:**

1. Contact HHVB Help Desk to identify HHA’s HHVB primary contact, HHVBquestions@cms.hhs.gov
   - (include primary contact’s name, email address, HHA’s name, address, phone number & CMS Certification Number (CCN))

**Questions:** Helpdesk at (844) 280-5628 or email HHVBquestions@cms.hhs.gov.

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CHANGE REQUEST 9198

CR 9198, “Corrections to the 2015 Home Health (HH) Pricer Program,”

- Implementation date on/after October 5, 2015
- CR 9198 instructs MACs to install new HH Pricer program which contains updates to allow processing of type of bill 032Q or 033Q, as required by CR 8581
  - CR 9198 also corrects errors affecting payments on 2015 claims & instructs MACs to adjust claims to correct payment amounts
  - CR 9198 also corrects recoding issue with 2014 DOS (20+ therapy visits)

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RECENT MEDICARE CHANGES

Hospice

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CHANGE REQUEST 9460

CR 9460, Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data


- Implementation Date: April 1, 2016

Provider Action: CR 9460 revises Chapter 3, Section 40 of “Medicare Quality Reporting Incentive Programs Manual” to reflect changes to payment reconsideration process and includes general clarifications

- Fully rescinds CR 9091

CHANGE REQUEST 9201

- “Implementation of the Hospice Payment Reforms,”
- Effective on/after January 1, 2016
- CR 9201 implements service intensity add-on (SIA) payments for hospice social worker & RN visits provided during last 7 days of life when provided during routine home care

CHANGE REQUEST 9201

- Implements two routine home care rates
  - Higher rate paid first 60 days of hospice election
  - Lower rate for days 61 and later
- Revises sections 20.1.2, 30.1, & 30.2 of Publication 100-04, Chapter 11
  - Creates new section, 30.2.2, “Service Intensity Add-on (SIA) Payments”
Howard Do I Find Hospice Payment Rates?

- Visit the CGS "Hospice Payment Rates" Web page,
  http://www.cgsmedicare.com/hhh/claims/fees/hospice_rates.html

Change Request 9255

- "Reporting of Anti-Cancer and Anti-Emetic Drugs,"
  - Effective on/after January 1, 2016
  - Revises Medicare systems to allow oral anti-cancer & anti-emetics drugs to be reported on hospice claims as intended by CR 8398
  - Current instructions:
    - Remove drug codes from claims when returned in error; and
    - Omit these codes from original claim submissions until the error is corrected on January 4, 2016
    - Submit adjustments after January 1, 2016, to restore services lines for oral anti-cancer and anti-emetic drug

CPR 8877 Resources

- Hospice Claims Filing Web page,
  http://www.cgsmedicare.com/hhh/education/materials/hospice_cf.html
- Submitting Claims for Untimely Notices of Election (NOEs),
  http://www.cgsmedicare.com/hhh/education/materials/submitting_claims_untimely_noes.html
- Requesting an Exception for an Untimely NOI,
  http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html
- Submitting Hospice Notices of Election (NOEs) quick resource tool,
- Examples of Denied/Granted Exception Requests" Web page,
  http://www.cgsmedicare.com/hhh/education/materials/examples_denied_granted_exceptions.html
Top Claim Submission Errors (CSEs)
Home Health & Hospice

CGS Billing Errors – Home Health

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<thead>
<tr>
<th>Reason Code</th>
<th>Billing Error</th>
<th># of Errors</th>
</tr>
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<tbody>
<tr>
<td>38107</td>
<td>FISS can’t find matching RAP</td>
<td>19,941</td>
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<tr>
<td>38157, 38200</td>
<td>Duplicate RAP/Claim – same beneficiary/same dates of service/same billing provider</td>
<td>19,259</td>
</tr>
<tr>
<td>U5381</td>
<td>Overlap another HHA’s episode</td>
<td>5,176</td>
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<td>31018</td>
<td>Less than 60 days billed on home health claim and patient status code billed equals “30”</td>
<td>2,466</td>
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<tr>
<td>32006</td>
<td>“TO” date after Medicare provider termination date</td>
<td>2,320</td>
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CGS Billing Errors – Hospice

<table>
<thead>
<tr>
<th>Reason Code</th>
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<tr>
<td>37402</td>
<td>Sequential billing – no prior processed claim</td>
<td>6,008</td>
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<tr>
<td>38200</td>
<td>Duplicate claim</td>
<td>2,199</td>
</tr>
<tr>
<td>U5106</td>
<td>NOE falls within current hospice election</td>
<td>2,028</td>
</tr>
<tr>
<td>U5194</td>
<td>Hospice claim rec’d for untimely NOE &amp; OSC 77 is missing or invalid</td>
<td>1,862</td>
</tr>
<tr>
<td>34952</td>
<td>Service facility NPI not reported</td>
<td>1,827</td>
</tr>
</tbody>
</table>
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HOSPICE CENTER

Hospice Center,
https://www.cms.gov/Center/Provider-Type/Hospice-Center.html

- Spotlights current events & hot topics
- Provides information regarding Open Door Forums (ODF)
- Links to MLN Matters Articles & Fact Sheets

CGS HH&H WEBSITE: myCGS PORTAL

HTTP://WWW.CGSMEDICARE.COM/HHH/MYCGS/index.html

No costs associated with access to myCGS

MYCGS HAS THE TOOL FOR YOU!

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  - Respond to Medical Review (MR) Additional Documentation Requests (ADRs)
  - Submit Requests for Redeterminations (including attachments)
    - Upload attachments to your myCGS redetermination requests up to 40MBs in size (not to exceed a total attachment size of 150MBs)
  - View & Print Copies of Remittance Advices
  - Check Patient Eligibility 24/7
  - Request an "immediate offset" of a demanded overpayment (eOffset)
  - View Number of Claims Approved for Payment & Approved Amounts
  - NEW: Submit general inquiries via myCGS

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- Chapter One: FISS Overview
  - Moving around in FISS, status/locations
- Chapter Two: Checking Beneficiary Eligibility
  - Eligibility screens, fields, data/codes
- Chapter Three: Inquiry Menu
  - Checking claim status, validity of codes
- Chapter Four: Claims and Attachments Menu
  - Entering NOE/claims
- Chapter Five: Claims Correction
  - Correcting, adjusting, canceling claims

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