Questions & Answers
“Top Medicare Claim Denials...and How to Avoid Them”
Webinar 3.5.13

The following questions were asked during a recent webinar about Medicare claim denials. Answers have been provided by our webinar presenter, Julianne Haydel from Haydel Consulting Services. For more information about Haydel Consulting Services, please visit www.haydelconsultingservices.com

1. **Does the OASIS have to be submitted prior to billing?**

   Effective January 1, 2010, the Home Health Prospective Payment System was updated and the requirement that agencies submit OASIS data prior to billing was elevated from a Condition of Participation to a Condition for Payment: “As such, we are implementing the provision to require the submission of OASIS, for final claims, as a condition of payment, and revising § 484.210 ‘Data used for the calculation of the national prospective 60-day episode payment’ to reflect this requirement.” - Federal Register /Vol. 74, No. 216 /Tuesday, November 10, 2009

2. **How are we to know if the physician bills for a date of service or not?**

   You will not know if the physician bills for a date of service.

   Recent activity from Zone Contractors indicates that they are looking at physician records in the HIMR and denials are resulting when the physician information on the plan of care is in conflict with the information in the database. This does not mean that you will automatically be denied if the physician signing the POC and F2F has not billed. You may be at high risk for a denial if the information regarding the physician conflicts with information in the HIMR.
Should a conflict occur for a legitimate reason such as a patient decision to see a new physician, you should be able to successfully appeal with supporting documentation. Should there be extenuating circumstances resulting in a different physician signing the F2F, include documentation as a matter of routine.’

3. I didn’t believe that the MD signing the POC had to be the same MD signing the F2F as long as the MD signing the F2F is for the same reasons the patient is receiving home care services? Can you clarify?

The expectation is that the same physician who signs for the plan of care will also sign the face to face.

From the CMS F2F Q & A:  *In the case of patients admitted to home health following an acute or post-acute stay, a CMS-485 form signed by the community physician who assumes oversight of the patient’s home health care with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting satisfies the documentation requirements is allowable (assuming all content requirements of the certification and face-to-face documentation are otherwise met).*

However, even when another physician signs and documents the face to face, the certifying physician must sign or use it as an addendum to his or her plan of care.

4. Does the certifying physician need to also sign the documentation completed by the hospital physician who cared for the patient?
The certifying physician must document that the face-to-face encounter took place and therefore must sign and date the encounter documentation from the hospital physician who cared for the patient, if he/she chooses to utilize it as the encounter documentation.
5. **Does each page of the POC need to be signed by the MD or is the last page sufficient?**

   The page where the physician signature is indicated is sufficient provided that the pages clearly indicate that the document has multiple pages. They should be marked 1/3, 2/3, etc.

6. **Can a hospitalist who referred a patient for home health sign the face to face and then the 485 be signed by the PCP who will follow the home health care?**

   The hospitalist may perform the face to face to face and sign it, but the physician ordering the plan of care must either add it as an addendum to the plan of care he or she signs or co-sign it. It must be labeled clearly as the face to face documentation. The same holds true for discharge summaries signed by other MDs if they contain all of the requirements and the certifying physician states that the documentation is being used to satisfy the F2F requirements.

7. **Is it required that a patient see the MD every 60 days?**

   No, that is not a requirement.

8. **How long does it take for an ADR to get reviewed? And where do you find the results?**

   The MAC has a time limit of 45 days and the results will be posted online.

9. **If a Nurse Practitioner or Physician Assistant sign the f2f, who signs the 485?**

   If a Nurse Practitioner or Physician Assistant signs the F2F, the MD must sign behind them. The requirements state that the NP or PA may perform the encounter but the physician must co-sign.
10. What is the time frame to have all paperwork in when responding to ADRs?

Some letters will state 35 days from the receipt of the letter and others will state 30 days from the date of the letter. Each request should have the requirements included within. The MACs are advised to deny if the documentation is not received within 45 days, but they have the leeway to deny the first day it is late.


The answer to this question has so many variables that you cannot generally look at average numbers and make any assumptions. The first and most important variable in determining appeal success is the quality of the records submitted. The next variable is the quality of the reviewers at the different levels. Finally, the ALJs are reasonable human beings but they have received additional training over the years. Generally, I would go with:

- Good Records: Not perfect but the patient received good care and all signatures are dated and in place. You have a 90% chance of getting it paid.
- Bad Documentation/Good Care and Signatures in Place: You have a 50% chance of getting paid.
- Bad Documentation/No Evidence of Good Care: You have less than a 10% chance of getting paid.

If there is any indication of inappropriate behavior, the agency’s problems are just beginning.

12. Please confirm if the face to face should be signed when the referral is sent in.

The face to face encounter is separate from the 485, although they do typically go together. The visit may take place anywhere from 60 days prior to 30 days
after the start of care. Signed documents should be obtained as soon as possible. However, billing may not occur until you have the signed document indicating that the patient was seen within the time frame.

If you are confident that the patient was seen (i.e. the office nurse calls you with the referral while the patient is being seen), you are okay if the signed document is a few days late. It is inconvenient but unless you bill without it, you haven’t crossed any lines. On the other hand, if the physician does not see the patient timely, you are in violation and as such, you should not bill.

13. How do I get on the "DDE"?

DDE stands for “Direct Data Entry” and is an online application that allows direct online access to your Medicare claims.

Access is controlled by a submitter ID number that is tied to your agency’s provider number. This information should never be shared without proper authority because whoever gets in has the ability to commit fraud. Therefore, I do not ask for nor accept access.

I do look regularly review at my clients’ Business Intelligence reports from HEALTHCAREfirst, as they are updated from the same sources every day. If you are interested in learning more about Business Intelligence, please contact them at 800.841.6095 or sales@healthcarefirst.com.