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, 25 May 2018

Please take a moment Monday to remember those who have given their life to protect our country.

CHAMPS Group Purchasing

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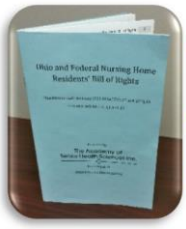
WORKING HARDER FOR OHIO EMPLOYERS



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Ohio News

National News

Ohio News

1. CHOP? Use correct provider number for MDS submission

The Ohio Department of Medicaid notified the provider associations this week that some providers that have acquired facilities have been submitting MDS data to CMS with the incorrect Medicaid provider number. Providers have not updated their software systems to include the new provider number after a change of ownership (CHOP). Some old provider numbers date back as far as 2016.There is concern that these providers may be at risk for a reduction to their Medicare rate for not properly submitting the MDS data for the Medicare quality payment. According to ODM:

"Here is an example of the Warning messages that may appear on the Validation Report the provider receives after a record is submitted to the CMS - QIES ASAP system. If the information is incorrect the provider must follow the correction policy to fix the incorrect data submitted.

Warning

-3806

Inconsistent A0100C: The value submitted for A0100C (State Provider Number) does not match the State Provider Number in the QIES ASAP System for the provider identified by the FAC ID in the file.

Below is a screen shot of the guide:

Error ID	Sev	Error Message	Error Description
-3806	Warn	Inconsistent A0100C: The value submitted for A0100C (State Provider Number) does not match the State Provider Number in the QIES ASAP System for the provider identified by the FAC ID in the file.	**Cause:** The state provider number submitted in item A0100C does not match the state provider number known to the QIES ASAP system for the provider identified by the FAC ID in the file. **Example:** The state provider number was entered incorrectly into the encoding software that created the submission file. **Action:** Verify that the state provider number in the encoding software is correct. Contact your software vendor. Contact your State Agency for additional assistance, if needed.

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2. Patient liability process becoming priority for ODM

The Ohio Department of Medicaid met with The Academy and other interested parties to discuss the problems with patient liability and MyCare Ohio. ODM has agreed that in order to proceed with MLTSS in the future, the PL process needs to be fixed. At the meeting, ODM admitted that there were some issues around the data in MITS, especially with the importation of data from Ohio Benefits. A recent fix that went into effect in early May should have resolved a major issue relating to a person going from a positive PL to zero. (MITS would not accept the zero amount.) ODM and the OAHP agreed to pick a MyCare plan and follow the data for a subset of NH residents from when the county inputs the information to when it is used in claim processing. By following the data through the process (input into OB, OB export to MITS, MITS export to the plan (834 file), 834 to the claim), the goal is to find where the data is changing so the cause can be isolated and corrected. ODM has also hired a consulting firm, Myers & Stauffer, to review the PL process and recommend improvements. Also, ODM is making upgrades to their IT system with the goal of having one central database. This would remove MITS from the process described above and allow the counties, plans, providers, and beneficiaries to access the same database. There is no timeline for when this will be implemented. Finally, ODM continues to have discussions with CMS on making the PL process for MyCare NH residents similar to how it is done for waiver providers - using a third party to manage PL. ODM plans to know more over the next few months as they have meetings scheduled with CMS. (Back to top)

3. FBI raids Rosenberger; House may spend summer without a speaker

The FBI raided Rosenberger's personal residence, a storage unit, and the Riffe Center to collect items that appear to be part of an investigation into campaign finances. Questions have been raised about Rosenberger's travels and now there is speculation that the failed charter school ECOT may also be involved. Regardless, the move by the FBI has created a dark backdrop for the speaker conundrum facing House Republicans. The House canceled sessions this week as Rep. Schuring, the acting speaker, could not confirm the 50 votes needed to determine the next speaker. Rep. Schuring has indicated that he wants the next speaker to have the majority of votes and will not hold another session until that is confirmed. The battle is between Reps. Smith and Thompson, the latter of which will not be a member of the House next year. Rep. Smith used strong language in accusing Rep. Householder of strong-arming members to deny Smith the votes he needs to be speaker. Rep.Smith has said he will refuse any deals. Rep. Householder, who plans to run for speaker in January, unequivocally denies the allegations and questioned how wild accusations would lead to a resolution, but instead creates further division among the caucus. The hypocrisy is self-evident as Rep. Smith continues to try and persuade at least 3 more members to vote for him in order to reach the necessary 50 votes. The Democrats, who hold 33 House seats, have said they will not vote for a Republican and plan to nominate their own member, Rep. Strahorn. The House has several "as needed" sessions scheduled over the next few weeks, so Rep. Schuring could call for a session and hold a vote. Should the House hold a session and a majority vote does not occur, the House can vote 10 times without a majority. On the 11th vote, the member with the most votes becomes speaker. As it stands now, the House may not meet again until after the elections in November, at which time any elected speaker would be residing over a lame duck House for two months. Should the stalemate continue beyond then, the current House would not pass any further legislation. The next speaker would be elected at the start of the new General Assembly in January. (back to top)

4. Bills on the move before summer break

The members of Ohio's General Assembly are beginning to think about long summer days, many of which will be spent campaigning by some. Both House and Senate committees worked over the past few weeks to clear their docket ahead of the break. Below is a list of LTC related health care bills that have cleared their respective chamber and have recently had a committee hearing.

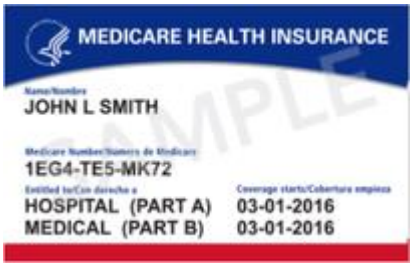
H.B. 131 Physical Therapy - The bill includes in the practice of physical therapy the evaluation of a person to determine (1) a physical therapy diagnosis to treat physical impairments, functional limitations, and physical disabilities, (2) a prognosis, and (3) a plan of therapeutic intervention. Furthermore, the bill specifies that "physical therapy diagnosis" does not include a medical diagnosis. The bill had its first hearing in Senate committee this week with sponsor testimony. The sponsors of the bill are now tying the change to the opioid epidemic. They note that PT can be used to reduce the need for long-term use of opioids and thus help in reducing opioid addiction.

H.B. 286 Palliative Care - The bill, among other items, creates the Palliative Care and Quality of Life Interdisciplinary Council to consult with and advise the Department of Health on matters related to palliative care initiatives and the Palliative Care Consumer and Professional Information and Education Program in the Department of Health and requires the Department to publish on its website certain information regarding palliative care. It also requires specified health care facilities and providers to establish a system for identifying patients or residents who could benefit from palliative care and to provide information on palliative care. The bill had a hearing in Senate committee this week that included a sub bill that changes the definition of palliative care to be more specific: "Palliative care" means specialized care for a patient of any age who has been diagnosed with a serious or life-threatening illness that is provided at any stage of the illness by an interdisciplinary team working in consultation with other health care professionals, including those who may be seeking to cure the illness, and that aims to do all of the following: (1) Relieve the symptoms, stress, and suffering resulting from the illness; (2) Improve the quality of life of the patient and the patient's family; (3) Address the patient's physical, emotional, social, and spiritual needs; (4) Facilitate patient autonomy, access to information, and medical decision making. It also allows certain hospice providers to provide palliative care to non-hospice individuals.

S.B. 158 Elder Fraud - The bill would develop best practices and educational opportunities to combat elder fraud and exploitation and to fine and require full restitution from offenders who are found guilty of certain fraud-related crimes against the elderly. The bill had its second hearing in House committee this week. Proponent testimony in support of the bill noted how difficult it is to detect elder fraud and also to recover the funds once it has been identified. It was also noted how some counties may lack the adult protective funds to pursue cases. The bill is up for a third hearing next week.

The Academy continues to track these, and many other bills and advocate on your behalf. If you have any questions about these or other legislative matters, please contact The Academy. (back to top)

Federal News



5. News from CGS: ABN, Overlapping claims

CGS, the Medicare Part A claims contractor for Ohio, recently released the following information:
New SNF ABN Requirements
The purpose of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) is to inform a beneficiary before he or she receives services or items that may otherwise be covered that Medicare will not, or most likely will not, pay for the services or items for a particular reason. The SNF ABN allows the beneficiary to make an informed choice to either receive the services or not. The SNF ABN also allows the beneficiary the option to have the potentially non-covered charges submitted to a review by a Medicare Administrative Contractor (MAC) for payment in the form of a Demand Bill. On March 30, 2018, CMS

released Change Request (CR) 10567. This CR discontinued the five (5) previously accepted SNF denial letters. As cited by CMS, these letters, namely the Intermediary Determination of Non-coverage, the UR Committee Determination of Admission, the UR Committee Determinations on Continued Stay, the SNF Determination on Admission, the SNF Determination on Continued Stay, and the Notice of Exclusion from Medicare Benefits (NEMB-SNF) will no longer be utilized when notifying beneficiaries of potentially non-covered services or items. CMS has revised the SNF ABN, Form CMS-10055. Providers should utilize Form CMS-10055 for SNF Demand Bills. This change is effective as of April 30, 2018.

Additional information related to the revised SNF ABN can be found in the following:
CMS MLN Matters MM10567: Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)
CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 30

06/12/18 Reducing Overlapping Claims - A Collaborative Effort Between CGS and WPS
Overlapping claims continue to be a top claim rejection for providers. Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect. Often, overlapping claims can be prevented by knowing how to properly submit claims in these situations.

CGS and WPS GHA are coming together to provide a unique opportunity for our provider communities in the Louisville, KY, area. We would like to invite all Part A providers (billing on a UB-04) to join us in this joint endeavor to offer an educational event like no other.

During this full day seminar, the MACs will go over the most common reasons for overlapping claims and steps providers can take in an overlapping claim situation. Some of the topics to be covered include:

- Billing during a leave of absence (LOA)/interrupted stay
- What "hospital bundling" includes
- How to determine the proper patient status to use on your claim
- Main cause of SNF overlaps (aside from Consolidated Billing)
- 3/1 day payment window
- End Stage Renal Disease (ESRD) Consolidated Billing
- Home Health Consolidated Billing
- What Place of Service (POS) Part B providers should use
- Steps you can take to resolve overlapping claim issues with another provider

Read more and Register today!

Seminar – 06/13/18 SNF Consolidated Billing - A Collaborative Effort Between CGS and WPS

Do you want to become a “pro” at Skilled Nursing Facility (SNF) Consolidated Billing? Become the go-to person in your office for related questions? Then you’ll want to join us for this full day, interactive seminar! CGS and WPS GHA are coming together to provide a unique opportunity for our provider communities in the Louisville, KY, area. We would like to invite all Medicare providers to join us in this joint endeavor to offer an educational event like no other. This will be an INTENSIVE day of hands-on training and implementing strategies that will give you the tools you need to be the subject matter expert in your office.

You will learn the whys, ifs, ands, and buts when it comes to SNF Consolidated Billing. Then, working in groups, you’ll put what you have learned into action. Using laptops, each group will determine who the responsible payer would be in a variety of situations. Read more and Register today!

Part A Webinar Recording Now Available

For those who were unable to attend CGS live webinars, take advantage of this opportunity to replay the live presentation. The following webinar recording is now available on the CGS website.

- May 10, 2018 – New Medicare Card for Part A Providers

Access this recording and others on the Part A Recorded Webinars Web page, all at your own convenience.

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6. CMS MLN Connects Provider eNews

News & Announcements

- MIPS Promoting Interoperability Performance Category
- Provider Documentation Manual on Home Use of Oxygen: Submit Comments on Draft by May 31
- Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
- Targeted Probe and Educate Video
- Hospice Compare Quarterly Refresh
- CQM Annual Update
- Break Free from Osteoporosis

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- FY 2019 ICD-10-PCS Procedure Codes

Upcoming Events

- Hospice Quality Reporting Program Data Submission and Reporting Webinar — May 30
- DMEPOS Dietary Related Items, Templates and CDEs Special Open Door Forum — May 31
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- MIPS Promoting Interoperability Performance Category Webinar — June 12

Medicare Learning Network® Publications & Multimedia

- RARC, CARC, MREP, and PC Print Update MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
- Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
- World of Medicare Web-Based Training Course — Revised
- Your Office in the World of Medicare Web-Based Training Course — Revised
- Your Institution in the World of Medicare Web-Based Training Course — Revised

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