# Noridian Announces Results of Home Health Claim Review

by: DecisionHealth Staff , Jan 17, 2024

A supplemental medical review of home health claims found nearly three out of every four reviewed claims, or 72%, were denied due to errors.

That's according to Noridian, the Supplemental Medical Review Contractor tasked with post-payment reviews of 2020 claims. The results were published Jan. 16.

Noridian noted that 17% of claims were denied due to no response to the additional documentation request.

The common reasons for denial are similar to targeted probe & educate medical reviews by the Medicare Administrative Contractors: medical necessity and physician's certification of eligibility.

Here is Noridian's summary of the results:

*Common Reasons for Denial*

- **Medical Necessity:** Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1, and 42 CFR 409.44(b). "Documentation submitted does not support skilled nursing services are reasonable and necessary." To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury and must be intermittent. Documentation submitted did not support the home health services provided were medically necessary as evidenced by a new medical diagnosis, exacerbation of a chronic condition, recent hospitalization, and/or documentation to support the beneficiary was at risk of exacerbation and/or hospitalization related to their chronic condition.
- **Physician's Certification of Eligibility:** Refer to CMS IOM Publication 100-08, Chapter 6, Section 6.2.1. A physician certification/recertification of patient eligibility for the Medicare home health benefit is a condition for Medicare payment per sections 1814(a) and 1835(a) of the Social Security Act (the "Act"). The regulations list the requirements for eligibility certification and recertification. The requirements differ for eligibility certification and recertification; however, if the requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered—even if the requirements for recertification are met. Documentation submitted did not include the initial plan of care, therefore services on the subsequent episode may not be

allowed, and/or the documentation submitted did not include the initial valid certification of eligibility and/or valid face-to-face documentation.

- **Requested Records Not Received:** Refer to Internet-only Manual, Pub. 100-08, Chapter 3, Section 3.2.3.8, 42 CFR 424.5(a)(6) and Social Security Act Title XVIII, Sections 1815(a), 1833(e), and 1862(a)(1)(A). “No medical record documentation was received.” The inpatient documentation was not submitted or not submitted timely, to support the claim as requested by the additional documentation request (ADR).

See more at https://noridiansmrc.com/current-projects/01-086/.