HOME CARE & HOSPICE
CONFERENCE AND EXPO

Monday, October 14, 2019 11:30 AM

302 Meet Your Medicare Contractor: National Government Services

Meet Your Medicare Contractor: National Government Services

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Agenda

- National Government Services Resources
- New MBI
- HETs Updates
- Hospice System Issues
- Home Health Updates

National Government Services Resources

- National Government Services Products
  - NGSConnex
- Live tutorial
  - NGSMedicare
  - NGS Medicare University

NGSConnex

- National Government Services' free, secure, web based application (Portal)
  - NGSConnex.com
- Allows provider access to a variety of services
  - View provider accounts
  - MBI Lookup
  - Check Eligibility
  - View check and remittance
  - Appeals
  - Complete A&R documents
  - Submit credit balance reports
  - View/search for MR ADR submission & documents

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New Medicare Beneficiary Card

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New Medicare Cards

- Starting 1/1/2020 You must use the Medicare Beneficiary Identifier (MBI)
- Claims will reject with few exceptions if submitted with the Health Insurance Claim Number (HICN)
- All eligibility transactions will reject

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Start Today Using the MBI

- MBI Usage
  - 66.4% home health agencies
  - 60% hospices
  - 78% national average

Medicare Beneficiary Identifier

How to find an MBI

- Ask beneficiaries for the new Medicare card
  Beneficiaries can log into mymedicare.gov to their MBI
- Use the MACs secure MBI look up tool
  NGSConnex
- Check the remittance advice

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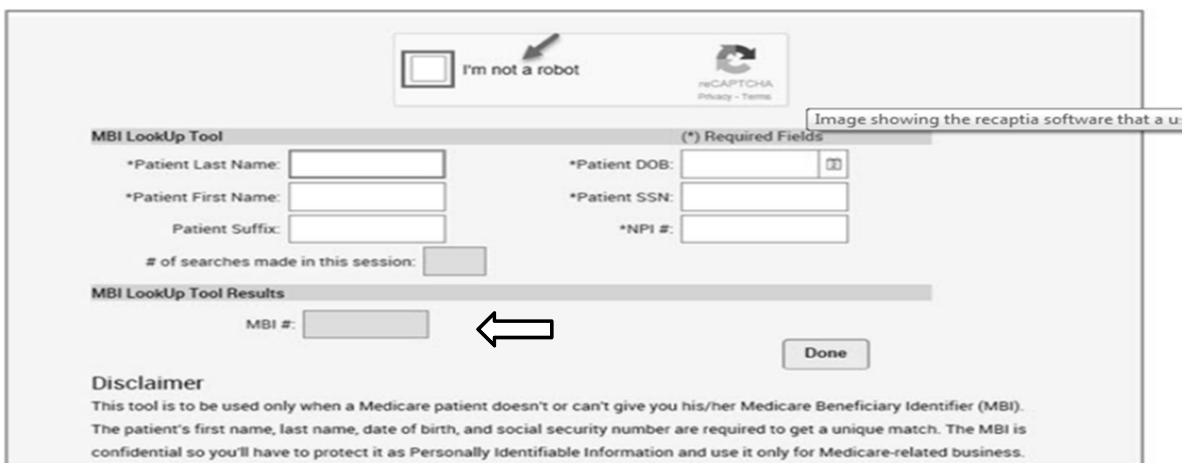
NGSConnex – MBI Look Up Tool



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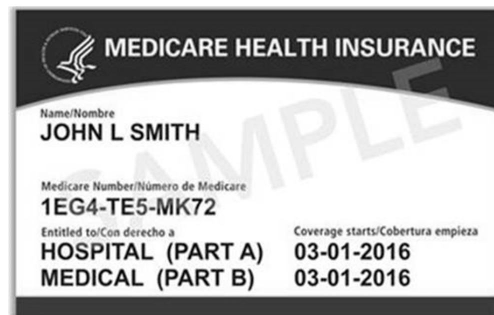
MBI Reminders

Hyphens on the card are for illustration purposes
- ❑ Do not include the hyphens or spaces on transaction

MBI
- ❑ Uses numbers 0–9
- ❑ All uppercase letters except (S,L,O, I, B and Z)



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HIPPA Eligibility Transaction System Updates

HIPPA Eligibility Transaction System Updates

MLN Matters® Special Edition Article SE1249

- Revised article in 2017
- Provider instructions for moving to HETS from CWF eligibility queries

Discontinuing Duplicate Provider Medicare Fee-For-Service (FFS) Beneficiary Health Insurance Eligibility Systems

- Article release date 3/27/2019 to provide a new timeline

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HIPPA Eligibility Transaction System Updated

- Beginning the fall of 2019 CMS plan to terminate access to CWF eligibility queries for those who already utilize HETs
- If you currently use both CWF and HETS to get Medicare beneficiary health insurance eligibility information, you should immediately being to use HETS exclusively
- If you do not currently use HETS, start to look at how you will need to modify business processes to use HETS to access Medicare beneficiary eligibility information

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NGSConnex – Hospice Information

- The hospice information panel will display information if the beneficiary has currently elected to receive hospice care or has elected to receive hospice care in the past.
- NGSConnex will display hospice care elections for the previous four years from the date of the eligibility search*

*Subject to changes with upgrade of HETS

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NGSConnex – Home Health Information

The following information will be provided for hospice eligibility:

- ❑ Start date
- ❑ End date
- ❑ Earliest Billing Date
- ❑ Latest Billing Date
- ❑ Patient Status
- ❑ NPI- the NPI for the home health agency providing the care will display

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NGSConnex – Home Health Information

Home Health Plan Information Search No Records Show More

Start Date	End Date	Earliest Billing Date	Latest Billing Date	Patient Status	NPI

NGSConnex – Hospice Information

The following information will be provided for hospice eligibility:

- ❑ Start date
- ❑ End date
- ❑ Revocation indicator
- ❑ Benefit period
- ❑ PTAN
- ❑ NPI

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NGSConnex – Hospice Information

Hospice Information Search 1 - 2 of 2 Show More

Start Date	End Date	Revocation Indi	Benefit Period	PTAN	NPI
8/3/2018	10/31/2018	0 - Not Revoked	1	XXXXX	XXXXXXXXXX
5/5/2018	8/2/2018	0 - Not Revoked	2		

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Hospice Updates

- Hospice Final Rule issued August 6, 2019
  - Payment rates for FY2020 released
  - Modification to the hospice election statement
    - Information about the holistic, comprehensive nature of the Medicare hospice benefit
    - A statement that, although it would be rare, there could be some necessary items, drugs or services that will not be covered by the hospice because the hospice has determined that these items, drugs or services are to treat a condition unrelated
    - Information about cost-sharing
    - Notification of the beneficiary's right to request an election statement addendum and information about appealing to the BFCC-QIO
  - Requirement in FY2021 for a hospice addendum

Home Health Updates

Patient-Driven Groupings Model (PDGM)

- Effective for periods of care that begin on or after January 1, 2020
- New payment model for HH PPS
  - Relies more heavily on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories and eliminates use of therapy service thresholds
- Change in unit of home health payment from 60-day episode to 30-day period

PDGM Home Health Resource Groups (HHRGs)

- For each 30-day period, patient assigned into one subcategory for each category:
  - Admission source (two subgroups): community or institutional admission source
  - Timing of the 30-day period (two subgroups): early or late
  - Clinical grouping (twelve subgroups –see chart): based on principle diagnosis
  - Functional Impairment Level (three subgroups): low, medium or high
  - Comorbidity adjustment (three subgroups): none, low or high – based on secondary diagnoses
- 432 possible case-mix adjusted payment groups per 30-day period
  - Reported as HIPPS codes on the RAP and claim

PDGM HHRGs

Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

PDGM Payments

- HH PPS payment made in two installments
  - RAP (initial payment)
    - New providers with Medicare participation dates on or after 1/1/19 will not receive RAP payments
  - Period of care claim (final payment)
- **Note:** OASIS, certification/recertification and plan of care still based on 60 days

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PDGM Period of Care Sequence/Timing

- First 30-day period classified as early
- All subsequent periods classified as late
- Periods are considered subsequent as long as there are no more than 60 days between claims

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HH Consolidated Billing

- HHA must bill for all home health services which include
  - Skilled nursing services
  - Skilled therapy services (PT, OT, SLP)
  - Routine and nonroutine medical supplies
  - Home health aide services
  - Medical social services
  - NPWT furnished using a disposable device
  - Covered osteoporosis drugs as defined in Section 1861(kk) of the Act
- All HH services paid on cost basis included in PPS rate
- Payment made to primary HHA regardless of whether or not items or services were furnished by the HHA

RAP

- Requests initial split percentage payment for HH PPS period of care
  - Initial period = 60% split (40% for final claim)
  - Subsequent period = 50% split (50% for final claim)
- Submitted after receiving physician’s verbal orders and after delivering at least one service to the beneficiary
- Establishes agency as primary HHA
- Opens new home health period of care in CWF

Split Percentage Payments

- HHAs newly enrolled in Medicare on/after January 1, 2019
  - Will not receive split percentage payments beginning CY 2020
  - Need to submit a no-pay RAP at the beginning of each 30-day period to establish the home health period of care and submit final claim at the end of each 30-day period
- HHAs certified for Medicare prior to January 1, 2019
  - Continue to receive split percentage payments in CY 2020
  - Need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period.
  - For the first 30-day period of care, split percentage payment would be 60/40 and all subsequent 30-day periods of care would be split 50/50

Final Period Claim (End of Period Claim)

- Submitted at end of each 30-day period, when beneficiary transferred, or when beneficiary discharged
  - Must be submitted after all services for the period have been provided and physician has signed plan of care and all verbal orders
  - Face-to-face encounter must have been completed prior to submitting the claim
  - OASIS assessment must be submitted and accepted without errors in the state repository prior to billing the claim
- RAP payment recouped when final period claim is submitted and 100% payment is made once claim processes
- Information from the OASIS and the claim information used to determine 30-day period payment

PDGM 30-day Period Billing Timeliness

- Thirty-day period claim must be billed within 60 days of the date the RAP processed or 90 days from the period start date (whichever is greater) to be considered timely for HH period billing
  - If claim is not submitted timely, FISS will auto-cancel the RAP for that HH period

PDGM Billing Requirements

- Occurrence Code 50 with OASIS completion date (OASIS item M0090) – MMDDYY format
  - Only required on claims, not RAPs
  - Claim will be returned if missing
  - Date reported should be for the start of care, resumption of care, recertification, or other follow-up OASIS occurring most recently before the claim “From” date
- Occurrence Code 61 – Hospital Discharge Date
  - Reported, but not required, on final claims
  - Not reported on RAP
  - Report discharge date (“Through” date) of inpatient hospital stay that ended within 14 days of the HH period’s “From” date
  - Grouped into “Institutional” payment groups

PDGM Billing Requirements

- Occurrence code 62 – Other Institutional Discharge Date
  - Reported, but not required, on final claims
  - Not reported on RAP
  - Reported only on admission claims, if applicable (claim "From" and "Admission" date match)
  - Report discharge ("Through") date of SNF, IRF, LTCH or IPF stay that ended within 14 days of HH period's "From" date
  - Admission claims with other institutional discharges within 14 days are grouped into "Institutional" payment groups

- Report only one occurrence code 61 or 62 on a claim. If two inpatient discharges occur during the 14-day window, report the later discharge date.

HIPPS and Grouper Tool

- HIPPS code can be produced by Grouper software or be any valid HIPPS code
  - Grouper-produced HIPPS code from Medicare claims processing system replaces submitted HIPPS and is used for payment
- CMS created an Interactive Grouper Tool for learning about PDGM HIPPS codes
- Obtain resulting HIPPS code and case mix weight by entering information on patient's 30-day period for each PDGM category
- Purpose of this tool is informational and illustrative only – final CMS grouper software available in 2020

LUPA

- Applied when HHA provides fewer than the threshold of visits specified for the period's HHRG
- Standardized per visit payment instead of a payment for a 30-day period of care
- Each of the 432 different PDGM payment groups has threshold that determines if 30-day period receives LUPA
  - For each payment group, the 10th percentile value of visits used to create payment group specific LUPA threshold with minimum threshold of at least two for each group (range is 2-6 visits in a 30-day period)
  - Thresholds found in Table 32 in the CY 2019 HH PPS Final Rule (83 FR 56493) and on CMS' HHA Center webpage

PDGM Resources

- MLN Matters Article MM11081 - "Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation"
- MLN Matters Article MM11395 - "Home Health Patient-Driven Groupings Model - Revised and Additional Manual Instructions"
- MLN Matters Article MM11272 - "Home Health Patient-Driven Groupings Model - Additional Manual Instructions"
- Overview of the Patient-Driven Groupings Model (PDGM) - Centers for Medicare & Medicaid Services (CMS) presentation
- Home Health Patient-Driven Groupings Model: Operational Issues - CMS presentation
- CY 2019 HH PPS Final Rule
- Home Health Agency (HHA) Center web page on the CMS website

Proposed Changed for CY2020

- Change in split-percentage payment for all 30-day periods of care (initial and subsequent) to 20% starting in CY 2020
- Eliminate split-percentage payment for all providers beginning CY 2021
- NOA requirement beginning in CY 2021
  - Notice of Admission submitted within 5 calendar days of the start of care
    - Establishes home health period in CWF
  - Submitted only at the beginning of the first 30-day period (not required for subsequent periods of care)

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- Log on to National Government Services' Medicare University
  - http://www.MedicareUniversity.com
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    - Catalog Number = To be provided
    - Course Code = To be provided
  - Visit our website for step-by-step self-reporting instructions.
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