Regulatory Round-Up
A publication of the National Hospice and Palliative Care Organization.

NHPCO Regulatory Recap for Activity from August 2011

Volume 1, Issue No.8

To: **NHPCO Membership**
From: **NHPCO Regulatory Team**

IN THIS ISSUE:

Item	*NewBriefs* Date/Link
CMS "Help Prevent Fraud" Campaign… This CMS campaign tells people how to protect themselves against fraud by checking their billing statements and reporting suspicious charges. People should also report other suspicious activities, like being asked over the phone for their Medicare or Social Security number or banking information. Medicare will NEVER call for this information. Watch for the CMS "Help Prevent Fraud" Campaign on TV and newspapers in your area, especially if you live near Los Angeles, Miami or New York. People can report suspicious activities by calling 1-800-MEDICARE (1-800-633-4227). Providers can help, by making sure people with Medicare have the information they need to identify and report fraud. Check out the CMS Fraud Prevention Toolkit.	August 25, 2011 *NewBriefs*

CMS Provider Compliance Group Outreach Call notes… CMS facilitated a listening session on August 24 for providers and suppliers to address specific vulnerabilities identified in the OIG reports and issues involving Medicare Fee-For-Service. Hospice provision was reviewed in context of the 2009 OIG report, "Medicare Hospice Care for Beneficiaries in Nursing Facilities," which many providers are familiar with. The OIG's findings purported that 82% of examined hospice claims for beneficiaries in nursing facilities in 2006 did not meet at least one Medicare coverage requirement. (NHPCO reminds members that the data for this report involved less than 500 patient records and that the overwhelming majority of non-compliance issues did not involve quality or clinical care.) OIG recommendations to CMS: 1. Educate Hospices About the Coverage Requirements and Their Importance in Ensuring Quality of Care 2. Provide Tools and Guidance to Hospices To Help Them Meet the Coverage Requirements 3. Strengthen Its Monitoring Practices Regarding Hospice Claims The listening session reviewed the requirements for the following regulations: • 418.200 - Requirements for coverage • 418.20 - Eligibility requirements • 418.21 - Duration of hospice care coverage--Election periods • 418.22 - Certification of terminal illness • 418.24 - Election of hospice care • 418.3 – definitions for Attending physician, Employee, Representative Slides from the call (PDF) have been made available by CMS. Providers are encouraged to complete a self assessment of these areas using NHPCO's OIG Reports on Hospice Care in the Nursing Home - OIG Compliance Audit Tool (PDF).	August 25, 2011 *NewsBriefs*
Final 2012 Medicare Hospice Wage Index Spreadsheets Posted… NHPCO's Regulatory Team posted the FY 2012 Medicare state-by-state/ county-by-county Hospice Wage Index spreadsheets for our membership. The rate calculator will be coming soon! Visit the NHPCO Hospice Wage Index webpage and click on the "State by State/County by County spreadsheets: FY2012 Wage Index (Excel)" link. Judi Lund Person talks about the FY2012 Hospice Wage Index. *(This is a 10 minute YouTube video clip available to members only.)*	August 11, 2011 *NewsBriefs*

Final FY2012 Wage Index and Rate/Cap Amount Released… The Final FY2012 Wage Index was posted in the public inspection section of the Federal Register on July 29 and the final rule was published in the Federal Register (PDF) on August 4, 2011. CMS has also published the FY2012 hospice rates and cap. • The Final FY2012 Wage Index includes wage index values for rural areas and CBSAs; new cap calculation methodologies; clarifications on the hospice face-to-face encounter; clarifications on the QIO ruling when a patient appeals discharge; and the launch of the CMS hospice quality reporting program with two quality measures (one structural and one outcome) for which data will be collected in 2012. NHPCO provided a complete analysis of the final rule on the Hospice Wage Index page. • CR 7518, released on July 29, provides updates on Hospice Payment Rates, the Hospice Cap, and the Hospice Wage Index and Hospice Price for FY2012. The rates reflect a 3.0 percent increase in the hospital market basket, with a minus 0.5 percent reduction in the rates as a result of the BNAF being incorporated into the Wage Index values. To assist members, NHPCO has posted the state-by-state rate chart for FY2012 available on the NHPCO website.	**August 4, 2011 NewsBriefs**
HIPAA Version 5010 and D.0 Transactions - Save the Date - National Provider Call on Medicare FFS Implementation… CMS will host its eighteenth national education call regarding Medicare FFS's implementation of HIPAA Version 5010 and D.0 transaction standards on Wednesday, August 31, 2011. This national call will include a Medicare Administrative Contractor Panel Question & Answer Session as well as brief status updates from all MACs. Participants will have the opportunity to ask their MAC specific questions related to 5010 implementation. CMS will offer a webinar as part of this call, enabling participants to follow the presentation online as it is given (this will not have any effect on participants who are only dialing in). Those not participating in the webinar may download the presentations from the CMS website registration page.	August 25, 2011 *NewsBriefs*
HIPAA 5010 implementation items – Update…The HIPAA 5010 compliance date is fast-approaching. There are only 5 months left until full implementation on Jan 1, 2012. Please contact your local Medicare Administrative Contractor (MAC) and Test Now! **Reminder –** Jan 1, 2011 marked the beginning of the 5010/D.0 transition year. **Reminder –** Versions 5010 & D.0 FAQs **Reminder –** National Testing Day Message **Reminder –** 5010/D.0 Errata requirements and testing schedule **Reminder –** Contact your MAC for their testing schedule **Readiness Assessment –** Have you done this to be ready for 5010/D.0? **Readiness Assessment –** What do you need to have in place to test with your MAC? **Readiness Assessment –** Do you know the implications of not being ready? • **December 31, 2011 - End of the transition year, and the beginning of 5010 production environment!**	**August Regulatory Round-Up EXTRA**

HIPAA 5010 - First National Version 5010 Testing Day Results Now Available… CMS Version 5010 Team held its first National Testing Day on June 15, 2011. On National Testing Day, 349 Medicare fee-for-service (FFS) trading partners conducted testing using the Version 5010 format that all covered entities are required to use starting January 1, 2012. From those 349 trading partners, 974 files were submitted and there were no significant error scenarios reported. Sixty-eight trading partners responded to a follow-up survey about National Testing Day. Of those who responded to the survey, 32 percent stated that they feel ready to process Version 5010 production transactions. In addition, 39 percent of the respondents stated that they were able to receive and process a 277CA while testing on National Testing Day. The following metrics represent **5010 production** transactions: • Part B claims processed (May and June) – **59,778** • COB Part B claims (May and June) – **4,041** • Trading Partners for Part B Claims and COB (as of June) – **Part A - 43, Part B-84, COB- 24** • Eligibility inquiries (May and June) – **305,884 inquiries** CMS and the Medicare FFS Program scheduled a National 5010 Testing Week for August 22 - 26, 2011. **Keep Up to Date on Version 5010 and ICD-10.** Please visit the resource page for 5010 at CMS for the latest news and resources to help you prepare!	**August Regulatory Round-Up EXTRA**
Hospice Discharge Clarifications… CR 7473 was also released by CMS on July 29, 2011. The CR, and the accompanying MedLearn article, contains no new policy. The requirements of CR7473 improve the implementation of longstanding policy under Medicare regulations at 42 CFR 418.26 and revise the Medicare system to ensure hospice discharge claims update the beneficiary's hospice benefit period correctly. CR7473 makes various revisions to chapter 11 of the Medicare Claims Processing Manual to remove outdated language and clarify existing instructions by adding more detailed instructions for hospices about coding claims. The official instruction (PDF) regarding CR7473 issued to your RHHI and AB/MAC, and the MedLearn Matters article (PDF) may be viewed on the CMS website.	August 4, 2011 *NewsBriefs*
Identity Theft ALERT… AdvanceMed, the Program Safeguard Contractor (ZPIC) for the CGS MAC region has alerted providers to a new identity theft approach. Criminals are calling provider's offices posing as the Board of Medicine and asking for key identifying information. Should you receive such a call ZPIC advises: • Take the caller's name. • Ask them to call back at a later time. • If you have caller ID, note the number from which the call is received. • Do not provide the information. • Do not call any number the person gave to you but rather verify the Board's number on the web or in the phone directory. If the numbers do not match, please contact AdvanceMed at 614-801-2343 immediately.	August 18, 2011 *NewsBriefs*

Medicare Summary Notice (MSN) changes… CMS announced that the format of the MSN is changing to make it easier for beneficiaries and to make sure it is current and consistent with applicable regulations. Download the Change Request for CR7449 (PDF).	August 4, 2011 *NewsBriefs*
National Version 5010 Testing Week is Coming Up… The Version 5010 compliance date – **Sunday January 1, 2012** – is fast approaching. All HIPAA covered entities should be preparing, this includes conducting external testing to ensure timely compliance. To assist in this effort, CMS, in conjunction with the Medicare FFS Program, designated **August 22 through August 26, 2011** as National 5010 Testing Week. More details concerning transactions to be tested are forthcoming from your local MAC. There are several State Medicaid Agencies who will also be participating; more details on Medicaid testing will become available soon. For more information on HIPAA Version 5010, please visit the CMS dedicated 5010 website.	August 4, 2011 *NewsBriefs*
NHIC's top claims processing problems… • Top return to provider errors for April to June 2011 (PDF) for Hospice providers have been published. • Top rejection errors for April to June 2011 (PDF) for Hospice providers have been published. • Top denial errors for April to June 2011 (PDF) for Hospice providers have been published.	**August Regulatory Round-Up EXTRA**
Notes from CMS Home Health, Hospice & DME Open Door Forum… CMS conducted a Home Health, Hospice & DME Open Door Forum on August 17, 2011 which included a review of the items included in the FY2012 Final Hospice Wage Index and a statement of the release of the Medicare hospice rates for FY 2012. Updates regarding the content of the FY2012 Final Hospice Wage Index included: • **Aggregate Cap Calculation** – CMS will issue instructions to restart the Cap calculation process (which has been on hold) to MAC's by the end of August 2011. Guidance will incorporate provisions in the final rule. • **Voluntary Submission of QAPI Indicator in 2011** – CMS will post a quality submission user manual and helpline access information for providers sometime in November 2011. The user manual and helpline information will on the CMS website. • **Face to Face Encounter Clarification** – CMS reiterated that same physician is not required to complete the face to face encounter, certification and narrative statement. A physician may complete the face to face encounter only. Read NHPCO's analysis of the FY2012 Final Hospice Wage Index final rule (PDF). CMS stated that CR 7518 was issued on July 29, 2011 and provided the updated hospice payment rates for FY 2012. Access CR 7518 (PDF) and the NHPCO's Wage Index resources online.	August 18, 2011 *NewsBriefs*

Podcasts Available from Four Popular CMS ICD-10 National Provider Calls Limited on time? CMS has created podcasts from four popular National Provider Calls on ICD-10. These podcasts are perfect for use in the office, on the go in your car, or on your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs. ▪ "CMS ICD-10 Conversion Activities" ▪ "Preparing for ICD-10 Implementation in 2011" ▪ "Basic Introduction to ICD-10-CM" ▪ "ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks)" To access these podcasts, select the links above or visit the CMS Sponsored ICD-10 Teleconferences webpage at ICD-10 Teleconferences; select a call date from the list of previous National Provider Calls to access related presentation materials, audio recordings, and written transcripts.	**August Regulatory Round-Up EXTRA**
Provider Enrollment Revalidation… All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to submit their enrollment information so they can be revalidated under new risk screening criteria required by the *Affordable Care Act* (section 6401a). Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time. **Do NOT submit your revalidation until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2013.** This will allow MACs to process revalidations in a timely fashion and allow providers to take advantage of innovative technologies and streamlined enrollment processes now under development. Updates will be shared with the provider community as these efforts progress. For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, "Further Details on the Revalidation of Provider Enrollment Information" (PDF).	August 18, 2011 *NewsBriefs*
Recovery Audit Contractor Demand Letters… As of January 3, 2012, CMS is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to a provider, they will submit claim adjustments to the Medicare (claims processing) contractor. The Medicare contractor will then establish receivables and issue automated demand letters for any overpayment identified by the Recovery Auditor. The Medicare contractor will follow the same process as is used to recover any other overpayment from your hospice.	August 4, 2011 *NewsBriefs*
Survey Deficiency Tip Sheet and Audit Tool from NHPCO's Regulatory Team…The new *"CMS FY 2010 Top Ten Hospice Survey Deficiencies"* tip sheet and accompanying audit tool are now available. This compliance tip sheet: • Lists the survey deficiency by Medicare hospice Condition of Participation* and by Hospice Program Interpretive Guidance** L-Tag from federal Fiscal	August 18, 2011 *NewsBriefs*

Year 2010. • Provides an example of the deficiency based on actual CMS survey deficiency data. • Provides suggestions from a clinical, documentation, and administrative perspective for compliance. • Lists the standard and practice example from the NHPCO Standards of Practice for Hospice Programs (2010) related to the cited deficiency. Use the *"CMS FY 2010 Top Ten Hospice Survey Deficiencies"* audit tool to complete a self assessment and identify areas for performance improvement. The tip sheet and the audit tool are available from the Regulatory and Compliance Center of NHPCO's website.	

EDUCATION AND RESOURCES:

Medicare Learning Network
"The Medicare Overpayment Collection Process" Fact Sheet Revised
"The Medicare Overpayment Collection Process" fact sheet (PDF), which includes the definition of a physician or supplier overpayment and information about the overpayment collection process, has been revised and is now available.

Centers for Disease Control (CDC)
New Public Health Emergency Response Guide
The Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors is an all-hazards reference tool for health professionals who are responsible for initiating the public health response during the first 24 hours (i.e., the acute phase) of an emergency or disaster. It provides useful information on the activation and integration of a jurisdiction's public health system into the existing emergency response structure during the acute phase of an incident.

Palmetto GBA
Multiple resources
• J11 Part A Comprehensive Error Rate Testing (CERT) Webinar Handout
• Going Beyond Diagnosis: Preventing Payment Errors by Improving Provider-Payer Communication
• Clarification of the First Level Appeal Decision Letter

Education/Publications
NHIC, Inc:

- Upcoming education events
- Publications

NGS:

- Upcoming education events

CGS:

- Upcoming education events

Regulatory Alerts and Regulatory Round-Ups can be viewed in their entirety on the NHPCO Regulatory & Compliance website at nhpco.org/regulatory.

The past six months of *NewsBriefs* can be viewed on the *NewsBriefs* archive page, nhpco.org/newsbriefs.

Member inquiries about regulatory and compliance issues may be sent via email to regulatory@nhpco.org.

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CMS Hospice-Related Q&As – AUGUST 2011

I. QUESTIONS ABOUT CLAIMS AND DATA ON THE CLAIMS FORM

Question

Published 07/11/2008 01:04 PM | Updated 08/09/2011 01:16 PM | Answer ID 9353

Change Request (CR) #5567 provided instructions for the expanded claims data reporting requirements for Medicare hospice claims. As part of those instructions, in Section 30.3 "Data Required on Claim to FI" of Chapter 11 "Processing Hospice Claims" of the Medicare Claims Processing Manual CMS states that as part of the reporting of visit information on the hospice claim, hospices are required to report "charges" for the services described on each revenue code line. Can CMS provide further guidance as of how to report "charges" on the hospice claim?

CMS Answer

With regards to guidance to hospices on how to report charges on the hospice claim, we refer hospices to three areas of CMS's manuals.

1. At Pub 100-04, CMS's Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the Form CMS-1450 Data Set, we provide the following guidance/instructions:
   a. Under Section 75.5 – Form Locators 43-81, for "FL 47 – Total Charges", we say the following:
      i. "This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

2. Furthermore, in CMS's Provider Reimbursement Manual, Part 1, Chapter 22, "Determination of Costs of Services" , we say at:

   a. Section 2203, "Provider Charge Structure as Basis for Apportionment", that to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what

its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

b. Section 2204, "Medicare Charges", we further say that The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)

c. Section 2202, "Definitions", at 2202.4 "Charges", we say that charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (See §2206.l for information on accrual of charges and § 2204.l for hospital based physicians charges.)

Link to Q&A on CMS website.

Access the CMS Hospice Center's Q&A webpage

- *Questions and Answers: Hospice*

Search instructions: *Click on "advanced search" and enter search parameters at they appear in the screen shot below to access new and updated Q&As related to hospice.*