News and information for LTC providers.

The Academy Weekly

News & Information for LTC Providers

The Academy of Senior Health Sciences, Inc.
www.seniorhealthsciences.org

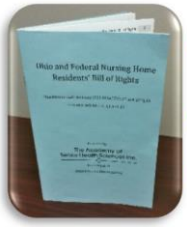
Friday, 30 March 2018

Happy Easter! Happy Passover!

Have a wonderful weekend!

CHAMPS Group Purchasing

compmanagement
WORKING HARDER FOR OHIO EMPLOYERS



Click to order RR booklets!

Ohio News

1. DODD prepares rules for new reimbursement formula set for July 1
2. Molina provides claims, other info, in latest provider update
3. What's up with RCS-I? Find out at the OANAC/ASHS Spring Conference!

National News

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Ohio News

1. DODD prepares rules for new reimbursement formula set for July 1

The balmy days of July might seem far away right now, but to the Department of Developmental Disabilities (DODD), it is approaching quickly. DODD worked with interested parties on developing a new reimbursement system for ICF-IID providers for more than a year. The statutory language was recently passed by the General Assembly, setting the ball rolling for a July 1, 2018 implementation date. The next step is to create the rules. Given the time frames required for the rules to be effective by July 1, DODD has fast-tracked them and released the business impact analysis, which includes the draft rules, for comment. Please click here to view the proposed rules. DODD has scheduled a conference call with interested parties, including The Academy, to review the rules for next week. Please

contact The Academy if you have any questions or concerns. (back to top)

2. Molina provides claims, other info, in latest provider bulletin

Molina Healthcare of Ohio's latest provider bulletin contains information on claims:

Concurrent and Post Payment Denials
When a prior authorization (PA) has been denied, a provider has 30 days to appeal the PA decision. Providers should submit a Claim Reconsideration Request if the service was still performed and billed for without an approved PA.

Provider PA Reconsideration – submission timeframe is 30 days from the date of the PA denial.

Member PA Appeals – submission timeframe is 60 days from the date of the PA denial. A provider can submit an appeal on behalf of his or her patient, but must also submit the Authorized Appeal Representative Form within 15 days of the date the appeal was received by the health plan. Providers also must specify on the request that this is an appeal on behalf of the member.

Claims Reconsideration – submission timeframe is 120 days from the date of the original remit, or the timeframe a provider has specified in his or her provider contract. It is important to note that if the claim is denied for a PA denial, the timeframe defaults backs to the Provider PA Reconsideration timeframe of 30 days from the date of the PA denial.

Corrected Claims
Submission of Corrected Claims: Effective April 1, 2018, corrected claims must be submitted with the Molina Healthcare claim ID number from the original claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Corrected claims received without this information will not be accepted and will receive the following denial information on the Molina Healthcare remittance:

- Category Code A3
- Status Code 748
- Entity Code 41
- Error Description: “Missing incomplete/invalid payer claim control number”

Submission of Final Claims after Interim Billing: Also effective April 1, 2018, inpatient facility claims billed on a UB claim form, bill type 0117 will no longer be accepted as the final original claim. Facilities which have submitted interim claims should submit a final claim upon patient discharge using the 0111 bill type.

Please Remember: Corrected claims are used to change or add information to a previously submitted claim. Corrected claims should be sent through the original claim submission process with a corrected claim indicator and Molina Healthcare claim ID number as outlined in the “Corrected Claim Billing Guide,” located on our website under the “Forms” tab. Corrected claims are not adjustments.

- Submit electronically with payer ID 20149 or on the Provider Portal
- Include all elements that need correction and all originally submitted elements
- Do not submit only codes edited by Molina Healthcare
- Do not submit via the claims reconsideration process
- Do not submit paper corrected claims

When submitting attachments through the Provider Portal:

- Supported file formats are PDF, TIFF, JPG, BMP and GIF
- Only 1 file is allowed per claim
- If a file exceeds 128 MB an alert will be sent and the claim will not process. For files that exceed 128MB contact your Provider Representative for submission alternatives.

Corrected claims must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days of the original remittance advice.

NDC Billing Guidelines

Effective Jan. 1, 2018, all professional and outpatient claims with CPT/HCP CS/Rev drug code details must have the corresponding valid NDC code submitted with the CPT/HCPCS drug code or the claims will be denied.

Drugs acquired through the 340B drug pricing program must be billed with an SE modifier so they can be properly excluded from federal drug rebates. For more information, see the Provider Manual on our website.

Per the final Medicare 2018 Outpatient Prospective Payment System rule, modifiers JG and TB will be used to signify use of a 340B drug. For claims that crossover directly to ODM from Medicare, ODM will request rebates for eligible drugs, as appropriate. If a provider submits a claim for a dually eligible individual directly to ODM, ODM will expect proper reporting of the SE modifier in accordance with ODM guidelines. This is important for providers who serve both Medicaid and MyCare Ohio members.

More information is available here by searching “Medicare 340B Reimbursement.”

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3. What's up with RCS-I? Find out at the OANAC/ASHS Spring Conference!

The 2018 OANAC/ASHS Spring Conference is slated for May 18 at the Quest Conference Center in Columbus, OH. Attendees can earn up to 6 BELTSS CEs (ASHS-30-P-18). This one-day conference covers vital information for MDS nurses and NH administrators. You can learn the latest about the newly proposed RCS-I system. Or hear about the Medicaid exception review process. $110 gets OANAC and ASHS members in the door if you order before May 4. So don't wait, click here to register today!
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Federal News

4. OIG issues report on therapy claims and overpayments

The Office of the Inspector General reviewed Medicare physical therapy claims and found that 61% did not meet medical necessity or documentation standards. According to the report, available by clicking here, extrapolating their results for the 6 month period studied, CMS overpaid $367 million. CMS does not agree with the findings of the OIG noting that further analysis of the claims is necessary to determine if they do not meet Medicare requriements. (back to top)

5. McKnights: Study questions hospital readmission measure

A study published this week in the Annals of Internal Medicine and reported by McKnights Long-Term Care News raises questions as to how accurately the hospital readmission measure reflects quality and value. (Click here to read the McKnights article.) The study compared the readmission data used to determine the penalties with the same data for patients not included in the readmission calculations for the penalty. The study found "Within-hospital differences in ERRs varied widely among groups. Medicare reported ratios differed from Medicare unreported ratios by more than 0.1 for 29% of hospitals and from non-Medicare ratios by more than 0.1 for 46% of hospitals. Among hospitals with higher readmission ratios, ERRs for the Medicare reported group tended to overestimate ERRs for the non-Medicare group but underestimate those

for the Medicare unreported group." And drew the conclusion that "Hospital ERRs, as estimated by Medicare to determine financial penalties, have poor agreement with corresponding measures for populations and conditions not tied to financial penalties. Current publicly reported measures may not be good surrogates for overall hospital quality related to 30-day readmissions." Click here to view the research paper. (back to top)

6. CMS MLN Connects Provider eNews

News & Announcements

- MIPS Reporting Deadlines Approaching
- EHR Incentive Program: Hospital Attestation Deadline Changed to March 16
- Hospice Provider Preview Reports: Review Your Data by March 30
- IRF and LTCH Provider Preview Reports: Review Your Data by April 5
- Medicare Pharmaceutical and Technology Ombudsman
- Updated QRDA III Implementation Guide with Advancing Care Information Identifier
- Hospice QRP Timeliness Compliance Threshold Report: Footnote Update
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Provider Compliance Tips for Hospital Beds and Accessories

Claims, Pricers & Codes

- Integrated OCE Files for April 2018

Upcoming Events

- New Medicare Card Project Special Open Door Forum — March 20
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21
- Interdisciplinary Team Building, Management, and Communication Webinar — March 21
- Hospice Quality Reporting Program Webinar — March 27
- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Managing Transitions with Adults with Disabilities Webinar — March 28
- Building Partnerships: Health Plans and Community-based Organizations Webinar — April 4

Medicare Learning Network® Publications & Multimedia

- Appropriate Use Criteria for Advanced Diagnostic Imaging: HCPCS Modifier QQ MLN Matters Article — New
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article — New
- April 2018 Update of the Hospital OPPS MLN Matters Article — New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
- Provider Compliance Tips for Walkers Fact Sheet — New
- Provider Compliance Tips for Home Health Services Fact Sheet — New
- Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet— New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised

- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes MLN Matters Article — Revised
- Provider Compliance Tips for Laboratory Tests: Other Fact Sheet – Revised
- Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet — Revised
- Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet — Revised
- Provider Compliance Tips for Enteral Nutrition Therapy Pumps Fact Sheet — Revised
- Provider Compliance Tips for IRF Fact Sheet — Revised
- Ambulatory Surgical Center Payment System Fact Sheet — Revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet—Revised
- Medicare Ambulance Transports Booklet — Revised
- Medicare Provider-Supplier Enrollment National Educational Products Listing — Revised
- Global Surgery Booklet — Reminder

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Our mailing address is:
The Academy of Senior Health Sciences Inc.
17 S. High St.
Suite 770
Columbus, OH 43215