E-Alliance Extra

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Home Health Medical Supply Bulletin Posted

The MOHealth Net Division has just published a Provider Bulletin detailing the Home Health Medical Supply Rule. A direct link to the Bulletin is: http://dss.mo.gov/mhd/providers/pdf/bulletin38-09_2015aug07.pdf

The Rule was published in the June 1st MO Register and is available here: http://www.sos.mo.gov/adrules/moreg/current/v40n11/v40n11.pdf

ICD-10 for In-Home and CDS

The change to ICD-10 for In-Home and CDS providers has been an area of confusion. MAHC met with representatives from Medicaid and the Dept. of Social Services this week to clarify what these providers need to be doing and what they can expect come October 1, 2015.

The good news is that for the most part these providers will not do anything different. The DSDS assessor or Provider Nurse Assessor will still put the diagnosis in the InterRAI. The provider will still use that diagnosis to look up the appropriate code prior to billing and put the appropriate ICD-10 code on the claim. Many software programs have an automatic ICD-9 to ICD-10 converter and will make the change automatically. For providers who were either using a coding book or chart to determine the ICD-9 code will continue to do the same thing using an ICD-10 book/chart. For those who look the code up on the web there are numerous sites to use.

The InterRAI will not automatically switch ICD-9 codes to 10 codes. That will happen as the client/consumer comes up for assessment or reassessment after October 1st.

To bill for services delivered after October 1st you must have a valid ICD-10 code. After October 1st you can bill for services delivered prior to October 1st using an ICD-9 code.

HOWEVER, the state encourages all providers to test their system NOW. By testing now, providers and the state will have time to work out any problem(s) that might come up. A direct link to the MoHealth Next Bulletin about ICD-10 and testing is available here:
http://dss.mo.gov/mhd/providers/pdf/bulletin38-04_2015jul30.pdf

Telephony Conference – A Success

Jessie Dresner, Director of MMAC, Bobbi Jo Garber, Deputy Director of DSDS and Jess Bax, Chief of the Program Integrity Unit were the presenters at MAHC's 2 hour phone conference on August 6th. Over 120 In-Home and CDS companies were on the call. The panel began by saying that "telephony" is an outdated term and the Rule has defined the "telephony" system using the currently accepted reference of Electronic Visit Verification or EVV. The speakers covered the entire Rule discussing the reasoning behind the specifics and how providers would be expected to implement the EVV program into their operation. After this, providers asked questions and gave their thoughts on the Rule. DSDS and MMAC are expecting this Rule to be published in the MO Register on September 1st. Whenever it is published there will be a 30 day public comment period when you will have an opportunity to make recommendations for changes to the Rule wording.

Home Health and Hospice Open Door Forum

The Next ODF is Wednesday, August 12th. Click on the link below for details:
https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HHHDME.html

NAHC Lawsuit Challenging the Medicare Face-to-Face Rule Presented in Court (From NAHC)

Counsel for the National Association for Home Care & Hospice (NAHC) presented oral argument before U.S. District Court Judge Christopher Cooper on August 6, 2015, regarding NAHC's lawsuit challenging the validity of the physician narrative requirement in the physician face-to-face encounter rule. While Medicare rescinded the narrative requirement from its rule after NAHC

filed its lawsuit last year, Medicare has not provided nearly $200 million in retroactive payments to home health agencies that were wrongfully denied claims because of the now-rescinded narrative requirement. NAHC brought litigation on the validity of the narrative requirement so that home health agencies that provided care to patients in good faith are paid for their inappropriately disallowed claims.

"We are trying to fix an injustice for the home health agencies that are stuck in limbo with nearly $200 million in unpaid claims because of the now-rescinded narrative requirement," stated Val J. Halamandaris, President of NAHC. "Medicare rescinded its ill-conceived narrative requirement after we filed this lawsuit last year. However, we are still trying to clean up the mess the narrative requirement left behind—nearly $200 million in wrongful claim denials to home health agencies. These home health agencies provided services to Medicare patients in good faith, and they should receive payment for the nearly $200 million in claims that they were wrongfully denied."

After months of back and forth legal briefs by NAHC and the Medicare program, the home care community finally had its day in court regarding its lawsuit challenging the validity of the physician narrative requirement in the physician face-to-face encounter rule. The parties presented their oral arguments to U.S. District Judge Christopher Cooper. It was quickly apparent that Judge Cooper was very engaged in the nuances of the litigation and fully cognizant of its importance to Medicare home health care beneficiaries and providers.

The NAHC position was argued by Bill Dombi, Director of NAHC's Center for Health Care Law. Counsel's argument focused on the language of the provision in the Affordable Care Act that mandated the physician face-to-face encounter, contending that the plain language requires only that the physician document that the encounter occurred. "The issue is what the whole provision states, not the single word 'document' as the Medicare program wishes to be the case," stated Dombi. That argument was directed to Medicare's contention that the word "document" is ambiguous and that Medicare has the authority to define ambiguous terms in any reasonable way that it wishes, including a requirement that the physician had to explain, in a narrative, why a patient meets Medicare coverage standards.

As an alternative, NAHC counsel argued that the narrative requirement was not a reasonable or rational interpretation, as the result of that policy leads Medicare beneficiaries and their providers denied coverage even where the whole record supports coverage. "Congress did not authorize a rejection of a claim based solely on the review of the limited physician narrative, particularly when the full record clearly demonstrates coverage," he stated. NAHC's counsel referenced the court to a Medicare determination where the contractor explicitly found that the full record supported a finding that the patient met

Medicare homebound and skilled care requirements, but denied it on the basis that the physician's homebound narrative was insufficient. While Congress intended the face-to-face requirement as a program integrity measure, "Medicare's implementation triggered the opposite outcome, where bona fide claims were denied based on a reviewer's rejection of the physician's choice of words, grammar, or sentence structure," he stated.

Medicare was represented by Justin Sandberg of the U.S. Department of Justice. Sandberg argued that Medicare has the discretion to interpret the law when it is ambiguous and reasonably did so with the face-to-face encounter law. He emphasized the points made in his written briefs that the word "document" is ambiguous and that the narrative requirement is consistent with congressional intent to address waste, fraud, and abuse.

District Judge Cooper posed numerous well focused questions to both parties. Of particular concern for the judge was whether the challenged rule, on its face, permitted Medicare to deny a home health services claim based solely on the sufficiency of the physician narrative, regardless of what the whole patient record revealed on the patient's homebound status and skilled care need. While Medicare's counsel tried to avoid a direct answer, NAHC counsel explained to the court that Medicare's rule empowered its contractors to issue such claim denials based on that basis alone. "Such a rule is not reasonable or rational as it leads to absurd results that are morally offensive," stated NAHC's counsel.

"We are confident that the judge fully understands the issues and we presented a strong and forceful argument on behalf of the home health care community," stated Halamandaris. "We will continue this fight as long as it takes to make things right," Halamandaris added.

There is no timetable for the court to issue its ruling in the case. If a favorable decision is rendered by the judge, Medicare will be required to reopen and pay all the claims rejected in the past on the basis that the face-to-face narrative was insufficient. While NAHC and the home health care community awaits the court's ruling, NAHC continues to press for congressional relief on the face-to-face encounter requirements including a reversal of past denied claims. "We must employ all options to protect home health agencies from misguided federal rules," explained Halamandaris.

CMS Issues Clarifications, Corrections to Freestanding Hospice Cost Report Forms and Instructions (From NAHC)

Effective for cost reporting years starting on or after October 1, 2014, freestanding hospices are required to file the revised hospice cost report Form CMS-1984-14. The new freestanding hospice cost report significantly expands data collection requirements to supply greater detail related to hospice costs by

level of care; data from the modified report may be used in future payment reform analyses by the Centers for Medicare & Medicaid Services (CMS). Form CMS-1984-14 underwent a lengthy review and comment process and was made publicly available in late August 2014. CMS has continued to receive recommendations to modify CMS-1984-14 to promote greater clarity and accuracy of the documents.

CMS recently issued Transmittal 2: New Cost Reporting Forms and Instructions -- Effective Date: Hospice Cost Report changes effective for cost reporting periods beginning on or after October 1, 2014 (dated July 31, 2015) to its website; the transmittal makes clarifying and correcting revisions to the freestanding hospice cost reporting forms and instructions as follow:

- Worksheet A: Shaded column 1 of line 70.
- Worksheet A-6: Modified form and instructions to separate reclassifications between salaries and other costs.
- Worksheets B and B-1: Removed shading from column 7 of line 17 for both Worksheet B and B-1. Modified column labels on Worksheet B-1.

ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: The electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2014. For automated cost report software purposes transmittals 1 and 2 will be merged and implemented simultaneously.

Ted Cuppett of The Health Group provided the National Association for Home Care & Hospice (NAHC) with an explanation and analysis of the changes to Form CMS-1984-14 represented in Transmittal 2; his comments are as follow:

Transmittal 2 provide two (2) technical corrections to the Hospice Cost & Data Report as previously issued and makes one distinctive reporting change as follows:

1. CMS has eliminated the potential of assigning any salary costs to the "Nursing Facility Room & Board" cost center (Line 70 of Worksheet A). This is an appropriate technical correction as payments to nursing facilities in the form of room and board payments do not include any salaries and wages paid to hospice personnel.
2. CMS is allowing input (housekeeping statistics and cost) on line 17 of Worksheet B and B-1. This allows for housekeeping costs to be allocated to "Patient Residential Care Services" (Line 17), which is then allocated to all inpatient and residential units on the basis of in-facility days. The original cost report did not appropriately allow for the allocation of housekeeping costs.
3. Worksheet A-6 has been modified to require the reclassification of costs as salaries and wages or other costs. [T]his correction [is beneficial] inasmuch as it [supports] tracking the ultimate reporting of salary and

wage costs. Salary and wage costs are used later in the cost report for purposes of allocating employee benefit and employee benefit department costs.

The changes identified above were included in changes to the "electronic reporting specifications." Other technical corrections were also made to enhance electronic cost reporting edits.

Special thanks to Ted Cuppett and The Health Group for this analysis.