March 22, 2016 Edition

Feature Focus

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

New HFS Requirement for Providers to Submit Monthly Billing for Reimbursement Purposes

The Illinois Department of Healthcare and Family Services (HFS) issued a Provider Notice on 3-14-16 (click here) that will require Long Term Care Facilities (LTC) and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ID/DD) to submit monthly billings for reimbursement purposes. This new process is required by P.A. 98-0104 and P.A. 98-0963. HFS will be implementing this process, following national billing standards, for LTC and ID/DD facilities beginning July 1, 2016. This billing process will follow the UB04 and 8371 Implementation guidelines. Providers or their billing agents will be required to electronically submit monthly claims for dates of service beginning July 1, 2016, using the Health Insurance Portability and Accountability Act (HIPAA)–compliant 8371 Institutional Health Care Claim. The monthly claim will be submitted via an X12 file transfer or direct data entry following the UB-04 format. Paper claims will not be accepted beginning July 1, 2016. Providers will be able to submit claims for consideration through the HFS Internet Electronic Claim (IEC) system, which is accessible through the Medical Electronic Data Interchange (MEDI). HFS currently supports HIPAA version 005010XX223A2 for 8371 claims in X12 format.

The billing system currently in place for providers to access and process claims will not change until the new billing process is fully implemented. Claims for dates of service prior to July 1, 2016 will continue to meet all requirements of timely submittal through MEDI or EDI vendor.

The requirement for providers to submit monthly billings for reimbursement purposes does not impact the reimbursement rates paid to providers. Providers will continue to be reimbursed in accordance with their Medicaid approved reimbursement methodology.

HFS will provide more detailed billing instructions, a list of acceptable codes and information on training sessions.

The Illinois Health Care Association (IHCA), The Center and several other organizations submitted a list of preliminary questions to HFS regarding the new electronic billing system. The following are responses/information we have received to date:

Software issues

1. Will providers be able to upload billing from accounting software programs? If so, when will testing be available?
Yes – the software will need to produce an 837I claim in X12 format. Regarding testing, HFS will be reaching out to some providers to do end-to-end testing, but it will not be open to everyone. The timing has not been established yet.

2. The state has had struggles with Java on their MEDI system. Can they ensure that their system will be user friendly and that their compatibility will be consistent?

IE 6 and later, including IE 11, works with the MEDI/LTCEDI web application.

3. Will IEC and LTC be available before 8 a.m., after 5 p.m. and on weekends?

The claiming side of MEDI is available 24/7. There is a small window where the system is down for normal maintenance, but the downtime is minimal. This is unlike the admission and discharge functionality that is in MEDI, which is only available 8-5 p.m.

**Filing Issues**

1. Will SLs be filing an UB04 for Medicaid and a 1500 for MCOs?

SLFs will be using the institutional claim form to record services. We have outlined a specific revenue code (0240 – All-inclusive Ancillary rate) to bill the all-inclusive rate. More will be published on this in the future.

2. What about the backlog that currently exists? Will the state process these through the current process?

The current backlog of claims will follow the normal protocol. Any admission prior to 7/01/2016 will have claims auto generated for services through 6/30/2016. Claims for services provided 7/01/2016 and after will be submitted by the provider.

3. The notice states we have to void claims for personal portion adjustments and wait for the void to be processed before we can rebill. This seems very inefficient.

Since the system currently cannot process an electronic void/rebill, we are bound by the paper process for voids. We are looking at incorporating the patient credit changes into our Department initiated adjustment process.

4. How will “rejections” be reported and will it be timely?

Rejections will be reported timely as they currently are on a remittance.

5. Will there be “timely” filing requirements and what would that be?

Yes, we will hold providers to the six (6) month timely filing restriction. There will be some instances where a timely filing override will be required, but we will outline those variables in a provider notice.

6. How do we communicate unpaid bed holds? Do we need to communicate this?

All bed holds (Leaves of Absence) should be reported on the institutional claim record with an occurrence span 74 along with the dates. In addition, a total of all days should be reported as a revenue line with revenue code 182 – patient convenience, 183 – Therapeutic or 185 – Hospital Leave. Revenue code 182 and 183 will both be considered Therapeutic Leaves.
7. Since HFS will not accept paper UB04s, will HFS allow providers to batch bill through their (or an approved) network service vendor? Or can it only be done via the IEC option in MEDI?

Yes, both options will be supported. Providers can go through a vendor/clearinghouse or claims can be submitted directly from the provider through the IEC links in MEDI. Direct data entry is also an option.

8. For the direct data entry option HFS refers to in the notice – do we understand that to mean that HFS will have an option in MEDI to allow the direct entry of each claim individually similar to Medicare’s FISS system?

Yes, that is correct. The IEC process is already established for other providers and can be reviewed in MEDI. Coding specific to LTC services will be provided. DDE has been updated for LTC claims entry, but will not accept claims for services prior to 7/1/2016.

9. After July 1, 2016, how will providers correct or amend any claims with issues prior to those dates?

For services prior to July 1, 2016, corrections will follow the process that is currently in place. Adjustments to those claims will still be auto generated by the Department.

10. What will be the timely filing expectation for claim submission?

180 days from the date of service or completed admit transaction.

11. Will Skilled Nursing Homes need to have the RUG on the claim?

Yes, we will request the RUG score be reported in the same manner as a Medicare claim. The RUG score on revenue line 0022 showing the number of days in the units and zero charges on the revenue line.

12. How will we report to the state when someone is on Medicare/Insurance? (we need the denial for the Medicare Bad Debt cost reporting)

If someone is Medicare primary we are expecting a claim to cross over from the Medicare COBC. If, for some reason, it does not cross over, the expectation is that the provider should bill Medicaid. Other Insurance primary claims should be billed to the other insurance and then a balance should be billed to the Department. These items are basically handled through a prior payer loop.

13. We have multiple facilities under the same TAX ID number that would be submitted on the claims, how will the state know the difference? (currently the state puts a code on the end of each one for them to recognize the difference)

HFS will use our NPI crosswalk table to uniquely identify the facility. HFS will be working with providers to get NPIs to a state where claims can be crosswalked successfully. It is recommended that there be a 1 to 1 ratio between the facility’s NPI and the legacy provider ID. If there is not a unique NPI for each provider number (including the 3 digit extension at the end), the NPI will not crosswalk correctly and will produce errors.

Payment Reports/Issues

1. Will we get a status report each time we bill – accepted, in process, acknowledged?

Each electronic file submitted will be responded to with the appropriate HIPAA 999 transaction. Response files can then be picked up through our MEDI portal. Additionally if a claim is submitted via MEDI DDE, a corresponding confirmation report can be printed.
2. What will remittances look like and can Management Companies get copies?

Proprietary remittances will be formatted the same as they are today. Payees can register to view remittances through IEC in an 835 format.

3. Will payments be sporadic, based on billing? Or will payments only be issued on a monthly basis?

The Department creates vouchers for payment and submits to the Comptroller. The timing of the payment is dependent on whether a provider is expedited and what other competing payment priorities are at the Comptroller’s Office.

Regarding the HFS processing, the only difference will be when claims are entered into MMIS. Currently, claims are entered uniformly once per month. Under the new system, the process will be dependent on the billing practices of each provider. Since we are requiring monthly claims, the effect of the new system might be negligible; but we will need to monitor and work with our fiscal staff.

4. How will payments be listed on the Vendor Website? Will the same DCN tracking be implemented?

It should be the same. There is no change to how the claims are paid and monitored.

5. Since providers have in the past relied heavily on the pre-payment report for many uses (tracking residents who are now accepted for coverage/dropped from coverage) is there anything that is going to be replacing it? If not, what advice are they prepared to give to facilities? Is it simply waiting for the payment detail and working issues from that? Or using MEDI/REV to monitor each resident on a monthly basis for eligibility and payment?

We recommend that LTC facilities utilize a 276/277 claim status inquiry and response. MEDI also can allow providers to do this inquiry and response on demand.

6. Will claims be paid in a more timely manner once processed correctly (i.e. in the state of Indiana once our facility claims are processed payment is usually received within a week)?

The new billing process should not have much of an impact on the timing of payment. Please see the response to question #3 in this section (Payment Reports/Issues) for an explanation of the impact.

7. Will payments come individually or on a remittance of claims submitted?

They will not be sent out individually. Our remittances will group claims and voucher according to the payee for the provider.

Communication/Training

1. Will all state workers be consistent in training and processing information?

That is the Department’s goal.

2. How does HFS plan on communicating with providers on the changes? How soon will HFS offer training on this subject as the go live date is not that far in the future for such a large change. Many providers that are Medicaid only will struggle with understanding the UB-04 as well and implementing a new billing process.

HFS anticipates provider education and training to begin in April. Prior to the end of March, we hope to have a schedule put together for dissemination.
3. How comprehensive is training going to be? Is it going to include Revenue Codes, if they will follow the Medicare format for condition and occurrence codes- and if not will they be able to provide something in detail for providers to reference?

   It will include billing examples and coverage of all revenue codes, value codes, bill types, etc. We will make sure the billing examples are provided for future reference.

4. Will the state be providing training on the MEDI system on how to submit claims, correct claims and verify if the claims have been processed? If not, could HFS establish provider training sessions for this purpose?

   There are links on the MEDI site with videos for how to get started submitting claims. The screens follow the normal UB04/Institutional claim form data elements.

5. Will there be a provider line to help correct claims and help with problems with claims not processing?

   Yes, HFS will provide contact information for this function, and it will most likely be the same staff that currently assist with billing issues.

6. Currently the state does not have the man power to process Application/Admission/Patient Liable changes, how can we be reassured they have the manpower for this function?

   HFS is actively testing the current MMIS system to make sure that we can receive, edit and adjudicate externally submitted LTC claims in our system. We do not foresee any issues with processing claims as we have the capacity to process millions of claims per day.

**MEDI**

1. Availability Issues:
   a. System shuts down when too many people are on it?
   b. Only available 8 a.m. – 5 p.m., M-F (No Holidays)?
   c. Frequent Java errors (Historically)?

   The claiming side of MEDI is available most of the time. There is a small window where the system is down for normal maintenance. This is unlike the admission and discharge functionality that is in MEDI.

2. Which Internet Explorer Browser is compatible? (Confirm IE 11);

   IE 6 and later, including IE 11, works with the MEDI/LTCEDI web application.

3. Is it true that if an individual transfers from Home #1 to Home #2, and Home #2 enters the individuals into MEDI, Home #1 cannot access or review info regarding the individual. No corrections can be made by Home #1.

   Home #1 should still be able to log into MEDI and have functionality for the dates of service that the individual was a resident of the home. If a provider is having issues, they should check their registration.

**Caseworkers** (Change in Income, Admissions, Readmissions, Discharges)

1. Processing Info:
   a. Some will only process income changes annually;
   b. Others will only process the change if it’s more than $100;
   c. Changes sometimes take 2 years or more, but we can only go back 6 months (NH) or 1 year (DD);
d. Patient Credits – If the change is in the state’s favor, we can change in MEDI. If the change is not in the state’s favor, caseworkers must make the changes (Why can’t the facility do both if we have documentation requirement met?);

2. What process is set up for when caseworkers don’t act in a timely manner – How should a provider ensure proper/timely processing?

Most of these issues are tied to caseworker processing and are not affected by the change in billing systems. In addition, the application of the timely filing limit will not change. For instances in which caseworkers make changes after the service date being billed, we base the 180 day timely filing limit on the caseworker transaction date.

Regarding patient credit changes, many of the requested changes are for uncovered medical expenses that ultimately get denied by the caseworkers. Therefore, the Department has determined to not accept those changes without caseworker review and approval.

Recoupment
1. Changes submitted in MEDI may take 6 months or longer for caseworker approval.

Unclear what the question is, but if it is regarding the timely filing limit that issue is addressed in the answer to the Caseworkers questions above.

Pre-payment Reports (An overview of what HFS believes occurred in a month)
1. Prepayment reports – an overview of what HFS has on record in order to review and make corrections;

Currently, the pre-payment report is a record of what the MMIS system has entered at the time the claim is generated by the Department. In the new billing system, providers will submit claims for entry of this information into MMIS.

2. They are required to be produced during OIG Audits;

We will have discussions with OIG to inform them the pre-payment report will no longer be generated.

3. They are needed for Cost Reports to verify bad debt claims for 72 Codes & Bad Debt Process;

Providers will receive remittances detailing rejected claims and zero paid claims. Medicare claims will crossover directly to the Department and the Medicaid payment amounts will be included on provider remittances.

4. Nursing Homes report bed reserves, but don’t get reimbursement.

For service periods after 6/30/2016, providers will be required to provide leaves of absence (bed reserves) on the claim form, rather than submitting via MEDI.

5. When/If income changes are made, do we resubmit corrected bills/claims?

The Department is developing an adjustment process to re-price claims for retroactive rate adjustments. We are discussing the possibility of using this automated process to re-price claims for patient credit changes as well. We will provide more information as we work through that development.
1. HFS 2249 – is not currently being used. Info is submitted via MEDI;

   This is correct, but since the Department will not be generating claims in the future, an HFS 2249 will be required to void a claim. Once the void is processed, the provider will be able to rebill the claim.

2. Need clarification of time frames required at each step (i.e.: 15 calendar days; 6 months, etc.). What will timely filing deadlines be?

   The timely filing deadlines will not change. Admissions still need to be entered into MEDI within 15 calendar days from receiving the screening, and claims must be submitted within 180 days from the service date. It is important to note that the 180 day filing limit is based on the caseworker transaction date (rather than date of service) for instances in which the caseworker makes changes after the service date.

3. If caseworker doesn’t have admission completed and entered, do we still submit claims?

   No, if there is not an approved admission on the system, a claim for services will be rejected.

4. If we wait until the caseworker enters the admission, will the claims be denied as untimely?

   Providers will have 180 days from the date the admission is placed on the system to submit claims for services provided prior to that date.

5. Does the recently adopted CMS ‘60-day Rule’ apply to Medicaid claims?

   Information will be provided on this at a later date.

6. Does the recently adopted CMS ‘60-day Rule’ apply to MMAI Claims?

   Information will be provided on this at a later date.

**Abuse Prevention Review Team Act - 210 ILCS 28**

The Abuse Prevention Review Team Act (210 ILCS 28 – [click here](#)) was created to review sexual assaults and suspicious deaths of residents in facilities licensed under the Nursing Home Care Act (210 ILCS 45), the Specialized Mental Health Rehabilitation Act of 2013 (210 ILCS 49), the ID/DD Community Care Act (210 ILCS 47) and the MC/DD act (210 ILCS 46). The Abuse Prevention Care Team Act creates review teams (North and South) whose purpose is to review and respond to sexual assaults of residents and unnecessary resident deaths.

The Abuse Prevention Review Teams (APRT) are made up of professionals from multiple disciplines including, but not limited to: nursing staff; social services professionals; attorneys; law enforcement investigators; ombudsman; and coroners. State agencies involved include: Illinois Department of Public Health (IDPH); Illinois State Police (ISP); Illinois Department of Human Services (DHS); State’s Attorney Office; Department of Financial and Professional Regulation (IDFPR); and the Department on Aging (DOA). The goal of the APRT is to gain a better understanding of the incidence and causes of sexual assaults and unnecessary deaths, such as deaths related to abuse and/or neglect. IDPH is responsible for referring any case that meets the definition in the Act for APRT review to the appropriate APRT team for an in-depth review. The team will report its findings to IDPH and to the appropriate agencies, such as the Illinois State Police and Department of Financial and Professional Regulation for their respective action and with recommendations to help reduce the number of sexual assaults on and unnecessary deaths of residents.
The two current review teams meet quarterly. The Northern Team reviews deaths and sexual assault cases that occur in facilities in the geographic area primarily north of Interstate 80 (IDPH Regions 1, 7 and 8) and the Southern Team reviews cases that occur south of Interstate 80 (IDPH Regions 2, 4, 5 and 6). IDPH has established secure databases to track:

- Residents who are victims of sexual assaults;
- Residents known to have died in a facility;
- Residents cited in quality of care deficiencies, who have died within 6 months;
- Residents whose care was the subject of a complaint or incident alleging death and/or sexual assault.

In 2014, IDPH staff reviewed 711 reports of sexual abuse and/or deaths. Of those, 111 were referred to the APRTs; 71 cases were referred to the Northern Team and 40 to the Southern Team for review.

It is also important to note that with regard to incidents and complaints involving abuse/neglect, IDPH sends these (1,765 in 2014) to the Illinois State Police Medicaid Fraud Control Unit (MFCU) for their review to determine which of these need to be investigated for possible criminal action. In 2014, the ISP MFCU had 18 convictions of resident abuse, neglect or theft cases. They also opened 192 cases of resident abuse, 42 cases for theft, fraud, drug diversion or financial exploitation, and 54 for immediate jeopardies.

The overall goal is to reduce the incidence of abuse, neglect and theft, and when necessary, to report those incidences promptly and accurately. Facilities must be proactive to prevent abuse, neglect and theft. Being able to screen prospective employees and residents thoroughly to identify risk factors; to train staff, residents and families; and to investigate reports are all keys to attaining and providing a safer environment for the residents.

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**CMS Releases Skilled Nursing Facility Utilization and Payment Data – Announce RAC Reviews**

Recently, CMS issued a press release titled *CMS releases Skilled Nursing Facility utilization and payment data* as part of its efforts to increase transparency in federal health programs. The Skilled Nursing Facility Utilization and Payment Public Use File (SNF PUF) contains information on utilization, payments and submitted charges organized by provider, state and resource utilization group (RUG). The data include information on 15,055 skilled nursing facilities, over 2.5 million stays and almost $27 billion in Medicare payments for 2013.

The data set identifies individual SNFs using their six-digit identification number. Services furnished by these SNFs are grouped according to resource utilization groups (RUGs). For each SNF and RUG, the data set has the total number of stays and days provided, number of beneficiaries served, the SNF’s total and average charges, the total and average allowed amounts, the total and average Medicare payments and the total and average Medicare standardized payments.

The data does not contain any individually identifiable information about Medicare beneficiaries and also has a number of limitations. Most notably: 1) the data does not indicate the quality of care provided by individual skilled nursing facilities; 2) the data are not risk adjusted and thus do not account for differences in the underlying severity of disease of patient populations treated by providers; and 3) the data only reflects Medicare fee-for-service (FFS) and not Medicare Advantage utilization.

The Skilled Nursing Facility PUF contains five Microsoft EXCEL tables:

1. [aggregated information by provider](#)
2. [aggregated information by provider and RUG](#)
3. [aggregated information by RUG](#)
4. aggregated information by RUG and state
5. aggregated information on therapy minutes by provider

CMS also provides a Frequently Asked Questions (FAQ) page related to the SNF PUF data.

CMS is very concerned that skilled nursing facility residents are receiving the highest levels of therapy in huge amounts that have driven CMS to turn the issue over to Recovery Care Contractors (RACs). In addition to information on payments and charges, the SNF PUF contains information on two categories of RUGs for patients who receive a significant amount of therapy: Ultra-High (RU) and Very High (RV) Rehabilitation RUGs. In an associated Fact Sheet, which includes several tables and maps highlighting utilization patterns of concern to CMS, the agency describes that the results are consistent with prior CMS findings. Specifically, the SNF PUF shows that for these two RUGs, the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify a patient for these categories.

Based on the 2013 information in the SNF PUF data, CMS found that:

- 51 percent of all RV assessments showed therapy provided between 500 and 510 minutes.
- 65 percent of all RU assessments showed therapy provided between 720 and 730 minutes.
- For 88 providers, all of their RV assessments showed therapy provided between 500 and 510 minutes.
- For 215 providers, all of their RU assessments showed therapy provided between 720 and 730 minutes.
- More than one in five providers had more than 75 percent of both RU and RV assessments that showed therapy provided within 10 minutes of the minimum threshold.

In the Fact Sheet CMS also provided the following announcement:

“To help ensure that patient need rather than payment incentives are driving provision of therapy services, CMS is providing approval to the Medicare Fee-for-Service Recovery Auditor Contractors (RACs) to investigate this issue.”

The Skilled Nursing Facility Utilization and Payment Public Use File shows Ultra High therapy billing accounted for the highest Medicare payments to SNFs, total therapy days, beneficiaries served and average Medicare payment per beneficiary in 2013. The three Ultra High resource utilization groups amounted to more than $16.6 billion in Medicare payments, and close to 36 million total therapy days provided during 2013. The Very High RUG categories followed with $5.7 billion in payments and 16 million therapy days. Many beneficiaries in the Ultra High and Very High RUGs barely made it over thresholds to get into those categories. More than 20 percent of facilities provided Ultra High and Very High therapy within 10 minutes of the minimum threshold, according to the report. Payments for these RUGs often exceed payments for other categories by 25 percent, CMS said.

What our members need to do
AHCA and IHCA are recommending that SNF providers review the information in the SNF PUF tables for 2013, especially those data that are specific to their individual nursing centers. In particular, SNF providers should review table 5) aggregated information on therapy minutes by provider. This table provides specific detail for the percentage of RU assessments with reported therapy minutes between 720 and 730 minutes in column J, and the percentage of RV assessments with reported therapy minutes between 500 and 510 minutes in column H. There is a likelihood that the RACs may focus their initial attention in the investigation assigned to them by CMS to those nursing centers at or near the 100% rate of assessments falling exactly on or within 10 minutes of the RV and RU RUG thresholds.

AHCA will be reviewing the extensive SNF PUF data files in more detail and will be seeking more details regarding the scope of the Recovery Audit Program investigation. We will provide updates as details become available.
Important Regulations, Notices & News Items of Interest

1) **RN Licensing**: or those RNs out there, remember that your licenses are due for renewal by **May 31, 2016**. The state is not sending notices anymore, so you’ll need to renew on your own through IDFPR. They recently announced implementation of electronic renewals for professions licensed and regulated by the Divisions of Real Estate and Professional Regulation. License renewals can be completed online via the agency website [click here]. Proof of licensure can be found at the License Lookup page. And if you want to be reminded electronically, just visit the online address change site to provide a current email address and contact information.

2) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-09 – ALL** – Certification Number (CCN) State Codes – State Operations Manual (SOM) Section 2779A Revisions. CMS has made revisions to this section in the SOM which provides guidance regarding the numbering system for CCNs for Medicare-participating providers and suppliers. The revision, specifically in Section 2779A1 for Medicare providers reflects the addition of new State Codes. Due to a lack of available CCNs for some providers wishing to enroll or modify their current certification in Medicare, additional state codes are being added to the Automated Survey Processing Environment (ASPEN), the Accrediting Organization System for Storing User Recorded Experiences (ASSURE), as well as Medicare payment processing systems, effective April 4, 2016.

- **S&C 16-10 – Transplant** – Advance Copy – Interpretive Guidelines for the Organ Transplant Conditions of Participation (CoPs) at 42 Code of Federal Regulations (CFR) §§ 482.68 through 482.104. CMS has now updated the Organ Transplant Interpretive Guidelines to incorporate previously-published changes, clarify certain areas, and address feedback received based on previously-released drafts. These Interpretive Guidelines supersede all previous versions and will be published in a new Appendix X of the State Operations Manual (SOM).

- **S&C 16-12 – ALL** – (No actual S&C Letter, just a notification). National Downtime of the Quality Improvement and Evaluation System (QIES). QIES Systems – Will be unavailable from March 16 through March 21, 2016. Submission of Patient/Resident Assessments will not be possible during the downtime – Providers were notified in several email messages that the QIES system would be unavailable during the downtime. Providers were advised to plan their business needs around the downtime.

3) Federal HHS/CMS released several notices/announcements since the last issue of Regulatory Beat:

- CMS Releases 2013 SNF Public Use File - [The Skilled Nursing Facility PUF](#) contains information on utilization, payment (allowed amount, Medicare payment and standard payment), and submitted charges organized by CMS Certification Number (6-digit provider identification number), Resource Utilization Group (RUG), and state of service.

- Medicaid State Drug Utilization Data Available on Data.Medicaid.gov - To allow viewers to be able to view the Medicaid State Drug Utilization Data (SDUD) in more user-friendly fashion, CMS announces that you can now view the Medicaid SDUD on [Data.Medicaid.gov](#).

- SNF Consolidated Billing Web-Based Training Course — Reminder - With Continuing Education Credit. The Skilled Nursing Facility (SNF) Consolidated Billing Web-Based Training (WBT) course is available through the [Learning Management and Product Ordering System](#). Learn about:
  - Payment information for SNF services, including services provided by entities other than the SNF
  - Bundled prospective payments
• HIPAA EDI Standards Web-Based Training Course — Reminder - With Continuing Education Credit. The HIPAA Electronic Data Interchange (EDI) Standards Web-Based Training (WBT) course is available through the Learning Management and Product Ordering System. Learn about:
  o Standards and code sets mandated under HIPAA
  o Information regarding electronic billing and other health care transactions
  o The steps involved in the Medicare electronic data interchange process

4) The Illinois Department of Healthcare and Family Services (HFS) released the following Provider Notices:

• **Handbook for Providers of Pharmacy Services Reissue.** The Department is reissuing the Handbook for Providers of Pharmacy Services. Providers are encouraged to review the handbook in its entirety. This handbook, in conjunction with the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures, provides information necessary for providers to receive payment from the Department for services.

• **IMPACT Provider Revalidation-Due Date Extensions.** CMS has extended the due date for all Medicaid providers to be revalidated to September 24, 2016. Please note that to meet this date a provider’s enrollment must be submitted in IMPACT and approved by the State prior to this date in order to avoid delays in Medicaid claims processing. As a result, HFS is extending the due dates for provider revalidations as follows: Facility/Agency/Organizations (FAOs) revalidation has been extended to June 30, 2016. Based on the above requirement and understanding that FAOs and groups must enter the IMPACT system prior to individual providers, HFS will further extend the revalidation due date for Individual/Sole providers to August 31, 2016. More information on the IMPACT system plus frequently asked questions, webinars and other training guides are available at the IMPACT website.

• **2016 Dental Office Reference Manual (DORM).**

• **Publication of Public Notices on Healthcare and Family Services (HFS) Website.** On October 29, 2015, CMS published final rules designed to ensure that states’ fee-for-service Medicaid payments comply with the access standards outlined in Section 1902(a)(30)(A) of the Social Security Act (SSA). The final rule became effective January 4, 2016. Pursuant to the provision of title 42 Section 447.205 of the Code of Federal Regulations, public notices are required for changes in statewide methods and standards for setting payment rates. This new rule recognizes electronic publications posted on the Medicaid state agency’s website as an acceptable form of public notice. Previously, states were required to publish notification of payment rate changes in either a state register or certain newspapers. The Department has developed a web page on the HFS web site for the purpose of providing public notice of proposed changes in methods and standards for setting payment rates for services. A link to the public notices can be found under the “Stay Informed” section located at the bottom left corner of the HFS Home Page.

5) There are two items with regard to the Illinois Department of Public Health:

• The Medication Aide Pilot Program application submission will close on March 31! Click here for information and instructions on how to apply!

• Also, please note that on the IDPH LTC Facility Questionnaire for 2015, Question 6 of Section 1 (page 8) is not required due to issues arising from the conversion from ICD-9 to ICD-10.

6) The Illinois Department of Financial and Professional Regulation adopted rulemaking (see page 3659 of this issue of the Illinois Register) to implement provisions in P.A. 98-148, which provided that enteral and parenteral nutrition therapy and developing and managing food service operations whose chief function is nutrition care shall only be performed by individuals licensed under the Act. Various non-substantive changes, including
changing references throughout the entire Part from "Department" to "Division" to reflect the consolidation of agencies into the Department of Financial and Professional Regulation and the creation of the Division of Professional Regulation were made.

7) The Illinois Department of Human Services adopted rulemaking (see page 3737 of this issue of the Illinois Register) affecting the Electronic Prescription Monitoring Program (PMP), which is designed to control the abuse of Schedule II, III, IV and V retail dispensed drugs. The proposed amendment changes the requirement that dispensers report to the central repository each time a Schedule II, III, IV or V drug or other selected drugs (see 77 Ill. Adm. Code 2080.230) is dispensed from not more than seven days after dispensing to no later than the next business day after dispensing; or, if no drugs are dispensed then a zero report is required. The amendment will result in more frequent reporting and will improve the use of the PMP in identifying patients exhibiting prescription seeking behavior.

8) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

9) Kaiser Health News recently reported on Medicare To Test New Payment Approaches For Some Prescription Medications. Medicare plans to test new ways to pay for prescription medications given in doctors’ offices and hospital outpatient centers — moves likely to win praise from some policy experts, but opposition from facilities and practitioners. Under a two-part proposal released Tuesday, regulators aim to reduce what some economists and policy experts say are financial incentives for doctors to choose higher-cost medications even when less expensive drugs may be equally or more effective.

10) The New York Times recently published an article entitled, “CDC Painkiller Guidelines Aim To Reduce Addiction Risk.” In an effort to curb what many consider the worst public health drug crisis in decades, the federal government published the first national standards for prescription painkillers, recommending that doctors try pain relievers like ibuprofen before prescribing the highly addictive pills, and that they give most patients only a few days’ supply. The release of the new guidelines by the Centers for Disease Control and Prevention ends months of arguments with pain doctors and drug industry groups, which had bitterly opposed the recommendations on the grounds that they would create unfair hurdles for patients who legitimately have long-term pain. In the end, the agency softened the recommendations slightly but basically held its ground, a testament to how alarmed policy makers have become over the mounting overdoses and deaths from opioid addiction. Opioid deaths — including from heroin, which some people turn to after starting with prescription painkillers — reached a record 28,647 in 2014, according to the most recent federal statistics.

11) The Pittsburgh Post-Gazette reports that Hospice Fraud Becoming a Costly Problem for Medicare. Theft has been called a crime of opportunity, which would make cheating Medicare’s hospice benefit a bag of Skittles left open on the coffee table. No one knows how big the problem of hospice fraud is — all types of improper Medicare payments are estimated at $65 billion for 2010 — but federal investigators prosecuted more than 60 cases in the last year alone, involving hundreds of millions of dollars nationwide. The system that was built to help dying patients live out their remaining days with dignity and comfort has few quality metrics to meet, no minimum requirements for how often care is provided, and low barriers to getting into the business. Critics say that can make end-of-life care seem ripe for abuse.

12) HealthDay reports:

- **Brain Bleed Risk From Warfarin May Be Higher Than Thought.** The widely used blood thinner warfarin -- also known as Coumadin -- may raise the risk of severe bleeding inside the skull by much more than previously thought, a new study suggests. Researchers examined data from nearly 32,000 U.S. veterans, aged 75 and older, with a common heart rhythm disorder called atrial fibrillation. The investigators found that almost one in three suffered an "intracranial" bleed while taking warfarin for the condition.
• **Diabetes May Raise Risk For Dangerous Staph Infection.** People with diabetes may be significantly more likely to develop potentially deadly "staph" blood infections than those without diabetes, a new study suggests. As the Danish researchers explained, *Staphylococcus aureus* bacteria live on the skin and are normally harmless. However, the germs can cause dangerous infections if they enter the bloodstream. In fact, the 30-day death rate from such infections is 20 percent to 30 percent, according to the research team from Aalborg University Hospital and Aarhus University Hospital. Overall, they found that people with any form of diabetes were almost three times more likely to acquire a staph blood infection outside of a hospital, compared to those without diabetes. The risk jumped to more than seven times higher among people with type 1 diabetes, and almost three times higher for those with type 2 diabetes.

• **Women With Alzheimer’s May Keep Verbal Skills Longer Than Men.** In the early stages of Alzheimer’s disease, women tend to remember words better than men do, which could delay diagnosis in women, new research suggests. The difference exists even though women and men have similar amounts of shrinkage in brain areas that show the earliest evidence of Alzheimer’s disease, according to the study involving hundreds of people.

13) **Medical News Today** reports:

• **Sinus Infection Symptoms: Signs, Duration and Complications.** Sinus infection, also referred to as sinusitis or rhinosinusitis, is an inflammation of the tissue lining the sinus cavities. The inflammation, caused by a virus, bacteria, fungus or as a result of allergies, prevents the sinuses - a connected system of air-filled cavities located in the skull - from draining normally, leading to a build-up of mucus and secondary infection. Acute sinusitis often occurs after a viral upper respiratory tract infection (URI). The main symptoms of sinus infection are nasal obstruction, discolored nasal discharge, and facial pain or pressure that has been present for 7 days or more.

• **Using A Computer Might Reduce Cognitive Decline.** A study released today strengthens the ever-deepening connections between maintaining a busy brain and reducing the risk of cognitive decline in later life. The results show that using a computer might be a positive influence as we enter our twilight years.

• **Tufts University Nutrition Scientists Provide Updated MyPlate For Older Adults.** Nutrition scientists at the Jean Mayer U. S. Department of Agriculture Human Nutrition Research Center on Aging (USDA HNRCA) at Tufts University with support from AARP Foundation have just introduced an updated MyPlate for Older Adults icon. The updated icon emphasizes the nutritional needs of older adults in a framework of the 2015-2020 Dietary Guidelines for Americans from the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. The icon and an accompanying website can be viewed at [http://hnrcana.tufts.edu/myplate/](http://hnrcana.tufts.edu/myplate/).

• **Multidrug-Resistant Organisms On Patients’ Hands In Post-Acute Care Facilities.** Patients commonly bring multidrug-resistant organisms (MDROs) on their hands when they are discharged from a hospital to a post-acute care facility and then they acquire more MDROs during their time there, according to an article published online by *JAMA Internal Medicine*. MDROs are increasingly prevalent at post-acute care facilities because of contact between health care workers, the environment and patients, who are encouraged to be mobile outside their rooms. Patients' hands come into contact with surfaces, health care workers’ hands and other patients in these post-acute care facilities.

14) **Medscape** reports:

• **Antibiotics Under Recognized Cause Of Delirium.** Antibiotic toxicity can represent an unrecognized cause of delirium in hospital patients, with manifestations observed in three distinct phenotypes, new research shows.
• ‘Chilling’ Data On Antibiotic-Resistant Infections In US Hospital Patients. U.S. hospitals and health care providers have made considerable progress in preventing some health care-associated infections (HAIs), but the battle is far from over, as antibiotic-resistant bacteria continue to threaten hospital patients, said officials with the CDC. "New data show that far too many patients are getting infected with dangerous, drug-resistant bacteria in healthcare settings," CDC Director Tom Frieden, MD, MPH, said in a news release. Antibiotic-resistant infections can be "difficult or impossible to treat." Physicians, nurses and health care leaders are "key to stamping out superbugs," Dr. Frieden added during a media briefing. "No one should get sick while trying to get well." It is possible to reduce these infections, but it will take "relentless effort," he continued.

• High-Risk Characteristics In Older Patients In The ED. A new study has identified clinical characteristics and management decisions that are associated with poor outcomes in elderly patients soon after emergency department (ED) discharge. Gelareh Gabayan, MD, MSHS, from the University of California, Los Angeles, and colleagues published the results of their study online March 2 in the Annals of Emergency Medicine. "We found that older patients discharged from the ED with a change in disposition from 'admit' to 'discharge', cognitive impairment, systolic blood pressure less than 120 mm Hg, and pulse rate greater than 90 beats/min were at increased risk of death or [intensive care unit (ICU)] admission shortly after discharge," the authors write. Elderly patients have the highest rate of ED use among all adults and are at a greater risk than younger patients for poorer outcomes, such as return ED visits, hospitalization, and death. However, although previous studies have identified predictors of poorer outcomes in this patient population, they have not identified specific patient and process-of-care characteristics that might contribute to these outcomes.

15) McKnight’s reports:

• Study Confirms: SNF Residents Transferred From Hospitals Have Higher Pressure Ulcer Risk. Nursing home residents who are admitted from hospitals have a higher risk of developing pressure ulcers than those who were transferred from the community, according to new study results. Researchers looked at data from more than 5,000 Canadian nursing home residents in order to back up the belief that pressure ulcers are reported more often among residents who transfer from hospitals. Of the 68 percent of residents who were admitted directly from a hospital, 9.2 percent of those were found to have a pressure ulcer upon admission. On the other hand, just 2.6 percent of residents who were admitted from the community had pressure ulcers. Results of the study, which was published in Medical Care, showed that residents who were admitted to nursing homes directly from the hospital — regardless of their susceptibility to ulcers — had a higher risk of developing pressure ulcers or higher chances of already having one.

• What Is Missing From 5-Star. CMS introduced the Five-Star Quality Rating System of long term care facilities in 2008 with the aim of improving consumerism in the selection of nursing homes. The three key components of the Five-Star include health inspections, staffing and quality measures reported through MDS collection. The rating system has gone through additional changes recently with the addition of psychotropic medications for short and long-stay admissions as an additional quality indicator. CMS plans to collect information directly from facility payroll records in order to calculate the nursing staff hours, rather than to rely on nursing homes' reports of the data. The calculation of the staffing star favors facilities with higher register nurses, adversely affecting the standing of nursing homes located in geographic areas with chronic RN shortages.

• More Than A Fourth Of Hospital Admissions Preventable, Study Finds. Improved discharge directions and communication between patients and providers could prevent up to 27 percent of hospital readmissions, according to a new study. Researchers at the University of California, San Francisco reviewed 1,000 hospital readmissions that occurred within 30 days of discharge, and found that 269 of those cases were potentially preventable. Results of the study were published online in JAMA Internal Medicine. The most
common factors for readmission were emergency room decision-making, premature discharge and lack of communication between patients and providers about post-discharge appointments, contacts and care wishes. Patients who were readmitted often didn't follow up with post-discharge appointments, or know who to contact about health concerns after discharge, researchers said.

- **NIC Unveils ‘Game Changer’ Data Reports.** Skilled care operators can soon gain quicker access to occupancy, patient mix and revenue data and other key information, thanks to free, quarterly reports the National Investment Center for Seniors Housing & Care will start releasing. The organization announced the new data source at its 2016 Spring Investment Forum in Dallas. Quality mix, patient day mix and payer source information also will be included, according to Robert G. Kramer, the organization's CEO. The NIC Skilled Nursing Data Report is intended to bring more transparency to industry data, he noted. The first installation will provide monthly data collected by the organization from October 31, 2011 through December 31, 2015. Data will be reported in the aggregate at the national level and is collected from a sampling of multi-facility skilled nursing operators. The availability of information that is less than three months old will be a “game changer,” said Formation Capital CEO Arnold Whitman. “Traditionally, we've relied on government reports that have 12- to 18-month-old data,” he explained. The quarterly reports also will offer managed Medicare rates and trends.

- **Rising Tide Of Medical Cannabis.** Eighty-one percent of respondents in a recent Harris poll percent favored legalizing medical cannabis. Few issues rate that level of approval. In many ways, this represents a social movement with broad support. Unlike in health care reform, which is driven from the top down, this movement represents more a rising tide of public expectations driven by affected stakeholders. Much the effort has occurred as a result of the actions of states and initiative petitions. Federal law still allows federal enforcement of those who grow, consume sell or otherwise deal in cannabis. This ambiguous situation leaves many providers at risk for zealous or ambitious prosecutors who seek to perpetuate the failed war on drugs. It keeps providers in a state of limbo with state laws that cover medical cannabis dispensaries but may not cover providers. States are working their way through these issues despite the continued federal prohibition.

- **LTC Exempted From Newly-Passed Drug Bill's 'Lock-In Provision.** A bill passed by the Senate earlier this month is earning praise from a leading long term care pharmacy group for exempting nursing homes from its controversial “lock-in” provision that limits Medicare beneficiaries to using one pharmacy. The Comprehensive Addiction and Recovery Act of 2016 allows the U.S. Attorney General to award states, local governments and nonprofit organizations grants to address the “national epidemics” of heroin use and prescription opioid abuse. The final CARA bill, which now moves to the House, “strikes the right balance” between protecting communities from the opioid epidemic and protecting the needs of long-term care residents, Rosenbloom added.

- **NIC Report: Occupancy Down, Managed Care Use Up In Skilled Nursing Facilities.** Skilled nursing facility occupancy has dipped from 2011 to 2015, according to the National Investment Center for Seniors Housing & Care's inaugural Skilled Nursing Data Report. The report, unveiled as part of the group's Skilled Nursing Data Initiative, saw occupancy rates drop from just under 85 percent in October 2011 to 82.8 percent in December 2015. That decrease can be attributed to resident turnover resulting from lower lengths of stay, especially for short-stay residents, NIC said. NIC also found that an increasing percent of patient days were paid through managed Medicare, signaling an increase in Medicare Advantage enrollees. Medicaid also saw a slight increase within the patient day mix, while Medicare and private pay both saw decreases between 2011 and 2015.

- **Medicare Reimbursement Caps For Hospice Constitutional, Court Says.** Medicare's payment cap for hospice treatment doesn't violate a clause of the constitution meant to protect private property rights, a federal appeals court ruled earlier this month.
16) **Interesting Fact**: Have a cheeseburger and fries - and be happy - Very low cholesterol levels are associated with violence. According to Golomb and colleagues in their study of 79,777 patients, violent criminals had a much lower level of cholesterol than non-violent individuals. Low cholesterol is also associated with higher rates of suicide.