January 30, 2019 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

Summary of the January 23, 2019 IDPH LTC Provider Association Meeting

On Wednesday January 23, 2019, the Illinois Department of Public Health (IDPH) Bureau of Long-Term Care held their Quarterly LTC Provider Association Meeting. A summary of the issues presented and discussed is below:

1) A major discussion item at this meeting was the new EPOC system that IDPH will implement on March 4, 2019. Please click here to see the summary of the EPOC implementation guidance.

2) Updated status of IDPH required rulemakings:
   - Subpart S Rulemaking – IDPH is still working on this Section. Hopefully with the new Governor’s Office, this issue will get resolved and move forward.
   - Distressed Facility Rulemaking and Legislation – IHCA will again introduce legislation to make this process workable.
   - Informed Consent Rulemaking – This is being worked on by the LTC Advisory Board and there should be agreed upon language in the near future to begin the rulemaking process.
   - Behavioral Health Unit Rulemaking – IDPH stated that they will contact the Department of Human Services and begin working on this requirement. Again, hopefully the new Governor’s Office will push this issue forward.
   - PA 100-0217 – Nurse Staffing Waivers – IDPH has drafted language and it is in IDPH Legal review.

3) IDPH had no new information/guidance on either medical marijuana or electronic monitoring devices. IHCA did raise the concern about privacy issues related to smart speaker devices like Amazon Echo and Google Home that residents want to use in their rooms within an LTC facility or an Assisted Living facility. IDPH stated that they would take this issue to their Legal unit and see what if any guidance/direction they could provide. The only statement IDPH made was that facilities should have this addressed in their policies and procedures and there is some related guidance in the electronic monitoring device legislation with regard to a resident’s right to privacy.

4) IDPH noted that two issues related to medications will be discussed at the next LTC Advisory Board Meeting (2-21-19). There will be discussion related to emergency/convenience boxes (expanding the number of medications) and changing the state language with regard to on-site Drug Regimen Review to coincide with the federal language deleting the requirement of this review always being on-site.
5) IHCA has asked several times for the ALJ Supervisor to attend these meetings to discuss several issues regarding the Involuntary Discharge hearing process. IDPH stated that the current ALJ supervisory position is vacant. As soon as it is filled, IDPH stated they would invite the lead ALJ to attend this meeting and have a full discussion of the issues.

6) IDPH stated that IDPH Legal will not respond to our request for guidance on the use of paid caregivers in LTC facilities. This will have to be addressed by facility policies and procedures as determined by the facility’s Governing Body.

7) IDPH Legal is reviewing our inquiry with regard to IDPH fine reductions. IDPH has taken the position that any state fines can’t be reduced to 25 percent until the federal fine has been paid. They rely on the word “paid” in the statute. This to the LTC Industry is another example of IDPH taking an unreasonable position. The timing of a provider paying the federal fine shouldn’t dictate whether we are entitled to the up to 75 percent reduction. What if we waive the state fine and pay 65 percent? Is there a mechanism to get back the money from IDPH once we’ve paid the corresponding federal fine? To us, IDPH should just accept that the federal fine is going get paid at some point and just let us pay the 25 percent. Hopefully, IDPH Legal will respond to this at the next Quarterly Meeting.

8) With regard to the new survey process:
   - IDPH and CMS continue to make updates and changes to the survey process as issues arise.
   - Connie Jensen will provide the most recent Top Ten Health and LSC Deficiencies and we will then make available to our members.
   - IDPH has made some changes to the entrance communication form, is revising the daily status process and is working on better guidance to surveyors on the exit process.
   - No information has been provided by CMS on the upcoming Phase 3 requirements effective in November of 2019. As soon as information is available, they stated they would share with providers.
   - CMS holds a state meeting for health care survey agencies every year. The meeting for this year is in May. IDPH is hopeful that this meeting will provide a lot of updates that they can then share with us.
   - IDPH is still in the process of developing a FAQ for the new survey process to help providers with guidance.
   - IDPH stated that federal CMS has informed them that they need to focus on staffing issues as noted in the PBJ information. 50 percent of the required 10 percent off-hour surveys (weekends and nights) will be focused on facilities with low staffing as reported by PBJ data. Also, any facility that has below minimum RN staffing (per PBJ data) will be tagged and that issue will be reviewed during any type of survey at that facility.

9) IHCA asked about PA 100-0754 (DSP Credentialing Pilot Program) – Does this mean that a CNA, who is also a DSP, can use their active role/duties as a DSP, to show they are actively “performing nursing or nursing-related services,” to prevent losing their CNA Certification? Does this allow CNAs to work in ICFDD/IDs without becoming DSPs? IDPH stated that they are discussing this internally and will respond soon.

10) IDPH will soon announce their 2019 Town Hall Meeting Schedule. These meetings are very informative and we applaud IDPH for continuing these meetings into 2019.

11) IDPH stated that facilities need to notify IDPH of any serious incidents per required time frames. If on weekends or after hours, the IDPH Hotline will accept such calls. Also, IDPH wants to be alerted to any possible union issues that could possibly result in a strike or other staffing problems.

The next IDPH LTC Provider Association Meeting is scheduled for April 24, 2019. If you have any concerns/issues you would like raised, please contact me.
**CMS Details 6 Steps to Reduce Harm in Nursing Homes**

A new federal report delves into the first steps nursing home leaders can take to avoid preventable harm to their residents.

The National Nursing Home Quality Improvement Campaign hosted a webinar with experts on January 24, 2019 to explore some of those strategies in this “change package” of recommendations. The 60-page resource from the Centers for Medicare & Medicaid Services was released late last year and created with the Quality Innovation Network National Coordinating Center.

One-third of Medicare beneficiaries experienced temporary harm or adverse events during a SNF stay, and about 60% of those instances were preventable, according to previous reports from the HHS Office of the Inspector General.

“There is no single, magic bullet to prevent all causes of harm to residents, and therefore, the change package covers a wide range of strategies and actions to promote resident safety,” report authors stated.

The report includes a two-page appendix with six strategies SNFs can pursue to get started, including shoring up staffing, identifying gaps in care, and promoting multidisciplinary team work.

**Focus F-Tag – F947 Required In-Service Training for Nurse Aides**

This Regulatory Beat’s Focus F-Tag is **F947 Required In-Service Training for Nurse Aides**, which is part of the Training Requirements regulatory group. The federal regulation requires that nurse aides receive at least 12 hours of in-service training annually, but states have varying requirements for education that exceed this minimum requirement, believing more hours may be needed based on a number of areas such as a changing resident population that requires specialized education. Additionally, the Interpretive Guidance (IG) clearly states that 12 hours is the minimum number of training hours, but training must be sufficient to ensure the continuing competence of nurse aides, which may require more than 12 hours a year.

The requirement under F947 states that training must include dementia management and resident abuse prevention training. For staff that will be working with cognitively impaired individuals, care for these individuals must be specifically provided as well. Additionally, in Phase 1, in-service training for nurse aides was required to address individual areas of weakness that are determined by nurse aides’ performance reviews. Surveyors are guided to identify how in-service education has addressed identified areas of weakness on performance reviews and how the facility evaluates nurse aides’ performance to determine where additional education and training is needed. Effective in Phase 2, the in-service training also needed to address the unique needs of a facility’s resident population based on the Facility Assessment and as determined by facility staff.

During survey, surveyors do not need to find a negative outcome to cite the facility under F947. The surveyors will be reviewing the adequacy of the in-service program not just by looking at hours of completed education, but also by observing nurse aides. These observations may indicate that there are skill deficiencies that could be a result of an inadequate training program or that the nurse aides’ performance reviews are inadequate—for example, observing staff working with residents in a way that indicates a training need. During resident, representative and staff interviews, surveyors may identify areas where training may be needed, including when a surveyor has identified a concern and asks a nurse aide about the relevant education and skills competencies he/she has received. This is the time to take a hard look at your In-service Education Program for your nurse aides and address any areas of weakness that are identified in providing necessary education and doing follow-up quizzes or discussion to assess staff understanding of the education provided. While you are taking a look at the associated systems, take a look at the last time each nurse aide had a performance evaluation (hopefully it is not from 2016 or earlier) that was accurately completed. What do we mean by this? No nurse aide, nor any of us, is so “perfect” an employee that only time and attendance need improvement. Educate staff who are responsible for completing the performance evaluations on the need to be honest in their annual review of each nurse aide. For example, if a nurse aide’s manner is rushed and upsets the cognitively impaired residents she is responsible for, develop a performance improvement plan for this area – especially if the aide is too frequently reporting a bruise after providing care.
Antipsychotic Drug Use in Nursing Homes: Trend Update

CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent of residents received an antipsychotic medication; since then there has been a decrease of 38.9 percent to a national prevalence of 14.6 percent in the second quarter of 2018. Success varies by state and CMS region; some states and regions have a reduction greater than 40 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website.

Illinois is ranked 48th in the U.S. with a rate of 18.5 percent, which is an improvement, but we still have a lot of work to do to meet the 15 percent goal.

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Important Regulations, Notices & News Items of Interest

1) The following Federal CMS Quality, Safety and Oversight Letter (formerly known as Survey and Certification (S&C) Letters) was released since the last issue of Regulatory Beat:

- **QSO 19–04 – NH/HHA/CLIA** – Notice of Final Rule Adjusting Civil Monetary Penalties (CMPs) for Inflation. The Department of Health and Human Services (HHS) has published in the Federal Register on October 11, 2018, a final rule that adjusts for inflation CMP amounts authorized under the Social Security Act (See Adjustment of Civil Monetary Penalties for Inflation). **New CMP Amounts:** The final rule lists the new CMP amounts and ranges and is effective as of October 11, 2018. **Selected Providers Highlighted:** The CMPs under the authority of HHS affects multiple areas, but we are highlighting only on those CMPs assessed for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs), SNFs/NFs, Home Health Agencies (HHAs) and Clinical laboratories effective October 11, 2018.

2) Federal HHS/CMS released the following notices/announcements:

- **New Medicare Card: Web Updates.** New Medicare cards are mailed; visit the New Medicare Cards website for the latest updates. Get answers to your questions and find out what you need to do before the transition period ends this year:
  - Provider and Office Manager webpage
  - Getting Medicare Beneficiary Identifiers (MBIs) webpage
  - Using MBIs webpage

- **CDC Opioids Training Modules.** Help stop the growing number of drug overdose deaths in the United States. Take the final three modules in a training series from the Centers for Disease Control and Prevention (CDC): Applying CDC’s Guideline for Prescribing Opioids. Each module includes clinical scenarios, knowledge feedback prompts, and a resource library to help enhance learning:
  - Opioid Use and Pregnancy
  - Motivational Interviewing
  - Fostering Collaborative Patient-Provider Relationships in Pain Management and Opioid Prescribing
View additional modules on the Interactive Training Series webpage. The modules offer free continuing education.

- **Open Payments Data Update.** On January 18, CMS updated the Open Payments dataset to reflect changes to the data that took place since the last publication in June 2018. Use the Open Payments Search Tool to view the data. The refreshed dataset includes:
  - Record updates: Changes to non-disputed records made on or before November 15
  - Disputed records: Updated information for dispute resolutions completed on or before December 31
  - Record deletions: Removed records deleted before December 31

The Search Tool is updated with the following features:
  - Query builder: Conduct payment searches not tied to an entity. The results organize payments by program year with the option to download the results for additional analysis.
  - Entity profile updates: Payment types are converted to tabs to make this data easier to access and navigate. The summary table is consolidated with the top summary section and accessible by a “table” toggle button. The Nature of Payment chart includes a “company filter.”

For More Information:
  - Open Payments website
  - Resources webpage
  - Submit questions to the Help Desk at openpayments@cms.hhs.gov or 855-326-8366 (TTY: 844-649-2766)

- **Continue Seasonal Influenza Vaccination through January and Beyond.** Vaccinate as long as influenza activity continues, even in January or later. People 65 years and older are at greater risk of serious complications from seasonal influenza. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older – to help protect your patients, your staff and yourself. Medicare Part B covers the influenza virus vaccine once per influenza season. Medicare covers additional influenza vaccines if medically necessary. You may also want to recommend the pneumococcal vaccine during the same visit. Medicare covers:
  - An initial pneumococcal vaccine for Medicare beneficiaries who never received the vaccine under Medicare Part B
  - A different, second pneumococcal vaccine 1 year after the first vaccine was administered

For More Information:
  - Preventive Services Educational Tool
  - Influenza Resources for Health Care Professionals MLN Matters® Article
  - Influenza Vaccine Payment Allowances MLN Matters Article
  - CDC Influenza website
  - CDC Information for Health Professionals webpage
  - CDC Tools to Prepare Your Practice for Flu Season webpage
  - CDC Make a Strong Flu Vaccine Recommendation webpage

- **Reporting Changes in Ownership — Reminder.** An Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. You must update your enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges.

Resources:
  - Timely Reporting of Provider Enrollment Information Changes MLN Matters Article
  - Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article
  - Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure OIG Report, May 2016
• **Hospice Quality Reporting Program: Quality Measure User’s Manual.** Version 3.00 of the Hospice Quality Reporting Program Quality Measure User’s Manual is available. The measure specifications for Hospice Visits when Death is Imminent Measure 1 and Measure 2 are included in this new version. Visit the Current Measures webpage for more information.

• **Qualified Medicare Beneficiary Billing Requirements.** Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:
  - Use Medicare 270/271 HIPAA Eligibility Transaction System (HETS) data; see MLN Matters® Article SE1128
  - Check your Medicare Remittance Advices (RAs); see MLN Matters Article MM10433
  - Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing and issuance of Medicaid RAs for payment of Medicare cost-sharing. Check with the states where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

For More Information:
  - QMB Program webpage
  - Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
  - QMB Program Billing Requirements FAQs
  - Materials from 2018 Medicare Learning Network call
  - Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Booklet

• **Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder.** After a stratified random sample review of hospice election statements and certifications of terminal illness, the Office of the Inspector General (OIG) reports that more than one-third of hospice General Inpatient (GIP) stays lack required information or had other vulnerabilities.
  - Hospice election statements did not always mention – as required – that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative
  - In 14 percent of GIP stays, the physician did not meet requirements when certifying that the beneficiary was terminally ill and appeared to have limited involvement in determining that the beneficiary’s condition was appropriate for hospice care

Hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. Resources:
  - Hospices Should Improve Their Election Statements and Certifications of Illness OIG Report, September 2016.
  - Hospice Payment System Booklet: Includes a section on the hospice election statement
  - Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters Article
  - Sample Hospice Election Statement MLN Matters Special Edition Article
• **Home Health Patient-Driven Groupings Model Call — Tuesday, February 12 from 12:30 to 2 pm CST.** [Register](#) for Medicare Learning Network events. During this call, learn about the Patient-Driven Groupings Model (PDGM) that will be implemented on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:
  - Overview of PDGM model
  - Walkthrough of payment adjustments, including low utilization payment adjustments, partial payment adjustments, and outliers payments

A question and answer session follows the presentation. For more information, visit the [Home Health Prospective Payment System](#) webpage; review the CY 2019 [final rule](#) and [Overview of the PDGM](#).

• **New Part D Opioid Overutilization Policies Call — Thursday, February 14 from 12:30 to 2 pm CST.** [Register](#) for Medicare Learning Network events. CMS implemented new [opioid policies](#) for Medicare drug plans effective January 1. The new policies include:
  - Improved safety alerts when patients fill opioid prescriptions at the pharmacy
  - Drug management programs for patients at-risk for misuse or abuse of opioids or other drugs

During this call, CMS experts discuss the new policies and answer questions. Prior to the call, participants should review the following materials:
  - Training materials, including slide decks and tip sheets for prescribers, pharmacists and patients
  - [A Prescriber’s Guide to the New Medicare Part D Opioid Overutilization Policies for 2019](#) MLN Matters Article
  - [Reducing Opioid Misuse](#) webpage for more information on the CMS strategy

• **New Medicare Card Mailing Complete, 58 Percent of Claims Submitted with MBI.** CMS finished mailing new Medicare cards to people with Medicare across all [mailing waves](#), including Wave 7 states and territories and also to people with Medicare Parts A&B who live in Canada and Mexico. Medicare patients are using their new cards in doctor’s offices and other health care facilities. For the week ending January 11, 2019, fee-for-service health care providers submitted 58 percent of claims with new Medicare Beneficiary Identifiers (MBIs), showing that many of you are already successfully submitting claims with MBIs. While you can continue using the former Social Security Number-based Health Insurance Claim Numbers during the transition period, we encourage you to use the new MBIs for all Medicare transactions. To ensure that you have access to your patients’ new numbers, you can individually look up MBIs if you have access to your Medicare Administrative Contractor’s secure [provider portal](#). Likewise, your patients can access their new Medicare numbers or print official cards within their secure [MyMedicare.gov](#) accounts. If your Medicare patients say they did not get a card, instruct them to:
  - Look for unopened mail. We mailed new Medicare cards in a plain white envelope from the Department of Health and Human Services.
  - Sign into [MyMedicare.gov](#) to get their new numbers or print official cards. They need to create an account if they do not already have one.
  - Call 1-800-MEDICARE (1-800-633-4227), so we can help them get their new cards.
  - Continue to use their current cards to get health care services. They can use their old cards until December 31, 2019.

• **Hospice Quality Reporting Program (HQRP) Data Collection for the Fiscal Year (FY) 2021 – Reporting Year Began January 1, 2019.** This is the first quarter for data collection for the FY2021 reporting year (data collection period 1/1/19 – 12/31/19). For Hospice Item Set (HIS) data, remember that the timeliness threshold requirement for the FY2021 reporting year and beyond is 90 percent. This means that to be determined compliant with HIS requirements, hospices must submit at least 90 percent of their HIS records on time (within 30 days of the patient’s admission or discharge date). There are no size or newness exemptions for HIS reporting. For more information on the Timeliness Compliance Threshold, please refer to the Timeliness Compliance Threshold Fact Sheet in the Downloads section of [Hospice Item Set (HIS)](#) webpage.
Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data collection period for the FY2021 reporting year began on January 1, 2019, and will continue through December 31, 2019. This data collection period impacts hospice payments for FY2021. Providers who have not been participating in CAHPS® and do not qualify for an exemption should begin immediate preparations to participate in the survey. For assistance, please email or call the CAHPS® survey technical assistance team at hospicecahpssurvey@HCQIS.org or 1-844-472-4621.

For additional tips on ensuring compliance for the HQRP overall, please refer to the HQRP Requirements and Best Practices webpage.

- “Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines” Training Materials and Audio Recording Now Available. On December 13, 2018, 1-2:30 PM Eastern Time, CMS hosted a two-part webinar entitled, “Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines.”

  The first part of this training focuses on the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #3235), also known as “the Hospice Comprehensive Assessment Measure,” including measure background, how this measure is calculated and how providers can use their Certification And Survey Provider Enhanced Reporting Quality Measure Reports (CASPER QM Reports) to understand their hospice’s performance on this measure.

  The second part of this training focuses on the 4.5 Month Data Correction Deadline for the Public Reporting policy update that was finalized in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (83 FR 38622, see pages 38638-38640). Under this new policy, beginning January 1, 2019, providers will have approximately 4.5 months following the end of each calendar year (CY) quarter to review and correct their HIS records with target dates in that quarter for public reporting. After this 4.5 month data correction deadline has passed, HIS data from that CY quarter will be permanently frozen for the purposes of public reporting. Part two of the training explains how this new policy change will be implemented and the implications of this new policy.

  To download the Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines training materials, please refer to the Downloads section of the Hospice Quality Reporting Training – Training and Education Library webpage. An audio recording of the webinar is also available.


• **New Waived Tests MLN Matters Article — New.** A new MLN Matters Article MM11080 on [New Waived Tests](#) is available. Learn about claims submission updates.

• **ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised.** A revised MLN Matters Article MM11005 on [International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)](#) is available. Learn about coding changes.

• **Skilled Nursing Facility ABN MLN Matters Article — Revised.** A revised MLN Matters Article MM10567 on [Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)](#) is available. Learn about the revised CMS-10055 form.

• **Medicare Preventive Services Educational Tool — Revised.** A revised [Medicare Preventive Services](#) Educational Tool is available. Learn about:
  - HCPCS/CPT and ICD-10 Codes
  - Who is covered
  - Frequency
  - What the beneficiary pays

• **Remittance Advice: An Overview Booklet — Revised.** A revised [Remittance Advice: An Overview](#) Booklet is available. Learn about:
  - Which types are available
  - What information is included
  - How to view

• **Proof of Delivery Documentation Requirements MLN Matters Article — New.** A new MLN Matters Article SE19003 on [Proof of Delivery Documentation Requirements](#) is available. Learn about updates to support compliance for payment purposes.

• **Canes and Crutches: Provider Compliance Tips Fact Sheet — New.** A new [Provider Compliance Tips for Canes and Crutches](#) Fact Sheet is available. Learn about:
  - Reasonable and necessary requirements
  - Documentation requirements
  - How to prevent claim denials

• **Tracheostomy Supplies: Provider Compliance Tips Fact Sheet — New.** A new [Provider Compliance Tips for Tracheostomy Supplies](#) Fact Sheet is available. Learn about:
  - Coverage criteria
  - How to prevent denials
  - Refill requirements

• **Ventilators: Provider Compliance Tips Fact Sheet — New.** A new [Provider Compliance Tips for Ventilators](#) Fact Sheet is available. Learn about:
  - Coverage criteria
  - Required documentation
  - Common reasons for claim denials
  - How to prevent denials

• **Commodes, Bed Pans, and Urinals: Provider Compliance Tips Fact Sheet — New.** A new [Provider Compliance Tips for Commodes, Bed Pans, and Urinals](#) Fact Sheet is available. Learn about:
  - Conditions of coverage
  - Reasons for claim denials
  - Requirements for payment
• **DMEPOS Update MLN Matters Article — Revised.** A revised MLN Matters Article MM10838 on *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update* is available. Learn about updating the ViPS Medicare System to process claims for beneficiaries who reside in a previous Competitive Bidding Area.

• **ESRD PPS: Payment for Dialysis Furnished for AKI: CY 2019 MLN Matters Article — Revised.** A revised MLN Matters Article MM11021 on *Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019* is available. Learn about rate updates, payment updates and changes to Chapter 11, Section 60 of the Medicare Benefit Policy Manual.

• **Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — Revised.** A revised MLN Matters Article MM10871 on *Quarterly Influenza Virus Vaccine Code Update - January 2019* is available. Learn about new influenza virus vaccine code 90689.

• **Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised.** A revised MLN Matters Article MM10824 on *Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement* is available. Learn about the new Care Management Home Visits Benefit Enhancement for program year four.

• **ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool — Reminder.** The *ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets* Educational Tool is available. Learn about:
  - Code set definitions
  - Payment information

3) The federal Centers for Disease Control and Prevention (CDC) provides updates on the 2018-2019 Flu Season:

• **Weekly U.S. Influenza Surveillance Report**

4) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of *Regulatory Beat*:

• HFS posted a new provider notice regarding *Revised Orthodontia Scoring Tool*. You may view the new notice [here](#).

• HFS posted an updated *Practitioner Fee Schedule* effective 01/10/19. You may view the updated schedule [here](#).

• HFS posted a new provider notice regarding *Handbook for Providers of School Based/Linked Health Centers Services Reissue*. You may view the new notice [here](#).

• HFS posted an updated *Preferred Drug List for Illinois Medicaid*, effective January 1, 2019. You may view the updated list [here](#).

5) The Illinois Department of Public Health reports:

• The *2019 Town Hall Meeting Schedule* is being prepared and will be out shortly.

• With the implementation of the new *ePOC process*, IDPH will be sending out Frequently Asked Questions and Answers regarding ePOC. Click [here](#) to view all the questions that IDPH has received to this point and their answers.
6) The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) report on:

- **The 2019 AHCA/NCAL National Quality Award Application Deadline is TOMORROW, January 31.** Don't miss out on the opportunity to be recognized for your commitment to quality care with this national honor. The deadline to apply is quickly approaching on January 31, 2019 at 8 p.m. EST! Log on to the Quality Award portal to submit today. For more information on the Quality Award Program, visit [www.ahcancal.org/qualityaward](http://www.ahcancal.org/qualityaward) or email our staff at qualityaward@ahca.org.

- The **AHCA/NCAL Emergency Preparedness Committee** provided the following resources:
  - Geriatric Triage Cards for Triage Training and Exercise
  - Active Shooter Training in a LTC Facility

- **CMS Inflation Adjustments.** Last week CMS published a [memo](http://www.ahcancal.org/qualityaward) summarizing the inflation adjustments to the CMP amounts that may be imposed for noncompliance by nursing centers. The new CMP amounts and ranges can be found in the Appendix of the memo. The adjusted amounts apply to CMPs assessed on or after October 11, 2018, which is when the [rule](http://www.ahcancal.org/qualityaward) was published that finalized the adjustments. The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 required CMS to make annual inflation adjustments to the CMP amounts. For 2018, CMPs have been increased by a multiplier of 1.02041. The [CMP Analytic Tool](http://www.ahcancal.org/qualityaward) instructions and calculations will be updated to reflect these changes. The final rule only affects authorized CMP amounts and not other provisions in the CMP Tool, such as the factors for assessing CMPs.

7) **Telligen** reports on:

- **Telligen Update**

8) **Today's Geriatric Medicine** reports on **Memory Loss and Medication.** Recent studies have found that some anticholinergic drugs boost the risk of dementia. On the good side, awareness can make such drug use a modifiable risk and possibly help reduce the incidence of dementia.

9) **McKnight's** reports that **NCAL Says It’s Pleased With EPA’s Decision on Hazardous Waste Pharmaceutical Rule.** *McKnight’s Senior Living* recently reported, "Assisted living communities can breathe a sigh of relief now that Environmental Protection Agency Acting Administrator Andrew Wheeler has signed the agency’s final rule regarding the disposal of hazardous waste pharmaceuticals." The article mentions that the nation’s largest senior living association, Argentum, "had submitted comments" on the previously proposed rule "in December 2015 individually and as part of a separate letter that included several organizations, among them the American Health Care Association / National Center for Assisted Living (NCAL) and LeadingAge." The article says, "Argentum, NCAL and LeadingAge representatives said they were pleased that the federal agency listened to their concerns." Additionally, an NCAL spokeswoman said, "NCAL is pleased to see our comments with other key stakeholders were acknowledged and accepted by the EPA in regard to excluding assisted living communities from this rule. It only makes sense given that assisted living is regulated by the states, and residents are often the ones in charge of their medications. We support the agency’s recommendation that communities develop voluntary pharmaceutical collection programs as a best practice."

10) The **Newark (NJ) Star-Ledger** reports that **Pioneering Care Management Program May Help Patients With Alzheimer’s Disease Regain Lost Skills.** The *Newark (NJ) Star-Ledger* reported, researchers found that "a pioneering care management program" can help "patients in the advanced stages of Alzheimer’s regain lost skills and begin to function again at a far higher level than was previously thought possible." The *Star-Ledger* notes that "the Zachary and Elizabeth M. Fisher Alzheimer Disease Education and Resources Program at NYU Langone" developed the program, which "does not halt the progression of Alzheimer’s," but "research has shown that Alzheimer’s patients who go through this specialized care management can perform daily tasks at a level far higher than those who don’t, delaying some of the disease’s more damaging effects and easing the burden on both them and their families."

11) **Provider Magazine** reports on **IRS Rule Limits Scope of Which Providers Quality for 20 Percent Tax Rate Deduction.** *Provider Magazine* recently reported that long term and post-acute care (LT/PAC) advocates are concerned SNFs will not
be able to "qualify for a 20 percent tax reduction that was part of the 2017 federal tax cut package after a recent IRS rule offered details for implementing the deduction." The American Health Care Association/National Center for Assisted Living had led an initiative to "make all SNFs and assisted living providers eligible for the cuts, but the IRS did not agree." The piece mentioned that the AHCA "said it would continue to work for a fix to the IRS interpretation of the qualifications of all SNFs and assisted living communities for the tax deduction."

12) **Skilled Nursing News** reports:

- **Providers Should Emphasize ICD-10 Coding Under PDPM.** *Skilled Nursing News* reports that under the Patient-Driven Payment Model (PDPM), "ICD-10 codes will form the basis of reimbursements, making it crucial for SNFs to have accurate coding," according to experts. It appears the majority of providers "have noticed; in Skilled Nursing News’ 2019 reader survey, 63% of more than 400 respondents said that PDPM would result in a greater emphasis on coding for their organization." While "ICD-10 procedure and diagnosis codes number in the tens of thousands, making them a daunting training task," SNFs "may not have to do as much training as they might think." According to Mike Cheek, Senior Vice President of Reimbursement Policy at the AHCA, providers need to train their billing teams "on what they need to know" and not the full scope of the details. The piece adds that the AHCA has developed "ICD-10 diagnosis code training for its members" as a resource providers can utilize.

- **PDPM Exposes SNFs, Rehab Providers to Litigation Risk Over Therapy Hours.** *Skilled Nursing News* reports that because the Patient-Driven Payment Model (PDPM) "shifts incentives away from the volume of therapy hours, providers could find themselves accused of not providing enough rehabilitation time for residents," exposing them to legal pushback. While CMS "explicitly pointed to fraud reduction as a key selling point" of PDPM, Timothy Ford, partner at the firm Einhorn Harris, said, "Diligent plaintiffs’ attorneys will try to use any reduction in the number of hours of therapy as evidence of neglect and malpractice."

13) **Interesting Fact:** IS A CUP OF COFFEE OR A SIP OF BRANDY A GOOD WAY TO WARM UP? Nope. Caffeine and alcohol actually speed up heat loss. Instead, drink warm water. Even better, provide a warm, sweet, nonalcoholic, non-caffeinated beverage to help warm the body.

*If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*

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