PATHFinder

A Troubleshooting and Information Newsletter for McKesson Customers

August • Volume 19 • Issue 6

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McKesson creates new healthcare IT company

By Bob Dean, Vice President and General Manager

Late last month, McKesson announced that it has entered into an agreement with Change Healthcare to create a new healthcare information technology company. The transaction will combine the majority of McKesson's Technology Solutions (MTS) businesses, including McKesson Homecare™ and McKesson Hospice™, with Change Healthcare to form a new company that will deliver wide-ranging financial, operational and clinical benefits to payers, providers and consumers.

McKesson will own approximately 70% of the new company and John Hammergren, Chairman and CEO of McKesson, will serve as the Chairman, underscoring McKesson's deep commitment to the new company's success. The transaction is expected to close during the first half of calendar year 2017.

As Pat Blake mentions in the article following, there are no changes to your daily contacts for service, support or sales; and contracting, invoice and billing procedures will remain the same until further notice.

By bringing together two leading healthcare organizations with complementary capabilities, we believe that we're creating a business that can offer a comprehensive suite of solutions that will help lower healthcare costs, improve patient

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Look for McKesson at these upcoming tradeshows:

September 13-14:
Ohio Council for Home Care Annual Conf. at the Hyatt Regency in Columbus, OH

September 27-29:
McKesson NUC at the Grand Hyatt in San Antonio, TX

Icon Keys

Home Health

Home Health & Hospice

Hospice

BUSINESS CARE CONNECTIVITY

McKesson creates new healthcare IT company

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access and outcomes, and make it simpler for you to manage the transition to value-based care.

If you have any questions about the announcement, please don't hesitate to contact me or your Account Executive.

By bringing together two leading healthcare organizations with complementary capabilities, we believe that we're creating a business that can offer a comprehensive suite of solutions with no changes to your daily contracts for service, support, or sales; and contracting, invoice and billing procedures will remain the same until further notice.

McKesson and Change Healthcare Form New Company

By Patrick J. Blake, Executive Vice President and Group President, McKesson Technology Solutions

As we continue to support the needs of our customers in the transition to value-based care, I'm excited to let you know about McKesson's and Change Healthcare's agreement to form a new healthcare information technology and services company. The new company will combine the majority of our McKesson Technology Solutions (MTS) businesses with Change Healthcare to deliver wide-ranging financial, operational and clinical benefits to payers, providers, and consumers. McKesson will own approximately 70% of the new company, and John Hammergren, Chairman and CEO of McKesson, will serve as the Chairman, underscoring our deep commitment to the new company's success.

The MTS businesses joining the new company include Health Solutions, Imaging & Workflow Solutions, Business Performance Services, and Connected Care & Analytics (CCA), with the exception of RelayHealth Pharmacy Solutions and the Enterprise Information Solutions (EIS) division, which will be retained by McKesson. McKesson separately announced that it will explore strategic alternatives for EIS, recognizing the importance of accelerating the development of Paragon® and EIS's other core provider information systems.

What the new company means for our customers

Forming a new company that's entirely dedicated to healthcare information technology represents a significant move to innovate and deliver the next level of value for our customers in a way that neither company would have been able to do alone. As we combine our complementary capabilities, our goal is to provide the solutions needed to lower healthcare costs, improve patient access and outcomes, and make it simpler for payers, providers, and consumers to manage the transition to value-based care.

Neil de Crescenzo, the President and CEO of Change Healthcare, will assume the leadership role of the new company. The management team will include leaders from both companies and will be determined as part of the transition process over the next few months. I will remain very actively involved as we plan the integration of our organizations and launch the new company, which is expected during the first half of calendar year 2017.

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McKesson and Change Healthcare Form New Company

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As we work through a transition plan in the coming months, we will continue to conduct business as usual, with MTS and Change Healthcare operating as two separate companies.

- We understand that you have many choices for meeting your healthcare IT solutions needs, and we want to do everything we can to make sure we maintain our good relationship both before and after the combination.
- We remain committed to meeting your needs with the high-quality products, support and services you expect from us.
- There are no changes to your daily contacts for service, support or sales; and contracting, invoice and billing procedures will remain the same until further notice.
- Our goal is to provide a smooth customer experience as we transition to the new company. To that end, arrangements will be put into place between the MTS businesses moving to the new company and the businesses remaining at McKesson.

Strategic alternatives for EIS core systems

If you are an EIS customer, you may have seen the announcement that we are exploring strategic alternatives for the EIS business. We appreciate the critical importance of the electronic medical record (EMR) and other core health IT systems to your success. As we embark on building a new healthcare information technology company with Change Healthcare, we believe that it is in the best interest of our EIS customers to identify a strategic alternative that will enable more focus on the core provider systems. The overall strategies for EIS remain unchanged, and we will continue the many efforts we have underway to strengthen process, technology and product as we find the best path that serves the long-term interests of our EIS customers.

For more information

In the coming weeks, McKesson account representatives will be contacting you to discuss any questions you may have. In the meantime, for more information, please read the press release or visit our microsite at www.HealthTech-Transformation.com, which includes short executive messages, a fact sheet and other information that may be of interest.

In closing, this announcement reflects McKesson's vision and initiative to make bold strategic moves that drive continued growth for our customers, our company, our employees and the industry. We thank you for your partnership, and we are committed to your success.

Generally Available (GA) Releases

If special load order considerations exist, they are noted in the table below. Review the ReadMe.txt document for these releases before you plan to upgrade. You can download releases and release documents from the Download page on InfoCenter.

For complete information about the compatibility of McKesson Homecare™ and McKesson Hospice™ releases, download the McKesson Homecare™ and McKesson Hospice™ Compatibility Matrix from InfoCenter.

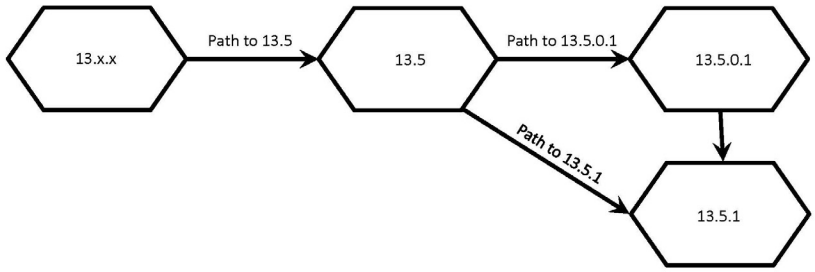
Release	ESD?
Summer Regulatory Release 13.5	Yes
Maintenance Release 13.5.0.1	Yes
HospPharmImportUpdate_Jul2016	No
PreClaimReview_Jul2016	Yes
Summer 2016 Medication Update	Yes
Web Chart 13.5.0.1	No
MobileCare 3.0/3.0.1	No
Insight 9.9.1	No
Telephony 13.1	No

Development/Alpha/Beta Releases

Any descriptions of future functionality reflect current product direction, are for informational purposes only and do not constitute a commitment to provide specific functionality. Timing and availability remain at McKesson's discretion and are subject to change and applicable regulatory approvals.

Release	Status	ESD?
Fall Regulatory Release 13.5.1 (formerly 13.6)	In Development	Yes
MobileCare CheckPoint 1.0	In Development	No
MobileCare 3.5	In Development	No
Base Release 14.0	In Development	TBD

Recommended Upgrade Paths



Note: If installing Homecare on a new machine, you MUST first load the base version, then follow the chart above. For example, if you need to load 13.5 on a new machine, you would first install 13.0, then 13.5. This process will ensure the Horizon Client is properly installed on the new machine.

Regulatory Calendar 2015/2016

Legend:	Pale blue: Information for your agency, no change to the product was required	Green: Changes to the product have already occurred	Dark orange: Changes will occur in a scheduled release

Number/ HHA Hospice Both	Description	Effective Date	Reference
R3269CP Home Health	Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement	10/01/2015	MM9192
CR 9192, provides the quarterly update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of HH services. CR 9192 announces the addition of HCPCS codes 97607 and 97608; negative pressure wound therapies, to the HH consolidated billing therapy code list, effective for services on or after October 1, 2015. These codes replace codes G0456 and G0457, negative pressure wound therapies, which are deleted from the HH consolidated billing therapy code list. In addition, code A7048 replaces code A7043 on the HH Consolidated billing non-routine supply code list, effective for services on or after October 1, 2015. Make sure your billing staff is aware of this update.			
CMS-1629-F Hospice	Medicare hospice payment rates and wage index (FY 2016 Final wage index)	10/01/2015 *01/01/2016	Click here
CR9301		10/01/2015	Click here
The Centers for Medicare & Medicaid Services (CMS) issued final rule (CMS-1629-F) that would update the Medicare hospice payment rates and wage index (FY 2016 proposed wage index) for fiscal year (FY) 2016. The final hospice payment rule reflects the ongoing efforts of CMS to support beneficiary access to hospice care. Hospices would see an estimated 1.3 percent ($200 million) increase in their payments for FY 2016. CMS approved the two routine home care rates in a budget-neutral manner to provide separate payment rates for the first 60 days of care and care beyond 60 days, which will go into effect 01/01/2016. The final reform seeks to recognize the lower cost of care for very long-stay patients and ensure that hospices are properly enrolling beneficiaries that meet the benefit criteria. In addition to the two routine home care rates, a service intensity add-on payment that would help to promote and compensate for the provision of skilled visits at end of life will be effective 01/01/2016 as well.			
R3268CP HHA	Corrections to the 2015 Home Health (HH) Pricer Program	10/05/2015	MM9198
Related to CR 8581. Change Request (CR) 9198 instructs MACs to install a new Home Health (HH) Pricer program which contains updates to allow processing of type of bill 032Q or 033Q, as required by CR8581. CR9198 also corrects errors affecting the payments on 2015 claims and instructs the MACs to adjust claims in order to correct payment amounts. Make sure that your billing staff is aware of these changes.			

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Number	Description	Effective Date	Reference
HR 2208 Hospice	New legislation: Hospice CARE ACT	TBD	Click here
05/19/2015 New legislation (HR 2208, The Hospice Commitment to Accurate and Relevant Encounters ACT – Hospice CARE) has been introduced to address "key issues related to the requirement that hospice providers conduct a face-to-face encounter with patients entering their third or subsequent benefit period to gather information that helps support documentation for continuing eligibility for hospice care." The legislation would make the following changes into law: ▪ It would allow any of the following practitioners to conduct the hospice face-to-face encounter: hospice physician, nurse practitioner, clinical nurse specialist, or physician assistance, or other health professional as designated by HHS. ▪ In cases of a new readmission to hospice care where exceptional circumstances exist, it would allow the face-to-face encounter occur no later than seven calendar days after the individual's election of services. 11/23/2015 Note: The bill entered the House Committee on Ways and Means on 05/01/2015, no additional activity has occurred.			
CMS 1625-F HHA	CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value Based Purchasing Model; and Home Health Quality Reporting Requirements	01/01/2016	Click here
In the CY 2016 proposed rule, CMS is implementing the third year of the four year phase-in of the rebasing adjustments to the HH PPS payment rates required by the Affordable Care Act. In addition, CMS is proposing to decrease the national, standardized 60-day episode payment amount by 1.72 percent in each year for CY 2016 and CY 2017 to account for nominal case-mix growth between CY 2012 and CY 2014 and proposing updates to the Home Health Quality Reporting Program. Finally, CMS is proposing to implement a Home Health Value-Based Purchasing (HHVBP) model effective for CY 2016. CMS estimates that the net impact of this proposed rule would result in a decrease in Medicare payments to HHAs of 1.8 percent ($350 million decrease) for CY 2016.			
CR 9136 R121DEMO Hospice	Medicare Care Choices Model (MCCM) - Per Beneficiary per Month Payment (PBPM) - Implementation	01/01/2016	Click here
Hospices that participate in the Model will be paid the full $400 PBPM for providing services for 15 or more days per calendar month and $200 PBPM for services provided for less than 15 days in a calendar month, with the exception of the month of discharge which will be paid $400 PBPM.			

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R3378CP Both	Additional G-Codes Differentiating RNs and LPNs in the Home Health and Hospice Settings	01/01/2016	MM9369
CR9369 establishes new G-codes to differentiate levels of nursing services provided during a hospice stay and a home health episode of care. These two G-codes and the retirement of G0154 will be effective on institutional claims (Types of Bill 032x, 081x, and 082x) for hospice dates of service on and after January 1, 2016, and for home health episodes of care ending on or after January 1, 2016.			
R3383CP HHA	Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016	01/04/2016	MM9406
CR9406 Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016; informs providers about updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment(LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for CY 2016. Make sure your billing staff is aware of this update.			
SE 1524 HHA	Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015	Notice	Click here
SE 1524 In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) is to be used as the basis for certification of home health eligibility. The certifying physician can incorporate information obtained from or generated by the HHA into his or her medical record, to support the patient's homebound status and need for skilled care, by including it in his or her documentation and signing and dating to demonstrate review and concurrence. CMS is implementing a Probe and Educate medical review strategy to assess and promote provider understanding and compliance with the Medicare home health eligibility requirements. CMS is issuing guidance to MACs about how to select home health claims for review during the "Probe and Educate" program for home health episodes that began on or after August 1, 2015. CMS anticipates MACs will begin sending Additional Documentation Requests (ADRs) after October 1, 2015, and that the first round of claim reviews and provider education will conclude in approximately one year. This document contains a summary of the technical direction that CMS will issue to the MACs.			

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Number	Description	Effective Date	Reference
R3326CP Hospice	Implementation of the Hospice Payment Reforms	01/04/2016	MM9201
CR 9201 Change Request implements service intensity add-on payments for hospice social worker and nursing visits provided during the last 7 days of life when provided during routine home care. CR9201 also will implement two routine home care rates, paying a higher rate in the first 60 days of a hospice election and a lower rate for days 61 and later. CR 9201 revises Sections 20.1.2, 30.1, and 30.2 of Chapter 11 in **"Medicare Claims Processing Manual."** The CR also creates a new section, 30.2.2, "Service Intensity Add-on (SIA) Payments" in that manual. The new and revised sections are attached to CR9201. Make sure your billing staff is aware of this update.			
R116MSP Both	Utilizing 837 Institutional Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A Claims in Direct Data Entry (DDE) and 837I 5010 Claims Transactions	01/01/2016	MM8486
CR 8486 Change Request 8486 is limited to providers billing Part A claims. Include your CAS segment adjustments from the primary payer(s) remittance advice report (835 electronic remittance advice (ERA) or paper remittance) on your 837I transaction, DDE, or your paper claim when you send your claim to Medicare for secondary payment. These adjustments are needed to process your MSP Part A claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claims billed amount was not fully paid.			
R3417CP HHA	Therapy Cap Values for Calendar Year (CY) 2016	01/01/2016	MM9448
CR 9448 Change Request 9948 describes the amounts and the policy for outpatient therapy caps for CY 2016. **For physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960. For occupational therapy, the cap for 2016 will be $1,960.** Please make sure your billing staffs are aware of these updates.			
R52QRI Hospice	Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data – This CR Rescinds and Fully Replaces CR9091	01/01/2016	MM9460
CR 9460 Change Request 9460 revises Chapter 3, Section 40 of the "Medicare Quality Reporting Incentive Programs Manual", to reflect changes to the payment reduction reconsideration process. It also includes general clarifications to the section. This article fully replaces MM9091, which has been rescinded by the Centers for Medicare & Medicaid Services (CMS). **Implementation Date: April 1, 2016** Revises Chapter 3, Section 40 of "Medicare Quality Reporting Incentive Programs Manual" to reflect changes to payment reconsideration process & includes general clarifications. CMS Hospice Quality Reporting Web page.			

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R3423CP Physicians	Summary of Policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount	01/01/2016	MM9476
CR 9476 Change Request 9476 is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries. The article provides a summary of the policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff is aware of these updates for 2016.			
R15280TN Hospice	Reporting of Anti-Cancer and Anti-Emetic Drugs	01/01/2016	MM9255
This article is based on Change Request (CR) 9255, which revises Medicare systems to allow oral anti-cancer and anti-emetic drugs to be reported on hospice claims, as intended by CR 8358. See the Background and Additional Information Sections of this article for further details, and make sure that your billing staffs are aware of these changes.			
R633PI HHA	Medicare Program Integrity Changes - Pub. 100-08 Chapter 7	02/16/2016	MLN article not provided Chapter 7 link here
Change Request (CR) 9497 will remove 7.2.2.15-Policy Development from Chapter 7 of Pub. 100-08. 7.2.2.15-Policy Development is being removed due to duplication in the MACs (Medicare Administrative Contractors) Statement of Work (SOW) of the Work Breakdown Structure (WBS) for Policy Development. Improper Payment Strategy Reduction Plan (IPRS) and Strategy Analysis Report (SAR) workload tables will be updated to include a row labeled One on One Education.			
R3398CP Hospice	Processing Hospice Denials When Face-to-Face Encounter is Not Received Timely	04/01/2016	MLN article not provided Chapter 1 link here
R339CP Medicare coverage of hospice services requires a face-to-face encounter with a physician to be completed before the third hospice benefit period. As of the effective date, Medicare will use payer-only occurrence code 48 for internal processing with the definition "Date hospice face-to-face encounter was untimely." The medical reviewer will indicate the untimely date on the claim using this occurrence code and non-cover all subsequent line item dates of service, as currently happens in a partial denial situation. When the partially-denied hospice claim is sent to the Common Working File (CWF), CWF will post the occurrence code 48 date as the revocation date on the current benefit. The hospice claim will be accepted by CWF with line item dates beyond the revocation date when occurrence code 48 is reported, as long as those line items are non-covered. **This action will require the hospice to submit a new Notice of Election before any future dates of service can be submitted.** Make sure your billing staff is aware of this update.			

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Number	Description	Effective Date	Reference
R3411CP Both	Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE	04/01/2016	MM9350
CR 9350 Change Request 9350 is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries. This article instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2016. *EDI = Electronic Data Interchange			
R3413CP Both	Claim Status Category and Claim Status Code Update	04/01/2016	MM9427
CR 9427 Change Request 9427 informs MACs about the changes to Claim Status Category and Claim Status Codes. MM9427 is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7, and as needed the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions will be updated.			
R3418CP Both	Remittance Advice Remark and Claim Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update	04/01/2016	MM9374
CR 9374 Change Request 9374 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it. *EDI = Electronic Data Interchange			

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Number	Description	Effective Date	Reference
R3429CP Both	New Influenza Virus Vaccine Code	04/01/2016	Click here
CR 9357 Change Request 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015. Home Health Agencies (HHAs) – TOB 34X. Make sure your billing staffs are aware of this code change.			
R16230TN Both	Using scrubbed Medicare beneficiary/legal rep address data within the Fee-For-Service (FFS) systems - Analysis and Design	07/01/2016	MLN article not provided Click here
CR 9464 Change Request 9464 is to allow CMS shared system maintainers to conduct analysis and design activities to standardize Medicare beneficiary/legal rep address data across CWF, the Shared Systems, the Medicare Administrative Contractors (MACs), and all other entities. Enrollment Data Base (EDB) shall start sending scrubbed Medicare beneficiary address data to CWF instead of address data received from Social Security Administration (SSA) that is currently being shared with CWF. CWF shall store and provide Medicare beneficiary address data to all Shared Systems, A/B MACs and Durable Medical Equipment (DME) MACs. Implementation of this CR would eliminate the need for local data stores and minimize the use of Finalist at various systems.			
R3457CP HHA	New Condition Code for Reporting Home Health Episodes with No Skilled Visits	07/01/2016	MM9474
CR 9474 Change Request 9474 informs you of revisions of the Medicare billing instructions for home health claims to allow the use of a new condition code - 54. The code indicates that the HHA provided no skilled services during the billing period, but the HHA has documentation on file of an allowable circumstance. Make sure that your billing staffs are aware of these changes.			
R16220TN Hospice	Shared System Enhancement 2015 Analysis and Design HUOPCUT Hospice Period and Health Maintenance Organization (HMO) Processing	07/01/2016	MLN article not provided Click here
CR 9419 Change Request 9419 informs the Centers for Medicare & Medicaid Services (CMS) requests that the Common Working File (CWF) Maintainer standardize the claim logic for hospice periods and determination of Medicare liability dates. Claim logic is in all three CWF *CUT programs.			

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Number	Description	Effective Date	Reference
CMS-2348-F RIN 0938-AQ36 F2F HHA	Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health	*07/01/2016	MLN article not provided Click here
The final rule (CMS-2348-F) goes into effect on July 1, 2016; however, CMS acknowledges that states and providers may need more time. As a result, CMS is delaying compliance for up to one year in states like New York, and possibly two years for those states where the Legislature meets every other year. McKesson note to customers: Per CMS, "No states have submitted their state plans yet, therefore compliance/effective date for any state is not active."			
OASIS C2 HHA	Outcomes and Assessment Information Set (OASIS C2)	01/01/2017	MLN article not provided OASIS C2 Item Set-Effective 01/01/2017
The OASIS-C2 is scheduled for implementation on January 1, 2017. ▪ The version includes three new standardized items (M1028, M1060, GG0170c), along with modification to and renumbering of select medication and Integumentary items to standardize with other post-acute settings of care (M1311, M1313, M2001, M2003, and M2005). ▪ The lookback period and item number was changed in five items (M1500, M1510, M2015, M2300 and M2400). ▪ Formatting changes were made throughout the document to convert multiple check boxes to a single box for data entry, where responses are mutually-exclusive, and to change the numbering for pressure ulcer staging from Roman to Arabic numerals. ▪ New grouper will publish HH-PPS Grouper – Effective Date 10/01/2016 and 01/01/2017			

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Number	Description	Effective Date	Reference
R3475CP MACS	Updates to the "Medicare Claims Processing Manual," Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages	06/06/2016	MM9424
CR 9424 Change Request 9424 revises chapters 4 and 5 of the "Medicare Claims Processing Manual" to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. CR 9424 directs MACs to use remittance coding that is compliant with nationally standard Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules.			
R3467CP Both	Healthcare Provider Taxonomy Codes (HPTCs) April 2016 Code Set Update	04/01/2016 07/01/2016	MM9461
CR 9461 Change Request 9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC). CMS guidance: **Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016.**			
R3467CP EHR	Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 (CMS-3311-F)	03/30/2018	MM9461
This rule establishes the requirements for Stage 3 of the program as optional in 2017 and required for all participants beginning in 2018. The rule continues to encourage the electronic submission of clinical quality measure data, establishes requirements to transition the program to a single stage, and aligns reporting for providers in the Medicare and Medicaid EHR Incentive Program. CMS-3310-FC and CMS 3311-FC align with The Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. The program is a voluntary certification program established by the Office of the National Coordinator for Health IT to provide for the certification of health IT standards, implementation specifications and certification criteria adopted by the Secretary. The ONC Health IT Certification Program supports the availability of certified health IT for its encouraged and required user under other federal, state and private programs.			
SE1521 Revised	Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims	04/18/2016	SE1521
This Special Edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and QICs regarding the scope of review for redeterminations (Technical Direction Letter-160305, which rescinds and replaces Technical Direction letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after April 18, 2016, and will not be applied retroactively.			

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R3487CP HHA	Corrections to Recoding in the Home Health (HH) Pricer Program	01/01/2016 Effective 04/26/2016	MM9608
CR 9608 Change Request 9608 is to install a corrected HH Pricer program. It also requires Medicare Administrative Contractors (MACs) to adjust claims to correct recoding errors that resulted in inaccurate payments. This Recurring Update Notification applies to chapter 10, section 70.5.			
R3481CP MACS	Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages	06/20/2016	MM9562
CR 9562 Change Request 9562 informs MACs about revisions to Chapters 3, 6, 7 and 15 of the "Medicare Claims Processing Manual" to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout the manual. CR9562 does not reflect any change in Medicare policy.			
R3489CP Both	Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update	07/01/2016	Click here
CR 9466 Change Request 9466 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.			
Hospice	Medicare Program; FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements	NPRM	MLN article not provided CMS-1652-P
This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2017. In addition, this rule would propose changes to the hospice quality reporting program, including proposing new quality measures. The proposed rule also solicits feedback on an enhanced data collection instrument and describes plans to publicly display quality measures and other hospice data beginning in the middle of 2017. Finally, this rule updates hospice monitoring data analysis and provides discussion about ongoing monitoring efforts.			

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Legend:	Pale blue: Information for your agency, no change to the product was required	Green: Changes to the product have already occurred	Dark orange: Changes will occur in a scheduled release

Number	Description	Effective Date	Reference
MD/NPPs	Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)	NPRM	MLN article not provided CMS-5517-P
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changes the way Medicare rewards clinicians (Physicians/NPP) for providing quality care by streamlining multiple quality programs into a new Quality Payment Program tied to Part B Fee-For-Service payments. With the implementation of MACRA and the replacement of the Sustainable Growth Rate, CMS will pay clinicians (Physicians/NPP) participating in the Merit-based incentive Payment System or Advanced Alternative Payment Models of the Quality Payment Program beginning in 2019.			
RIN-0938-AS25 Both	Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability	07/05/2016	MLN article not provided CMS-2390-F
This final rule modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries.			
R1658OTN MACS	Coding Revisions to National Coverage Determinations	07/05/2016	MM9540
CR 9540 Change Request 9540 is the 7th maintenance update of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically, CR7818, CR8109, CR8197, CR8691, CR9087, and CR9252. You may review the corresponding MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM8907, and MM9252 for these CRs on the Centers for Medicare & Medicaid Services (CMS) website. Some are the result of revisions required to other NCD-related CRs released separately. Updated NCD coding spreadsheets related to CR9540 are available here.			

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Number	Description	Effective Date	Reference
R3518CP MACS	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2016 Update	07/05/2016	MM9636
CR 9636 Change Request 9636 informs Medicare providers and suppliers that effective for claims with dates of service on or after **July 1, 2016**, new Healthcare Common Procedure Coding System (HCPCS) codes Q9981 (rolapitant, oral, 1mg); Q9982 (flutemetamol f18 diagnostic); and Q9983 (florbetaben f18 diagnostic) will be payable for Medicare. In addition, the HCPCS code set will contain code Q5102 (Inj., infliximab biosimilar), which is effective for dates of service on or after April 5, 2016. Claims for Q5102 must also have the modifier ZB (Pfizer/hospira). Make sure that your billing staffs are aware of these changes.			
R3525CP	July 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)	7/05/2016	MM9658
CR 9658 Change Request 9658 intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and which are paid under the Outpatient Prospective Payment System (OPPS). CR 9658 describes changes to, and billing instructions for, various payment policies implemented in the July 2016 OPPS update. It identifies the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions that are reflected in the July 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.			
CMS-6069-N 5 State HHA	Pre-Claim Review Demonstration of Home Health Services (CMS-6069-N)	08/01/2016	Click here
CMS will be implementing a 3-year Medicare pre-claim review demonstration for home health services in the states of Illinois, Florida, and Texas by the end of 2016. CMS plans to include Michigan and Massachusetts in the demonstration in 2017. CMS is testing whether pre-claim review helps reduce expenditures, while maintaining or improving quality of care. The State of IL has an effective date of 08/01/2016.			
R3533CP HHA	Payments to Home Health Agencies That Do Not Submit Required Quality Data	08/30/2016	MM9651
CR 9651 Change Request 9651 updates instructions to the MACs for the home health 2 percent payment reduction process applicable to those HHAs that do not submit required quality data to Medicare. It also moves the instructions from the "Medicare Claims Processing Manual," Chapter 10, to the "Medicare Quality Reporting Incentive Programs Manual," Chapter 3. Thus, CR9651 conveys no changes to Medicare policy, but only transfers that existing policy from one Medicare manual to another. The revised manual chapters are attached to CR9651.			

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Number	Description	Effective Date	Reference
R3537CP Hospice	Billing of Vaccine Services on Hospice Claims	10/03/2016	MM9052
CR 9052 Change Request 9052 informs MACs about the changes to Original Medicare systems and provides billing instructions to allow hospices to submit institutional claims for influenza, pneumococcal, and hepatitis B vaccine services. Make sure that your billing staffs are aware of these changes.			
R3502CP Hospice	Making Principal Diagnosis Codes Mandatory for Notice of Election (NOE) to be Accepted	10/03/2016	MM9575
CR 9575 Change Request 9575 which informs MACs that hospice must report a principal diagnosis code with an NOE. Failure to submit the principal diagnosis code with the NOE will result in the claim (type of bill 8xA) being returned to the hospice without being processed. Make sure that your billing staffs are aware of this requirement.			
R3527CP	Claim Status Category and Claim Status Codes Update	10/03/2016	MM9550
CR 9550 Change Request 9550 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staffs are aware of these changes.			
R3538CP Revised	JW Modifier: Drug Amount Discarded/Not Administered to any Patient	01/03/2017	MM9603
CR 9603 Change Request 9603 informs MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals. Effective January 1, 2017, providers are required to: Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals) and Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded.			
CMS-1648P	Proposed Payment Changes for Medicare Home Health Agencies for 2017 (CMS-1648-P)	01/01/2017	Click here
The Centers for Medicare & Medicaid Services (CMS) announced proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2017 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Approximately 3.4 million beneficiaries received home health services from approximately 11,400 home health agencies, costing Medicare approximately $17.8 billion in 2015.			

MobileCare 3.0 offers new GUI and features

By Kristin Persson, Business Systems Analyst

McKesson Homecare MobileCare™ (MC) Release 3.0 became generally available to McKesson customers in June. Keeping all the features and functionality of MobileCare 2.0, MC 3.0 is an easy-to-use, intuitive iPhone® application with several exciting new features. MobileCare 3.0 is currently only for use with the Paraprofessional role; the Professional role will be added in the MC 3.5 update due out this fall.

New Features in MC 3.0:

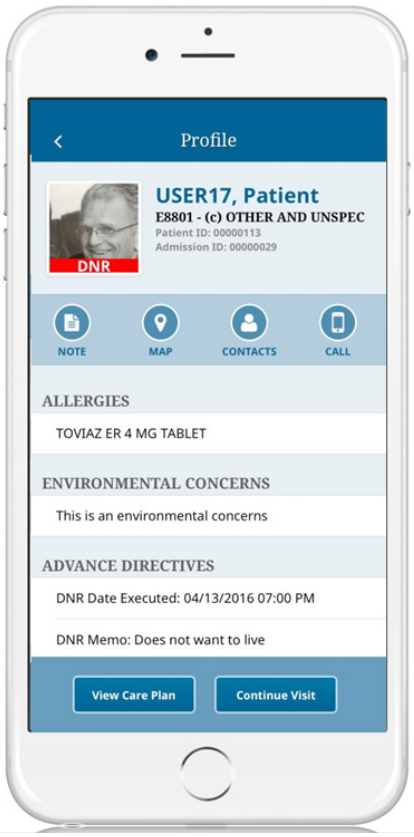
- MC 3.0 uses a 2-step authentication process to help ensure the highest level of security available to protect your agency's data.
- Works in both a connected and disconnected environment… No WiFi access necessary. If you have a cell phone signal, you're connected. If you don't have service, MC 3.0 stores the user's responses and inputs until the device has service again. MC 3.0 will automatically transfer the visit information back to the server; no manually syncing or transferring required.
- Patient signature – If you choose, your users can capture a patient's signature directly on the device at the end of the visit. ***(See Figure 1)***

This feature provides additional verification and validation that the visit occurred at the right time, in the right place with the right patient. This information is available in reporting on the Admin Console.

Figure 1

- Patient photo – Users can capture a photo of their patients to be included in the patient's profile in MC and in McKesson Homecare™ and McKesson Hospice™. Including the patient's picture in their profile helps provide an added level of patient safety. ***(See Figure 2)***

Figure 2



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MobileCare 3.0 offers new GUI and features

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- Easy to use, easy to train – Like many smart phone applications, MC 3.0 is extremely user-friendly and intuitive.
- MC Admin Console – The console received a facelift for MC 3.0. It still includes all the features and functionality of the MC 2 Admin Console but in a cleaner, easier to use format. A home page is even provided to give agency administrators at-a-glance information and alerts.

Coming this fall – MC 3.5

- Addition of the Professional Role
- Prevent visit time overlaps
- Ability to end a visit early without addressing all care plan items individually
- Expanded note functionality
- Enhanced patient profile
- Enhanced schedule screen – including filtering capabilities, visit duration, status icons
- Demo mode – great for training users on the use of MobileCare

Hardware/Software Requirements for MC 3.0 & MC 3.5:

- **Supported Devices (Touch ID required):**
  - iPhone 5s, 6, 6s, 6plus, 6splus – with iOS 9.x+
  - Carrier/Service: No known carrier restrictions in the United States.
  - Phones will need data plans. Data plans will vary depending upon usage, but 3-5GB monthly is recommended.
- **Environment:**
  - SQL Server 2008R2 and greater (to our max support limit)
- **Application:**
  - V13.3.3 (or greater) required
- **Browsers (for the Management Console):**
  - Most modern browsers, including IE 11, Chrome and Safari

If you are interested in implementing MobileCare for your organization, please contact your Account Executive.

Existing customers of MobileCare 2.0

During the development of MC 3.0 and MC 3.5, all existing MC 2.0 worklists were reviewed and addressed in the new application whenever possible. Because MobileCare 3.0 only runs on the Apple iOS platform and requires iPhone 5s or greater, we want to give your agency plenty of time to upgrade. We will continue to support MobileCare 2.0 until **June 30, 2017**.

Please contact McKesson Support today about upgrading to MobileCare 3.0 to take advantage of all the great functionality the application offers.

Focus group recommends revenue cycle priorities

By Deb McWhirter, Financial Product Manager

Significant updates are planned for the revenue cycle functionality in McKesson Homecare™ and McKesson Hospice™. The focus group kicked off earlier this year to plan and prioritize the project with 28 agencies participating. The group has determined and voted on the top 5 problem areas, and product management has conducted several interviews and onsite visits to gather requirements.

Top 5 areas

1. Solve for claim and A/R management
2. Solve for workflow that prevents accurate claims preparation
3. Solve for automating existing manual processes in system
4. Solve for authorizations management and tracking
5. Solve for episode recycling

Our approach to addressing these areas will be to redesign the financial functionality in a phased approach based on the priorities established by the focus group. We'll incorporate new technology rather than simply making updates to existing functionality. Various items from the top 3 priorities are planned for phase 1 of the project, which is currently targeted for the first quarter of 2017.

1. Solve for claim and A/R management

2. Solve for workflow that prevents accurate claims preparation

3. Solve for automating existing manual processes in system

The focus group has requested the following functionality:

- Ability to status claims. This includes denial and appeal tracking including reminders for claims that are nearly timely filing.
- Automate billing process. This includes the ability to sweep clean claims nightly and automatically create claim batches that are ready to send to a clearing house or payer.
- Create work queue for bills that do not pass edits
- Automate payment process. This includes automatically pulling in payment batches and creating those batches for review/generation. Most ERA files contain denial information. This information should be pulled in as well.
- Ability to track patient status from admission to claim submission
- Ability to track timely filing/ appeal guidelines
- Move billing rules that are currently in the claim formats to the payer/plan level

4. Solve for authorizations management and tracking

- Create work queue to manage authorizations
- Link authorizations to scheduling (optional)
- Recognize authorization per unit of measure (visits, hours)
- Manage authorizations based on visits performed not visits generated

5. Solve for episode recycling

- Update the areas of the application that cause recycles
  - For example: allow user to change payers for episodic plans without requiring a new admission
- If a recycle cannot be prevented, automated the process

Overall Business Value

The value of updating the financial backend to reflect a more process-driven workflow means savings in the following potential areas:

- Staffing
- Time savings
  - Automation
  - Reduced re-work
- Financial write-offs

In addition, our goal is to increase the following areas:

- Flexibility in managing own payer rules
- Satisfaction of using the system

Great collaboration makes a great conference better

HHNUG Helps Set the Agenda for the 2016 McKesson Homecare & Hospice National Users' Conference

September 27-29, 2016
Grand Hyatt San Antonio
San Antonio, TX

- Review the agenda
- Register for the conference
- Book your hotel

Past attendees to the McKesson Homecare & Hospice National Users' Conference know that we bring in the best conference speakers possible. This year's conference, September 27-29, 2016, is shaping up to be the strongest yet, thanks to our vibrant alliance with the Homecare and Hospice National Users' Group (HHNUG).

The HHNUG Board has worked with McKesson staff from the earliest stages to help define the agenda, identify conference speakers and recommend participants for the vendor fair. The result is a conference agenda that showcases the broadest product-driven sessions we've offered in years.

In addition to more than three dozen education sessions aimed at executives, clinical staff, operational/billing staff, hospice staff and technology/IT, you'll also get ample opportunity to visit with industry experts, McKesson staff, key vendors and other home care providers.

This year's theme, "Making it Happen – Together," reflects McKesson's relationship with HHNUG, with you and with every home care organization as we face – together – current and future challenges and opportunities.

Register now for the 2016 McKesson Homecare & Hospice National Users' Conference, September 27-29, 2016, in San Antonio, TX.

Registration deadline:
September 22, 2016
$375 Early Bird rate (prior to September 2, 2016)
$425 after 9/2/16

McKesson Homecare & Hospice Users' Conference

- September 27, 2016: 3:30 - 5:00 p.m.
- September 28, 2016: 8:00 a.m. - 5:15 p.m.
- September 29, 2016: 8:00 a.m. - 4:00 p.m.

Grand Hyatt San Antonio
600 East Market St.
San Antonio, TX 78205
Phone: 210.224.1234

Rates:

- Single: $199
- Double: $224
- Triple: $249
- Quad: $274

Deadline: September 2, 2016

Q&A with the Technical Resource Team

As a monthly feature of PATHFinder, we include the Q&A section of the previous upgrade management call to provide a handy reference for your IT staff.

Q: How soon after we install Summer Regulatory Release 13.5 do I need to install WebChart/Portal 13.5.0.1?

Q: What happens if we wait a month to update Web Chart after the 13.5? Will an error happen whenever a physician wants to look at a medication? What about signatures for medication verbal orders?

Q: Also if we are medication-conversion-exempt is the Web Chart update still as critical?

A: The Web Chart 13.5.0.1 release specifically addresses the ability for the portal to pull data from the new Medication Profile tables. If your agency has the conversion, until you upgrade your WebChart system, your users will be unable to pull up medication information. If your agency is exempt, you will not be required to install the Web Chart upgrade until you install McKesson Homecare and Hospice v14.0.

Q: Will we need the exemption script even if our agency has an active IPU?

Q: We don't think we have any IPU set up anywhere. Is there any way we can check and make sure?

A: If your agency currently has an active IPU the 13.5 install will recognize this and will not require the Exemption Script to be run. If you are unsure of your IPU status, contact McKesson Support so we can help you determine this status.

Q: If we have built the various PRN variations in Med Frequency (i.e. 2x/day PRN), will those require the medications to be manually updated?

A: Yes. PRN frequencies do not have a one-to-one conversion entry in the new Medication Profile so the system is not able to determine how to match them during the 13.5 upgrade.

Q: If we will be running the Exemption Script, what is the impact to the Point-of-care devices if they do not complete a transfer prior to installing the 13.5 ESDs? Are the Utility meds being affected if we run the Exemption Script?

A: If you are exempt from the Medication Profile, either from having an active IPU or from having the Exemption Script run on your environment, none of the medications in the system will be converted. Medications that have not been transferred to the server do not need to be converted either so users will not be affected.

However, Utility medications are not directly addressed by the 13.5 upgrade and agencies should have clinicians actively reconciling medications that fall into the Utility category. Since the 14.0 upgrade is currently scheduled to fully update all environments to the Medication Profile, agencies should be preparing now for that conversion if they are exempt currently.

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Q&A with the Technical Resource Team

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Q: Can we have laptops install Summer Meds and 13.5 during same upgrade?

A: Yes. However, agencies should allow enough time for all records created by both the Summer Meds install AND the 13.5 Meds conversion to process through Audit Publisher before opening up the transfer system and allowing laptops to download the upgrades. Please remember that users will pick-up any new "Classic Meds" table changes on their second subsequent transfer along with the Medication conversion updates and install times will be longer than normally expected.

Q: Can you give us an indication of how many more records can be expected in AudRaw after the 13.5 upgrade? What about a time frame for how long it may take to process the records?

A: We released scripts on InfoCenter to run before your 13.5 upgrade to give an estimate on how many records may be created by the 13.5 Datasync. You can find these on the InfoCenter Downloads page under the title, "Pre 13.5 Medication Conversion Scripts". To plan for the amount of time it will take to process all records created, we highly suggest running the 13.5 install in a TEST environment that is a copy of PROD. This will allow you to plan for Audit Publisher to be able to process all records for distribution to field devices.

Q: Does the attestation display during the laptop ESD install or does it only show up on the server?

A: The attestation statement is only displayed when doing a Server/Workstation install.

Q: I ran the custom Medication script to find medications that need updating before upgrade. However, it is not clear what exactly is needed to be done with these in advance. Who do I reach out to for explanation on what was found that needs to be fixed?

A: Contact McKesson Support and choose either the Advanced Clinical or the Clinical Management teams for assistance in addressing Utility medications.

Q: We use IPU, what version will the Phase II medication profile update be released?

A: Phase II of the Medication Profile, which includes updating the IPU system, is currently scheduled for release in version 14.0.

Q: We are currently using a custom pwhc.exe and pwchgpwd.exe designed by McKesson. With 13.5 do our custom files need to be updated to be compatible?

A: If you have customizations of any kind, it is possible that any upgrade may affect their functionality. Your agency should contact McKesson Support and choose the Customization queue so we can check to see if new versions of the applications are needed.

Q: Will Homepages be for users of Clinical Explorer or Clinical Management?

Q: Are Homepages mandatory? Can we install 13.5 but disable Homepages and then enable them at a later time?

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Q&A with the Technical Resource Team

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A: The new Homepages feature is currently for any Clinician regardless of if you are using Clinical Explorer or Clinical Management. Future releases will add the similar functionality for other roles in your agency. Homepages are delivered in 13.5 disabled for ALL users. Agencies can turn this on for individual users to begin testing. A script will be provided on request to turn on Homepages for all users at once or classes of users when agencies are ready to fully implement the feature.

Q: Do users have to be administrators to install the Microsoft C++ ESDs?

A: The two executables are new versions of C++ and will require elevated privileges to be installed. If your agencies end-users do not have the required rights, the ESDs should be delivered with override privileges. Since 13.5 is an MSI and requires elevated install privileges, agencies should follow the same setup for the C++ executables.

Q: If we have to re-stage a laptop, can we install version 13.0 then version 13.5 followed immediately?

A: Yes, and if your agency uses Rapid Deployment, it will reduce your install time since only the latest MSI install of the main application, in this case 13.5, will be installed.

Q: Do we know when the new Grouper will be required?

A: There will be two Grouper updates this year. The first will be delivered in the Fall Regulatory update (v13.5.1) and the second with the Winter Regulatory updates (versions to be determined).

Q: Do we need a Services contract to set up MobileCare 3.0 in a TEST environment?

A: If your agency currently has MobileCare 2.0, you need to make some modifications to the existing VPN in order for it to work with MobileCare 3.0. Contact McKesson Support to arrange a meeting with our Automation Team to plan for these changes.

If your agency would like to implement MobileCare 3.0, contact your Account Executive to discuss what is required to add this feature to your system.

Q: Could MobileCare 3.5 be considered as a replacement for point of care laptops for use by skilled clinicians? Will OASIS visits be able to be performed?

A: MobileCare 3.5 will add the current 2.0 functionality for Professional users. This functionality includes the ability to log visit arrival and departure times, verify the location of the Professional user, and utilize the “add-a-stop” functionality. MobileCare 3.5 is not a replacement for the full functionality a Point-of-care device delivers to users in the field.

Q: Any information on the Electronic Visit Validation (EVV) application that you can give?

A: We look forward to presenting information on this new application in an upcoming Technical Release Management Call closer to the release date.

Support FAQs

Based on trends in the McKesson Homecare™ and McKesson Hospice™ Product Support calls we receive, we have identified several areas of potential confusion for our customers. These tips are documented in the Knowledge Base or Work List, which you can access on InfoCenter.

Frequently Asked Questions on Release 13.5 Medicaid Hospice SIA functionality (KB 1023438)

Effective for dates of service on or after January 1, 2016, CMS established new payment rate called Service Intensity Add-on (SIA). This payment is made for visits provided by a skilled nurse or a social worker to patients receiving Routine (RT) home care during the last seven days of the patient's life. Many state Medicaid Hospice plans require additional information to be reported on claims in order to make the SIA payment. 13.5 provides functionality to include additional information depending on the requirements defined by each state.

The intent of this knowledgebase (KB) is to serve as a Frequently Asked Questions (FAQ) document on SIA included in the 2016 Summer Regulatory Release (v13.5) - Projected GA Date 6/17/2016.

Q: Prior to installing the 13.5 release, is there anything we can do to prepare for billing SIA for Medicaid Hospice? Is there any setup required for my Medicaid Hospice plans specific to pulling SIA to the claims?

A: Many Medicaid Hospice plans require the non-billable SN and MSW services to be reported in 15 minute increments on the claim. In order to capture the non-billable service units in 15 minute increments, set up the billing units and price for the non-billable services in Insurance Payors.

To set this up, follow the steps below:

1. Go to Insurance Payors and select the Medicaid Hospice plan.
2. Go to Set Plan Rates and Reimbursement and add a new billing rule.
3. Set the Effective Begin Date to 01/01/2016.
4. On the Billing Rules dialog box, on the Billing tab, make sure Visit is unchecked.
5. Under Billing Units, set 'Per unit of service' to 4.
6. Set the Minimum Quantity to 1.
7. In the Rounding Fractional Units area, select 'Nearest Whole'. Leave the default of 0.5 in the Breakpoint Unit field and 7.5 in the Breakpoint Minute field.
8. On the Charges & Payment screen under Price Rules, select 'Override standard price' and enter what the price is for one 15 minute increment.
9. Click on the OK button to save the record.

If you have generated SN and MSW services for Medicaid Hospice patients since 2016 that qualify for SIA prior to setting up the Plan Rates and Reimbursements with 'Per unit of service' set to 4, then the services will not appear on the claim in 15 minute increments. These services will need to be removed and regenerated using Adjustment Action #9.

Hospice Verification & Adjustment Process (HVAP) can assist with identifying services provided to Medicaid Hospice patients receiving RT Home Care during the last seven days of life. This will help if the visits need to be removed and regenerated to pull in 15-minute increments to the claim.

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Support FAQs

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To do this, follow the steps below:

1. Click on the Processed tab in HVAP and set 1/1/2016 as the Death Date through the current date.
2. Select all Processing Status checkboxes and click on Apply.
3. Records will appear for any qualifying patient. In the header line for the results, click on the checkbox on the left side. This will check all of the records on the page. Make sure all of your records are selected, then click on the button 'Export to Excel' on the lower right hand side.
4. Name your file and save it. You can use this file to provide a list of patients and their non-billable SN and MSW visits that were delivered during the last days of their lives. These services may potentially need to be removed and regenerated if they do not print on the claims in 15 minute increments.

Q: Is there any setup required in Services Maintenance to include SN and MSW services on Medicaid Hospice claims for RT Home Care Level of Care (LOC)?

A: Yes, the non-billable services that need to be included on the Medicaid Hospice claims for the RT LOC services need to be set up in Services Maintenance under the Hospice discipline by expanding Services, finding the specific Routine LOC service, Billing Codes, and finally Revenue. If there is an existing Revenue Code and current date range set up, click on it to view the Associated Non-Billable Services for the RT LOC Revenue Code. Revenue Codes for disciplines other than SN and MSW defined here will not trigger those disciplines to pull to the claim. However, Revenue Codes for SN and MSW must be defined in order to pull these disciplines to the claim.

If there is are no Revenue Code records setup under the RT LOC service(s), expand Plan Override, then Revenue to see if the non-billable Revenue Codes are associated at a plan level. If there are Plan Override records, check the Insurance Plans on these records to see if Medicaid Hospice is one of the plans. If not, you will need to setup the Associated Revenue Codes at either the service level or the Plan Override level for SN and MSW Revenue Codes.

Q: 13.5 provides a new Claim Rules screen in Insurance Payors on the Reimbursement Rules Tab. What does this do?

A: For Hospice plans, there are four checkboxes that enable certain functionality.

Occurrence Code 55 Required will automatically output Occurrence Code 55 and the date of death when the check box is checked and the begin date of the claim is past the Effective Begin Date defined.

Non-billable Services Required will cause the claim to pull SN and MSW non-billable services to the claim when they are provided during the last seven days of a patient's life and HVAP has been run to create SIA.

Occurrence Span M2 Required will allow Occurrence Span Code M2 with and date range to print to the bill for every instance of Respite (RP) care a patient receives.

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Support FAQs

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SIA Service Required will allow Bill Processing to report the SIA payment amount along with a specified Revenue Code, HCPC Code, and Modifier.

For Hospice and Home Health, there is an option on how to report Visits Spanning Midnight Rules on the claim. The choices are to report the visit on the first day, the 2nd day, or span the visit across days.

Q: How do I know whether to select Non-billable Services Required or SIA Service Required checkboxes?

A: If the Medicaid Hospice plan requires the non-billable services, meaning the SN and MSW services that qualify for SIA, to appear on the bill, use the Non-billable Services Required checkbox. Claims will report the non-billable services along with the fee defined in Service Maintenance or in Insurance Payors.

If the Medicaid Hospice plan requires a specified Revenue Code, HCPC Code, and possibly a HCPC Modifier, along with the SIA payment rate, use the SIA Service Required checkbox. The majority of the state Medicaid Hospice plans require the non-billable services, but there are a few that require an SIA line.

If both Non-billable Services Required and SIA Service Required checkboxes are selected, the claims will print with detail lines for the SN and MSW services in addition to a SIA line. Do not select both checkboxes.

Q: Will new claim formats be posted for 13.5?

A: At this time we are not planning to repost claim formats for 13.5. Changes have been made in Insurance Payors to accommodate the changes to include SIA. There may be a few claim formats that will be reposted depending on regulations for those payors, but at this time we are not aware of any requirements that would require claim format changes.

Support FAQs

Frequently Asked Questions (FAQ) on 13.5 Home Health Value-Based Purchasing (HHVBP) reporting (KB 1023701)

This KB serves as a FAQ document on the HHVBP functionality delivered with v13.5.

Last updated 7/12/2016

Q: How are patients pulled to the Admissions Statistics Report for Home Health Value-Based Purchasing (HHVBP) reporting after loading v13.5?

A: Patients pull to the Admission Discharge Report (HHVBP option) by the following criteria:

1. Completed Assessment where M0030 is prior to the report end date
2. Completed Assessment where M0090 is within the report date range
3. Must have a plan in the billing sequence that is an HHVBP plan (as selected in Insurance Payors)
4. Must be a Homecare Admission (not hospice or bereavement)

In Clinical Explorer, an Assessment is considered completed when a User does one of the following:

- Completes the Assessment via a Visit Note and marks the visit complete through the Tools "Complete Visit Note" process and sees the red check mark on the Visit, OR
- Completes the Assessment via Clinical Forms and marks the Form complete through the Tools "Complete Clinical Form" process and sees the red check mark on the Form.
- Once a Clinical Explorer Assessment is extracted to CMS, it then becomes locked.

Depending on the date range the user is running the report for, the system will determine whether the patient is included in the report or not based on the following dates:

- Completed (not locked) M0030 SOC date that is prior to OR during the reporting period
- Completed (not locked) M0906 DC/TRF date that is during the selected reporting period
- A patient who isn't pulling to the report because the patient's SOC has been completed, but has not yet discharged (DC/TRF) from the Agency as of the end of the reporting period, will eventually pull to the report after the DC/TRF Assessment has been completed.

*Note: The patient will not come over on the Admission Discharge Report (HHVBP option) Report without having a complete SOC and/or DC/TRF Assessment with a M0906 date. The M0906 discharge date is going to determine WHEN they are reported on.

Q: We have all the System Options enabled for tracking the Herpes Zoster (Shingles) Vaccine, yet we are unable to add the HZ (ZS/ZV) Event to patients to track vaccination status. Why?

A: Whichever Event Code entered for the "HHVBP - Zoster (Shingles) Vaccination Event" System Configuration option needs to be manually entered in Miscellaneous Codes > Event Type Codes (EVT). Once this Code is added within Miscellaneous Codes, it will be available for selection in Event Summary.

McKesson Homecare™/McKesson Hospice™ Support

When you make a call to the McKesson Extended Care Solutions Group Customer Support Department regarding a new issue, you will be routed directly to a Support Analyst. The Support Analyst will begin researching your case. Your call will be assigned a priority level depending on the severity of the issue. The three priority levels are Critical, High and Standard:

Critical: Any issue adversely affecting the delivery of patient care or causing financial liability due to operational or information deficiency.

High: Any issue that is not adversely affecting the delivery of patient care or causing financial liability but is repeatedly affecting customer usage or data integrity.

Standard: Any issue that does not impact the operation of use of the system or an issue for which an alternative solution or workaround exists.

When you call Support, please have your Enterprise ID number or Case ID number available for the Support Call Coordinator.

When you send a fax to Support, please put the Enterprise ID or Case ID on the cover sheet of the fax.

Please have the following information available when the Support Analyst returns your call:

1. The exact error message.
2. Can the error be reproduced?
3. The exact steps leading up to the error.
4. The version of Horizon Homecare, McKesson Homecare™, Horizon Hospice, or McKesson Hospice™ and the database in which you are getting the error.
5. Are other users/workstations experiencing the problem too?
6. Error messages in the NT Event Viewer or SQL error log.
7. If the issue is occurring on a field device, McKesson's Support department may require direct access to that machine for troubleshooting.

Support hours
Standard: 7a—7p CST
Monday through Friday

Critical/High: 24 hours a day

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