Top Six Home Health Denial Reasons

Based on Medical Review

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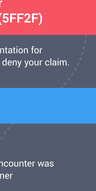
1 Requested Records not Submitted (56900)

When you receive an ADR, responding in a timely fashion is essential to avoid denials. Usually, this denial occurs when agencies forget to check a claim post-billing and the ADR goes undiscovered until receiving a denial notice. Without proper documentation, Medicare is unable to determine medical necessity.

How to avoid:



Check the status of your claims daily. By utilizing reporting and analytics software, you'll be notified about ADRs requiring attention. This allows you to quickly address issues before they result in a denial.

2 Face-to-Face Encounter Requirements Not Met (5FF2F)

When you submit insufficient documentation for face-to-face encounters, Medicare will deny your claim.

How to avoid:

The certification must include:

- A statement that the face-to-face encounter was performed by an approved practitioner
- The date of the encounter
- Medical documentation that is provided as requested

A face-to-face encounter must occur no more than 90 days prior to the home health start of care or within the 30 days following the start of care.

3 Medical Review HIPPS Code Change Due to Partial Denial of Therapy (5CHG3)

This means that services billed were reimbursed a lower payment level. Based on medical review of your submitted records, Medicare didn't allow some of the therapy visits, resulting in a partial denial and a change in the original HIPPS code.

How to avoid:

Submit the most accurate and complete documentation as possible for skilled therapy services.

4 No Plan of Care or Certification (5FNOA)

When there's no record of a physician-approved plan of care approved for services billed, Medicare will deny your claim. This particular denial can also occur when your documentation lacks a physician signed certification or re-certification. The necessity for home health services must be certified by the same physician who establishes the plan of care.

How to avoid:

Make sure the plan of care and certification or recertification are signed and dated by the physician and that the certification statement includes all required components.

5 Info Provided Does Not Support the Medical Necessity for Therapy Services (5A301)

You'll likely receive a denied claim when clinical documentation for therapy services doesn't support its medical necessity. Based on a patient's illness or injury, the skilled therapy services must be deemed reasonable and necessary for the treatment.

How to avoid:

When referencing the benefit manual, take careful note of the details within the Improvement Standard Settlement.

6 Unable to Determine Medical Necessity of HIPPS Code Billed as App Oasis Not Submitted (5FNOA)

When an OASIS was not submitted for the billed HIPPS code, Medicare will deny your claim.

How to avoid:

Make sure the electronic OASIS file that generated the HIPPS code for the claim is always submitted.

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