Jurisdiction M (JM) Medicare Home Health Updates

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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.

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

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

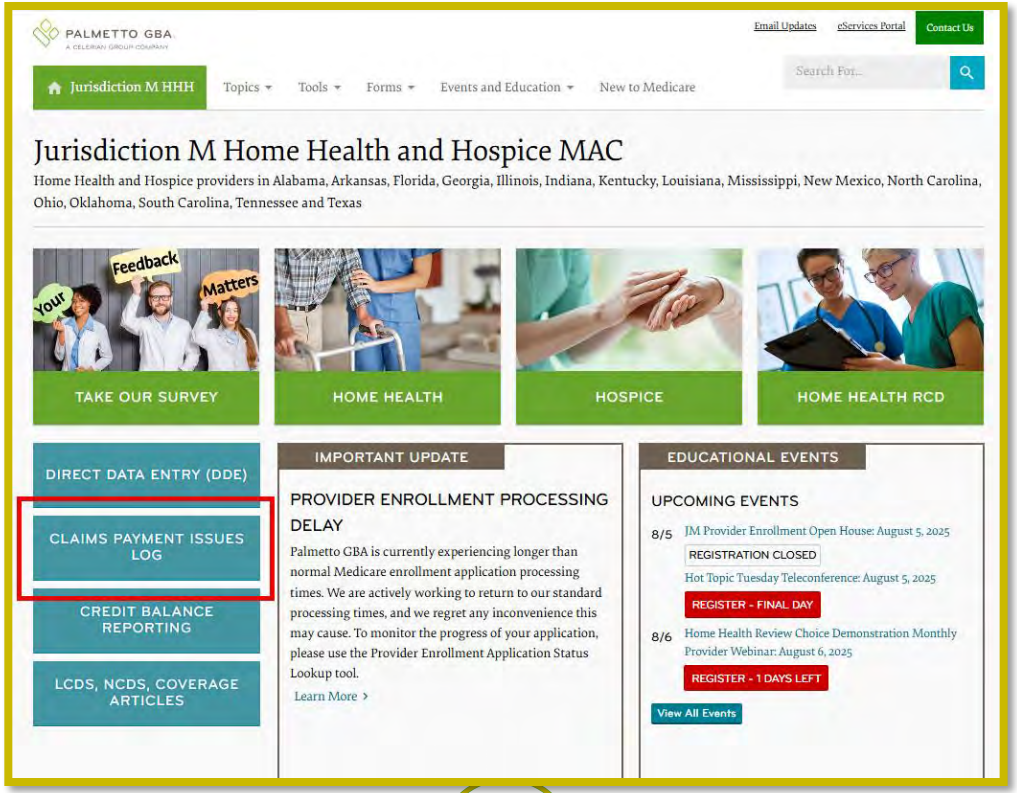
- Proposing the addition of four measures to the applicable measure set
  - This includes three OASIS-based measures related to bathing and dressing, and one claims-based measure, the Medicare Spending per Beneficiary for the Post-Acute Care (PAC) setting measure

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



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.

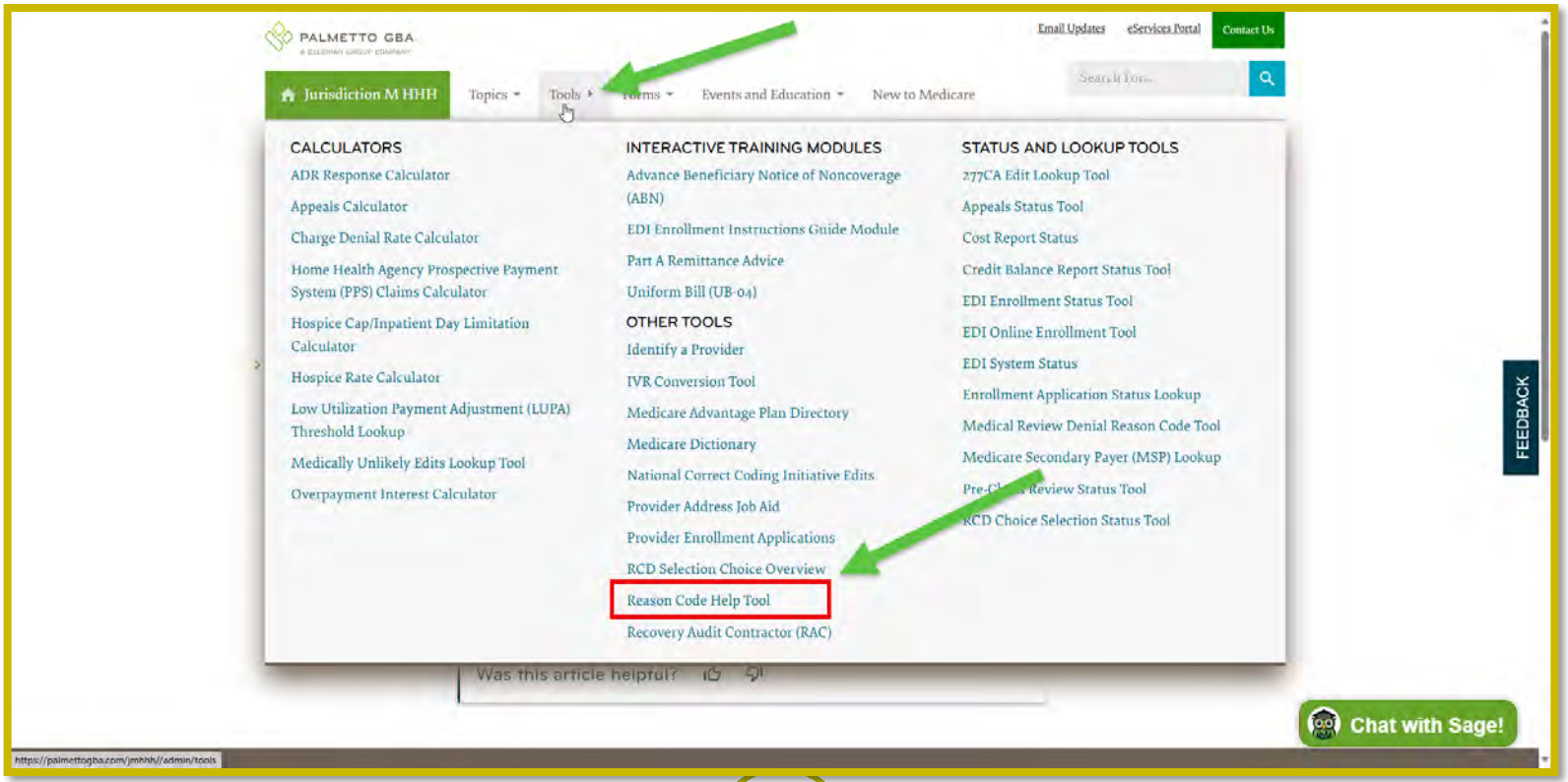
Home Health Face-to-Face Encounter and Telehealth Technology

Top Non-Medical Review Claim Denials

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



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

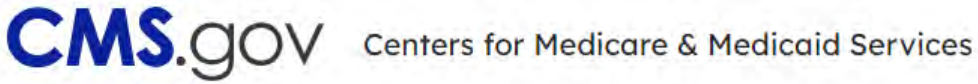
Cycle

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

Claim Selection → Medical Records → Medical Review → Calculation of the Improper Payment Rate → Reporting

$$i_e^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^d} e_{kj} - \sum_{k=1}^{c} W_k \sum_{j=1}^{n_k^d} e_{kj}$$

$$i_p^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^d} p_{kj} = \sum_{k=1}^{a} W_k \sum_{j=1}^{n_k^d} p_{kj}$$

$

Effectuation of appeals
Finalization of expenditure data
Cutoff Date: Mid-Oct. of year reporting

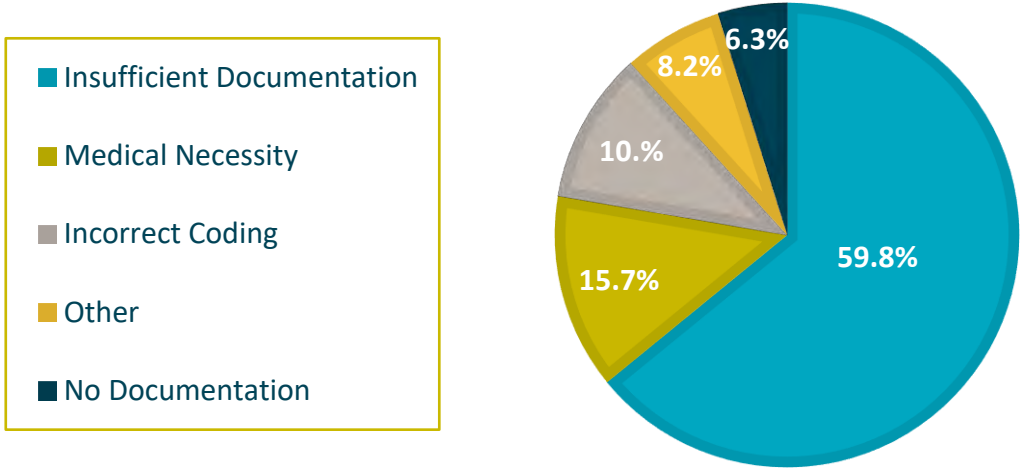
CERT Defined

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

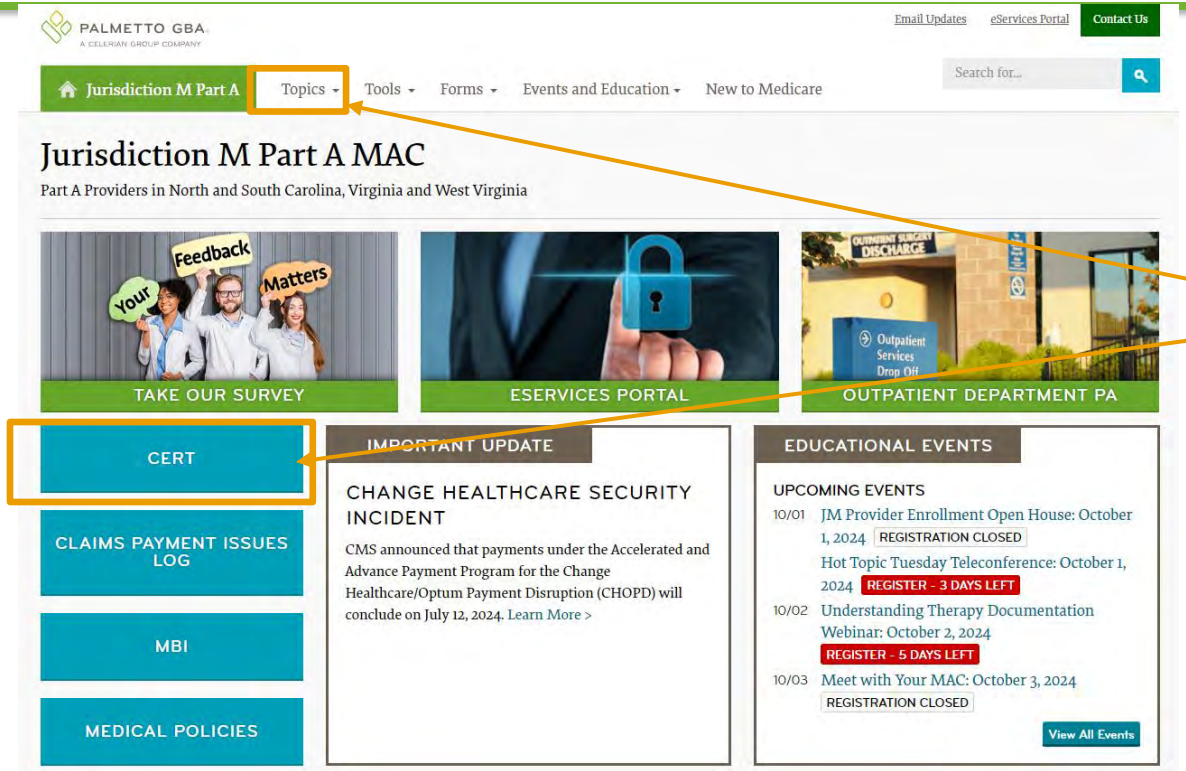
COMPREHENSIVE ERROR RATE TESTING CONTRACTOR'S 2024 NATIONAL IMPROPER PAYMENT RATE ERRORS DEFINED BY CATEGORY



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

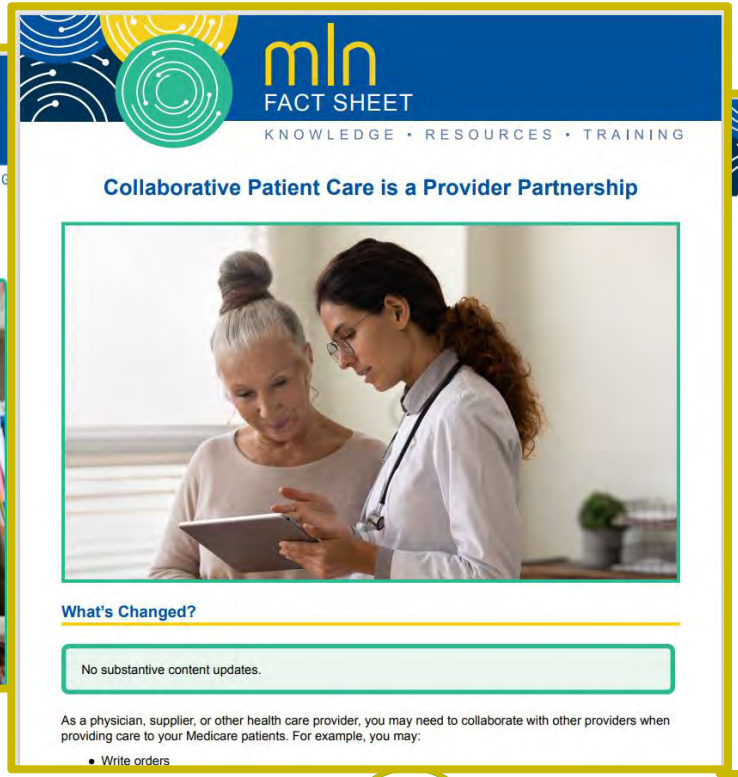
Comprehensive Error Rate Testing (CERT)

- 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



The CERT A/B MAC Outreach & Education Task Force | CMS

Home Health Resources

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