Webinar Agenda

- CY 2016 Proposed Rule
  - New Payment Rates
  - New Service Intensity Add-On
  - HQRP Updates
  - CAHPS Oversight Activities
  - Diagnosis Coding
- CMS Re-Issuing Change Request 9114
- ICD-10 Are you Ready?
- Important Reminders/Upcoming Changes and Mandates
- Medicare Administrative Contractors

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Hospice Regulatory Review

CY 2016 Hospice Proposed Rule

https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-10422.pdf

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/HPR-Lit-Review-Update-Report-.pdf

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2015-NHPCO-Slides-5-5-15-.pdf

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Fiscal Year 2016 Rate Increase

Hospital market basket update: 2.7 %

ACA productivity reduction: minus 0.6 % points

Additional ACA mandated Reduction: minus 0.3 % point

Net Market Basket Update: 1.8 %

Wage Index files: http://www.cms.gov/Center/Provider-Type/Hospice-Center.html

CBSA/Wage Transition Period: One year period

FY2016 Proposed RHC Payment Rates

Code	Description	Labor	Non-Labor	SIA BNAF (1-0.0081)	Hospice Pmt Update %	Proposed FY 2016 Pmt Rate
651	Routine Days 1-60	$68.71	$31.29	X0.09853	X1..018	$188.20
651	Routine Days 60+	$68.71	$31.29	X0.9967	X1.018	$147.34

*FY 2015 Payment Rate for Routine Care is $159.34

What is an "Episode of Care"

A hospice election period or series of election periods separated by no more than a 60-day gap.

CMS is proposing for the "count of days" to follow the patient (count the days relative to the patient's lifetime length of stay).

- Hospice patients discharged and readmitted to hospice within 60 days of that discharge, will have their prior hospice days continue to follow them and count toward their patient days for the receiving hospice upon hospice election.
- Applies to patients that transfer from one hospice to another

What is an "Episode of Care"

Day 1 Patient Elects Hospice
Day 75 Patient terminated due to no longer meeting requirements or electing to be terminated
Day 126 Patient re-elects hospice
(51 days in between elections – Patient would continue on with day 126 "payment day count" / Day 60+ rate amount)

Day 1 Patient Elects Hospice
Day 75 Patient terminated due to no longer meeting requirements or electing to be terminated
Day 155 Patient re-elects hospice
(80 days in between elections – Patient would start "payment day count" back at 1 due to more than 60 days in between elections)

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Service Intensity Add-On

Service Intensity Add-on applies when:

- Patient is in their last 7 days of care
- Patient is discharged due to Death
- Direct/in person patient care is provided by an RN or social worker on the day being billed as RHC
  - Additional rate equivalent to the continuous care rate may be billed up to 4 hours
  - CMS will create two separate G-codes to differentiate nursing visits by RNs vs. LPNs.
- Care is not being provided in an SNF/NF

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FY2016 Proposed Payment Rates (GHC, IRC, GIP)

Code	Description	Labor	Non-Labor	2015 Pmt Rate	Proposed Hospice Pmt Update %	Proposed FY 2016 Pmt Rate
652	Continuous Home Care Full Rate=24 hours of Care $=39.44/hourly rate	68.71	31.29	$929.91	X 1..018	$946.65
655	Inpatient Respite Care	54.13	45.87	$164.81	X 1.018	$167.78
656	General Inpatient Care	64.01	35.99	$708.77	X 1.018	$721.53

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Wage Index & Hospice Aggregate Cap

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3023CP.pdf

Cap Year 11/1/2014– 10/31/2015: $27,135.96

Anticipated Cap for 2016 : $27,624.41

§ 418.309 Hospice cap amount

Year	Cap Amont	Year	Cap Amont
1984	$ 6,500.00	2000	$16,650.85
1985	$ 6,884.00	2001	$17,930.89
1986	$ 7,391.00	2002	$18,143.26
1987	$ 7,898.00	2003	$18,143.26
1988	$ 8,406.00	2004	$18,963.47
1989	$ 9,010.00	2005	$19,777.51
1990	$ 9,787.00	2006	$20,585.39
1991	$10,712.00	2007	$21,410.04
1992	$11,551.00	2008	$22,386.15
1993	$12,248.00	2009	$23,014.50
1994	$12,846.00	2010	$23,874.98
1995	$13,469.00	2011	$24,527.69
1996	$13,974.00	2012	$25,377.01
1997	$14,788.00	2013	$26,157.50
1998	$15,313.00	2014	$26,725.79
1999	$15,916.98	2015	$27,135.96

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Alignment of Cap Year

- Modify the cap updated beginning with the 2016 cap year to reflect the changes included in the IMPACT Act.
  - Propose to update the cap with the hospice payment percentage for the applicable year versus calculating using CPI-U for medical care
- Align the Inpatient and Aggregate Cap accounting years with the federal fiscal year (Oct. 1 through Sept. 30) beginning in federal fiscal year 2017 and thereafter.

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Diagnosis Coding

- Hospice must report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.
- This is the 3rd year CMS has made mention of/stressed information about diagnosis reporting in the proposed or final rules
  - A high percentage of hospice claims are still only including one diagnosis

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HQRP Proposed Changes Beginning FY 2018

New providers would begin reporting on the date they receive their CCN/Medicare Provider

Hospices must submit all HIS records within 30 days of the Event Date beginning

Incremental HIS submission threshold beginning with all HIS Adm. and DC records that occur on or after:

- Jan 1, 2016 – Dec 31, 2016 = 70% (FY 2018)
- Jan 1, 2017 – Dec 31, 2017 = 80% (FY 2019)
- Jan 1, 2018 – Dec 31, 2018 = 90% (FY 2020)

No firm date yet for "Hospice Compare"

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HQRP Proposed Changes

Adopted quality measures will be retained for use in the subsequent FY payment determination unless otherwise stated

CMS is looking for feedback on potential future HIS measures:

1. Patient-reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
2. Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
3. Responsiveness of hospice to patient and family care needs;
4. Hospice team communication and care coordination.

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Hospice Experience of Care Survey

"CAHPS" for Hospice

- Participation will continue and be required to meet FY 2018 and 2019 APU's
- Hospices with fewer than 50 deaths from will continue to be exempt from requirements for payment determination
- Hospices who fail to participate in the Hospice CAHPS survey will have a 2% market basket reduction in each Fiscal Year

http://www.hospicecahpssurvey.org

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Hospice Experience of Care Survey

APU	Sample Months (Death Month)	Quarterly Submission Deadline
2017	Dry Run Jan-March 2015 (Q1)	August 12, 2015
2017	April – June 2015 (Q2)	November 11, 2015
2017	July – Sept 2015 (Q3)	February 10, 2016
2017	Oct – Dec 2015 (Q4)	May 11, 2016
2018	Jan-March 2016 (Q1)	August 10, 2016
2018	April – June 2016 (Q2)	November 9, 2016
2018	July – Sept 2016 (Q3)	February 8, 2017
2018	Oct – Dec 2016 (Q4)	May 10, 2017
2019	Jan-March 2017 (Q1)	August 9, 2017
2019	April – June 2017 (Q2)	November 8, 2017
2019	July – Sept 2017 (Q3)	February 14, 2018
2019	Oct – Dec 2017 (Q4)	May 9, 2018

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CAHPS Oversight Activities

- Continue the requirement that vendors/providers participate in oversight activities to ensure compliance
- Reconsiderations/Appeals process for hospices failing to meet CAHPS® data collection requirements will be part of the Reconsideration and Appeals process already developed for the Hospice Quality Reporting Program
- Use QIES and CASPER in addition to mail to notify providers of compliance with reporting requirements.
- Use several communication channels including memos, emails, MLNs, etc. to notify providers of report availability in CASPER.
- Publish list of hospices successfully meeting requirements.

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Submitting Comments

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- When commenting, refer to file code CMS-1629-P for Medicare.
- To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 29th, 2015.
- Two of the four ways to submit comments are:
  - Electronically at http://www.regulations.gov. Follow the instructions under the "More Search Options" tab.
  - By regular mail using the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1629-P, Mail Stop C4-26-05, 7500 Security Blvd, Baltimore, MD 21244-1850.

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Hospice Regulatory Review

Important Reminders/ Upcoming Changes

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CMS Re-Issuing Change Request 9114

Current language:
"Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician or Nurse Practitioner (NP) was designated as the attending physician. ***This must include, but is not limited to, the attending physician's name and NPI number."***

The revised language that CMS is expected to re-issue soon is expect to remove **"must include".**

http://www.nahc.org/NAHCReport/nr150420_2/

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9114.pdf

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PECOS for Part D Changes

Now effective Jan 1, 2016

Originally stated Part D plans could no longer cover drugs that were prescribed by physicians or other eligible professionals who are:

- neither enrolled in Medicare
- nor have validly opted out of Medicare

Now revised to include others that are permitted by state or other applicable law to prescribe medications

https://www.federalregister.gov/articles/2015/05/06/2015-10545/medicare-program-changes-to-the-requirements-for-part-d-prescribers

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

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Reminder: Sequestration Still in Effect

- The 2011 Budget Control Act mandates cuts equally over nine years (2013 – 2021).
- Does not apply to Medicaid.

CMS Transitioning Eligibility Systems

CMS is in the process of terminating all Eligibility systems other than the HETS 270/271

- PPTN and VPIQ
  - Multi Carrier System (MSC) – Discontinued April 2013
  - ViPS Medicare System (VMS) - Discontinued April 2013
- FISS/DDE
  - HIQA/HIQH – Currently still active
  - ELGH/ELGA – Currently still active

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1249.pdf

Hospice Item Set

Upcoming CMS HIS Training Session

- Wednesday, June 17th from 1:30pm to 3pm EST
- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html

First Quarter 2015 HIS Q&A now available:

- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/April-2015-Q_A-Document_FINAL.pdf

Hospice Item Set Cont.

New version effective June 28th (minor changes).

- Updated version number to V1.01.0
- Guam added to the valid values for State_CD
- A dash added as a valid value for A0245
- Several Edit/Validation modifications (new or revised)

Next version (1.02.0) will be effective April 1, 2016

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html

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Is ICD-10 a Reality?

- ***YES!***
- Last year's delay was announced in April
- CMS has not made any indications of further delays and has stated agencies need to start preparing!
- If you have not already begun your training programs/revised processes, ***NOW IS THE TIME TO START!***

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ICD-10 Resources/Links

Implementation Date is 10/1/2015

Palmetto GBA ICD-10 Split Billing Claims Links
http://www.palmettogba.com/palmetto/icd.nsf/vMasterDID/9W2E945787

Medlearn Matters Article for Claims Processing Guidance:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf

CMS Resources:
http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
http://cms.hhs.gov/Medicare/Coding/ICD10/index.html

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What is Dual Coding and Why is it Necessary?

- Including both an ICD-9 and the associated ICD-10 in your patient's chart.
- Claims will need to be billed as such that some patients will need both an ICD-9 and an ICD-10 assigned to them in their chart to allow your software program to correctly pull the applicable diagnosis into claims based on Dates of service.

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Hospice Billing Requirements for ICD-10

- ICD-9 codes will no longer be accepted on claims (including electronic and paper) with **FROM** dates of service (on professional and supplier claims) or dates of **discharge/through** dates (on institutional claims) on or after October1, 2015 .
- A claim cannot contain both ICD-9 codes and ICD-10 codes.
- For dates of service prior To October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code.
- For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code.

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When should I Begin Dual Coding for Hospice?

- Hospice agencies should begin dual coding no later than September for new Admissions AND all existing admissions/patients still on care.
  - Hospice claims must be split so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.

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Preparing for ICD-10

Questions to ask within your agency

- Which positions/people in your agency currently have any relationship with ICD-9 coding?
- Is your agency's current ICD-9 coding process effective?
- Who is responsible for preparing you agency for and leading it through the ICD-10 transition?
- What is your agency's current competency level of clinicians regarding completion of the OASIS C-1 and ICD-9 coding?

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Questions to Ask Within Your Agency

- Get to know your top 25 diagnoses in your agency.
- Learn the documentation requirements for these diagnoses first.

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Update on Medicare Care Choices Model Initiative

Dec 19, 2014 - Updated: Anticipated award announcement schedule early 2015

Apr 14, 2014 - Announced: Open Door Forum scheduled for April 16

Apr 04, 2014 - Announced: Introduction webinar for April 9

Mar 18, 2014 - Announced: Request for applications to improve care options for Medicare hospice eligible beneficiaries

http://innovation.cms.gov/initiatives/Medicare-Care-Choices/

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Hospice Regulatory Review

Medicare Administrative Contractors

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Home Health & Hospice Jurisdictions

Medicare currently has four Jurisdictions assigned for Home Health and Hospice Administrative Contractors.

Jurisdictions A – D are reserved from the HH & Hospice workloads. A map of the regions can be found at:

http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/HHH-Jurisdiction-Map-April-2015.pdf

It is important for your agency to be up to date with the instructions from your contractor. Make sure you are signed up for their newsletters and alerts.

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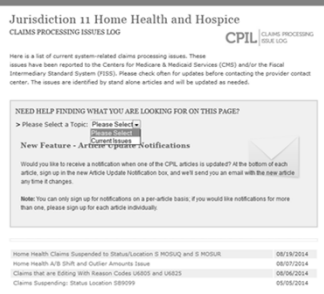
Palmetto GBA


Jurisdiction 11 Home Health and Hospice

CLAIMS PROCESSING ISSUES LOG

CPIL CLAIMS PROCESSING ISSUE LOG

Here is a list of current system-related claims processing issues. These issues have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS). Please check often for updates before contacting the provider contact center. The issues are identified by stand alone articles and will be updated as needed.

NEED HELP FINDING WHAT YOU ARE LOOKING FOR ON THIS PAGE?

> Please Select a Topic: Please Select

Please Select
Current Issues

New Feature - Article Update Notifications

Would you like to receive a notification when one of the CPIL articles is updated? At the bottom of each article, sign up in the new Article Update Notification box, and we'll send you an email with the new article any time it changes.

Note: You can only sign up for notifications on a per-article basis; if you would like notifications for more than one, please sign up for each article individually.

Home Health Claims Suspended to Status/Location S MOSUQ and S MOSUR	08/19/2014
Home Health A/B Shift and Outlier Amounts Issue	08/07/2014
Claims that are Editing With Reason Codes U6805 and U6825	08/06/2014
Claims Suspending: Status Location S89099	05/05/2014

http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Jurisdiction%2011%20Home%20Health%20and%20Hospice~Articles~Claims%20Processing%20Issues%20Log?

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National Government Services (NGS)

NEWS AND ALERTS

NEWS ARTICLES | ANNOUNCEMENTS | PRODUCTION ALERTS | MEDICARE MONTHLY REVIEW

Description of Problem	What This Means to You	Current Status of Problem
National Government Services has been made aware of a system issue that may cause an error for JK Part A claims to suspend to status location S MDART with reason code 39725 (the system is unable to determine ADR type request).	The claims involved are for local coverage determination L27360 Transthoracic Echocardiography (TTE) and are hitting edit 5X6AF; thus causing the claims to suspend.	**Update 5/5/2015:** ADRs have been generated in error for impacted claims. Providers should not submit medical records in response to ADRs for claims impacted by this issue. 4/30/2015: No provider action is necessary at this time. Please watch the Production Alerts section of our website and Email Updates for additional information regarding this issue.

http://www.ngsmedicare.com

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CGS Administrators

Provider Types Affected	Reason Code	Issue	Impact	Status	Resolved
Home Health and Hospice	NA	Some Medicare Secondary Payer (MSP) claims and adjustments are not paying appropriately.	No payment is being made on MSP claims and adjustments where Medicare secondary payment is appropriate.	**8/15/2014** – A resolution to this issue is scheduled for implementation on September 8, 2014. **8/4/2014** – This issue has been reported to the system maintainer.	
Home Health	37236 and 37237	Some home health claims are receiving reason code 37236 and 37237 incorrectly.	Claims with 37236 and 37237 are suspended in status/location S MPCOS.	**08/22/2014** – This issue is associated with a PECOS file error, and affects all Medicare Administrative Contractors (MACs) who process home health claims. Affected claims will continue to suspend in S MPCOS until a file fix is received. No provider action is necessary. **7/18/2014** – The resolution to this issue has been delayed. Claims remain suspended in status/location S MPCOS. **6/13/2014** – A resolution to this issue is scheduled for implementation with the July 2014 system release. No provider action is required.	
Home Health	V8030	Some home health claims with dates of service on or after October 1, 2013, have been paid and/or reported incorrectly.	Claims for dates of service on or after October 1, 2013, with reason code V8030, and Value Code 64 and/or 17 will be held until a resolution is implemented.	**8/4/2014** – The resolution to this issue is scheduled for implementation on August 25, 2014. **06/13/2014** – A resolution to this issue is scheduled for mid August. **03/17/2014** – Claims are being held in status/location S MVC00 until a resolution is implemented.	

http://www.cgsmedicare.com/hhh/claims/FISS_Claims_Processing_Issues.html

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