



**Home Health-POE Advisory Meeting
Meeting Minutes
Wednesday, February 17, 2010
10:00 a.m. ET**

Attendees: Elizabeth Chevreviski, Ann Mary Marsh, Maureen Hanlan, Brian Ellsworth, Marlene (Hallmark Health), Pat Kelleher, Tim Burgers, Peter Cobb, Susan Young, Juliette Chenian, Christa O'Neill, Emily Fox-Squairs, Sally Rosiello, Dave Garland, Mark White

Facilitator/Recorder: Juliette Chenian/Emily Fox-Squairs

Type (IS/IP/C)	Description	Responsible Person(s)
IS	Welcome: Meeting was called to order at 10:00 a.m. ET. Attendance was taken. All attendees were asked to introduce themselves to the group.	Juliette Chenian
IS/C	Review of Agenda: Juliette discussed some housekeeping items and then reviewed the agenda.	Juliette Chenian

Agenda Purpose: IS=Information Sharing IP=Information Processing C=Consensus Decision

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IS	<p>Audit and Reimbursement Reminder:</p> <p>Dave reminded providers that the Provider Statistical & Reimbursement (PS&R) reports for cost reporting periods ending on or after January 31, 2009 have been redesigned. The Medicare Administrative Contractors (MACs) will no longer issue PS&R summary reports for these cost reporting periods. Providers must register to gain access to the redesigned PS&R. Providers will request and receive their PS&R reports in the new CMS system. To begin the process to access the redesigned PS&R system, providers must register in IACS (Individuals Authorized Access to the CMS Computer Services). IACS is the CMS security system.</p> <p>Comment(s) from Members:</p> <p>A member asked how long the process takes and Dave advised the members that this process can be very lengthy. In this first year of IACS system, CMS did advise the contractors that if a provider is not registered in the IACS system, contractors will generate the PS&R report so that the cost report is completed by the regular due dates.</p> <p>A member stated that they have heard from agencies that when they go to sign up users, they are getting an error message that they cannot sign up users. Dave explained that the first step is to set up a Security Official (SO) that will be the gatekeeper for the organization. This SO will not have access to PS&R but will approve End Users for access to the new redesign. This process may take weeks as the SO will need to mail in supporting documentation to IACS to confirm the organization is an approved Medicare provider.</p> <p>Once the final approval is completed, the End User will be able to begin registration. Their</p>	Dave Garland
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	approval request will go to the SO and can be completed that day. It may also be beneficial to set up a back-up SO, which will also be approved by the SO.	
IS	<p>Claims Reminders/Updates:</p> <p>Mark advised the members that the Claims Department had an issue earlier this year with home health claims suspending for one of our reason codes in error. Originally, we had about 3,900 claims suspending across all contracts, but most have been manually worked and released for processing. The Claims Department is now down to about 200 claims that are being manually worked to release for processing.</p>	Mark White
IS	<p>Education:</p> <p>Christa reviewed the upcoming Home Health events for CY 2010. She advised the members that the Clinical Medical Review Findings-Therapy session listed in the material distributed to the members should not have been included as it does not relate to home health. Also, she explained that the schedule is tentative and is subject to change at any time. She reminded the members to go to the Educational Events Calendar on the NHIC, Corp. Web site at www.medicarenhic.com for current event information.</p> <p>Upcoming Home Health Events in 2010:</p> <ul style="list-style-type: none"> ▪ March 23, 2010-Home Health and Hospice Ask the Contractor Teleconference (ACT) ▪ April 14, 2010-Home Health Top RTPs/Rejects ▪ May 26, 2010-Home Health Billing 	Christa O’Neill

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	<ul style="list-style-type: none"> ▪ June 22, 2010-Home Health and Hospice ACT ▪ August 12, 2010-Home Health Basics/Eligibility ▪ September 13, 2010-Home Health Top RTPs/Rejects ▪ September 15, 2010-Home Health Billing ▪ October 13, 2010-Home Health and Hospice ACT ▪ November 17, 2010-Clinical Medical Review Findings – Home Health <p>Juliette also mentioned that we are planning to hold a face-to-face session in Maine. The date(s) for this session have not been determined yet, but we are looking to conduct the session in June. We plan on rotating our face-to-face sessions in different states so everyone has a chance to attend a face-to-face. However, all providers from any of our contract states are invited to attend any of our sessions regardless of the state that the session is held in.</p>	
IS/IP/C	<p>FY2010 Training Session Suggestions:</p> <p>Juliette asked members for suggestions on training that should be offered to the Home Health providers in FY2010. The members suggested training on the Home Health Advance Beneficiary Notice (HHABN). The members said that this is really important as it pertains to dually eligible beneficiaries. Also, the provider community is really confused on the rules and instructions surrounding the HHABN. Juliette explained that there is a draft HHABN PPT in development right now. Sally explained that we are waiting for CMS to finalize the revised HHABN before the presentation material can be finalized. Once the educational material is finalized, we will schedule the education for the HHABN. The members asked if the education would be conducted via teleconference or Webinar. Juliette explained that the education would</p>	Juliette Chenian

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	be done via teleconference. Sally advised the members to contact her if there are any specific issues that need to be addressed regarding the HHABN. The members said that they would let Sally know.	
IS/C	<p>Advisory Recommendations:</p> <p>Christa reviewed the advisory recommendations from the last meeting on October 27, 2009. She also advised the members to disregard the General Inpatient PPT recommendations as it pertains to the hospice.</p>	Christa O'Neill
IS/IP/C	<p>Credit Balance PowerPoint:</p> <p>Christa reviewed the Credit Balance PPT with the members.</p> <p>Comment(s) from Members:</p> <p>A member asked if Credit Balance submission was a new process. Or is it something that the home health community has not been doing in the past? Juliette explained that this is not a new process, but the contractor has found that some of the providers are not submitting their Credit Balance Reports timely, they are then put on 100 percent payment withhold, and then they call the contractor wondering why they were put on the withhold. Therefore, we are reviewing this PPT as we would like to conduct an education session on the Credit Balance Reporting process to avoid payment withholds in the future and help to clarify the process.</p> <p>A member asked if we would include this PPT in the education session that will be conducted in</p>	Christa O'Neill

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<p>March. Juliette explained that the Credit Balance Reporting Process will be its own education session and not included in the billing session in March.</p> <p>One of the members asked if the providers were notified when they were placed on 100 percent payment withhold for late credit balance submissions. The PowerPoint explains that a Suspension Warning letter is issued if we do not receive a credit balance report from a provider by 45 calendar days from end of each calendar year quarter. The letter states that the Medicare Administrative Contractor (MAC) will suspend all claim payments at 100 percent in 15 calendar days from the date of issuance of the letter and that the suspension will continue until we receive a credit balance report. Emily also advised the members that payment withhold amounts will be listed on the remittance advice summary page in the “Penalty” field.</p> <p>The members said that it would be very helpful to provide data that explains the percentage of providers that are not completing the Credit Balance reports timely. The members would like the data to be broken out by state. Juliette explained that she will look into this and find out if the data can be broken out. If it can, it will be provided to the members at the next meeting.</p> <p>A member requested that we not review the actual PPT and allow the members to read it themselves after the meeting and then disseminate the material to the provider community. Juliette explained that the intent of the POE Advisory Group is not to disseminate information, but to review the material during the meeting to provide feedback prior to any education being conducted to determine if it is a good educational program (is it easy to understand, does it</p>	
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	include all pertinent information, is there too much information, suggestions for improvement, etc.).	
IS/C	<p>Questions and Answers: Christa reviewed the pre-submitted questions document that was provided to the members prior to the meeting.</p> <p>Comment(s) from Members: The members said that, in regards to the TPL progress report, it would be interesting to know of the cases reviewed, what were the coverage decisions? Also, they are hearing from the providers that there are a lot of inconsistencies surrounding reviewer’s decisions based on errors with the HHABN.</p> <p>Juliette explained that in general, when she speaks with Medical Review regarding the coverage decisions, she is advised that about 97 percent of the time they agree with the provider’s determination of noncoverage. Juliette said that she will talk with the Medical Review Department and conduct some research regarding the reviewer decision inconsistencies surrounding the HHABN. Sally explained that some of the issues that she sees regarding errors with the HHABN include the use of abbreviations as well as the patient receiving services that are no longer Medicare-approved for an extended period of time (more than a year) and a new HHABN is not being issued every year. HHABNs are considered effective for no more than one year. So when an HHABN is given for services provided for more than one year, the HHABN will be found defective for the period of time exceeding one year. A new HHABN must be</p>	<p style="text-align: center;">Christa O’Neill/Sally Rosiello</p>

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	<p>issued every year.</p> <p>A member asked if Sally has seen any issues with the patient not checking any box in the Option Boxes section on the HHABN. Sally has seen this, and if there is not a box checked (and the HHA did not annotate its copy of the HHABN if the beneficiary refused to choose an option), the HHABN would be considered incomplete.</p> <p>A member asked for clarification on the use of abbreviations. The CMS Internet-only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 60.4 allows the use of abbreviations in the cost section but says they should be avoided elsewhere. However, if they are used, abbreviations would be part of what an HHA must cover verbally to assure that the beneficiary comprehends the HHABN. The manual suggests that, if used, abbreviations should be spelled out elsewhere in the HHABN. Without this clarification or some notation that the abbreviations were explained to the beneficiary and the beneficiary understands the abbreviations, how can we confirm that the notice is clear?</p> <p>Juliette explained that another questions was raised a few days ago that a member heard from some of their providers are in a Medicare Probe audit for claims that have four or less visits (Low Utilization Payment Adjustments (LUPA)). Sally explained that Medical Review did start a widespread review of LUPA claims. This probe is service specific, not provider specific. However, there was an error in the edit that suspends these claims (it was selecting too many claims). The edit has been corrected. If anyone believes that too many claims were selected for the probe review, they can contact Carol Humphrey at (207) 253-3603. They need to provide her with their OSCAR number, provider name, the MPP edit number and a phone number where</p>	
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	they can be reached.	
IS	<p>Change Request 6757:</p> <p>Christa advised the members that CMS recently published CR 5767 “Coding Patient Transfers under the Home Health Prospective Payment System (HH PPS)” to their Web site.</p>	Christa O’Neill
IS	<p>Education Session Counts:</p> <p>A member asked for attendance counts for our educational sessions. Juliette explained that for the last face-to-face, only about 20 home health providers attended. Also, the registration is always a lot higher than the actual attendance. Juliette explained that if providers are not registered for the Listservs, they are not receiving all of our reminders for the upcoming educations. One of the members suggested that we send the members an article regarding the listserv sign-up process and registration steps and they would in turn forward it to their providers and put the article in their newsletters. We will send the article via email to our POE Advisory Group members for distribution.</p>	Juliette Chenian
IS	<p>Clinical Education:</p> <p>Sally explained that she does teleconferences via invite-only regarding medical review. So if any providers would like specific clinical education, they can submit their request via the clinical email box (clinical.education@wellpoint.com) or by calling the clinical education line (1-800-338-6101) and leaving a message.</p> <p><i>Comment(s) from Members:</i></p>	Sally Rosiello

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	<p>A member asked if Sally could provide any information on what exactly gets a provider put on focused medical review. Sally explained that the PCA process is based on analysis of claims data. Statisticians look at all of the claims data for all the providers and compare them to each other. Sometimes things may jump out as being different or unusual. This data can change all the time. So there is not one thing that puts a provider on Focused Medical Review.</p>	
IS	<p>Clinical Data Review:</p> <p>Juliette reviewed the Home Health data for claims paid between July 2009 through December 2009 PowerPoint. She went over the top four diagnosis codes on paid claims by state and the Home Health Claims Statistics (number of beneficiary, visits per episode, episodes per beneficiary, and the percent of LUPAs).</p> <p>Comment(s) from Members:</p> <p>The members asked for clarification on diagnosis code V58. Sally explained that diagnosis code V58 is for Encounter for other and unspecified procedures and aftercare.</p> <p>The members asked if we could provide the top reasons for denials and the percentages surrounding the denials. Juliette explained that we would work on that data for our next meeting.</p> <p>The member said that the home health claims statistics data was extremely helpful.</p> <p>A member asked if would be possible to get the average case mix weights of the claims by state. Juliette said that she would look into this. This information is put together by our Data Unit.</p>	Juliette Chenian

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	<p>Juliette will submit the request and see if they can provide this type of data.</p> <p>A member suggested that the group go back to their providers to determine what data is the most useful to the members and then provide that data only at each of our POE Advisory meetings. Juliette said that it depends on the work involved in collecting the requested data. Juliette suggested that the member send her request and in turn we can then look to see how much is involved with the data collection and go from there.</p> <p>A member asked if the “visits per episode” included the LUPAs and the outliers. Juliette explained that the LUPAs and Outliers are broken out.</p>	
IS	<p>Association Meetings:</p> <p>The members asked if we could send our staff to their association meetings. Juliette said that she would like the requests for participation to be sent to her in writing with the date of the session and exactly what they would like us to do (man a booth, present, etc.).</p>	Juliette Chenian
IS	<p>POE Advisory Members:</p> <p>The members asked if we were open to add new members to this group. Juliette said that she would accept new members. She emphasized that the meetings are not an avenue to talk about claims issues, unresolved cases, etc. Members will provide advice, feedback and recommendations to the RHHI J14 MAC in relation to Provider Outreach and Education matters (this includes training material, training subjects, dates and locations of provider education workshops and events, information on the website, CBT, etc.).</p>	Juliette Chenian

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	The primary function of the Advisory group is to assist the contractor in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group shall be used as a provider education consultant resource, and not as an approval or sanctioning authority.	
IS/C	Meeting Closure: Meeting Adjourned at 11:35 a.m. ET. The next Advisory meeting will be on May 5, 2010 via Teleconference.	Juliette Chenian

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