E-Alliance Extra

***Missouri Alliance for* Home Care**
2420 Hyde Park, Suite A • Jefferson City, MO 65109 • P (573) 634-7772 • F (573) 634-4374

December 8, 2016

In This Edition:

MAHC Gearing Up for 2017 Legislative Session

Even though the election is over there are still many questions that remain on both the state and federal level.

In Missouri the home care industry will be facing many challenges including a newly elected Governor with no stated record on home care, a bleak fiscal outlook with possible additional withholds on the horizon, interest in expanding all populations into Managed Care and the possibility of union activity again in the CDS program.

2017 not only brings a new Administration it also brings five new Senators and 39 new Representatives. House leadership will most likely restructure committees again and the Senate is likely to modify their operating rules.

On the federal level, there seems to be a few bright spots and opportunities with the new Administration including the possibility of eliminating inappropriate regulations such as F2F, and the reinstatement of the companionship exemption. However, it is not all good news. There is the threat of Medicaid cuts including Medicaid Block Grants, and changes to the Medicare program including privatization and copays.

MAHC will be sending out a legislative relationship survey soon. Please be watching your email for this important survey that will help in our advocacy efforts.

Home Care Advocacy Day – Mark Your Calendar

MAHC's Home Care Advocacy Day will be held on February 8th. Advocacy Day is your opportunity to visit with legislators about the industry's issues and to reinforce the importance of home care. Click on the following link for the registration brochure. http://homecaremissouri.org/eventfiles/event_597_650.pdf

Nominations Being Solicited for MAHC Board Candidates

Are you an active member of a MAHC committee? Are you interested in serving on the MAHC Board of Directors? If you would like to be considered by the nominating committee, now is the time. Visit the following link for the nomination form. http://www.homecaremissouri.org/mahc/documents/Websitepacket.pdf

Home Care Awards – Nominate Today

Don't delay. Nominate your outstanding employee or member of your community who has advanced home care. The process is easy. Visit the following link for the award criteria and application. http://homecaremissouri.org/events/awards.php

MAHC Annual Conference – All Connections Matter

The MAHC Annual Conference Planning Committee has been busy pulling together another spectacular conference. The theme "All Connections Matter" indicates the future of home care. With the development of new payment models and many collaborative initiatives, no longer can home care agencies survive alone; they must prepare to align with other healthcare industries and work together to provide the most cost effective and best quality of care. As always, the conference will include many expert speakers on home care and hospice "hot" topics. Be watching your email for more details.

Mark your calendars for April 26-28, 2017 at Tan-Tar-A.

Provider Application Fee Increase

State and federal regulations (13 CSR 65-2 and 42 CFR 455.460) require Missouri Medicaid Audit and Compliance (MMAC) to collect an application fee from all new and revalidating, institutional Medicaid providers. Individual providers such as

physicians, dentists and other individual non-physician practitioners are not required to pay the application fee.

The application fee is currently set at $554.00, and it will increase to $560.00 on January 1, 2017.

Click here to read more about the application fee and hardship waivers.

DSS Medicaid Fee-for-Service Access Monitoring Plan – Notice of Public Comment Period

The Department of Social Services Medicaid Fee-for-Service Access Monitoring Plan has been posted to the MO HealthNet website at: www.dss.mo.gov/mhd under Alerts and Notifications.

MO HealthNet will accept written public comments within 30 days from December 6, 2016.

CMS to Begin Covering Disposable Negative Pressure Wound Therapy

(from NAHC Report)

In the final rule for the 2017 home health prospective payment (HHPPS) rate update the Centers for Medicare and Medicaid Services (CMS) issued policies for coverage and payment for disposable negative pressure wound therapy (dNPWT).

The Consolidated Appropriations Act, 2016 requires a separate payment to a home health agency (HHA) for dNPWT furnished on or after January 1, 2017, to an individual who receives home health services under the Medicare home health benefit. The act requires that the payment amount for a disposable NPWT device be set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the following HCPCS codes:

- HCPCS 97607—Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.
- HCPCS 97608—Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters..

CMS' payment policy for the dNPWT reflects the requirements to provide a separate payment for the device and follows the OPPS payment structure and fee schedule for reimbursement.

In order to cover dNPWT separate from the HH episodic payment, CMS will require that HCPSC codes 97607 and 97608 be reported Type of Bill (TOB) 34X. Most agencies should have some experience with this bill type since osteoporosis drugs, outpatient therapy, and vaccines are all billed on a TOB 34x.

CMS' billing policy for dNPWT, however, is unique from other TOB 34x services in that the professional service associated providing dNPWT is included in the reimbursement. This is because HCPCS codes 97607 and 97608 include in their description the "provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care"

This uniqueness raises some billing concerns relative to providing NPWT using a disposable device. In the final rule CMS addressed these concerns and provided the several examples.

There are essentially three potential billing scenarios for HHA patients receiving dNPWT:

- The sole reason for the visit is place a new, or replace a, dNPWT device;
- The reason for the visit is a combination of both placement (replacement) of the device and additional HH services, such as inserting an indwelling urinary catheter or;
- A follow-up visit for wound assessment, wound management, and dressing changes where a new dNPWT device is not applied.

Example # 1:
On Monday, a nurse assesses the patient's condition, assesses the wound, and applies a new dNPWT device. The nurse also provides wound care education to the patient and family. On the following Monday, the nurse returns, assesses the wound, and replaces the device that was applied the week before with an entirely new dNPWT device. In this scenario, the billing procedures are as follows:

++ For each visit, all the services provided by the nurse were associated with furnishing NPWT using a disposable device because the nurse applied a new dNPWT device during each visit. The nurse did not provide any services other than furnishing NPWT using a disposable device. Therefore, all the nursing services for both visits should be reported on TOB 34x with HCPCS code 97607 or 97608. None of the services should be reported on TOB 32x.

Example # 2:
On Monday, a nurse assesses the wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or

dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient's condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device. In this scenario, the billing procedures are as follows:

++ For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with HCPCS code 97607 or 97608. None of the services should be reported on TOB 32x.

++ For the Thursday visit, the nurse checked the wound, but did not apply a new dNPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.

Example #3:
On Monday, the nurse applies a new dNPWT device. On Thursday, the nurse returns for a scheduled visit to change the beneficiary's indwelling catheter. While there, the nurse assesses the wound and applies a new fluid management system (or dressing) for the existing dNPWT device, but does not replace the device entirely. In this scenario, the billing procedures are as follows:

++ For the Monday visit, all the nursing services were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, the HHA should report the nursing visit on TOB 34x with HCPCS code 97607 or 97608; the visit should not be reported on a 32x claim.

++ For the Thursday visit, while the nursing services included wound assessment and application of a component of the dNPWT device, the nurse did not furnish a new dNPWT device. Therefore, the nurse did not furnish NPWT using a disposable device, so the HHA should report all the nursing services for the visit, including the catheter change and the wound care, on TOB 32x.

Example # 4:
On Monday, the nurse applies a new dNPWT device, and provides instructions for ongoing wound care. During this same visit, per the HH plan of care, the nurse changes the indwelling catheter and provides troubleshooting information and teaching regarding its maintenance. In this scenario, the billing procedures are as follows:

++ The visit included applying a new dNPWT device as well as services unrelated to that NPWT service, which means the HHA will submit both a TOB 34x and a TOB 32x.

++ For furnishing NPWT using a disposable device, that is, the application of the new disposable NPWT device and the time spent instructing the beneficiary about ongoing wound care, the HHA would bill using a TOB 34x with HCPCS code 97607 or 97608.

++ For services not associated with furnishing NPWT using a disposable device, that is, for the replacement of the indwelling catheter and instructions about troubleshooting and maintenance, the HHA would bill under TOB 32x.

Similar to the influenza vaccine administration rate for HHAs, reimbursement for the dNPWT is based on the OPPS rates, which is determined each calendar year. Sixty percent of the rate is wage adjusted using the hospital wage index for the core based statistical area (CBSA) where the service is provided. The 2017 unadjusted payment rate under the OPPS for both HCPCS 97607 and 97608 is $292.49.

To determine the amount the HHA will be reimbursed for the dNPWT the agency will need to use the hospital wage index that applies to the CBSA where the service is furnished and adjust 60 percent of the national unadjusted payment for dNPWT by the applicable wage index.

For example, the 2017 national unadjusted payment rate is $292.49. If the hospital wage index for the applicable CBSA is .99, payment to the HHA will be $290.74:

$292.49*.6 = $ 175.494(the portion to be wage adjusted);
$175.494*.99 (the wage index) =$173.73906 (the wage adjusted portion of the payment);
$ 173.73906 + $116.996 (the 40% of the national unadjusted payment that is not wage adjusted) = $290.74 (after rounding).

The dNPWT reimbursement rate is subject to a 20% beneficiary coinsurance.

It is hard to know at this point how overall reimbursement will be impacted for agencies using the dNPWT in lieu of DME NPWT. The NPWT professional services do not count towards the 4 visit LUPA threshold. However, in most instances, an HHA providing NPWT will bill both a 34X for the NPWT device along with the professional services and a 32X bill for other HHA professional and/or dependent services. This will mean a separate payment for the NPWT visits and a LUPA or full episode payment for the other services.

Government Appeals Injunction Against Federal Overtime Rule

(from NAHC Report)

On November 22, 2016, a federal judge with the U.S. District Court for the Eastern District of Texas issued a nationwide preliminary injunction blocking the implementation of a Department of Labor rule setting out qualifications for the overtime exemption of executive, administrative, and professional (EAP) employees that was scheduled to take effect on December 1. The enjoined rule would have reset

the minimum salary level needed to qualify for the exemption to $921 weekly ($47,892 annually) in contrast to the current $455 weekly.

However, on December 1, 2016, the Department of Justice, on behalf of the Department of Labor, filed a notice to appeal the preliminary injunction to the U.S. Circuit Court of Appeals for the Fifth Circuit. The Department strongly disagrees with the decision by the court," the government wrote in a statement posted to the Department of Labor website. "The Department's Overtime Final Rule is the result of a comprehensive, inclusive rule-making process, and we remain confident in the legality of all aspects of the rule."

From the Department's statement:

"Since 1940, the Department's regulations have generally required each of three tests to be met for the FLSA's executive, administrative, and professional (EAP) exemption to apply: (1) the employee must be paid a predetermined and fixed salary that is not subject to reduction because of variations in the quality or quantity of work performed ("salary basis test"); (2) the amount of salary paid must meet a minimum specified amount ("salary level test"); and (3) the employee's job duties must primarily involve executive, administrative, or professional duties as defined by the regulations ("duties test"). The Department has always recognized that the salary level test works in tandem with the duties tests to identify bona fide EAP employees. The Department has updated the salary level requirements seven times since 1938.

"The Department strongly disagrees with the decision by the court. The Department's Overtime Final Rule is the result of a comprehensive, inclusive rule-making process, and we remain confident in the legality of all aspects of the rule."

In issuing the injunction late last month, the U.S. District Court for the Eastern District of Texas found that the "plain language" of the FLSA exemption focuses on the duties of workers in determining whether those workers are "executive, administrative, or professional" employees. That plain language does not include a salary test. In that regard, the Court stated that it was not making a general statement on the legality of a salary-level test, but rather it was only evaluating the amended test in the new rule.

The Court found that the new rule "creates essentially a de facto salary-only test and that "Congress did not intend salary to categorically exclude an employee with EAP duties from the exemption." The new rule did not change the "duties test" of the exemption in any way. Only the salary-level test was amended. As such, the Court held that the new rule is contrary to the FLSA language and Congressional intent.

While this appeal is ongoing, it is important to remember that the incoming Administration may have a different view of what should be done than the outgoing one. President Obama initiated the rule change with an Executive Order. The Trump Administration is likely to take a fresh look at the matter.

One element in play is the ongoing effort of Congress (with the apparent support of the Trump team) to block any pending regulations from taking effect at least until the new administration has a chance to determine its position on those changes.

The issues in this case are not going away soon and the new Administration and Congress are likely to have strong views on the subject.

CMS Seeks Public Input on Medicaid HCBS *(from NAHC Report)*

The Centers for Medicare & Medicaid Services (CMS) has issued a Request for Information (RFI) on reforms and policy options for home and community-based services (HCBS) to Medicaid beneficiaries.

Through this RFI, CMS is seeking input from the public on how best to ensure high quality HCBS that promote the health and well-being of beneficiaries, enhance policies that ensure the integrity of such services and protect beneficiaries from harm, and address workforce challenges particular to this set of services, such as wages, training and retention.

The RFI provides background on the history and current status of HCBS, the dynamics that affect the provision of HCBS, and actions CMS has taken to implement HCBS in the context of expanded Medicaid authority and increased public demand. CMS is soliciting input on the following general topic areas to inform the agency's future decision-making on actions to be taken within its statutory authority:

- What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid long-term services and supports (LTSS) system to meet the needs and preferences of beneficiaries?
- What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS including beneficiary health and safety?
- What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?
- What are specific steps CMS could take to strengthen the HCBS home care workforce, including establishing requirements, standards or procedures to ensure rates paid to home care providers are sufficient to attract enough providers to meet service needs of beneficiaries and that wages supported by those rates are sufficient to attract enough qualified home care workers.

To be assured consideration, comments must be received no later than 5 p.m. on January 9, 2017.

House Passes 21st Century CURES Bill that includes Home Care Related Provisions; Senate Expected to Pass Bill Soon *(from NAHC Report)*

The 21st Century CURES bill passed the House of Representatives last night by a vote of 392-26. The bill represents a combination of the original CURES legislation that was intended to bring new efficiencies to the FDA drug review process along with a previously-passed House bill on mental health reform and a series of unrelated items addressed by other pending House bills. The Senate is expected to pass the bill before adjourning for the year.

The legislation includes several provisions that have impact on home care. These include:

- A required report on the expanded use of telehealth services and the barriers to such technology in Medicare.
- New Medicare coverage of home infusion therapy.
- Mandatory use of Electronic Visit Verification in Medicaid personal care and home health services.
- Application of moratoria based on the site of services rather than the location of the provider.

There are several other provisions that can have indirect impact on home care. These include standards for issuance of Local Coverage Determinations by Medicare contractors, monitoring of terminated Medicaid providers, and the publication of a Medicare fee-for-service provider directory.

Telehealth

Section 4013 of the bill requires that CMS provide a report on the populations of Medicare beneficiaries "whose care may be improved most in terms of quality and efficiency by the expansion,…of telehealth services." In addition, the required report must include information on any ongoing telehealth demonstration projects, the types of services that might be suitable to be furnished using teleheath, and the barriers to the expansion of telehealth in current Medicare law.

A MedPAC report is also required on what Medicare and private plans cover on telehealth services and how Medicare can be reformed to pay for telehealth within the Medicare fee-for-service program.

The bill provides key insight into congressional support for telehealth in a section entitled "Sense of Congress." There the bill states that "eligible originating sites should be expanded." Currently, the home is not an originating site. NAHC has pushed for the inclusion of a patient's home as an originating site for a number of years. The congressional "sense" also includes a broad statement of support in stating that "telemedicine is the delivery of safe, effective, quality health care services."

This provision is a clear indication that significant inroads have been made in establishing the value of telehealth. While it does not get us to where we should be, it is a good step in that direction.

Home Infusion Therapy

The effort to establish a Medicare home infusion therapy benefit began in the mid 1980s. With the passage of the Medicare Catastrophic Coverage Act of 1988, infusion therapy became a full-fledged Medicare benefit. That change was lost with the 1989 wholesale repeal of the Catastrophic Coverage Act (repealed for reasons unrelated to the infusion therapy provision). Since that time, despite widespread reform of commercial insurance and Medicaid benefits to include infusion therapy coverage, Medicare has had to operate under a fragmented, cobbled-together approach to coverage with a combination of the DME, home health services, and Part D drug benefits. That approach does not work well.

The CURES bill now includes a new home infusion therapy benefit that would begin in 2021. However, it remains to be seen if this is any real improvement. A starting point in understanding this change is that the Congressional Budget Office estimates that the "new benefit" will save $372 million in Medicare spending by 2026. As such, it is highly unlikely that the benefit will be implemented in a way that will expand access to and coverage of home infusion therapy. The structure of the benefit might be the best source of an explanation.

To start with, the home infusion therapy benefit would not bundle services, drugs, equipment, and supplies into a single benefit. Instead, the new home infusion therapy benefit only covers "professional services, including nursing services," along with "training and education…,remote monitoring, and monitoring services." Any other items and services such as equipment and drugs would be covered separately under other Medicare benefits.

Second, the new benefit is subject to a 20% copay for Medicare beneficiaries. This may be a significant source of the projected savings as currently there is no copay for nursing services provided as part of the Medicare home health benefit when such is used to create a delivery method for home infusion therapy.

Third, the new benefit specifically excludes "home infusion therapy" from the definition of "home health services." That provision likely will lead CMS to block any use of the home health benefit to makeup the care provided to a home infusion therapy patient. For example, a patient that needs both nursing and home health aide services could lose the aide services coverage. NAHC will oppose an implementation of the new benefit if it deprives patients of Medicare coverage of services that they could get covered today.

The new benefit is structured to require a plan of care established by a physician, nurse practitioner, or physician assistant. The provider of home infusion therapy could be a pharmacy, physician, or other provider of services (including a home

health agency or hospice). The provider will need to meet standards and conditions of participation that include accreditation by an approved organization.

Payment for the home infusion therapy services will be in the form of a "single payment" for "each infusion drug administration calendar day in the individual's home." The payment amount is capped at an amount not to exceed the fee schedule for infusion therapy services in a physician office. Payment rates are subject to geographic, productivity, and annual inflation adjustments.

NAHC will be monitoring the implementation of the new home infusion therapy benefit very closely. The projection of savings from it raises serious concerns as to whether it is an improvement or deterioration of current benefits. NAHC continually supported legislative efforts to enact a comprehensive home infusion therapy benefit. This version has elements of bills that NAHC supported, but also includes provisions that were not in those bills that appear to have resulted in an undesirable program reform.

Medicaid Electronic Visit Verification

The CURES bill includes provisions from the House-passed mental health reform legislation. One provision of that bill is relevant to home care. Section 12006 requires state Medicaid program to implement a electronic visit verification system (EVV) for personal care and home health care services or face a financial penalty. EVV would be required for Medicaid personal care services starting in 2019 and home health services in 2023. The genesis of the EVV requirement is the growth in Medicaid fraud by providers of personal care and home health aide services in both consumer-directed and agency model programs. In recent years, there have been numerous audits and prosecutions across the country based on allegations that services billed have not been actually rendered. Some states have implemented EVV on their own to track caregiver time and attendance.

The EVV legislation provides basic standards for state Medicaid program compliance, but leaves much of the actual implementation standards to the states to develop. For example, states will be permitted to require providers to use a system of provider choice, institute a state-run EVV system, or operate an "open-platform" model that allows various EVV supplier system integration.

While NAHC offered qualified support for an EVV requirement, NAHC expressed serious concerns with states forcing a one size fits all on providers. Further, the legislation does not specifically require that state adjust provider payment rates to cover EVV costs. Finally, NAHC objected to the inclusion of Medicaid "home health services" in the EVV mandate as there has been no showing of time and attendance issues in that benefit. It appears that congressional advocates of EVV may have confused the fact that some personal care is provided by home health agencies with the distinct nature of the home health services benefit.

Advocacy will now need to shift to the state Medicaid programs and CMS as both have significant discretion in how the EVV requirements will be implemented. The

delayed 2023 application to home health services also provides an opportunity to amend the law.

Moratoria Application

The final home care and hospice relevant piece of the CURES legislation is the establishment of a prohibition for payment of services furnished by newly enrolled providers where the services would be within a temporary moratorium area. This reform is intended to address the "work-around" that some providers and suppliers found with current moratoria that are focused on the location of the provider/supplier rather than the location of service. For example, there has been extended moratorium on new home health agencies in Miami-Dade County in Florida. New HHAs found that they could locate their business outside of Miami, but serve patients in Miami because the moratorium only concerned their office location.

NAHC had long been critical of the "bricks and mortar" approach taken by CMS on the application of moratoria given that home health services is about the patient location, not the office site. Recently, CMS had proposed to modify its regulations to include a site of patient moratorium authority. With the current absence of that authority, CMS recently expanded home health agency moratoria statewide in Florida, Texas, Illinois, and Michigan because of the work-around actions of HHAs. Those expansions would not have been needed if CMS had a site of patient authority.

CBO estimated the savings from this provision at $11 million through 2026.

The above home care relevant provisions in the CURES bill must be considered from the viewpoint that, other than the telehealth provision, each provided a funding offset for items that added costs to the federal budget from the FDA drug approval process changes and mental health reforms in the bill. Many of the reforms sought by NAHC such as the physician certification/F2F reforms and the extension of certification authority to non-physician practitioners are "costers" with CBO estimates in excess of $1 billion. Congress was not looking to spending anymore in 2016 legislation. As such, NAHC will need to advance these crucial measures in 2017 with a new Congress and a new Administration.

CMS Releases Recent Hospice Item Set (HIS) Updates *(from NAHC Report)*

The HIS Manual V2.00 is available as a .zip file download on the Hospice Item Set (HIS) webpage. This version of the HIS Manual accompanies V2.00.0 of the HIS that will be effective April 1, 2017. Also included in the .zip file is a change table that outlines major changes from the HIS Manual V1.02 to V2.00.

CMS Allows Exception for Untimely NOEs When Hospice Cannot Make Corrections While NOE Processing through System *(from NAHC Report)*

UPDATE: The Centers for Medicare & Medicaid Services (CMS) has indicated that the new exception to the timely filing requirement discussed in this article is effective for claims submitted on or after November 16, 2016.

Effective with the implementation of Change Request (CR) 8877, hospices have been required to submit a Notice of Election (NOE) for hospice patients admitted on or after October 1, 2014 within five days following the date of admission. In instances where a hospice fails to file the NOE on a timely basis, payment will be denied for days of service prior to the Medicare Administrative Contractor's (MAC's) receipt and acceptance of the NOE. Hospices are also required to submit a Notice of Termination/Revocation (NOTR) within five days following the date of live discharge, as well, but no penalty for late submission is being assessed at this time.

Since October 2014, many hospices have failed to meet the NOE timely filing requirement because they have submitted NOEs that include errors. To correct NOE billing errors, hospices were initially instructed to wait for the NOE to be returned to provider (RTP), after which a new NOE could be submitted. In virtually all cases, the systems time required to process the RTP has meant that a replacement NOE could not be submitted and accepted in time for the hospice to be in compliance with the five-day rule and hospices have lost significant revenue.

In February 2015, the Centers for Medicare & Medicaid Services (CMS) and the MACs clarified that hospices that discover they have submitted a NOE with a systems-detectable billing error that will cause the NOE to RTP - such as an incorrect HICN – could immediately submit a corrected NOE rather than having to wait for the RTP to process. The ability to resubmit the NOE **is contingent on the error being one that the system can detect and that would result in an RTP if the NOE or NOTR is left to process through the system.** These errors are ones that the FISS or CWF system edits would detect as part of systems cross-checking.

Following are just a few examples of some common NOE and/or NOTR billing errors that could cause the submission to RTP:

- Invalid marital status
- Invalid/missing FROM date
- Invalid HICN
- Invalid/missing payer code
- Occurrence code 27 required on NOEs
- Invalid NPI – hospice agency or attending/certifying physician
- Invalid type of bill – inconsistent with provider number
- Beneficiary's name/HIC don't match
- NOE falls within established hospice benefit periods

In cases where an error on a NOE is not detectable by edits in FISS or the CWF - such as an incorrect date of admission - immediate resubmission will not work because the systems have no way to know whether the information that has been changed was incorrect. In such cases the original NOE will process through the system.

In welcome news, CMS has issued notice (MLN Matters Number SE1633: Exceptions for Late Hospice Notices of Election Delayed by Medicare Systems), under which the MACs have been instructed to grant an exception to the five-day timely filing requirement for late NOEs in cases where the NOE contains an error THAT **CANNOT BE CORRECTED WHILE THE NOE IS IN PROCESS**. CMS has determined that NOEs that have been submitted timely but that include inadvertent errors that cannot be immediately corrected are the fault of system constraints and therefore are not under the control of the hospice provider. CMS has instructed the MACs to grant an exception to the timely filing requirements in such instances if the hospice is able to provide the MAC documentation showing:

1. When the original NOE was submitted
2. When the NOE was returned to the hospice for correction or was accepted and available for correction, and
3. When the hospice resubmitted the NOE.

CMS indicates that the MACs will grant the exception if all documentation is provided and confirms that the hospice took appropriate actions within 2 business days to make corrections. Once the NOE is returned for correction the hospice will have 2 business days to resubmit. When the NOE was posted to the CWF and must be cancelled and resubmitted, the hospice will have 2 business days to cancel the NOE and then 2 business days to submit the new NOE after the date that the cancellation NOE finalizes.

CMS notes "If the hospice provides sufficient information in the Remarks section of its claim to allow the MAC to research the case, then MACs will make a determination without requesting the additional supporting documentation described above." The provider's documentation, however, must provide the circumstances and time frames in order for the MAC to make such a determination, otherwise the MACs will request additional documentation.

CMS stipulates that the exception laid out in SE1633 will NOT be applicable in cases where hospices are able to edit NOEs while they are in process (as referenced above), nor will it be applicable in cases where hospices submit a partial NOE to fulfill the timely-filing requirement. MACs will also not grant exceptions in cases where hospices with multiple provider identifiers submit the identifier of a location that did not actually provide the service.

Finally, CMS indicates that in cases where a NOE is submitted prior to a Medicare system "dark day" but the system does not assign a "receipt date" until the "dark days" have concluded and the hospice can provide sufficient documentation of these

circumstances, the MACs may allow for an exception to the timely filing requirement (although CMS expects this will only occur rarely).

CMS is working on additional changes to address issues related to the timely filing requirements; for an update on these efforts, please see here.

Legislation Introduced to Allow Occupational Therapists to Conduct Initial Assessment for Therapy-Only Care *(from NAHC Report)*

A new bipartisan bill introduced in the House of Representatives would allow occupational therapists to conduct the initial home health assessment for certain rehabilitation cases under Medicare's home health benefit. Occupational therapists currently cannot conduct the initial assessment, even in situations when the physician has ordered only occupational therapy.

The bill, the Medicare Home Health Flexibility Act of 2016 (H.R. 6404), was introduced on November 30 by Rep. Charles Boustany (R-LA-3) and Rep. Lloyd Doggett (D-TX-35).

Occupational therapy is an important component of home health because therapists have the expertise to identify safety issues in the home and create patient-specific routines to minimize risks and maximize patient compliance with the plan of care. The restrictions currently in place limiting the role of occupational therapists are unnecessary and unreasonable and do not serve the best interests of patients and this legislation would remedy that problem by removing the arbitrary restrictions that currently exist.

The legislation would not change current Medicare criteria for establishing eligibility for the home health benefit, and the bill would only allow occupational therapists to conduct the initial assessment in limited circumstances of rehabilitation-only cases, when skilled nursing is not included in the physician's order. Under the legislation, an occupational therapist could conduct the initial assessment where the physician orders occupational therapy along with physical therapy and/or speech language pathology services. Nurses would still be required to conduct the initial assessment for all home health cases in which skilled nursing is ordered by the physician.

The National Association for Home Care & Hospice (NAHC) supports the legislation as a means of making it easier for Medicare beneficiaries to receive home health occupational therapy services in a timely manner. Nearly one in five occupational therapists work in home health as their primary or secondary setting, and occupational therapists are integral participants in the home health team to maintain the independence and well-being of patients in their own homes. Occupational therapy is important to patient outcomes and will be necessary if home care is going to live up to its awesome potential to help people live longer and more fulfilling lives in their own homes and communities.

Thank you,

Carol Hudspeth
Executive Director
Missouri Alliance for Home Care