

Centers for Medicare and Medicaid Services
Home Health, Hospice DME/Quality
Open Door Forum
Moderator: Jill Darling
July 20, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Kim) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Home Health, Hospice DME/Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Kim). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication and thank you for joining us today for today's Home Health, Hospice and DME Open Door Forum. So, an updated agenda was just recently sent out, so a few of the agenda items were taken off and then a couple were added on, so just to let you know ahead of time.

So before we get into today's agenda, one brief announcement from me. This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

So first up, we have (Danielle Shearer) who will have an announcement about the Home Health CoP final rule effective date.

(Danielle Shearer): Thanks, Jill. On July 10th, CMS published a final rule to postpone the effective date of the new Home Health Agency CoPs. The new HHA CoPs are now effective on January 13th, 2018 instead of the original July 13th, 2017 date. The final rule also made conforming changes to dates that appear within the CoPs.

Specifically, the new Home Health Agency administrator personnel qualifications for new hires will become effective on January 13th, 2018. The grandfathering clause for all currently employed administrators' remains in effect. The requirement for HHA to begin conducting performance improvement projects will not be effective until July 13th, 2018.

You'll still able to get adequate time to collect the data that is used to identify and implement performance improvement projects. A link to the rule is available on the cms.gov HHA provider website, that's [cms.gov/center/provider-type/home-health-agency-hha-center](https://www.cms.gov/center/provider-type/home-health-agency-hha-center) and with a dash in between each, so [home-health-agency-hha-center.html](https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html).

So again, that's the CMS HHA provider website that you're probably all familiar with. The links to the rule are available there and the new HHA CoPs are effective on January 13th, 2018. That's all I have, thanks.

Jill Darling: Thank you, (Danielle). Up next, we have (Will Gehne) who has an update on the Home Health claims processing.

(Will Gehne): Thanks, Jill. Since April 1st, Medicare systems have checked all Home Health claims to ensure the presence of a supporting OASIS assessment. If under the OASIS reporting timeline, an assessment should be present and it's not found, the claim is denied with reason code 37253.

We received an increasing a number of questions about these denials, so I wanted to address a few common concern. Many denials appeared to be cases where the provider believe an OASIS assessment was submitted and accepted

but due to software errors, it was not submitted or it was submitted by the agency was unaware it was rejected.

Before submitting your claim – a claim to your MAC, Home Health Agency should ensure the OASIS was successfully accepted by reviewing your OASIS validation reports. Checking the validation report and including it in the patient's record are best practices to avoid denials. The report should provide all of information needed, (chose) many to call the (inaudible) helpdesk or the MAC.

Denials for the OASIS was submitted and accept – was not submitted and accepted are typically not reverse upon appeal. Providers also report denials where an assessment was actually submitted and accepted, they have a validation report proving this. These are cases where the supporting assessed OASIS could not be found because key data elements on the OASIS and the claim didn't match.

As CMS stressed in MedLearn Matters articles FE17009, it's important to ensure that the CMS certification number, the beneficiary's Medicare number and the assessment completion date matched on both transactions. Regarding the Medicare number, we've seen cases where the health insurance claim number is no submitted at all with the Home Health Agency reporting the Medicaid number or other identifier instead.

More frequently, we see cases where a beneficiary's Medicare number is changed. Often, this change occurred several months ago and the HHA continues to submit the old HIT number. Medicare systems may change the number and use the current number to perform the match. This can result in denials when an assessment was present.

CMS is researching whether we can make system changes to reduce the frequency of these situations but in the meantime HHA should be careful to use the most recent HIT number they're aware of on both the OASIS and claims. Regarding the assessment completion date, the OASIS may not be found if there's an error in the date encoded in positions 5 through 8 of the claims treatment authorization code.

For example, April 1st, 2017 is encoded on the claim as 17DN. An error in that encoding say 17DO will result in no match and a denial. These errors should be rare. If HHA is using CMS provider grouper software or software that correctly emulates the CMS version, the correct translation is done automatically.

HHA should ensure their software is correctly placed in the assessment completion date in the treatment authorization code and not using some other value with the start of care date. CMS is instructed to master reverse denials – to reverse denials upon appeal in cases where the OASIS was accepted but a clerical error like the ones I’ve described prevented a match.

We did not intend to deny claims when an OASIS was submitted as required but was simply not found. The intent of the edit is to deny when the OASIS was not submitted at all at the time the claim was received.

Finally, I want to clear up the misconception that our systems are enforcing the timeliness of the OASIS assessment. Medicare system enforced that if an OASIS is due, a supporting assessment is received before the claim, our systems will not deny claim when the assessment was received before the claim but that assessment was received later than regulations required.

The misconception may arise because we compared the receipt date of the claims to the assessment completion date. We do this to see if the assessment is due. We’re looking to see if the claim was received too early, say in the case of a discharge on day 15 which was billed on day 20 and the assessment isn’t required until day 30.

This is a fail-safe to prevent denying too often, denying when the assessment was not yet due. That’s the only consideration in our systems regarding the timing. Thanks, Jill.

Jill Darling: Thank you, (Wil). Up next we have Charles Nixon who has an update on the hospice claims processing.

Charles Nixon: Thank you, Jill. Good morning. We have a couple of hospice update we would like to share with you. During the May open door forum, we announced CMS would issue an article providing nationally (consisting) guidance about hospices submitting claim adjustment to correct a routine home care and service intensity add-on payment errors.

Shortly afterward, we issued this information in MedLearn Matters article FE17014. The hospice industry expressed concerns about the workload associated with individual claim adjustment. The National Association asked CMS whether hospices could submit a list of claims to be adjusted for the contractors instead.

CMS reviewed this possibility with the MACs and recently issued instructions for the MAC to develop a list-based process. The MACs will each recruit a volunteer hospice from the provider outreach workgroup. And their volunteered hospice will submit a list of claims that need to be adjusted. The MACs will develop an adjustment process performing following using a list and provide CMS feedback about what we expect.

Then, CMS will issue another article providing national instructions for submitting these lists. We are hopeful that this (inaudible) will help us develop the more efficient process that is responsive to provider concern. Hospices will not be required to submit list. Providers may continue submitting claim adjustment based on previous instructions if they choose to. Thank you, Jill.

Jill Darling: Thank you, Charles. Next is Lori Teichman who has updates on HHCAHPS.

Lori Teichman: Thank you, Jill. Today is the data submission deadline for Home Health CAHPS data for the period of the first quarter in 2017. And I'm happy to report that all of the survey vendors have submitted their respective data from the Home Health Agencies that are contracted with them.

But if there are some questions about the data that you submitted or you know that your vendor is submitting an updated file, you might want to contact them

just to make sure their file is submitted today by midnight. And now the next couple of items pertain to the Home Health CAHPS' website.

On June 23rd, we posted the Home Health Agency preview report of Home Health CAHPS data that was publicly reported on Home Health Compare on July 12. And just to remind you that the Home Health Agency preview report for Home Health CAHPS data is always accessible through the Home Health CAHPS' website. It's not in other folders such as CASPER.

And all HHAs, (Home Health Agencies), can only access their own reports, their private reports and they will use their assigned identification number and password that they created to access the Home Health Agency portal that's on the Home Health CAHPS' website. On April 1st, we posted the new Home Health CAHPS Participation Exemption Request form for the current period which is calendar year 2019.

This is for data that's submitted in the period of April 2017 through March 2018. And that form is now on the website. If you need any older forms such as the calendar year 2018 participation exemption request form, the best way to obtain it is to call RTI. They are the federal contractor for Home Health CAHPS and their telephone number is 866-354-0985.

Also on the website on July 1st, we posted the July Home Health CAHPS Team quarterly newsletter, for the newsletter out that has some interesting and informative news and also some fun news about Home Health CAHPS. The next – it's just a one pager, so it's very easy to view, it has some graphics. It's a nice report and then the next one will be posted on Monday, October 2nd. It's usually posted the first day of the month or as close to it as possible.

Also on the website, we have the new Home Health Agency's responsibilities paper which is about a 10-page paper that outlines all the details to what Home Health Agencies need to do for Home Health CAHPS. And we updated annually because the responsibilities change according to the date. So, we updated it with the new date for the calendar year 2019 annual payment update requirement.

As always, if you are an agency not yet participating in Home Health CAHPS, if you're interested in participation or you have any questions about Home Health CAHPS at all please contact RTI, again our federal contractor. You may call them, again the number is 866-354-0985 or you may simply e-mail them at HHCAHPS, that's Home Health CAHPS@rti.org. Thank you, Jill.

Jill Darling: Thank you, Lori. Next we have Debra Dean-Whittaker, who had some updates on the hospice CAHPS.

Debra Dean-Whittaker: Thank you, Jill. I have some information about hospice CAHPS, first related to the hospice quality reporting program. Letters had been mailed notified hospices of noncompliance with the requirements for the FY 2018 annual payment update. If you receive such a letter, please read it carefully.

It is probably a good idea to keep the records, although that is just a suggestion. The letter contains contact information if you have questions and instructions about how to file for a reconsideration. Also, be sure to check your CASPER folder for more information. If you decide to file for a reconsideration, please carefully review and follow the instructions in the letter.

Here are some tips for filing a reconsideration. Please do not send us PHI. We cannot accept it and if you send it, it triggers a process which involves deleting your reconsideration, asking you to resubmit, don't go down that road, don't send us PHI. Also, make sure you are using the correct provider number, relatively easy to check and very helpful. If you have evidence in support of your case, please provide it to us but still do not send us PHI.

You may receive a letter for noncompliance with the requirement for the CAHPS hospice survey or the hospice (inaudible) or both. The document in your CASPER folder will have more detail. Only those hospices that are deemed out of compliance will receive a letter.

Let me now turn to the next data submission deadline. The next CAHPS, the data submission deadline is August 9th, 2017. We recommend that you check

your data submission reports to make sure your vendors have submitted your data.

If you have questions about how to retrieve your reports, please get in touch with our technical assistance team. Their contact information is on the agenda. Do not hesitate to get in touch with them. They're very willing to help you. No question is considered stupid.

Also, the CAHPS exemption for size. We find that some small hospices are neglecting to request a CAHPS exemption for size. Reminder, the CAHPS participation exemption for size form is now available on the survey website. This form is for small hospices to request exemption from collecting hospice CAHPS data.

Please note this has nothing to do with (HIT). It is CAHPS only. This CAHPS form will be available until December 31st, 2017 and you can submit it anytime between now and then. However, we encouraged you to submit it sooner rather than later, so you don't forget because we cannot accept late submission. Please do save the confirmation e-mail that come after you submit the request, that's please save the confirmation e-mail that you will receive.

The exemption is only good for one year. We have found some hospices don't realize this. If you submitted the form last year and you still qualify, resubmit it again. If you have questions, get in touch with our technical assistance team. There is more information about the size exemption on the CAHPS hospice survey website. Today's agenda shows the survey website URL and contact information for the CAHPS technical assistance team. That is all I have. Thank you very much.

Jill Darling: Thank you, Debra. And last, we have Cindy Massuda who has some hospice quality reporting program update.

Cindy Massuda: Thank you, Jill. So the following are the updates for the Hospice Quality Reporting Program and this is somewhat similar to what Debra was just

talking about related to CAHPS and I'm just going to describe it more broadly.

The annual payment update identifying hospices as noncompliant, CMS has provided notifications to facilities that were determined to be noncompliant with the Hospice Quality Reporting Program requirements for calendar year 2016 which will affect the fiscal year 2018 annual payment update.

Noncompliance letters were dated and sent both by the United States Postal Service and via the QIES Certification and Survey Provider Enhancement Report, also known as the CASPER system, dated July 18th, 2017.

The CASPER letter also identifies why the provider is noncompliant. Please check your CASPER folder to determine if your hospice received this letter. Any hospice determined to be noncompliant with the Hospice Quality Reporting Program requirements may be subject to a 2 percentage point reduction in their annual payment update.

So for example the calendar year 2016 date will affect your fiscal year 2018 payment. Every hospice that is noncompliant with their Hospice Quality Reporting Program requirements received notification on July 18th, 2017. So, it's clear that the 30-day period starts on July 18th and ends on August 17th, 2017 for (sending) a reconsideration request.

So, I just want to make it – repeat that, that the last day to send in a reconsideration request for a noncompliant hospice is August 17th, 2017. Hospices that received a letter of noncompliance can submit their reconsideration to CMS via e-mail no later than 11:59pm Pacific Standard Time on August 17th, 2017.

(So if) you do not submit a request for reconsideration by the deadline means that the hospice accepts that they're noncompliant with the Hospice Quality Reporting Program requirements. If you received a notice of noncompliance and would like to request a reconsideration, see the instructions in your notification letter and it's also on the hospice reconsideration request web page.

The second update has to do with we just posted today the Hospice Quality Reporting Program questions-and-answers document for the second quarter of 2017. So, a new question-and-answer document is now available in the download section of the Hospice Item Set web page.

The Q&A document reflects frequently-asked Hospice Item Set related questions that were received by the Quality Help Desk during the second quarter which is April to June of 2017. The document also contains quarterly updates and events from the second quarter, as well as what's coming in the third quarter.

The third update is that for the hospice quality reporting program, we're going to be holding training and education scheduled for September 20, 2017. It's going to be from 1:30 to 3:00 p.m. Eastern Standard Time at the Medicare Learning Network Event and we want people to be on the outlook – to be looking out for this announcement. And then finally, the Hospice Compare Website is expected to go live soon. So, we also want people to be on the lookout for that new and exciting website, the Hospice Compare Website.

Thank you very much, Jill.

Jill Darling: Thank you, Cindy. And thank you to all of our speakers today. And (Kim) will go into our Q&A please.

Operator: Thank you. As a reminder ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one, again, to rejoin the queue.

And your first question comes from the line of Cindy Cameron with VNA Hospice. Your line is open.

Cindy Cameron: Hi. I was just wondering if, they fix the problem; with the home health claims rejecting to do not submit within 30 days of the start of the episode?

(Will Gehne): Hi. This is (Will Gehne). I'm not sure what problem you're particularly referring to.

Cindy Cameron: We have some claims rejecting that they work – they work submitted within 30 days and it's a 60-day episode, so that's kind of impossible.

(Will Gehne): I'm not familiar with the problem in that – in that area. Have you contacted your MAC about that?

Cindy Cameron: Yes, and they told me it was CMS' regulations that we had to bill within 30 days and that's ...

(Will Gehne): Well that's ...

Cindy Cameron: ... (Something) we're looking into it.

(Will Gehne): That's incorrect. There's nothing in our system that enforces that and there's no such policy that claim time they follow and create is still 12 months from the date of service.

Cindy Cameron: And we appeal?

Female: Yes.

Cindy Cameron: So, we need to appeal this?

(Will Gehne): Yes, definitely, you happen to know what the reason code was on the denial?

Cindy Cameron: I don't have it with me right now. No.

(Will Gehne): OK. But not – if that happened, you need to appeal the claim, yes.

Cindy Cameron: OK. Thank you.

Operator: And your next question comes from the line of (Sherry Thomas) with (AAHHT). Your line is open.

(Sherry Thomas): Hello. Thank you so much, (Will), for taking our call. This question is for you. Understand from CMS from a letter I received from the Claims Division at CMS that the – that CMS did not direct the MACs in how they need to do the reconsiderations for the claim denials related to the OASIS.

So, what I wanted to say and strongly encourage is if CMS would work with the MACs to allow reopening or in the case where they feel like they need to do reconsiderations to allow the agencies just to send in the validation reports where they have proved that the OASIS was correctly submitted and timely in relationship to decline and that's really all I want to say.

But I want to, you know, just encourage that to happen because otherwise it's a tremendous administrative burden and just so cost inefficient and just really and it appears with patient care to have to stand everything that you would have to stand with the full appeal.

(Will Gehne): Yes. And since we exchange e-mail on that subject, I would – my – I work on the response that you got from my group director that I've been working with the MACs about that and we worked as we work through the idea of using the openings but since we need the validation report in order to make them the necessary determination and you can't put all the information that's necessary from the validation report and remarks on a claim for reopening.

The appeals process is – have – is what we need to use. However, I think we hear the message that – about streamlining it and we just had to call with the MACs earlier today where we talked with them about specifying the appeal request to just include the necessary validation report information and not the entire record. So, we're working on doing exactly what you suggest.

(Sherry Thomas): I greatly appreciate that. And it – and just – it's preferably asking the consideration. Thank you so much.

(Will Gehne): Sure.

Operator: And your next question comes from the line of Sherry Teague with Kornetti and Kraft Health. Your line is open.

Sherry Teague: I had another clarification question on the OASIS. The denial based on the OASIS being submitted. So, just clarifying that if the OASIS is – if the bill is received and the OASIS was submitted but received an error and the clerical issue happened with the error was not identified and not identified as it not being submitted. The claim is no longer able to be paid more appeals?

(Will Gehne): If the OASIS was submitted and rejected and ...

Sherry Teague: Yes.

(Will Gehne): ... the – and then the claim – and the claim was submitted, yes that claim would be denied and – yes – would most likely not be reversed on appeal and then you can't speak to exactly what's going to happen on appeal and without a specific, you know, situation but for the most part, yes. The – because the agency should be ensuring that their OASIS was being transmitted and submitted and accepted correctly.

Sherry Teague: OK. And just a second part to that question, then – it's not – you know, working with agencies and trying to help them formulate their plans and processes just like the previous questionnaire. If they – if they submit the claim and have not submitted the OASIS with regard to rejection or not, then that is – what would you say is the chance – if percentage wise or not of a – an appeal being successful?

(Will Gehne): I don't know, the sign percentage to that but I think it's very unlikely.

Sherry Teague: OK. So, literally, they would – they're willing to have that care provided for zero payment for that period of time.

(Will Gehne): That's correct. Because OASIS submission ...

Sherry Teague: OK.

(Will Gehne): ... is the condition to payment for that time period.

Sherry Teague: OK. Thank you so much.

Operator: And your next question comes from the line of (Becky Marr) with Hospice and Community. Your line is open.

(Becky Marr): Hi. Thank you. I just had a quick question regarding the testing process for submitting a list of hospice claim correction. Can you mention, again, the entity that will be asking for volunteer hospices?

Charles Nixon: The MAC should be asking for a volunteer hospice to participate in their trial.

(Becky Marr): And do you know how they will ask?

Charles Nixon: There's a work group.

(Becky Marr): Is it the Hospice Advisory Work Group for the MAC?

Charles Nixon: No. I'm looking for the ...

(Will Gehne): Yes, they're going to reach out through one of the standing provider outreach groups. What they are called varies across the three sites so I can't tell you exactly what the name it is.

(Becky Marr): OK.

(Will Gehne): But again we were speaking with them about this just earlier today as well and two of them have already identified the volunteer.

(Becky Marr): OK. Thank you.

Operator: And your next question comes from the line of (Kathleen Watson) with (Internal). Your line is open.

(Kathleen Watson): Oh, hi. I was just wondering if we had any date for when the Home Health PPS Proposed Rule for 2018 would be out.

Brian Slater: Hi. This is Brian Slater. I'm the Deputy Director at the Division of Home Health and Hospice and unfortunately, we apologize that's why it was removed from the agenda, and also unfortunately, I cannot comment on the time frame in which it will be displayed.

(Kathleen Watson): Oh, OK. Thank you.

Operator: And your next question comes from the line of (Karen McCool) with (Vegas). Your line is open.

(Karen McCool): Hi, yes. Hello. I have a couple of questions. First of all, the hospice training that's going to be September 20th. I was wondering if you can tell us what that training is going to be related to. And also as far as the Hospice Compare Website which is going to be going live soon, can you give us any more specifics about how soon that is, will that be within one week, two weeks, longer, just was hoping to get some information. Thank you.

Cindy Massuda: Hi. This is Cindy. So, for the training that we're doing in September, that training is going to be related to the hospice – to the – to help out with hospices on their annual – improving results for the annual payment update. Our goal for – as we work through the year is to work with the hospices to improve the likelihood of, you know, getting hospices being compliant with the Hospice Quality Reporting Program.

So, we're going to be doing training and education related to both – to the submission reporting of data for the Hospice Item Set and CAHPS Hospice Survey. And then for the Hospice Compare Website going live soon, the most that can be said at this point is that to just keep looking for it. It should be soon. I mean, we have been saying summer 2017 and we're still committed to meeting that expectation and there's not that much left to the summer.

So, I can't give more than that in detail because, you know, these things that are out of our control– until it actually happens, you know, so we're anticipating it very soon though. So, thank you very much and I'm glad you're very excited about it as we are.

(Karen McCool): Thank you.

Operator: And your next question comes from the line of (Ayes Green) with Duke Home Care. Your line is open.

(Ayes Green): Hi. One of the things that I think we've been noticing is that we've had a few late research where the (MO 90 date) doesn't fall in window of date 56 or 60 of the previous episode and we're getting a denial even though the recert assessment is actually submitted on time. It's submitted within the 30 days. It just doesn't fall within the date 56 to 60 window. Is that being addressed?

(Will Gehne): Have you provided examples of that to the MAC because the claim shouldn't deny for that reason.

(Ayes Green): Yes. We've actually provided example and we've actually appealed them all but consistently. The denials that we've been getting for the 30 – for the 37253 reason is something that was a late recert.

(Will Gehne): Yes, I'm not familiar with the – a problem in that area but – so, can you give me an e-mail address where I could contact you and we could work offline to look at those example because I'd like to see what's going on.

(Ayes Green): Sure.

(Will Gehne): Go ahead.

(Ayes Green): G-R-E-E-N as in Nancy ...

(Will Gehne): Yes.

(Ayes Green): ... 173@mc.duke.edu.

(Will Gehne): OK. I will be in touch with you tomorrow and let's see what's going on.

(Ayes Green): Great. Thank you.

(Will Gehne): OK.

Operator: And your next question comes from the line of (Jacob Henry) with Excellent Health Care. Your line is open.

Female: Hello. Good afternoon. I had a question regarding the denials when they are actually permitted on time. I've had three of them. Do we have that complete the full appeal until the situation is fixed?

Male: Yes. Meaning, do we need to submit all the – all the documents like the previous caller – one of the previous caller say something, you know, instead of get the validation report, you know, you guys are asking right now for a face-to-face and all the other documents also. So, we should submit all those documents until future letters say that we just need the validation reports.

(Will Gehne): I think ...

Male: Or can we appeal – yes, sorry about that.

(Will Gehne): I'll call your MAC and see what they want you to do. I don't want to tell you don't be responsive to a letter that's in your hand, but I also don't want to tell you to send more information than you need to. So, I'd recommend to contacting the MAC and see how they want you to handle that.

Male: I'll pick on that. Yes. You know, Palmetto, you know, we called our MAC is Palmetto and we call them and they, you know, their responses that you need to do just respond to the letter accordingly. But even though you know, what we were – what you guys have been discussing earlier, I think our validation report would actually be the answer to the real denial. But they are actually asking for more than really necessary.

Male: Face-to-face 485.

Female: Yes, they are asking for face-to-face ...

Male: 485 ...

Female: ... on the denial and the acceptance report.

Male: Yes, the acceptance report and the (Inaudible) still ...

Female: Then the OASIS.

Male: ... then the OASIS. It's a lot of ...

(Will Gehne): Yes.

Male: ... like the previous caller – one of the previous callers, there's a lot of administrative work that we have to, you know, administrative costs because all that stuff, you know, take time and money. But to get back – you know, Palmetto is wanting us to then to submit all the stuff that they've asked for. That's what they are ...

(Will Gehne): Well, they are – they haven't received any input from CMS to do any differently instead of 1:30 today. So, you might track on, again, next week and double checking before you send (that) documentation.

Male: OK.

Female: We have the one year or how long do we have from rejection to – like if we wanted to just wait to see what they say of the new rules of sending it.

Male: No. The letter says August 20th. There's a deadline to each letters, yes.

(Will Gehne): Yes, yes. And unless you hear – unless you hear otherwise before then, respond by the deadline on the way.

Male: Yes. OK. All right. Thank you. Yes, very good. (Inaudible), the ADR left?

(Off-Mic)

Operator: And your next question comes from the line of (Pamela Haw) with Lake Ford Hospice. Your line is open.

(Pamela Haw): Thank you very much. Could you please tell us when we're looking in the CASPER Folders what will be the title if you will of this – of the noncompliant letter that we'll be looking for?

Cindy Massuda: Is this a letter in your folder? It will let you – it will clearly be stated that it's a noncompliant letter for your annual payment update.

(Pamela Haw): OK.

Cindy Massuda: And so that you've been found to be at this time preliminarily found to be noncompliant with the Hospice Quality Reporting Program. So, there's no letter in your folder. That's good news. So, it's only being sent for people who are noncompliant and as I said, you have to – if you – if there is a letter in that CASPER Folder, there's 30 days to send in a reconsideration request to have as we consider a – we consider your situation to waive that issue for you. And that's deadline in August 17, 2017 at 11:59 p.m. Pacific Standard Time.

(Pamela Haw): Thank you very much. We just – we don't know what we're looking for. We're not seeing anything but if we have that title to know exactly what we're looking for that's helpful. Well, I appreciate it.

Cindy Massuda: And we also – we sent it both ways. Both by mail and by – and also electronically to the CASPER Folder to help – you know, make sure our people received this information and it's clearly marked that in annual pay – that provider is noncompliant with their annual payment updates.

Operator: And your next question comes from the line of (Nancy Maloba) with Hospice of Michigan. Your line is open.

(Nancy Maloba): Hi. I think my question is due to – (well do you need alpha). We are the hospice that our (RMS) is going to work with for the mass adjustment but I'm a little bit confused because I know we're talking for mass adjustment but the fix that you have out there currently doesn't work. And we just pushed another claim through to, you know, when we heard that and it is rejecting immediately.

So, I – it didn't sound like that was what you were – you were just talking mass adjustment. What's out there right now does not work whether you're doing one claim or trying to mass adjust.

(Will Gehne): I don't know exactly what situation you're saying that doesn't work.

(Nancy Maloba): So, there was instructions in how to reprocess your adjusted – your claims for (CI) and the two tier that were paid incorrectly because of not recognizing prior periods. That information that was put out there is not working. To follow those instructions, the claim still rejects.

So, until we have that fixed, you really can't do mass adjusting, and I thought that's what I was working with the MACs on.

(Will Gehne): Well there are – there are processing steps that the MAC can take that you cannot, but if you provide them with a list they can create a mass adjustment process that can work so just continue to ...

(Nancy Maloba): So ...

(Will Gehne): ... work with them and test the process rather than ...

(Nancy Maloba): OK.

(Will Gehne): ...assuming it's not going to work before you start.

(Nancy Maloba): OK. All right. Sounds good. I just wanted to be clear because again what's out there right now doesn't work for one claim or yes, OK, thank you.

Operator: And your next question comes from the line of (Mercedes Carlsson) with the Carolina Center. Your line is open.

(Mercedes Carlsson): Good afternoon. Thank you so much for the Q&A and all that's going on today.

I wanted to I think we all have some questions about the claims adjustment and the piloting process, could you tell us the names of the MACs that have already gotten volunteers and who those volunteers are and could you also clarify for us again in terms of the process for the claims adjustment or the tier payment and for SIA payment.

(Will Gehne): In terms of we had volunteers, its NGS and CGS. I do not know who they are. I think it would be appropriate to me to tell you if I did. The last part I don't know. I'm not sure exactly what you're asking.

(Mercedes Carlsson): I just wanted to clarify the process in terms of currently what you're asking hospice providers to do. They are – they are not to submit a list, but to continue to do what they have been doing in terms of getting their claims adjusted for payment – the two-tier payment.

(Will Gehne): If you have had the – information that identifies the claims that need to be adjusted and you can continue to submit adjustments as you – as you have been doing and you could wait until we work out the list process if you think that's going to be easier for you. That's you have the option to do whatever you choose to do at this moment.

(Mercedes Carlsson): In terms of the time sensitive, in terms of the time periods, in terms of providers being able to submit those claims, will that – will they be penalized if they wait after the 12-month period or ...

(Will Gehne): Yes, yes, as we said on this call ...

(Mercedes Carlsson): ... give them a pass for that if they decided to wait.

(Will Gehne): ... as we said on this call before the – a variety of time we're following on these adjustments were necessary.

(Mercedes Carlsson): Thank you.

Operator: And your next question comes from the line of (Shelley Marquez) with Optimal Health. Your line is open.

(Shelley Marquez): Hi. I was wondering if somebody can tell me when the 2016 Home Health Pricer is going to be released.

(Will Gehne): I wish I had a date for that, but I don't. We're in the process of finalizing its development and I've seen prototypes of it, but we're still working out the –

working out the final details of testing it so it's a – it's a coming soon I hope, but I don't know how soon.

(Shelley Marquez): All right. Thank you.

Operator: And your next question comes from the line of (Shasta Mackey) with (Anderson). Your line is open.

(Shasta Mackey): Hi, thank you for taking my call. I just have a quick question regarding the OASIS denials and I just – I just want to make sure that what I'm understanding is correct. So we should receive a denial if the start of episode is after – on or after 4/1 and if there is no OASIS found. So if we have an OASIS and that has a warning, we shouldn't receive denial right.

(Will Gehne): Right. Right. If it was – if it was accepted, but receive the warning message that should be fine.

(Shasta Mackey): Right and so are there any validations against the HIC number because we're receiving denials where initially the HIC number was ending in a B and then once the final claim billed the HIC number was then ending in a D and we received denial on that for the 32753.

(Will Gehne): Yes, those are the exact situations that I described in my remarks earlier in the call and ...

(Shasta Mackey): Right. I actually was accepted on the call right after the remarks so I didn't ...

(Will Gehne): OK.

(Shasta Mackey): ... I didn't hear exactly what you were saying.

(Will Gehne): Yes, then the HIC number ...

(Shasta Mackey): So ...

(Will Gehne): ... the HIC number is one of the situations that we're – one of the data elements I should say that we're using ...

(Shasta Mackey): Exactly.

(Will Gehne): ... to match them and if there is a change in between those can result in denials, we're working on how we can refine the system to reduce that, but in the meantime those needed to be appealed and that's the situation that would be reversed because it's a administrative error.

(Shasta Mackey): Right. OK. So that it was – it was corrected at the initial assessment, but it changed that so that's appealable and they're going to be overturned.

(Will Gehne): Yes.

(Shasta Mackey): Perfect. OK. Thank you.

Operator: And your next question comes from the line of (Loretta Chatford) with NorthBay Healthcare. Your line is open.

(Loretta Chatford): Hi. My question is regarding the SE17014 and it is regarding the 90-day plus election period that we were not allowed to adjust, but wait until Medicare adjusts it on August 24th. So I adjusted my other claims and quickly got paid and now I wonder if I can do with the one that are 99 days plus.

(Will Gehne): No, you should continue to hold those until the (fix that's done) on August 21st.

(Off-Mic)

(Loretta Chatford): OK. OK. Thank you for the answer.

(Will Gehne): Yes.

Operator: And your next question comes from the line of (Nicole Faltier) with Carroll Health Services. Your line is open.

(Jennifer): Hi. My name is (Jennifer). I'm call – my question today is for the SIA and tier claims that are continuing to process incorrect as of today, when is the next release or the update on that fix?

(Will Gehne): You need to provide a more specific situation in that for me to know exactly what you're talking about.

(Jennifer): OK. Its current claims. They are from just last month billing that are processed recently still paying incorrect tier and SIA.

(Will Gehne): Because? And that's the scenario.

Female: That's it.

(Jennifer): It's because Medicare is not paying as a correct tier right. The system is not processing at the correct tier rate. It's either over or underpaying based on the day.

(Will Gehne): OK. That's not – that's not happening uniformly on all claims. That's happening in some very narrow circumstances or can happen in some very narrow circumstances. I'm trying to ask you for specifics about the scenario or if you work with (Nicole), she has my e-mail, you could send them to me.

(Jennifer): OK.

(Will Gehne): Thank you.

Operator: And your next question comes from the line of (Amy Parkinson) with (Sparrow) Home Care. Your line is open.

(Amy Parkinson): Yes hello. Can you hear me?

Operator: Yes, we can.

(Amy Parkinson): OK great.

My question is regarding the interpretative guidelines, which – for the new home health conditions or participation, which I understand are not available

to us yet, but in regards to what they say the propose guide or the guideline say that we need to identify the patient representative, can you give some ideas to what will be looked for to know that we have identified that patient representative, would that patient representative have to find somewhere, find something or have a signature somewhere.

(Danielle Shearer): This is (Danielle Shearer). I don't think we have anybody from survey and certification on the line who could answer that question.

(Amy Parkinson): OK.

Jill Darling: Hi, this is Jill Darling. If you want to e-mail your question to the Home Health Hospice ODF e-mail, if you received the agenda it's on there and you can send ...

(Amy Parkinson): OK.

Jill Darling: ... your question there. Thank you.

(Amy Parkinson): Yes. Thank you.

Operator: And your next question comes from the line of (Heather Cooke) with Florida First Care. Your line is open.

(Heather Cooke): Hi, yes. I had a question in regards to the OASIS rule and the applicability to the LUPA. I was under the impression that it did not apply to a LUPA, however, we have since had two claims that have denied due to the OASIS not being found; can you go into a little bit of detail about that please.

(Will Gehne): Hi, it's (Will) again. There's never been an exception that excluded LUPAs from that – from that process or impose any condition to payment that advise in our – to all payment adjustment.

(Heather Cooke): Oh I thought there was like an extension for timeline because the LUPA is only the five-day window for them to have the OASIS there prior to the final being submitted.

(Will Gehne): But it's not specific – it's not specific to LUPA. I mean it's – if the claim is submitted before the assessment would be due, that shouldn't deny.

And if you have examples where it is, please bring this to the attention of your MAC because that – because that would mean we have a system error that we're not aware of.

(Heather Cooke): I have reached out to our MAC. Once again, we have Palmetto and they were unable to provide me any further detail. They said that I would just need to submit an appeal to this because the specific thing that happen is we had the assessment. We discharge the patient the very next day, submitted the OASIS on the day of the, excuse me, submitted the final bill the day of the discharge so it was not due yet, but we still receive a denial.

(Will Gehne): OK. Well I would submit the appeal. It may be that there was something else going on, but it's a circumstance of exactly what you describe, the MAC should research that as a – as a system error rather than a denial.

(Heather Cooke): OK so right now, my only recourse is to submit the appeal as requested.

(Will Gehne): Yes. OK.

Operator: And your next question comes from the line of (Marissa Mechado) with Texas Association. Your line is open.

(Marissa Mechado): Good afternoon. This is (Marissa Mechado). So I just wanted to give comment and wanted clarification.

There was a caller earlier (Will) that talked about the OASIS and having denials for claims that were filed within the year requirement.

So I think it goes to the way the letter is written, the e-mail and letter where it talks about and it's in the – it's on the third, no the second page at the very top where it talks about if the OASIS assessment is not found and the receipt of the claim is more than 30 days after the assessment completion date reported on the claim, the system will deny.

And what we've heard here in Texas that we have had providers report that the claim is being denied if it's not received within 30 days from the assessment date. So that was – that's just that. So I think people or the MACs need clarification on that. The MAC we've heard this from is Palmetto GBA.

(Will Gehne): OK. Well does – have that (allegation) and research examples and the denials were for other reasons so those were ...

(Marissa Mechado): Because that ...

(Will Gehne): ... misunderstanding, right.

(Marissa Mechado): ... so if that ...

(Will Gehne): ... just like I said in my – just like I said in my remarks, we're using that receipt data and the OASIS completion date to determine whether the OASIS should be there ...

(Marissa Mechado): Right.

(Will Gehne): ... not to determine whether it's late or to do anything with regard to the timeliness of the claim.

(Marissa Mechado): Correct, yes and I think the – I think the confusion maybe in the – in the language in the way the letter was written or the direction was written. That's just – that's just my opinion.

(Will Gehne): And I don't know how we could – I don't know how you could avoid referring to the receipt date when the receipt date is the data element that we have and can use to determine whether the OASIS is due so if you have a suggestion about how to say that differently that would be clearer, I've been struggling for it honestly and ...

(Marissa Mechado): OK.

(Will Gehne): ... I will gratefully receive that if you have a suggestion.

(Marissa Mechado): OK great. Can I e-mail our suggestion to the Home Health ODF address as well?

(Will Gehne): Please.

(Marissa Mechado): OK great.

(Will Gehne): That will be great.

(Marissa Mechado): And then my other question you guys may or may have more – may not have this information, but I know there was a question earlier about the interpretative guidelines, is there – is there a timeline on that yet when to expect those, to see those.

(Danielle Shearer): Again, this is (Danielle Shearer). There is nobody from the survey and certification staff here that could answer that question.

(Marissa Mechado): OK, great. Is that something I can e-mail in and you – and get it – get it to the right person?

(Danielle Shearer): If you could send it to the Open Door Forum e-mail then it is routed through CMS to the correct staff.

(Marissa Mechado): OK great. Thanks for your help.

(Danielle Shearer): OK.

Jill Darling: Hi, (Kim), this is Jill. Unfortunately folks, we are at the top of the hour now so if you were in the queue waiting to ask your question or comment, we thank you for that, but please send it in to the Home Health Hospice DME ODF e-mail that was on the agenda today. We do appreciate all your questions as always and thank you all for joining today.

Operator: Thank you for participating in today's Home Health Hospice DME Quality Open Door Forum Conference Call. This call will be available for replay beginning today at 5 p.m. Eastern through midnight, July 24th.

The conference ID number for the replay is 59185437. The number to dial for the replay is 8558592056.

This concludes today's conference call. You may now disconnect.

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