FRIDAY, NOVEMBER 16, 2012 HEADLINES:

Survey data shows jump in IJs

ULTCSS Workgroup gets update on current state LTC initiatives

Notes from the ODH provider meeting

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CMS Update

Survey data shows jump in IJs – The latest Ohio Department of Health quarterly nursing home report shows another significant increase in Immediate Jeopardy (IJ) findings. According to the report, there were 25 IJs at 16 different facilities. This is a significant increase over the previous quarter’s 2 and close to the 19 IJs for the same quarter a year ago. There also appears to be an increasing trend of more of the total deficiencies at G-level or higher. The clinical findings are mixed, as pressure ulcer deficiencies are falling and weight loss/nutrition is showing an increase. The person centered care deficiencies are showing either an increasing trend or remaining constant. For more information on the quarterly report, please contact Chris Murray. (Back to top).

ULTCSS Workgroup gets update on current state LTC initiatives – The Unified Long-Term Care Services and Supports Advisory Workgroup met this week and was presented updates on various state long-term care initiatives:

- **Severe & Persistent Mental Illness** – ODMH Director Tracy Plouck noted that the state continues to focus efforts on moving individuals with SMI out of nursing facilities. They have made a concerted effort to use the Home Choice option to move people out of facilities. They are also looking at using the Section Q data of the MDS to find individuals who may be able to transition to the community. There was also discussion around congregate living designed for a special population. Although HUD has no intention of changing its regulations around congregate settings for a specific population (such as those with SMI), the Department of Justice has legal concerns around segregation. The DOJ is looking into it on a case-by-case basis.

- **ICDS** – Director McCarthy provided an update on the status of the ICDS program. He noted that the implementation date was delayed and it would not start until sometime after May. CMS has given the state a draft memorandum of understanding and the state expects CMS to propose rates within the next few weeks. The Office of Medical Assistance will be conducting outreach meetings with various provider and advocacy groups over the next several months in preparation of implementation.

- **NH Reimbursement** – The workgroup was updated on the work of the NH Reimbursement Subcommittee. In general, there is no expectation of radical changes in the upcoming budget as the administration understands that the ICDS is a significant change and they do not want to add more disruption. It appears the administration will be addressing the issue of some counties being in peer group three despite the cost data indicating they should be in peer group two (stark and Mahoning, for example). The Academy is had been advocating for a change since the new peer groups were established. Other changes expected in the budget include updating the quality measures and better alignment of regulations with person centered care initiatives.

- **Regulatory Reform** – The state has convened five internal workgroups to tackle regulatory reform. These groups have been looking at issues such as: making sure survey deficiencies are corrected in a systematic way and in a manner that is consistent with state initiatives if applicable; creating standards for facilities that provide specialized care (e.g. bariatric); review of state licensure requirements compared with federal requirements; consideration of
increased HCBS oversight; and, ensure consistency of the concept of the “front door.” The outcomes of these workgroups will most likely be seen in the Governor’s budget proposal at which time the state will engage interested parties.

If you have any questions or concerns about any of these initiatives, please contact The Academy.

Notes from the ODH provider meeting – The Ohio Department of Health met with provider associations and other state officials last week at the monthly provider meeting. Below are notes from the meeting:

- Providers should be following their policies regarding documentation of meal intake. There is no regulation that requires a provider to document meal intake for all residents; however, if that is a policy of the facility, it needs to be implemented.
- Providers are reminded that they need to follow manufacturer’s instructions when using humidifiers.
- Providers are reminded to make sure that an active, monitored e-mail account is on file with the EIDC. This is important now that the survey process has gone paperless and there is more electronic communication between ODH and providers.
- Providers still have to print and post survey results despite the electronic reporting to the facility.

ODH is aware that follow-up surveys are running late and are working on finding a solution. ODH also noted that the time between surveys for a facility is averaging more than 12 months. This is because the QIS is more time intensive than the traditional surveys. Other states that are using the QIS survey are experiencing the same difficulties in maintaining the 12 month average. ODH noted the goal was still to have the surveys done within the 15 month window.

Notes from the OMA provider meeting – The Office of Medical Assistance met with provider representatives and other state officials this week. Below are notes from the meeting:

- The state will no longer be issuing zero balance CPAO reports beginning with the 2008 reports, which will be issued in early January. Providers are reminded that if they do get a CPAO report, they must respond within 30 days.
- OMA is still working on how to reconcile the leave day reimbursement amount for the 84 providers whose rates changed because of the cost report occupancy data.
- There will be no further discussion of changes to the cost report until after the budget process.
- OMA is still working through several claims issues, including:
  - Hospital leave days – OMA will be issuing a guidance soon related to how to properly bill for hospital leave days that will ensure both SNFs and hospitals get paid.
  - Restricted eligibility – Still a problem and they continue to work on it. The current manual fix is taking about 3 weeks. Providers should still send issues to the NFdirectbill mailbox.
  - Outpatient Part B Therapy Crossovers – Still working on a solution. Providers are reminded that the incorrect denials only apply to non-residents receiving the therapy.

The next OMA provider meeting is scheduled for mid-January. Please contact The Academy if you have any issues or concerns you would like addressed at the meeting.

CMS Update – The following information was released by CMS:

New and Revised MLN Matters

SE1245 – Alert Concerning Impacts Arising from Having Non-Compliant Physical or Practice Address Information on File with Medicare – New

MM7864 – Revision to Chapter 15 (Section 15.5.20) of the Medicare Program Integrity Manual (PIM) - New

MM8120 – Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2013 - New

MM7858 – Quarterly Update to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS).- New

MM7869 – Implementation of Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Consolidated Billing Requirements for Daptomycin and a Clarification of
Outlier Services for Calendar Year 2013 - New

MM8078 – The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2010 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs) - New

SE1232 – Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients - New

MLN New and Revised Products

“Screening for Depression” Booklet (New)
The “Screening for Depression” Booklet (ICN 907799) is now available in hard copy format. This booklet is designed to provide education on screening for depression. It includes coverage, coding, billing, and payment information.

“Medicare Guidance Regarding Meningitis Outbreak” MLN Matters® Article (New)
MLN Matters® Special Edition Article #SE1246, “Medicare Guidance Regarding Meningitis Outbreak” was released and is now available in downloadable format. This article is designed to provide education on the interim treatment of fungal meningitis based on guidance from the Centers for Disease Control (CDC). It also includes information about Medicare coverage for CDC-recommended items, services, and antifungal medications.

“Medicare Claim Submission Guidelines” Fact Sheet (Revised)
The “Medicare Claim Submission Guidelines” Fact Sheet (ICN 906764) was revised and is now available in hard copy format. This fact sheet is designed to provide education on Medicare claim submissions. It includes information about enrolling in the Medicare Program; private contracts with Medicare beneficiaries; filing Medicare claims; deductibles, coinsurance, and copayments; and coordination of benefits.

“Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC” Booklet (Revised)
The “Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC” Booklet (ICN 006973) was revised and is now available in downloadable format. This booklet is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors; in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Contractor, and the Comprehensive Error Rate Testing Program.

“Phase 2 of Ordering/Referring Requirement” MLN Matters® Article (Revised)
MLN Matters® Special Edition Article #SE1221, “Phase 2 of Ordering/Referring Requirement” was revised and is now available in downloadable format. This article is designed to provide education on phase 2 of the requirement by which CMS will deny Part B, DME, and Part A HHA claims that fail ordering/referring provider edits, as outlined in final rule CMS-6010-F, which CMS published on April 24, 2012. It includes resources and information about phases 1 and 2 of the requirement and which types of providers are eligible to order or refer items or services to Medicare beneficiaries. The article was revised to add a reference to the Affordable Care Act and clarify the type of providers who may order/refer Portable X-Ray services. All other information remains the same.

CMS Issues 2 Payment Rules
On November 1, CMS issued two final regulations updating Medicare payment rates and policies in CY 2013 for services furnished by physicians and other practitioners, and hospital outpatient departments and ambulatory surgical centers. The final CY 2013 Medicare Physician Fee Schedule (MPFS) rule will be published on November 16, 2012. It will take effect January 1, 2013 with a comment period that closes on December 31, 2012.

- Final Rule with comment period
- Fact Sheet

The final CY 2013 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) rule will be published on November 15, 2012. It will take effect January 1, 2013 with a comment period that closes on December 31, 2012.

- Final Rule with comment period
- Fact Sheet