

**2026 ANNUAL
CONFERENCE & EXPO**
Celebrating 60 Years
Then. Now. Next.

Are You Sinking With PPEO and Other ADRs?

June 23, 2026

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<p>Overview</p> <p>ADRs, the types of ADRs that occur. New PPEO program for specific states, Fraud Waste & Abuse</p>	<p>How to Read The ADR Request Letter</p> <p>How to figure out what they want..</p>
<p>Proper Review</p> <p>Records must be reviewed prior to submitting to the requester How to Best Prepare for an ADR.</p>	<p>Top ADR denial Reasons and your appeal rights</p>

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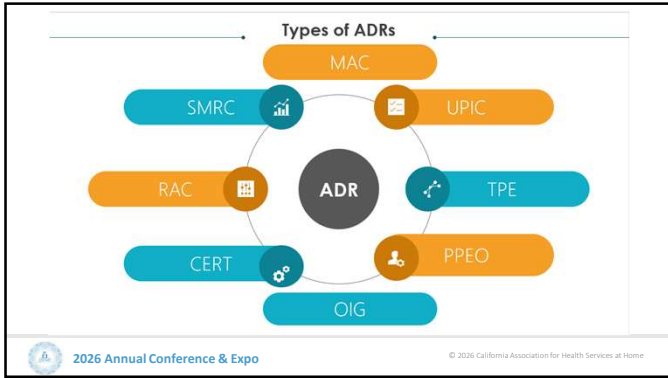
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Survey Versus ADR Review

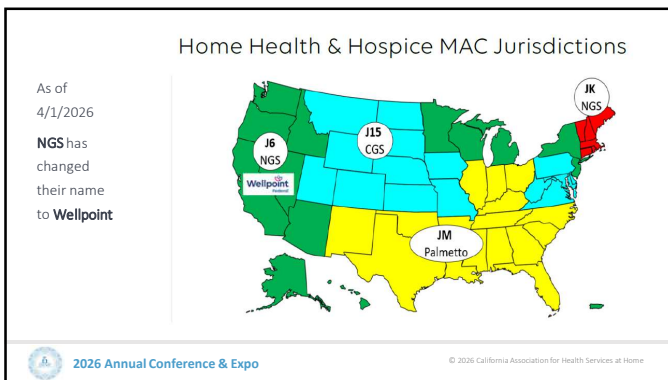
<p>Survey</p> <p>Conditions of Participation State Regulations Agency Policies Accreditation Standards</p>	<p>ADRs/Records Requests</p> <p>Medicare Benefit Policy Manual: - Chapter 7 - Home health - Chapter 9 - Hospice - CMS Program Integrity Manual - Local Coverage Determinations (LCDs)</p>
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MAC ADRs

- You will receive these when processing your claims. They will not come through the mail.
- Make sure your billers are paying attention!

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For California, Your MAC is Wellpoint Federal

- These can be prepayment or post payment ADR requests.
- Typically, you have 45 days from the date of the letter to get it to Wellpoint to be considered timely.
- Easiest way to submit is through the NGS portal.
- Last resort – sent by Mail. Not recommended.

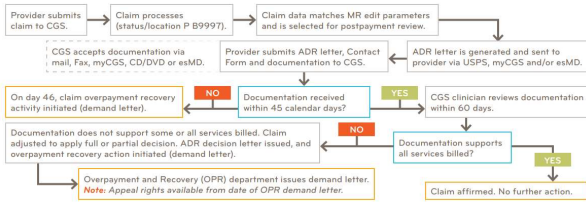


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POSTPAYMENT MEDICAL REVIEW ADDITIONAL DOCUMENTATION REQUEST (MR ADR) — QUICK RESOURCE TOOL



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TPE Target Probe and Educate



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What is a Target Probe and Educate?

When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers that bill a particular item or service rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers.



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TPE (Target Probe & Educate)

TPE is intended to increase accuracy in very specific areas.

MACs use data analysis to identify:

- Providers and suppliers who have **high claim error rates** or unusual billing practices, and
- Items and services that have high national error rates and are a financial risk to Medicare.



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How Would You Be Notified that you are in TPE?

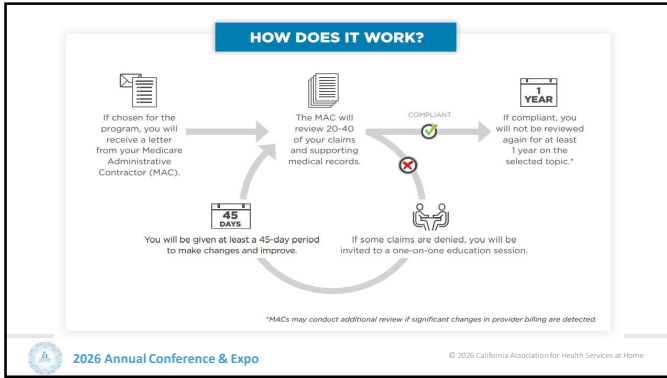
Providers/suppliers who are included in the TPE process will receive a notification letter from their MAC. This letter will outline why the provider/supplier has been selected for review as well as what to expect throughout the review and education process.



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Traditional Versus Low Biller Probe

Traditional TPE round consists of 20-40 claims but there are variations

- The **“Low Biller Probe and Educate Program.”** This nationwide program is designed to include and provide education to providers and suppliers who have lower claim volumes and would otherwise not be selected for the traditional TPE program.
- MACs will focus on those providers/suppliers who, based on data analysis, provide the most risk to the Medicare program and could benefit from education.

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Rounds Time Frames

- MACs can begin sending documentation requests for claims with dates of service no earlier than 45 days after the previous post-probe one-on-one education. This time gives the provider/supplier the opportunity to make changes based on the education received prior to being subjected to additional review. If a provider declines to schedule education within a reasonable time after receiving the offer, subsequent reviews will be for claims with dates of service no earlier than 45 days from the one-on-one post probe education offer.

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Round 1 Initial Probe	Round 2	Round 3	CMS Referral for Corrective Action
• Provider notification	• ADRs: 45-56 days after education	• ADRs: 45-56 days after education	• Extrapolation
• ADR request	• Validation	• Validation	• Referral to UPIC or RAC
• Validation	• Calculation	• Calculation	• 100% prepayment review
• Calculation	• Review results letter	• Review results letter	• List not all-inclusive
• Review results letter	• One-on-one education	• Referral (if applicable)	
• One-on-one education		• One-on-one education	

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What Happens if there are Errors in the Claims Reviewed?

- At the conclusion of each round of 20-40 reviews, providers/suppliers will be sent a letter detailing the results of the reviews and offering a 1-on-1 education session. MACs will also educate providers/suppliers throughout the TPE review process, when errors that can be easily resolved are identified, helping the provider to avoid additional similar errors later in the process. CMS' experience has shown this educational approach is well received by providers/suppliers and helps to prevent future errors.

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If Your Claims Don't Improve...

- The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action.



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TPE Error Rate to Pass

- NGS <15%
- Palmetto < 20%
- CGS <25%

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You Can Appeal TPE Claims

- The appeals process is unchanged under the TPE process. If a claim denial is appealed and overturned, this would be taken into consideration in subsequent TPE rounds. If the appeals results are not available at the time a provider progresses to a second or third round of TPE but are available when the provider is referred to CMS, CMS takes these results into consideration when determining the need for additional action. If a provider's adjusted error rate, after appeals, indicates no need for additional review, CMS will make that recommendation, and the provider will be monitored by the MAC as they would be had they passed the TPE process and been released from review.

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Comprehensive Error Rate Testing
CERT

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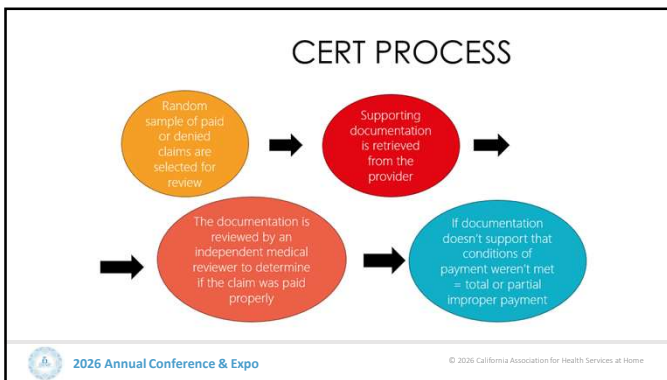
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CERT Mission

Designed to monitor and improve Medicare payment accuracy, evaluates provider **claim submission** practices and protects the Medicare Trust Fund

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ERRORS are categorized into five areas

1. No documentation
2. Insufficient documentation
3. Medical necessity
4. Incorrect coding
5. Other

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Results...

- Results will be forward to the MAC that processed the claim to be adjusted in the FISS system
- Once adjusted the provider will receive either additional money for an underpayment or demand letter informing of an overpayment



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PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor GS-00F-263CA CERT

	Doc Date: 04/20/2023	Medicare Part A Provider
	Patient Name:	
	Claim Control Number:	
	Request Date:	Date(s) of Service:
	NPI/Provider ID:	Universe Date:
	Contractor:	Contractor Type:
	Patient Date of Birth:	
CID: 	Letter Sequence: First Letter	

Example CERT
Request Letter

Providers and suppliers are required to maintain documentation supporting the submission of Medicare claims and to submit this documentation upon request. The documents listed in the following chart apply for medical to support Medicare payment of the claim with the date(s) of service specified above. Please provide all of the **aging** medical record/documentation and any additional documentation needed to support this claim. If any pertinent documentation is missing, incomplete, or requires explanation, please include this information in the comments section.

Consequence: If the provider/supplier fails to send the requested documentation or correct CMI by the Due Date specified above, the provider/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Please provide the name and contact phone number of the individual submitting the documents in support of this request. This information may be used if additional information is necessary.

NAME: _____ Contact Phone Number: _____



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- Discharge summary/discharge notes
- Documentation to support Home Health Resource Group (HHRG) billed.
- Home Health Agency (HHA) - Other Outcome and Assessment Information set (OASIS) assessments, as applicable (e.g., resumption of care, transfer, recertification, discharge).
- Home Health Agency (HHA) Outcome and Assessment Information Set (OASIS) assessment that supports the billed Home Health Resource Group (HHRG), including any changes or corrections.
- Home Health Agency (HHA) outcome-related physician progress notes.
- Home visit notes for all billed disciplines (e.g., nurse, physical therapy, occupational therapy, speech-language pathology, medical social worker, aide).
- Medication administration records.
- Physical therapy, occupational therapy, speech-language therapy assessments and re-assessments.
- Physician/Nonphysician Practitioners (NPP) signed and dated home health plan of care.
- Physician/Nonphysician Practitioners (NPP) signed and dated initial certification and recertifications (as applicable, for subsequent home health episode claims), as per 42 CFR 424.22.
- Physician/Nonphysician Practitioners (NPP) signed and dated order(s) for disciplines and billed dates of service.
- Signed and dated medical record of the face-to-face encounter by an allowed provider type per 42 CFR 424.22. The certifying physician/nonphysician practitioners (NPP) must also document the date of the encounter as part of the certification.
- Any Home Health Advanced Beneficiary Notice of Noncoverage (HBABN) issued to the beneficiary for each date of service and for each specific service in which a HBABN was issued.
- For Electronic Health Records, send a copy of the electronic signature policy and procedures that describe how notes and orders are signed and dated.
- **BEFORE YOU SEND:** Check for signatures on electronic progress notes or other medical record documentation. If the signature(s) are missing or illegible, send a completed signature attestation (find a sample attestation at <https://hhs.comerc.com/gov>). If the signature(s) are illegible, you may also send a signature log.

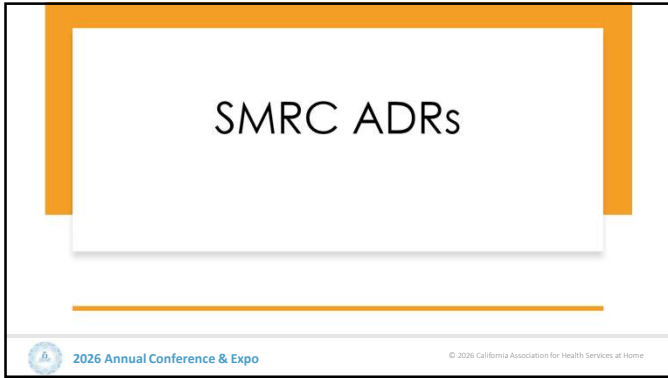
Make Sure Your Read the Whole Request Letter



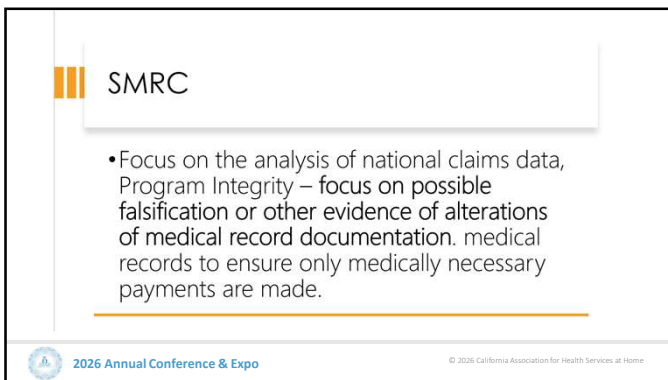
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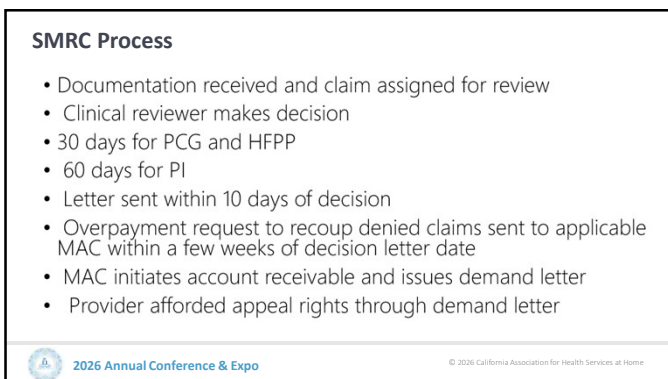
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SMRC Top Denial Reasons

- Hospice - Documentation supported beneficiaries were admitted to hospice with a stable chronic condition but not a terminal prognosis of six months or less
- Home Health – skilled services (nursing/therapies) were not reasonable and/or necessary. Could be because the beneficiary was at baseline level of function, etc.

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SMRC Example Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES
 7500 Security Boulevard, Mail Stop AB-21.53
 Baltimore, Maryland 21244-3099

CMS
 CENTER FOR MEDICARE & MEDICAID SERVICES
 CENTER FOR PROGRAM INTEGRITY

Fraud Investigations Group

June 23, 2022

Provider Address
 Project Number: xx-xxx
 Provider NPI Number: xxxxxxxxxx

Subject: Additional Documentation Request (ADR)

Dear Medicare Provider/Supplier,

This letter is a formal request for medical record documentation associated with the reopening of Medicare claims previously submitted for payment. Additional information is necessary to properly evaluate these claims. Please review the directions and information set forth within this letter.

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce the improper payment of Medicare claims. As part of our effort to accomplish this goal, CMS contracted with Nordium Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC) to conduct medical record reviews of selected claims.

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RAC

Recovery Audit Contractors

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Recovery Audit Contractors (RAC)

- Review claims on a post-payment basis.
- Detect and correct past improper payments.
- Try to prevent future improper payments.
- Identify overpayments and underpayments.

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RAC Process

- Select issue for review
- CMS approves issue
- Request claim selection
- Request documentation
- RAC reviews documentation (complex review) or claim (automated review) and makes determination
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over or underpayment

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RAC Process (Continued)

- The provider may receive up to three letters
- ADR (request for medical records for complex reviews)
- Initial Findings Letter for Automated Reviews or an RRL (Review Results Letter) for complex reviews
- Discussion Period Decision Letter (if a discussion period request was filed)

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You're Not Limited to Just Four Years

- Medicare can audit claims can go back at least **four years under standard administrative rules**. The window can expand to six or even ten years when fraud is involved, and certain reopenings have no time limit at all. The specific lookback period depends on which type of contractor is conducting the audit and whether the review involves routine billing errors or suspected intentional misconduct. Providers who discover their own overpayments face a separate six-year lookback obligation that carries its own penalties for noncompliance.



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UPIC

Unified Program Integrity Contractor



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Detect Fraud, Waste, and Abuse

- The Unified Program Integrity Contractors (UPICs) perform **fraud, waste, and abuse detection**, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPICs perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five (5) separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.



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- 60-day metric set to review medical records which have been received from the provider.
- Findings are relayed back to our investigative team to determine the next steps based on review findings:
- Educate providers
- Implement "administrative actions" such as suspend payments, deny payments, and recoup overpayments
- Refer the case to law enforcement for consideration of criminal or civil prosecution, imposition of civil monetary penalties (CMPs), or administrative sanctions

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EXTRAPOLATION



- The MACs, SMRC, and UPICs have the discretion to select cases for post-payment review on a claim-by-claim basis or use statistical sampling for overpayment estimation.
- When MACs, SMRC, and UPICs conduct claim-by-claim post-payment review, they shall only collect or refund the actual overpayment or underpayment amount.
- When MACs, SMRC, and UPICs conduct statistical sampling for overpayment estimation as specified in PIM chapter 8, they shall extrapolate the sampling results to the known universe of similar claims when calculating the projected overpayment or underpayment amount.

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Extrapolation

- Extrapolation is commonly referred to as a statistical sampling of overpayment estimation/extrapolation. A contractor will use a supplier/provider claim history (paid and/or partially paid claims) as part of the post payment review. A sample of claims, a subset of the claim history, is pulled. The sample is considered a statistical sample which is different from a Probe sample. Once reviewed, the sample is used to calculate and extrapolate the sample error rate to the claims universe. The extrapolation calculations determine the overpayment amount.
- The methodology used in the statistical sampling must be done by a statistician as defined by CMS.

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Appeal an Extrapolation

- A provider/supplier who doesn't agree with the extrapolation may submit a Redetermination request for all denied or partially denied claims in the sample. All such claims must be included in a single request. It is not acceptable to submit a separate request for each claim as the full sample is required to extrapolate the final amount. Each claim is reviewed, and a determination is made. The outcome for all appealed sample claims may positively or negatively impact the provider's/supplier's dollar.



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Medicare Program Integrity Manual Chapter 8

Statistical Sampling for Overpayment Estimation
8.2.1 – Overpayment Assessment Procedures (Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

- After an overpayment determination is made concluding an incorrect amount of money has been paid, contractors must assess an overpayment. The assessment options vary depending upon the type of sample used when identifying beneficiary claims for inclusion in the post payment review. Whenever possible, CMS encourages contractors to report post payment savings in terms of:
 - Actual overpayment;
 - Settlement based overpayment, or
 - Extrapolated overpayments



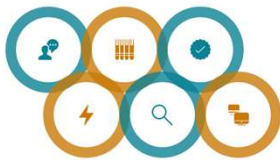
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PPEO

Provisional Period Of Enhanced Oversight



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PPEO

- The provisional period of enhanced oversight started July 13, 2023, in Arizona, California, Nevada, and Texas. Added Georgia and Ohio on December 30, 2025
- Enhanced oversight in four states with elevated fraud risk—Arizona, California, Nevada, and Texas—has resulted in more than 200 hospice Medicare enrollment revocations for failure to comply with CMS requirements. CMS has since expanded this targeted oversight approach to additional states as of December 2025, including Georgia and Ohio.

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PPEO applies to hospices in the affected states that meet any of these criteria: (Hospice Only)

- **Newly enrolling in Medicare** — Any hospice initially enrolling in the Medicare program
- **Change of ownership (CHOW)** — Hospices undergoing a change of ownership under 42 CFR 489.18
- **100% ownership change** — Any complete change in ownership structure
- **Reactivating enrollment** — Hospices reactivating their Medicare enrollment and billing privileges after being in a deactivated status (added in 2025)
- For Georgia and Ohio specifically, hospices meeting these definitions on or after December 30, 2025, are subject to PPEO.

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How You Will Receive Notice..

If we're placing you in a period of enhanced oversight, Medicare will mail a letter to the correspondence address on file in PECOS. It will include:

- Your effective date for the enhanced oversight period.
- The duration of the enhanced oversight period.
- A notice that Medicare may do a medical review of all your claims. If you don't respond to our requests, they may deny claims or revoke your Medicare enrollment.

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[Redacted]

- CMS will place your hospice on 100% prepayment review. EVERY SINGLE CLAIM YOU SUBMIT WILL BE PULLED FOR ADR.
- Intensive Documentation Scrutiny – NGS (now Wellpoint Federal) has been brutal!!
- CMS does NOT require CMS to provide education or allow additional records to be reviewed. If the reviewers find problems, they move directly to enforcement action.
- A period of enhanced oversight can last 30 days – 1 year.

[Redacted]

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Consequences of NOT Passing...

- Through December 2025, 817 hospices have already been subject to medical review under PPEO—and over 200 of them had their Medicare enrollment revoked.
- Failing PPEO can result in termination from the Medicare program, revocation of billing privileges, and even a re-enrollment bar that prevents you from participating in Medicare for years.

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You MUST have Significant Evidence

- Terminal prognosis of six months or less if the disease runs its normal course
- Physician certification with specific clinical findings supporting the prognosis
- Face-to-face encounter documentation (for recertification periods)
- Clear documentation of decline and disease progression

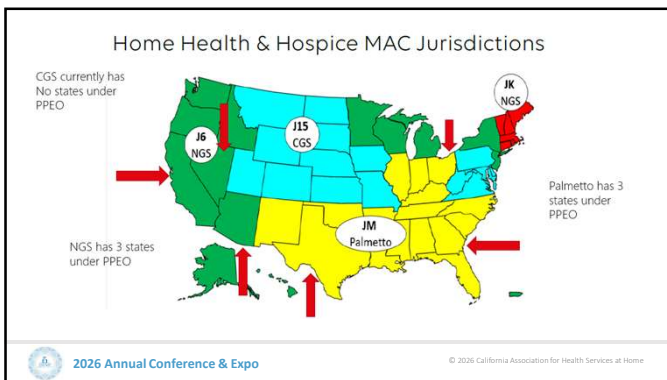
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- If you receive notice that you're being placed on PPEO or EPR—or if you start receiving ADRs without explanation—seek expert guidance immediately. This is NOT something you want to try to do on your own.
- Once you pass the PPEO (think positive), the MAC can still request other ADRs from your agency through different ADR programs (UPIC, RAC, CERT, etc.)

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Passing Rate

As part of our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), National Government Services, Inc., your Medicare Administrative Contractor (MAC), performs Medical Review to analyze provider compliance in accordance with the CMS instruction, Medical Review Includes a Review of Hospital Services on 05/22/2025, as per the CMS directive announced on September 5, 2024. This letter is to notify you of the results for Round 2 of this review. Thank you for your cooperation during this audit.

This letter includes a summary of the results of this review, our review findings and follow-up actions.

RESULTS

The following is a summary of the claims reviewed:

# Claims Requested	18
# Claims Reviewed	10
# Claims Denied	0
Claims Error Rate (CER)	0.00%
#Additional Claims Denied (Excluded from Error Rate Calculation)	0

They select 5 -10 claims for your agency that are considered into the "Round".

This doesn't mean they will ONLY pull 5-10 claims. They can pull numerous claims but only consider the 5-10 in your passing rate.

80% or above

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Where Does Preparation Start for PPEO?

- Preparation should start before you start admitting patients.
- Thorough examination of each patient must be made to ensure they meet the LCD guidelines completely. They don't meet one area of criteria it will not pass.
- If you are buying an agency, don't trust that the patient's they have on service will pass.
- Any claim you submit will be pulled.
- Every patient you service should be totally hospice appropriate. If you are questioning eligibility, don't admit them.



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OIG Office of the Inspector General



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OIG

• The Office of Inspector General (OIG) has been actively auditing home health and hospice services to ensure compliance with federal laws and regulations.

Uses other auditors (CERT, UPIC, etc.) to collect data for reporting purposes and data configuration.



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OIG Report 2026 - Hospice

- Years of OIG audits, evaluations, and investigations into hospice care have revealed that, while these services can provide great comfort to terminally ill patients and their families, there are **significant problems** with the program. Our reports and investigations have revealed several concerning issues, including **poor—sometimes harmful—quality of care, fraud schemes that involve enrolling beneficiaries without their consent, inappropriate billing practices, limited transparency for patients and their families, a payment system that creates incentives to minimize services, and a rapid growth in the number of new hospices, often to take advantage of these conditions.**
- To protect hospice patients, OIG conducts extensive audits and evaluations of the hospice program, monitors the impact of program changes, and investigates concerning allegations of fraud and abuse.



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OIG Report 2025 – Home Health

- Home Health complied with Medicare billing requirements for 80 of the 100 home health claims we reviewed. For the remaining 20 claims, Home Health incorrectly billed Medicare for claims with unsupported codes and for skilled services that did not meet requirements, including plan of care requirements.
- Fifteen claims did not meet billing and coding requirements, resulting in overpayments totaling \$2,291.
- Four claims did not meet plan of care requirements but did not result in an overpayment.
- One claim did not meet skilled need requirements but did not result in an overpayment.
- Based on our sample results, we estimate that Home Health received overpayments of at least \$100,696 for the audit period.



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Nationwide Medicare Compliance Audit of Home Health Claims Billed With an Institutional Admission Source

CMS created two new occurrence codes, 61 and 62, to allow home health agencies (HHAs) to indicate that an institutional stay occurred within 14 days of the home health admission. **HHAs institutional admissions result in higher reimbursement than community admissions, and HHAs may report institutional admissions using these codes even when no corresponding Medicare inpatient claim exists. Prior OIG audits found HHAs incorrectly billed institutional admissions using occurrence codes, sometimes based on emergency room visits or observation stays that do not qualify as inpatient stays.** We will determine whether home health claims billed with occurrence codes 61 or 62 were submitted in accordance with Medicare source of admission billing and coding requirements. Our review will assess documentation supporting the admission source and identify vulnerabilities that allow improper payments.

Top OIG Audit Targets for 2026



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Proposed Project to Decreased Fraud For Hospice

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Another Project to Decrease Fraud...

- CMS maintains that virtually all care and services needed for individuals approaching the end of life should be provided in a hospice setting except in rare and unusual instances. However, CMS has seen non-hospice spending continue to rise for terminally ill individuals in recent years. CMS' service and spending variation index (SSVI) will assign hospices a score based on a variety of metrics

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CMS gathers from hospice claims including non-hospice spending, percent of beneficiaries discharged with a length of stay of 180 days or more, average minutes per routine home care day, and percent of live discharges where beneficiaries return to the same hospice in seven days, among others. These metrics were chosen to compare spending and care delivery between hospices.

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High SSVI Score = Higher Level of Concern

- While this information is not a direct indicator of fraud, waste, or abuse, a high SSVI score would represent a potential higher level of concern, as this may signal potential program integrity risks or inappropriate utilization. This could potentially indicate further need for oversight.
- Provider-level data and each facility's SSVI score would be posted on CMS' Hospice Center webpage. While most hospices are anticipated to have a low score, facilities with high-end scores could be subject to additional review to assess potential program integrity or compliance issues.

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Proposals for Hospices

- To further support transparency and to help consumers make more informed choices regarding hospice care, CMS is proposing a new icon for the agency's Medicare.gov Care Compare site to identify hospices that did not meet requirements under the Hospice Quality Reporting Program (HQRP).
- CMS found that in CY 2025, the percentage of hospices that were not in compliance with HQRP reporting requirements was roughly 20%, similar to previous years. This consistent lack of data for approximately one-fifth of hospices limits CMS' ability to accurately measure the quality of care provided by hospices and limits the amount of data available to consumers.
- The potential addition of a consumer-friendly icon would aid people electing hospice and their families by indicating that CMS may not have sufficient quality data to assess a hospice's performance. The icon would also provide an incentive for hospices to meet reporting requirements.

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- CMS is also seeking to bolster transparency and further empower Medicare beneficiaries by proposing to require hospices to provide the hospice election statement addendum to all Medicare beneficiaries upon the election of hospice care.
- The addendum explains, in plain language, which items, services, drugs, and conditions the hospice says are not related to a patient's terminal illness and related conditions and will not be covered under the Medicare hospice benefit. Currently, hospices must provide a hospice election statement addendum only upon request by a patient (or their representative).
- The proposed rule would require hospices make the Addendum available to all beneficiaries, providing them with increased transparency regarding non-covered items, services, and drugs. This is intended to reduce confusion and ensure beneficiaries clearly understand coverage decisions at the time of hospice election. The change could decrease beneficiary out-of-pocket costs and lessen the burden created by having to proactively seek out information at a very vulnerable time.

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Proper Review of the Record Prior to Submitting to the Requester

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DON'T.....

- Have an office worker print off the chart and send it off without anyone reviewing it
- Guess on what to send. If you have questions, ask an experienced consultant or call the phone number provided on the request letter.
- Send all 5 episodes of a patient chart when only one 30-day episode was requested
- Don't use highlighter on the documents. It causes a shadow to be over the information that is highlighted and makes it more difficult to read for the reviewer.
- If Mailing -Bind all the records together, attach sticky notes or tabs.

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DO.....

- **Quality Review** the documents (see Medicare Benefit Policy Manual dated for the time frame the chart was requested).
- Compare visits completed versus claim submitted.
- Always include the **admission & start of care documents** if it is a subsequent episode requested.
- Always include a **cover letter** to pinpoint the reviewer to where the elements they need to see are found within the chart. (Number the pages to make this easier).
- Ensure it's **sent in timely**. If mailed make sure you are using certified mail with delivery confirmation.
- Ensure the **request letter is the first item** in the chart submitted.
- Provide a signature log (if signature(s) are not legible) or electronic signature policy.
- Ensure the patient's name is on each page.
- Verify all items that should have been submitted electronically from the chart have been accepted (NOA, NOE, Oasis)

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Submission of Medical Records

Ensure all medical records documentation is completely reviewed to ensure:

- All pages are the appropriate patient.
- PECS- Validation for all physicians involved in the patient's care for all DOS in the period of care.
- Appropriate OASIS submission
- Any and all therapy evaluations and reevaluations are included
- Identifiable names and credentials for each clinician signature (Signature log/attestation as appropriate)
- Accuracy of documentation
- Request letter is placed on top of the medical record
- The patient's name is on each page.
- The correct dates of service for the requested claim period of care.
- Dates of signatures are clear and appropriate.
- Legibility of all handwritten documentation.
- Pages are not folded over, cut off or crinkled
- Yellow Highlighter is not utilized
- All staples, paperclips, binder clips, sticky notes, rubber bands are removed prior to submission (if mailed).

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Home Health - Pinpoint the reviewer to elements to show the patient met:

- Homebound criteria (both elements)
- Reasonable and necessary/Skilled documentation
- Face to Face
- Physician's certification statement
- POC and other orders are signed and dated by the certifying provider
- Therapy Eval's and Re-Eval's are timely (at least every 30 days)
- All orders were signed and date prior to billing.

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Hospice – Pinpoint the reviewer to elements to show the patient met:

- Documentation of physician's certification of terminal illness (CTI)
- POC/IDG's and updates
- Comprehensive Nursing assessment
- Face to Face Encounter (If 3rd or later benefit period)
- LCD guidelines
- Hospice Election Statement
- Any additional documents that show the patient meets guidelines for hospice (LCD's, H&P, etc.)
- Documents to justify patient meets the 6-month prognosis

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Rank	Reason Code	Description
1	SHN18	Skilled nursing services weren't medically necessary.
2	SHC01	The physician certification is invalid since the required face-to-face encounter is missing, incomplete, or untimely.
3	SHC09	The initial certification is missing, incomplete, or invalid; therefore, the recertification episode is denied.
4	SHY01	The medical documentation submitted doesn't show that therapy services are reasonable and necessary and at a level of complexity that requires the skills of a therapist.
5	SHB00	Requested medical records weren't received within the 45-day time limit; therefore, we're unable to determine the medical necessity of the services listed and this claim is denied. If less than 120 days after the denial date on the remittance advice, submit records to the contractor requesting records. Don't resubmit the claim.

TOP Denial Reasons for Home Health

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Top Denial Reasons for Hospice

Rank	Reason Code	Description
1	5FMD1	According to Medicare hospice requirements, the information provided doesn't support a terminal prognosis of six months or less.
2	5FP06	The notice of election is invalid because it doesn't meet statutory or regulatory requirements.
3	5PC08	Face-to-face encounter requirements aren't met.
4	5B900	Medical records weren't received timely.
5	5PC01	A physician narrative is missing or invalid.

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Appeals

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Explanation of the Decision

The beneficiary was admitted to home health services on July 02, 2022, with the primary diagnosis of hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Included in the documentation submitted for review was the actual face-to-face encounter. The face-to-face encounter dated July 12, 2022, was timely, signed and dated by the certifying physician. However, the face-to-face encounter was not related to the primary reason for home health services. According to the documentation submitted, the beneficiary was discharged from the hospital on July 12, 2022. The discharge summary included in the documentation submitted mentioned hypertension and heart failure; however, the documentation submitted does not support the diagnosis of chronic kidney disease. Therefore, the dates of service under review will remain denied as the face-to-face encounter was not related to the primary reason for home health services.

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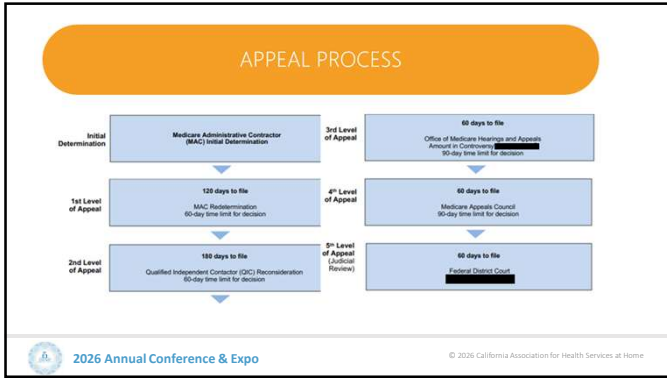
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Who Reviews Each Appeal

1. Level 1: Your appeal is reviewed by the Medicare administrative contractor.
2. Level 2: Your appeal is reviewed by a qualified independent contractor.
3. Level 3: Your appeal is reviewed by the Office of Medicare Hearings and Appeals.
4. Level 4: Your appeal is reviewed by the Medicare Appeals Council.
5. Level 5: Your appeal is reviewed by a federal district court.

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2026 Threshold Amounts

- This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2026. The calendar year 2026 AIC threshold amounts are **\$200** for ALJ hearings and **\$1,960** for judicial review.

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Forms – 1st & 2nd appeal

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Reports to Utilize

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Reports to Track Your Risk

PEPPER
Program for Evaluating Payment
Patterns Electronic Report

CASPER
Certification and Survey
Provider Enhancing Reporting

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PEPPER Reports
The Program for Evaluating Payment Patterns Electronic Reports

- Program for Evaluating Payment Patterns Electronic Report.
- Focus of all PEPPER reports (HH & Hospice) is looking at billing – Not necessarily quality.
- Focuses on areas that are “vulnerabilities” in the payment system.

Review your own report from
<https://pepper.cbrpepper.org/>

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PEPPER Reports (Program for Evaluating Payment Patterns Electronic Report)

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a Microsoft Excel file summarizing provider-specific Medicare data statistics for target areas often associated with Medicare improper payments due to billing, DRG coding, and/or admission necessity issues. Target areas are determined by the Centers for Medicare & Medicaid Services (CMS). PEPPER facilitates the prioritization of areas on which a hospital or facility may want to focus auditing and monitoring efforts. Hospitals and facilities are encouraged to conduct regular audits to ensure that medical necessity for admission and treatment is documented and that bills submitted for Medicare services are correct.



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PEPPER can be used to review three years of data statistics for each of the CMS target areas, comparing performance to that of other hospitals or facilities in the nation, specific Medicare Administrative Contractor (MAC) jurisdiction and state. PEPPER can also be used to compare data statistics over time to identify changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems and identify target areas where length of stay is increasing. PEPPER can help hospitals and facilities achieve CMS' goal of reducing and preventing improper payments.



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Obtain Report Yearly

The screenshot shows the PEPPER website interface. At the top, there is a navigation bar with links for Home, PEPPER, Training & Resources, Data, FAQ, Help/Contact Us, and CMS/MAC. Below the navigation bar is a sign-up form that says "Join our e-mail list to receive updates on training and PEPPER distribution. Provide your feedback on PEPPER." with a "Join Here!" button. The main content area features a "Welcome to PEPPER Resources" heading, followed by a paragraph explaining that PEPPERresources.org is the official site for information, training, and support. Below this, there are three buttons for "SHORT-TERM ACUTE CARE HOSPITALS", "CRITICAL ACCESS HOSPITALS", and "HOME HEALTH AGENCIES".



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Are You Out Of The "NORM"?

CLAIMS

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Rates over time resulting in greater risk of improper Medicare payments
- Your Target Rate (first row in the table below) is above the national 80th percentile

Average Case Mix

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Hospice Versus Home Health Quality Data

- Hospice (switched to IQIES) – Review and Correct Report, Hospice Quality Measure (QM), APU Non-compliance Notification Letters, Hospice Provider Preview Reports, Hospice CAHPS Preview Reports.
- IQIES - Home Health – Home Health Process Measures Reports, Patient Survey Rating (being revised), Claims-Based Quality Measure Reports, Outcome Measures Reports, Potential avoidable Events Report, Quality Rating)

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Measure Score Cut Points by Initial Decile Rating							
Initial Group Rating	Measure 1. Timely Initiation of Care	Measure 2. Improvement in Management of Oral Medications	Measure 3. Improvement in Ambulation	Measure 4. Improvement in Bed Transferring	Measure 5. Improvement in Bathing	Measure 6. Improvement in Dyspnea	Measure 7. Acute Care Hospitalization
1	0.5	0.0-82.5	0.0-51.6	0.0-57.4	0.0-57.8	0.0-82.4	0.0-53.8
2	1.0	82.6-90.4	51.7-63.4	57.5-69.1	57.9-70.2	82.5-73.2	53.9-69.6
3	1.5	90.5-94.3	63.5-70.7	69.2-75.4	70.3-77.6	73.3-79.2	69.7-77.1
4	2.0	94.4-96.5	70.8-75.6	75.5-79.5	77.7-81.6	79.3-82.8	77.2-81.7
5	2.5	96.6-97.8	75.7-79.6	79.6-82.4	81.7-84.3	82.9-85.6	81.8-85.1
6	3.0	97.9-98.7	79.7-83.1	82.5-85.0	84.4-86.5	85.7-88.1	85.2-87.7
7	3.5	98.8-99.4	83.2-86.2	85.1-87.6	86.6-88.6	88.2-90.3	87.8-90.0
8	4.0	99.5-99.8	86.3-89.4	87.7-90.2	88.7-90.8	90.4-92.6	90.1-92.4
9	4.5	99.9-99.9	89.5-94.0	90.3-93.6	90.9-94.3	92.7-95.7	92.5-95.7
10	5.0	100.0-100.0	94.1-100.0	93.7-100.0	94.4-100.0	95.8-100.0	95.8-100.0
11							
12	Your HHA Score	100.0	87.0	87.5	88.2	92.5	87.0
13	Your Initial Group Rating	5.0	4.0	3.5	3.5	4.0	3.0
14	Your Number of Cases (N)	287	245	250	250	250	189
15	National (All HHA) Mode Score	97.9	79.6	82.5	84.4	85.7	85.2
16	Your Statistical Test Results (is the p-value < 0.050?)	0.002	0.002	0.016	0.045	0.001	0.252
17	Your Statistical Test Results (is the p-value < 0.000?)	Yes	Yes	Yes	Yes	Yes	No
18	Your HHA Adjusted Group Rating	5.0	4.0	3.5	3.5	4.0	3.0
19	Your Average Adjusted Rating					3.7	
20	Your Average Adjusted Rating Rounded					3.5	

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What Do I Do With the Data?

- See what areas you are outside the "norm" for the national average. Investigate why you are outside the normal and "fix it".
- You can use some data for you QAPI plan to work on improvement.
- Be prepared for ADR's (possible from multiple entities) for data outside the normal range. Consult an expert to ensure you know how to improve to get out of the EYE of Medicare.

USE THE REPORTS TO IMPROVE, DON'T JUST PULL THEM AND THEN FORGET THEM...



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Questions?



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CARE AT HOME CONSULTANTS

Thank You!

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- [MLN7867599 - Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas, Georgia & Ohio](#)



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