



# Jurisdiction M (JM) Medicare Home Health Updates

August 13, 2025

Dan George  
Senior Provider Relations Representative



August 13, 2025



The content in this presentation is intended for Jurisdictions J and M providers and is current as of August 11, 2025. Any changes or new information superseding this information is provided in articles with publication dates after August 11, 2025, at <https://www.palmettogba.com>.

CPT® codes, descriptions and other coding data,  
copyright © 2024 American Medical Association.  
All rights reserved.



# Agenda

- Medicare Home Health Updates and Reminders
  - Calendar Year (CY) 2026 Home Health Prospective Payment System Proposed Rule Fact Sheet (CMS-1828-P)
  - Review of the Claims Payment Issues Log
- Palmetto GBA Updates
  - Top Non-Medical Review Claim Denials
  - eServices Portal Enhancements and Tools



# Agenda

- Targeted Probe and Educate (TPE) Process
- Comprehensive Error Rate Testing (CERT)
- Educational Resources for Providers





# Home Health Updates and Reminders



August 13, 2025



# 2026 Home Health Prospective Payment System Proposed Rule

- Calendar Year (CY) 2026 Home Health Prospective Payment System Proposed Rule [Fact Sheet](#)
- Issued on June 30, 2025



# CY 2026 Proposed Payment and Policy Updates for HHAs

- CMS estimates that Medicare payments to HHAs in CY 2026 would decrease in the aggregate by 6.4%, or \$1.135 billion, compared to CY 2025, based on the proposed policies.
  - Payment update of 2.4% (\$425 million increase)
  - An estimated 3.7% decrease that reflects the net impact of the proposed permanent behavior adjustment, required by statute, (\$655 million decrease)
  - An estimated 4.6% decrease that reflects the net impact of the proposed temporary adjustment (\$815 million decrease)
  - An estimated 0.5% decrease that reflects the effects of a proposed update to the FDL ratio (\$90 million decrease)



# CY 2026 Proposed Payment and Policy Updates for HHAs

- For the CY 2026 HH PPS proposed rule, using CY 2024 claims and the finalized methodology, CMS determined that Medicare still paid more under the new system than it would have under the old system
- Therefore, CMS is proposing an additional permanent adjustment of – 4.059% to be made to the 30-day base payment rate
- This proposal would continue to satisfy the statutory requirements at section 1895(b)(3)(D)(ii) of the Act to offset any increases or decreases on the impact of differences between assumed behavior and actual behavior changes on estimated aggregate expenditures, reduce the need for any future large permanent adjustments, and help slow the accrual of the temporary payment adjustment amount.





# CY 2026 Proposed Payment and Policy Updates for HHAs

CMS applied a permanent adjustment to the 30-day payment rate in CYs 2023–2025, though the adjustments finalized represented only half of the permanent adjustments calculated at the time.

Rulemaking Cycle	Adjustment level to achieve budget neutrality (Permanent adjustment estimated in that year's rulemaking less prior year adjustments)	Amount of Permanent Adjustment Applied	Remainder needed to achieve budget-neutrality based on estimates in rulemaking
CY 2023	-7.85%	-3.925%	-3.925%
CY 2023	-5.78%	-2.890%	-2.890%
CY 2023	-3.95%	-1.975%	-1.975%



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Recalibration of PDGM Case-Mix Weights

- CMS is proposing to recalibrate the case-mix weights, including updating the functional impairment levels, comorbidity adjustment subgroups, and LUPA thresholds using CY 2024 data to more accurately pay for the types of patients HHAs are serving

[Low Utilization Payment Adjustment \(LUPA\) Threshold Lookup](#)



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Proposed Changes to the Face-to-Face Encounter Policy

- CMS is proposing to change the face-to-face regulation to allow physicians, in addition to NPs, CNSs, and PAs, to perform the face-to-face encounter regardless of whether they are the certifying practitioner or whether they cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner
- This proposed change would align regulations more closely with the CARES Act language by removing the limitation on which physicians are allowed to complete the face-to-face encounter and broadening the number of practitioners who can perform the face-to-face encounter



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Home Health (HH) Quality Reporting Program (QRP)

- Proposing to remove the COVID-19 Vaccine:
  - Percentage of Patients Who Are Up to Date Measure and the corresponding Outcome and Assessment Information Set (OASIS) data element
- Proposing the removal of four assessment items in the standardized patient assessment:
  - One Living Situation item;
  - Two Food items; and
  - One Utilities item



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Expanded Home Health Value-Based Purchasing (HHVBP) Model

- **Changes to the Applicable Measure Set**
  - Proposed changes to the HHCAHPS survey, CMS is proposing to remove these measures:
    - Care of Patients;
    - Communications between Providers and Patients; and
    - Specific Care Issues



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Expanded Home Health Value-Based Purchasing (HHVBP) Model

- Proposing the addition of four measures to the applicable measure set
  - This includes three OASIS-based measures related to bathing and dressing, and one claims-based measure, the Medicare Spending per Beneficiary for the Post-Acute Care (PAC) setting measure



# CY 2026 Proposed Payment and Policy Updates for HHAs

## Medicare Provider Enrollment

- Proposing several new and revised provider enrollment provisions to prevent fraud, waste, and abuse. The principal proposals include, but are not limited to, the following:
  - Retroactive Revocations
    - Retroactive revocation allows CMS to collect monies that have been paid to the provider since the beginning of its noncompliance
  - Adding Bases for Revocation or Deactivation
    - Revoke providers where beneficiaries attest that a provider did not furnish them the service(s) they claimed
    - Deactivate Medicare billing privileges for enrolled physicians and practitioners have not ordered or certified services for 12 consecutive months



# Review of the Claims Payment Issues Log

The screenshot shows the Palmetto GBA website for Jurisdiction M Home Health and Hospice MAC. The header includes the Palmetto GBA logo, navigation links for Email Updates, eServices Portal, and Contact Us, and a search bar. The main content area features a title 'Jurisdiction M Home Health and Hospice MAC' and a description of the service area. Below this are four image-based links: 'TAKE OUR SURVEY', 'HOME HEALTH', 'HOSPICE', and 'HOME HEALTH RCD'. A sidebar on the left contains links for 'DIRECT DATA ENTRY (DDE)', 'CLAIMS PAYMENT ISSUES LOG' (highlighted with a red box), 'CREDIT BALANCE REPORTING', and 'LCDs, NCDS, COVERAGE ARTICLES'. The main content area also includes an 'IMPORTANT UPDATE' section about provider enrollment processing delays and an 'EDUCATIONAL EVENTS' section with upcoming events for August 5 and 6, 2025.

**PALMETTO GBA**  
A TELLEHEIM GROUP COMPANY

Email Updates eServices Portal Contact Us

Jurisdiction M HHH Topics Tools Forms Events and Education New to Medicare

Search For...

## Jurisdiction M Home Health and Hospice MAC

Home Health and Hospice providers in Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas

**TAKE OUR SURVEY**

**HOME HEALTH**

**HOSPICE**

**HOME HEALTH RCD**

**DIRECT DATA ENTRY (DDE)**

**CLAIMS PAYMENT ISSUES LOG**

**CREDIT BALANCE REPORTING**

**LCDs, NCDS, COVERAGE ARTICLES**

**IMPORTANT UPDATE**

### PROVIDER ENROLLMENT PROCESSING DELAY

Palmetto GBA is currently experiencing longer than normal Medicare enrollment application processing times. We are actively working to return to our standard processing times, and we regret any inconvenience this may cause. To monitor the progress of your application, please use the Provider Enrollment Application Status Lookup tool.

[Learn More >](#)

**EDUCATIONAL EVENTS**

### UPCOMING EVENTS

8/5 JM Provider Enrollment Open House: August 5, 2025

**REGISTRATION CLOSED**

Hot Topic Tuesday Teleconference: August 5, 2025

**REGISTER - FINAL DAY**

8/6 Home Health Review Choice Demonstration Monthly Provider Webinar: August 6, 2025

**REGISTER - 1 DAYS LEFT**

[View All Events](#)





# Review of the Claims Payment Issues Log

## RESOLUTION UPDATE: Home Health: Some Claims Editing for Reason Code U537I, HH Claim Falls Outside of an HH Admission Period for the Same Provider.

- On June 16, 2025, Medicare performed a utility to find beneficiaries with 36 periods on file for continuous HH admission with the same agency without a Notice of Admission (NOA) indicator on any of the periods. When located, a Notice of Admission (NOA) indicator was added to the oldest period on the Common Working File (CWF) (the April 21, 2025, fix will ensure NOA indicator periods will stay on file).
- The week of June 23, 2025, Palmetto GBA will reenter into processing the claims that edited/returned for Reason Code U537I with admission dates from January 1, 2022, to April 21, 2022, and claim “From” dates on or after January 1, 2025



# Review of the Claims Payment Issues Log

**RESOLUTION UPDATE:** Home Health: Some Claims Editing for Reason Code U537I, HH Claim Falls Outside of an HH Admission Period for the Same Provider.

- Reason code U537I is a valid code and will assign correctly if:
  - Another HHA admitted the beneficiary and submitted a NOA with Condition Code 47, ending the previous admission
  - The admission date does not match on the NOA and claim
  - There is no admission on file for the beneficiary and HHA
  - The NOA was submitted but was returned to the provider/rejected
  - The NOA was cancelled by the HHA and never resubmitted
  - That admission was closed by another claim with an earlier service date(s)



# Review of the Claims Payment Issues Log

**RESOLVED: HH, Certain Part A Claims: Reason Code W7113, Supplementary or Additional Code Not Allowed as Principal Diagnosis.**

- The system update was implemented on June 2, 2025, and the issue is now resolved
- Providers may return their RTP claims for processing on or after June 2, 2025
  - If the claims are resubmitted prior to June 2, they and new claims affected by this issue will suspend until June 2 when the fix is implemented



# Home Health Face-to-Face Encounter and Telehealth Technology

- Section 2207 (a) of the Full-Year Continuing Appropriations and Extensions Act 2025 extended the use of telecommunications technology for certifying a patient's eligibility for the home health benefit, that the certifying physician must document, or an allowed nonphysician practitioner (NPP), has had a face-to-face encounter with the patient
- This extension is applicable through September 30, 2025. It also temporarily removes geographic requirements and expands originating sites for telehealth services during the extension.

Home Health Face-to-Face Encounter and Telehealth Technology





## Top Non-Medical Review Claim Denials



August 13, 2025



# Reason Code Help Tool

- This lookup tool does not contain all reason codes found in the Direct Data Entry (DDE) Reason Code file
  - Please refer to [Section 5: Claims Correction](#) of the DDE Guide for additional information
- Reason codes may be added and are subject to change based on quarterly claim submission error data analysis
- You may search the tool by reason code, keyword or phrase. All records matching your search criteria will be returned for your review. You may also use the “Show All” button to view a complete list of reason codes available.



# Reason Code Help Tool

The screenshot displays the Palmetto GBA website interface. At the top, the Palmetto GBA logo is on the left, and links for 'Email Updates', 'eServices Portal', and 'Contact Us' are on the right. Below the header is a navigation bar with 'Jurisdiction M HHH' selected, followed by 'Topics', 'Tools', 'Forms', 'Events and Education', and 'New to Medicare'. A green arrow points to the 'Tools' dropdown menu, which is open. The dropdown menu is divided into three columns: 'CALCULATORS', 'INTERACTIVE TRAINING MODULES', and 'STATUS AND LOOKUP TOOLS'. The 'Reason Code Help Tool' is listed under the 'OTHER TOOLS' section and is highlighted with a red rectangle. A second green arrow points to this highlighted item. Other tools listed include 'ADR Response Calculator', 'Appeals Calculator', 'Charge Denial Rate Calculator', 'Home Health Agency Prospective Payment System (PPS) Claims Calculator', 'Hospice Cap/Inpatient Day Limitation Calculator', 'Hospice Rate Calculator', 'Low Utilization Payment Adjustment (LUPA) Threshold Lookup', 'Medically Unlikely Edits Lookup Tool', 'Overpayment Interest Calculator', 'Advance Beneficiary Notice of Noncoverage (ABN)', 'EDI Enrollment Instructions Guide Module', 'Part A Remittance Advice', 'Uniform Bill (UB-04)', 'Identify a Provider', 'IVR Conversion Tool', 'Medicare Advantage Plan Directory', 'Medicare Dictionary', 'National Correct Coding Initiative Edits', 'Provider Address Job Aid', 'Provider Enrollment Applications', 'RCD Selection Choice Overview', 'Recovery Audit Contractor (RAC)', '277CA Edit Lookup Tool', 'Appeals Status Tool', 'Cost Report Status', 'Credit Balance Report Status Tool', 'EDI Enrollment Status Tool', 'EDI Online Enrollment Tool', 'EDI System Status', 'Enrollment Application Status Lookup', 'Medical Review Denial Reason Code Tool', 'Medicare Secondary Payer (MSP) Lookup', 'Pre-Claim Review Status Tool', and 'RCD Choice Selection Status Tool'. At the bottom of the dropdown menu is a feedback section with the text 'Was this article helpful?' and icons for thumbs up and thumbs down. On the right side of the page, there is a vertical 'FEEDBACK' button. At the bottom right, there is a 'Chat with Sage!' button with a chat icon. The URL 'https://palmettogba.com/jmhhl/admin/tools' is visible in the footer.

PALMETTO GBA  
A ELDERMAN GROUP COMPANY

Email Updates eServices Portal Contact Us

Jurisdiction M HHH Topics Tools Forms Events and Education New to Medicare

Search Form

**CALCULATORS**

- ADR Response Calculator
- Appeals Calculator
- Charge Denial Rate Calculator
- Home Health Agency Prospective Payment System (PPS) Claims Calculator
- Hospice Cap/Inpatient Day Limitation Calculator
- Hospice Rate Calculator
- Low Utilization Payment Adjustment (LUPA) Threshold Lookup
- Medically Unlikely Edits Lookup Tool
- Overpayment Interest Calculator

**INTERACTIVE TRAINING MODULES**

- Advance Beneficiary Notice of Noncoverage (ABN)
- EDI Enrollment Instructions Guide Module
- Part A Remittance Advice
- Uniform Bill (UB-04)

**OTHER TOOLS**

- Identify a Provider
- IVR Conversion Tool
- Medicare Advantage Plan Directory
- Medicare Dictionary
- National Correct Coding Initiative Edits
- Provider Address Job Aid
- Provider Enrollment Applications
- RCD Selection Choice Overview
- Reason Code Help Tool
- Recovery Audit Contractor (RAC)

**STATUS AND LOOKUP TOOLS**

- 277CA Edit Lookup Tool
- Appeals Status Tool
- Cost Report Status
- Credit Balance Report Status Tool
- EDI Enrollment Status Tool
- EDI Online Enrollment Tool
- EDI System Status
- Enrollment Application Status Lookup
- Medical Review Denial Reason Code Tool
- Medicare Secondary Payer (MSP) Lookup
- Pre-Claim Review Status Tool
- RCD Choice Selection Status Tool

Was this article helpful?

Chat with Sage!

<https://palmettogba.com/jmhhl/admin/tools>



# Reason Code Overview

IF – Position 1 is:	THEN – The Type of Edit is:	AND – Positions 2–5 can be:
1	Consistency Edits	0125 – 9999
3	Online System Edits	0000 – 9799
4	File Maintenance	Alpha 001 – Alpha 899
5	Medical Review	0001 – 9999
7	Site Specific (non-medical)	0001 – 9999
A – Z (Except W)	CWF	Current CWF 4-Digit Error Codes
W	OCE/MCE and Grouper	0001 – 2999





# Reason Code 31947

## Description

- This claim line was submitted by the provider as non-covered. Providers are liable for these denials unless a specific modifier or indicator (i.e., occurrence code 32) on the claim attaches liability to the beneficiary.

## Resolution

- Condition code (CC) 20, 21 or occurrence code (OC) 32 is not present on the claim to indicate the non-covered reason
- If adjusting a claim that was reject/returned, ensure charges are moved back to covered



# Reason Codes 38031, 38157, 38158 and 38200

## Description

- The Fiscal Intermediary Standard System (FISS) has found a previously submitted billing transaction for the same beneficiary and dates of service with the same provider number; therefore, the second billing transaction submitted by the provider is a duplicate

## Resolution

- When appropriate, adjust rejected (R B9997) or paid (P B9997) claims instead of resubmitting them



# Reason Code 37364

## Subject

- The NOA receipt date is beyond the claim's "Through" date for the billing period, applying a late NOA payment penalty for all days billed

## Reason Code Description

- The NOA receipt date is 30 or more days from the claim from date on TOB 32x (excluding 32a, 322 or 320), indicating the NOA was late. NOAs received after day 5 will automatically receive a reduction in pay from the billing period. A late NOA exception was not submitted, incorrectly/impartially submitted or the exception request was denied on the claim. No provider reimbursement can be issued. Please see Palmetto GBA's article "Late Notice of Admission: The Exception Process." This reason code also applies to late submitted HH RAPs on or before 12/31/2021.



# Reason Code 37364

## Resolution

- If an HHA fails to file a timely-filed NOA, it may request an exception on the period of care claim(s), which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception are as follows:
  1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;
  2. An event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the HHA;
  3. A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or
  4. Other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA



# Reason Code 37364

## Resolution

If an HHA did not file an exception request or filed an incorrectly/impartially submitted exception on the claim, they may adjust the claim and request an exception. To request an exception the HHA shall append modifier KX to the Health Insurance Prospective Payment System (HIPPS) code reported on the 0023 revenue code line. The HHA shall also provide sufficient information in the Remarks section of the claim to allow the contractor to research the case. If the remarks are not sufficient, the MAC may return the claim for more information.



# Reason Code 37364

## Resolution

- Condition code (CC) 47 is required on NOAs in HH transfer situations and should also be used when the beneficiary has been discharged from another HHA, but their period of care claim has not been submitted or processed at the time of the new admission to discharge the beneficiary
  - If CC 47 is not applied to the NOA in these scenarios, the NOA will return for reason code U537F, the NOA admission date falls within an existing home health admission period for another HHA



# Reason Code 37364

## Medicare contractors shall not grant exceptions if:

- The HHA made no attempt to submit the NOA timely and did not meet any of the four circumstances that may qualify for an exception;
- The HHA can correct the NOA without waiting for Medicare systems actions;
- The HHA submits a partial NOA to fulfill the timely-filing requirement; or
- An HHA with multiple provider identifiers submits the identifier of a location that did not actually provide the service
- MBI changes that were accessible to the HHA more than two weeks prior to the admission date



# Reason Code 37364

## References

- Medicare Claims Processing Manual, [Chapter 10: Home Health Agency Billing, Section 10.1.10.3 — Submission of the Notice of Admission \(NOA\)](#)
- [Late Notice of Admission: The Exception Process](#)
- [Home Health Notice of Admission \(NOA\) Frequently Asked Questions \(FAQ\)](#)
- [Home Health and Hospice Billing When a New Medicare Beneficiary Identifier Is Assigned](#)





# Reason Code U5233

## Description

- Dates of service billed are within a beneficiary Medicare Advantage (MA) plan enrollment period; therefore, no Medicare payment can be made

## Resolution

- Upon admission and prior to billing, verify whether an MA plan will impact the dates of service by checking the beneficiary's eligibility file. This information is available in the eServices Plan Coverage tab.
- Since MA plan election records are updated the first part of each month, providers whose dates of service span two consecutive months or extend beyond 30 calendar days are encouraged to check MA plan information for the beneficiary monthly



# NOA Reason Code U537F

Reason Code U537F will assign correctly to NOAs when:

- There is an open admission period on file (Patient Status 30) from a different home health agency in 2022 or later and Condition Code (CC) 47 was not applied
  - CC 47 may be used when the beneficiary has been discharged from another HHA, but their period of care claim has not been submitted or processed at the time of the new admission to show the discharge of the beneficiary
    - Admitting HHA must confirm beneficiary was discharged or they may have payments recouped
- Duplicate NOAs were submitted (same beneficiary, admission date, provider, etc.)
  - In this scenario, one of the two NOAs is usually returned with U537F



# NOA Reason Code U537F

Reason Code U537F will assign correctly to NOAs when:

- New NOA is submitted when a patient readmits to the same HHA in the same 30-day period that they were discharged because of admissions to other provider types (i.e., hospitals, skilled nursing facilities)
- If an agency chooses to discharge, based on an expectation that the beneficiary will not return, but does return to them in the same period, the discharge is not recognized for Medicare payment purposes
- All the HH services provided in the complete period of care, both before and after the inpatient stay, should be billed on one claim
  - More information on this topic is available in the Medicare Claims Processing Manual Medicare Claims Processing Manual (Publication 100-04, [Chapter 10](#), Section 10.1.14 — Discharge and Readmission Situation Under HH PPS — Payment Effects)



# Beneficiary Elected Transfer Verification

In order for a receiving HHA to accept a beneficiary elected transfer the receiving HHA must document in the record that:

- The beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient
- It accessed the Medicare contractor's inquiry system to determine whether or not the patient was under an established home health plan of care, and
- It must contact the initial HHA on the effective date of transfer





# Targeted Probe and Educate (TPE)

*Designed to help providers and suppliers reduce claim denials and appeals through one-on-one education*



## Selection

### Data Analysis

Utilization patterns, trends, billing comparisons, questionable practices

## Notification

### Letter

- Reason for selection
- Process explanation
- Contact information

## ADR

### Generated for Each Claim

The MAC has 30 days (pre-payment) and 60 days (post-payment) from the date documentation is received to review and make a payment determination

## Cycle

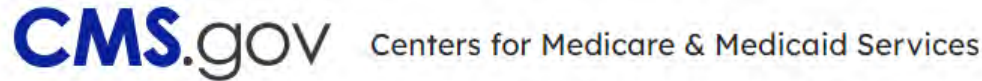
### Three Rounds

- 20–40 pre/post-pay claims
- Error rate >20%
- Subsequent rounds 45–56 days following results letter and educational session set up by MAC
- Error rate >20% following round three, referral to CMS



# To Learn More...

- Visit the [Palmetto GBA website Medical Review Portal](#) to review our [TPE Resources and Module!](#)
- Visit the [CMS TPE Portal](#)

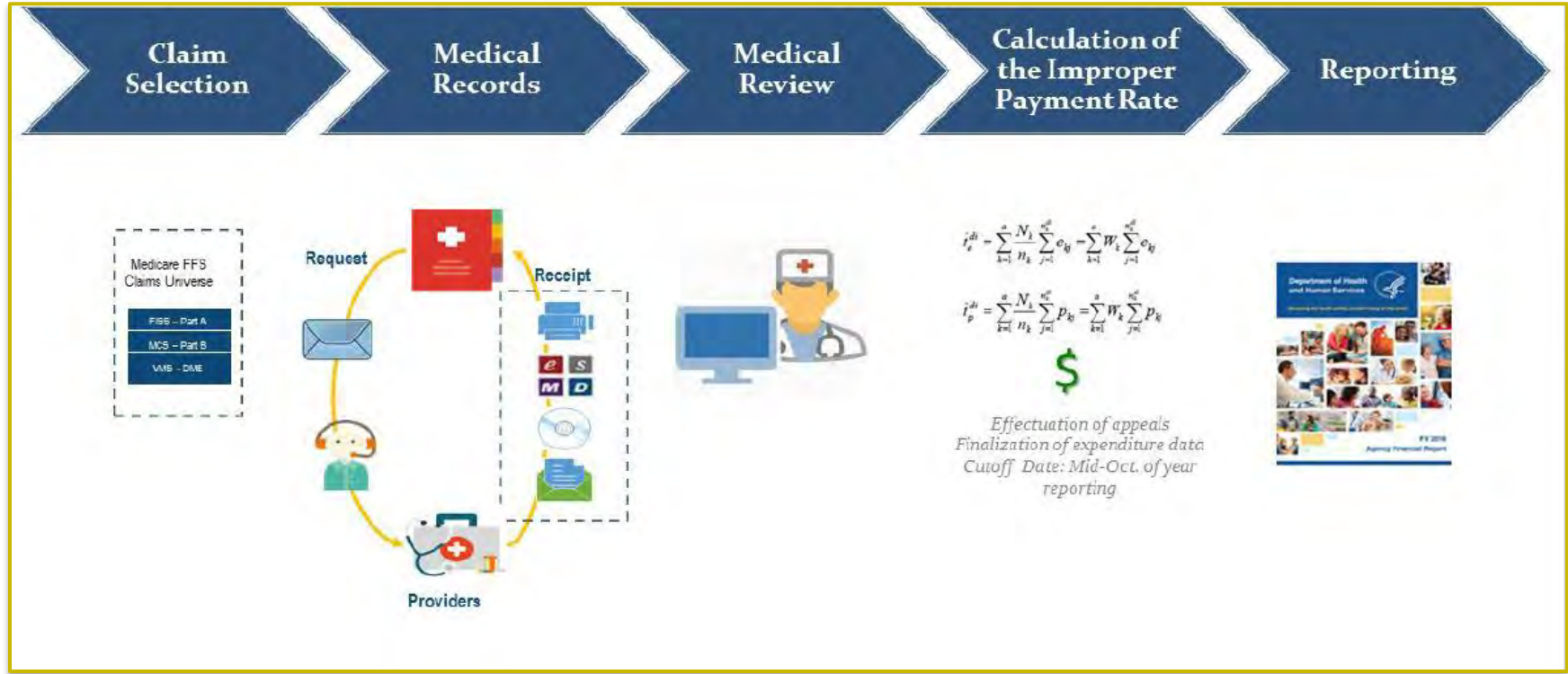




# Comprehensive Error Rate Testing (CERT) Program



# CERT Program





# CERT Defined

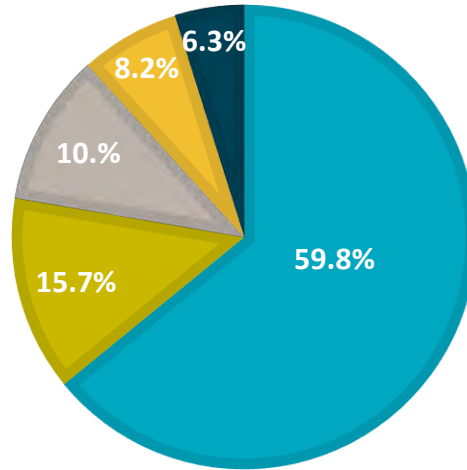
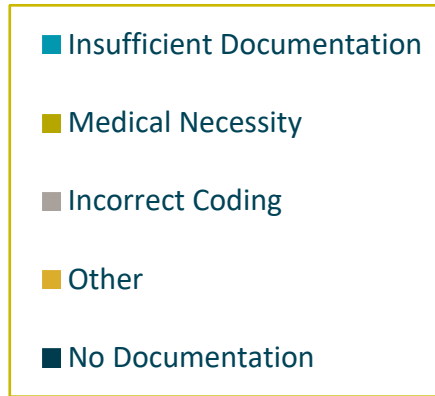
## CMS developed the CERT program to:

- Measure the accuracy of Medicare's payments on a national level for each MAC region
- Assist CMS in understanding the educational needs of the provider community and their contractors
- Prevent improper payments



# Improper Payment Categories

## COMPREHENSIVE ERROR RATE TESTING CONTRACTOR'S 2024 NATIONAL IMPROPER PAYMENT RATE ERRORS DEFINED BY CATEGORY



Each reporting year contains claims submitted **July 1 two years before the report through June 30 one year before the report**. For example, reporting year 2024 contains claims submitted July 1, 2022 through June 30, 2023.

2024 Medicare-Fee-for-Service Improper Payments



# Palmetto GBA CERT Resources

**PALMETTO GBA**  
A CELEBRITY GROUP COMPANY

Email Updates eServices Portal Contact Us

Jurisdiction M Part A Topics Forms Events and Education New to Medicare

Search for...

## Jurisdiction M Part A MAC

Part A Providers in North and South Carolina, Virginia and West Virginia

**TAKE OUR SURVEY**

**ESERVICES PORTAL**

**OUTPATIENT DEPARTMENT PA**

**CERT**

**CLAIMS PAYMENT ISSUES LOG**

**MBI**

**MEDICAL POLICIES**

**IMPORTANT UPDATE**

### CHANGE HEALTHCARE SECURITY INCIDENT

CMS announced that payments under the Accelerated and Advance Payment Program for the Change Healthcare/Optum Payment Disruption (CHOPD) will conclude on July 12, 2024. [Learn More >](#)

**EDUCATIONAL EVENTS**

**UPCOMING EVENTS**

10/01	JM Provider Enrollment Open House: October 1, 2024	REGISTRATION CLOSED
	Hot Topic Tuesday Teleconference: October 1, 2024	REGISTER - 3 DAYS LEFT
10/02	Understanding Therapy Documentation Webinar: October 2, 2024	REGISTER - 5 DAYS LEFT
10/03	Meet with Your MAC: October 3, 2024	REGISTRATION CLOSED

[View All Events](#)

## Palmetto GBA

### Comprehensive Error Rate Testing (CERT)

[Announcements and Reports](#)  
[CERT MAC Task Force](#)  
[Checklists](#)  
[Documentation](#)  
[Frequently Asked Questions](#)  
[Modules and Videos](#)  
[Tips](#)

## Provider Minute: Utilizing Your MAC




# CERT MLN Resources

[MLN Homepage](#) | [CMS](#)

**mln**  
FACT SHEET  
KNOWLEDGE • RESOURCES • TRAINING

### Complying with Medical Record Documentation Requirements



**mln**  
FACT SHEET  
KNOWLEDGE • RESOURCES • TRAINING

### Collaborative Patient Care is a Provider Partnership



#### What's Changed?

No substantive content updates.

As a physician, supplier, or other health care provider, you may need to collaborate with other providers when providing care to your Medicare patients. For example, you may:

- Write orders

[The CERT A/B MAC Outreach & Education Task Force](#) | [CMS](#)

**mln**  
FACT SHEET  
KNOWLEDGE • RESOURCES • TRAINING

### Medical Record Maintenance & Access Requirements





# Home Health Resources



August 13, 2025



# CMS Home Health Resources

- [CMS IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7](#)
- [CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 10](#)
- [CFR Part 484 — Home Health Services](#)
- [CMS IOM Pub. 100-08, Medicare Program Integrity Manual, Chapter 6](#)
- [Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies](#)
- [Home Health Agency \(HHA\) Center](#)



# Palmetto GBA Home Health Resources

- [Palmetto GBA Jurisdiction M Home Health and Hospice MAC home page](#)
- [Home Health Billing Codes Job Aid](#)
- [Late Notice of Admission: The Exception Process](#)
- [Home Health Notice of Admission \(NOA\) Frequently Asked Questions \(FAQ\)](#)
- [Billing the Home Health Notice of Admission \(NOA\) Electronically](#)
- [Billing the Home Health Notice of Admission \(NOA\) via DDE](#)
- [Low Utilization Payment Adjustment \(LUPA\) Threshold Lookup](#)



# Palmetto GBA Home Health Resources

- [Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims](#)
- [Telehealth Home Health Services: New G-Codes](#)
- [Home Health and Hospice Claim Correction Reopenings](#)
- [Home Health and Hospice Billing When a New Medicare Beneficiary Identifier Is Assigned](#)
- [Jurisdiction M HHH — Expanded Home Health Value-Based Purchasing Model](#)





# Connect with Us



Follow us on Facebook to learn about events and ask us general questions



#StayConnected on X for quick access to news and information



Go to YouTube for educational videos, tips and strategies



LinkedIn is your source for the latest Palmetto GBA news



# Customer Experience Survey

Overall, how satisfied are you with your MAC?

☐

**Extremely satisfied**

☐

Somewhat satisfied

☐

Neither satisfied nor dissatisfied

☐

Somewhat dissatisfied

☐

Extremely dissatisfied



# We'd Like Your Feedback

How likely are you to recommend our provider education to a colleague or peer?



# Customer Experience Survey

Don't forget to complete the feedback survey!



# Thank You for Attending!



## Better Together

