CLINICAL & REGULATORY UPDATE
2016-18 | November 21, 2016

The Connecticut Association for Healthcare at Home supports its members in the provision of exceptional quality and accessible services through collaboration, leadership, provision of information, advocacy and education.

HOME HEALTH

CMS Announces the Implementation Four New G Codes, Changes in Reporting Non-Covered Charges and Other Policy Changes for Home Health Agencies
Source: NAHC November 19, 2016

The Centers for Medicare & Medicaid Services (CMS) has issued Change Request 9736 which implements new payment policies to home health agencies (HHAs) effective 1/1/2017. The CR outlines payment policies for disposable Negative Pressure Wound Therapy (dNPWT) devices and outlier payments using the new methodology, which includes changes in reporting non-covered charges. In addition, the CR requires agencies to begin reporting four new G codes associated with registered nurse (RN) and licensed practical nurse (LPN) visits in the home. Lastly, the CR includes the updates for the PRICER logic for 2017 home health prospective payment system (HHPPS).

Continue Reading

Medicare PPS final rates effective January 1, 2017
Source: Brad Borbidge

Attached please find the calendar year 2017 final wage adjusted non-LUPA episode and LUPA visit rates based on the November 3, 2016 Federal register. The rates are pre-sequestration which we expect to continue.

The national pre-wage index adjusted rate increased from $2,965.12 to $2,989.97.

The national rural pre-wage index adjusted rate will be $3,079.67.
For Medicare PPS revenue budgeting, a key is the PPS episodic % change from the prior year highlighted in yellow on the attached spreadsheet. We suggest you consider reducing the applicable % by the case mix budget neutrality of 2.14% for purposes of budgeting the change in PPS revenue per episode.

**NO OASIS Submission Equals NO Payment**

*Source: HPS*

The day has come that many agencies are going to be surprised by and that many have feared. A long standing federal regulation requires the transmission and acceptance of the SOC or FollowUp (Recert) OASIS assessment, used in creation of the HIPPS code on the claim, at the ASAP database as a condition of payment.

Prior to 2012 the Medicare claims processing system was unable to enforce compliance with this requirement because the system that maintained OASIS data and the system that processes claims were not linked. This weakness was identified and addressed with Change Request (CR) 7760, which required the FISS systems to develop a file exchange interface between their claim processing systems and the Quality Information Evaluation System (QIES). That work was completed for the home health claims processing system in late 2014 and the initial implementation of this validation, as announced in MLN Matters article SE1504, went into effect April 1, 2015.

**Continue Reading**

**Massive backlog of appeals at ALJ level is shrinking rapidly, new HHS data show**

*Source HHL November 17, 2016*

HHS says the backlog of denied Medicare claims awaiting an Administrative Law Judge (ALJ) hearing is shrinking at a rate that now means it will be gone completely by the end of fiscal 2019 - two years earlier than originally anticipated.

That makes unnecessary the speed-up actions the American Hospital Association is asking a federal court to impose on the appeals process, the government contends in a Nov. 7 counter-motion submitted to the U.S. District Court in Washington, D.C.

**Continue Reading**

**Court announces new standard for timing of physician signatures on certifications**

*Source HHL, November 14, 2016*

At least in the short term, a recent court ruling could lead to a more stringent interpretation of a Medicare standard for the timing of obtaining physician signatures. It also could lead to more whistleblower cases.
In September, the U.S. Court of Appeals for the Sixth Circuit reversed an order dismissing a case against Brentwood, Tenn.-based Brookdale Senior Living. It concluded that when an agency receives a certification in which the physician signature is not dated at the date on which the plan of care was established, the agency must explain the reason for the delayed signature.

**HOSPICE**

**CMS Issues Temporary Fix for CBSA Payment Error**
*Source: NHPCO*

On Wednesday November 9, CMS issued instructions to the MACs with a fix for the FISS claims payment error where the Medicare system was incorrectly returning to providers (RTP) for claims with a date of service (DOS) on and after 10/1/2016 with a correct Core-based statistical area (CBSA) code (as per the FY2017 Hospice Wage Index listing).

The claim(s) are incorrectly RTPing with reason code 36458 which states, "Hospice claim with a CBSA code in the 50XXX-99900 range is present on the claim and the date of service is 10/1/06 or after. CBSA's in the 50XXX range are invalid for dates of service 10/1/06 and after. Standard CBSA code should be billed". Watch for a notice from your MAC that gives instructions on the date to begin billing for claims on or after October 1, 2016.

**Hospice QRP: Third Quarter Q&A Now Available**
*Source: NAHC*

A new Question and Answer document is now available in the "Downloads" section of the [Hospice Item Set (HIS)](https://ui.constantcontact.com/visualeditor/visual_editor_preview.jsp?agent.uid=1126452617772&format=html&print=true). The Q+A document reflects frequently asked Hospice Item Set related questions that were received by the Quality Help Desk during the third quarter (July-September) of 2016. This document also contains quarterly updates and events from the third quarter as well as a "HIS coding tip of the quarter."

**CMS Publishes List of HQRP-compliant Hospices, Extension of CAHPS Size Exemption Deadline, and other Quality Updates**
*Source: NAHC, November 16, 2016*

Following are several recent web notices related to the Hospice Quality Reporting Program (HQRCP) that the Centers for Medicare & Medicaid Services (CMS) has posted, including notice that the deadline for the Hospice CAHPS Participation Exemption for Size Form has been extended to December 31, 2016, and a link to the list of hospices that successfully met the quality reporting requirements for the FY2017 payment year.
New Nursing Home Requirements Implications for Hospice Providers

Source: NHPCO, November 10, 2016

The new Requirements of Participation for Nursing Homes represent the greatest change in practice and care delivery since OBRA ‘87. The Requirements for Participation, over 700 pages, were released October 2016. The changes are of such magnitude that implementation will be phased in over a three year period with the effective date of the final rule November 28, 2016. Subsequent phase-in dates are November 2017 and November 2019. CMS is developing a new survey process that will go into effect in November 2017.

QUESTIONS? CONCERNS? COMMENTS?

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