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HOME CARE WEEK™

News & Analysis On Reimbursement, Regulations, Finance, Operations, & Compliance

Nearly All HHAs Flunked TPE Review In Latest Round. The latest results from the Targeted Probe and Educate medical review program indicate you are virtually doomed if you land on TPE review. Out of the 122 home health agencies that HHH Medicare Administrative Contractor **CGS** reviewed under the TPE round 1 eligibility and medical necessity probe (5A000) from July 1 to Sept. 30, only one was found "compliant," according to a TPE update. (Page 346)

Take These Steps To Combat TPE. Home health agencies affected by Targeted Probe and Educate review, or those just wanting to stay off the TPE radar, should focus on the program's top denial reasons. "Most all areas relate to poor documentation or knowledge deficit, particularly regarding Face-to-Face, Plan of Care, and recerts for home health," highlights one industry expert. (Page 346)

TPE Performance Is Going The Wrong Way. When Medicare launched its Targeted Probe and Educate medical review campaign last year, providers were hopeful they would get the hang of it and the extreme TPE failure rates would improve. Instead, the opposite seems to be happening. New results from one HHH Medicare Administrative Contractor show that the proportion of home health agencies found "compliant" dropped from 20 percent last time to a tiny 0.65 percent. (Page 347)

Face-To-Face Tops Latest TPE Denial List. You don't have to experience Targeted Probe and Educate review first-hand to learn some lessons from the program. Take a look at the top denials for clues on where to direct your resources. To no one's surprise, the face-to-face physician encounter ranks as the number-one issue. (Page 348)

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Medical Review

Nearly All HHAs Flunked TPE Review In Latest Round

Medicare needs to examine its requirements, experts charge.

The latest results from the Targeted Probe and Educate medical review program indicate you are virtually doomed if you land on TPE review.

Why? Out of the 122 home health agencies that HHH Medicare Administrative Contractor **CGS** reviewed under the TPE round 1 eligibility and medical necessity probe (5A000) from July 1 to Sept. 30, only one was found "compliant," according to a TPE update posted on the MAC's website Nov. 29. The other 121 agencies that completed round 1 review for the topic moved on to round 2 of the program.

The results for long-stay and non-response probes were equally dismal, CGS reveals. The MAC completed one probe each for claims with lengths of stay exceeding 120 days (5A002) and 180 days (5A003), respectively. TPE reviewers deemed both agencies reviewed non-compliant, advancing them to round 2.

CGS reviewers completed 28 non-responses to Additional Development Request probes (5A004) in the three-month period, and found all 28 agencies non-compliant, moving them to round 2 as well.

"That failure rate is disheartening," notes consultant **Joe Osentoski** with **QIRT** in Troy, Michigan — not to mention almost "unbelievable."

"This is very troubling in so many ways," says **Lynn Olson**, owner of billing company **Astrid Medical Services** in Corpus Christi, Texas. "A statistician would find the results invalid, or data was intentionally skewed," Olson adds.

National Association for Home Care & Hospice President **William Dombi** finds the extreme numbers "very surprising," noting they have deteriorated from previous TPE results (*see story, p. 347*).

As in previous TPE periods, the Face-to-Face physician-encounter requirement continues to give HHAs the most trouble, CGS indicates. F2F accounts for about 25 percent of all TPE denials, the MAC says (*See story, p. 348, for top denial reasons*).

The extreme failure rate under TPE sounds crazy, notes reimbursement expert **M. Aaron Little** with **BKD** in Springfield, Missouri. But it, as well as the denial reasons, are in line with what BKD has seen.

TPE is very intensive, "where there is a large concentration of ADRs — rather than just one off here and there like was typical prior to TPE," Little explains. That intense level of review "is exposing a number of documentation deficiencies that haven't previously been escalated to the attention of the providers," he says.

Silver lining: "On the one hand, it's good that these issues are being identified so that the providers can have an opportunity to address them," Little says. "On the other, they are very costly lessons to be learned."

Past Time For A Change

With physicians responsible for the heavy lifting on F2F documentation, Osentoski wonders if Probe and Educate education from the MACs "is directed to the wrong target?" Perhaps physicians should be the ones receiving MAC education, he tells **Eli**.

Or an even bigger change is needed. "Given that the alleged noncompliance continues to be documentation-related, it is likely time for CMS to revisit its requirements to make them easier to understand and implement," Dombi proposes. "After seven years of repeated difficulties with the face-to-face documentation requirements, it seems the problem is more with the policy rather than the HHAs," Dombi tells **Eli**.

Finding only one of 122 agencies compliant "is just nuts," says **Sharon Litwin** with **5 Star Consultants** in Camdenton, Missouri. "They need to see it's the process and the auditors, not the agencies," Litwin agrees. ❖

Note: See the results at www.cgsmedicare.com/hhh/pubs/news/2018/1118/cope10075.html.

Reimbursement

Take These Steps To Combat TPE

Don't forget about appeals.

Home health agencies affected by Targeted Probe and Educate review, or those just wanting to stay off the TPE radar, should focus on the program's top denial reasons.

"Most all areas relate to poor documentation or knowledge deficit, particularly regarding face-to-face, plan of care, and recerts for home health," highlights **Sharon Litwin** with **5 Star Consultants** in Camdenton, Missouri.

Litwin advises providers to:

• make sure they have a good intake process for F2F;

• follow up and work with physicians to ensure they have all required documentation; and

• ensure the F2F reason is consistent with the home health primary reason/diagnosis.

And, as always, HHAs should be certain "of course, that the plan of care is patient-specific, has measurable goals, and has appropriate interventions," Litwin adds.

Don't forget: Recerts must indicate a continued skilled need, Litwin advises. HHAs that are having difficulty with these requirements may need outside help to get up to speed, she suggests.

HHAs facing TPE denials can zero in on their particular problem areas by carefully analyzing the feedback they get in their one-on-one education calls from the MAC. Remember, "providers found to be non-compliant at the completion of Round 1 will advance to Round 2 of TPE at least 45 days from completion of the 1:1 post probe education call date," HHH Medicare Administrative Contractor **CGS** says in its TPE results article.

"The education calls will be very important for all agencies to do to see exactly what the issue is," Litwin stresses.

But don't wait until you are on TPE to play defense, urges consultant **Joe Osentoski** with **QIRT** in Troy, Michigan. "The moral" of the latest results "is to not get targeted," he says.

In that vein, "CGS offers education at any time for providers," the MAC says in the TPE results article. "Providers do not have to be identified for TPE to request education. CGS encourages providers to request education and conduct self-monitoring based on our posted Medical Review Activity Log and using tools such as Comparative Billing Reports (CBRs) offered through our web portal."

Medical Review

TPE Performance Is Going The Wrong Way

More HHAs wind up in 'significant' error category in latest results.

When Medicare launched its Targeted Probe and Educate medical review campaign last year, providers were hopeful they would get the hang of it and the extreme TPE failure rates would improve. Instead, the opposite seems to be happening.

New results from HHH Medicare Administrative Contractor **CGS** show that out of 152 completed probes in the quarter ended Sept. 30, only one home health agency was found "compliant" — a tiny 0.65 percent.

In comparison, last time CGS reported TPE results, which went from Oct. 1, 2017 through March 31, 2018, about 20 percent of agencies were found "compliant" and 80 percent went on to round 2 (*see Eli's HCW, Vol. XXVII, No. 20*).

HHH MAC **Palmetto GBA** didn't publicly report how many agencies failed TPE round 1, but did tell **Eli** that as of May 23, 2018, reviewers had denied about 30.7 percent of claims (*see Eli's HCW, Vol. XXVII, No. 21*).

While failure rates appear to have increased dramatically for CGS agencies, "the areas of noncompliance virtually [are] the same ones, particularly face-to-face documentation," points out **National Association for Home Care & Hospice** President **William Dombi**.

Keep in mind that the TPE failure rate likely wouldn't hold true for the entire industry. "These agencies were targeted to be included in the reviews," notes consultant **Joe Osentoski** with **QIRT** in Troy, Michigan.

Another big difference: The new CGS results show a higher proportion of agencies in the "significant" risk category. From July 1, 2018, to Sept. 30, 85 percent of agencies fell in the "significant" category (indicating an error rate greater than 50 percent), 14 percent in the "moderate" category (error rate 26 to 50 percent), and 1 percent in the "minor" category (error rate 0 to 15 percent).

In contrast, during the time period from Oct. 1, 2017, to Sept. 30, 2018, 79 percent of agencies reviewed fell into the significant category, 18 percent moderate, and 3 percent minor. If you removed the latest quarter data from that, presumably the difference would be even greater. ❖

Plus: If you find denials under TPE are unfounded, exercise your right to appeal, Litwin urges. "If all agencies do this and can … have them overturned, *maybe* that will show CMS/OIG that the TPE system is the flaw," she exclaims.

There should be fertile ground for appeals, expects **Lynn Olson**, owner of billing company **Astrid Medical Services** in Corpus Christi, Texas. For example, AMS has seen "providers informed the FTF was not included with the documentation, even though many of the providers had included the documents. There was not a clarification if the FTF was incomplete, date errors, etc. When providers resubmitted the FTF, unchanged, it was accepted and the claim paid," Olson relates. ❖

Note: For more tips on staying off or defending against TPE, see Eli's HCW, Vol. XXVII, Nos. 11, 21, and 32.

Documentation

Face-To-Face Tops Latest TPE Denial List

Good news: One of the most common denial reasons will go away in the new year.

You don't have to experience Targeted Probe and Educate review first-hand to learn some lessons from the program. Take a look at the top denials for clues on where to direct your resources.

From Oct. 1, 2017, to Sept. 30, 2018, TPE reviewers for HHH Medicare Administrative Contractor **CGS** cite these reasons most often for denying claims:

1. Face-to-Face missing/incomplete/untimely — 25 percent of denials. Common problems were that the actual F2F encounter document was not submitted; the certifying physician did not document the date of the F2F encounter; the community physician was not identified when a physician who would not be following the patient after discharge signed the certification; and the required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification.

2. Initial certification invalid — 13 percent. See an example of a valid cert statement at www.cgsmedicare.com/hhh/pubs/news/2018/0118/cope5731.html.

3. Medical records were not received — 11 percent. In the latest quarter, CGS noted that in 30 of the 152 probes it conducted (20 percent), providers didn't respond to Additional Development Requests. "The non-response is inexcusable and feeds the 'waste, fraud, and abuse' narrative," says consultant **Joe Osentoski** with **QIRT** in Troy, Michigan.

4. Recertification estimate missing/invalid — 9 percent. It's no surprise this is on the list, since CGS "often receives calls from providers asking about the recertification requirement for physicians to include an estimate of how much longer the skilled services will be required," the MAC notes on its website. But the good news is that the requirement shouldn't dog HHAs much longer. The 2019 HH PPS final rule eliminates the requirement, as of Jan. 1, 2019, that the certifying physician estimate how much longer skilled services are required when recertifying the need for continued home health care, according to the rule published in the Nov. 13 *Federal Register* (*see Eli's HCW, Vol. XXVII, No. 38*).

5. Plan of care missing/invalid — 7 percent. A fact sheet on this requirement is at www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hpln-5hord_factsheet.pdf.

What else? "The five top denials account for 65 percent of the total," points out **Lynn Olson**, owner of billing company **Astrid Medical Services** in Corpus Christi, Texas. "I would like to know what the remaining 35 percent of issues are." ❖

*Note: You can find out about TPE hot topics from HHH Medicare Administrative Contractor **Palmetto GBA** in quarterly teleconferences throughout the year. The next one is March 4. Dial-in information is at www.palmettogba.com/event/pgbaevent.nsf/SeriesDetails.xsp?EventID=B74TM73304.*

Fraud & Abuse

Fraud Enforcement Focuses On Medicaid

Charges include fake time sheets.

Twelve people, including two sisters who are home health agency owners, have been indicted in an alleged scheme that bilked Pennsylvania Medicaid of millions.

Sisters **Arlinda Moriarty**, owner of **Moriarty Consultants**, **Activity Daily Living**, and **Everyday**

People Staffing, all in Pittsburgh, and **Day-nelle Dickens**, owner of **Coordination Care**, were named in the indictment, reports the *Pittsburgh Gazette*. Ten of their employees were also indicted, and four others were indicted on charges related to concealing the fraud.

"The indictment sets forth dozens of fraudulent acts by the defendants, including making false claims for services that were never provided, creating fake employees, improperly using consumers' personal identifying information, and falsifying documentation during state audits of the companies," the **Department of Justice** says in a release. "In some instances, the indictment alleges that the defendants were actually working at other jobs or living out of the area. In other instances, Medicaid claims were submitted for services for consumers who were actually hospitalized, incarcerated, or deceased," the DOJ says.

The sisters were the targets of a lawsuit brought by the federal government in 2017 alleging false Medicaid billings, the *Gazette* reports. Moriarty expressed surprise at the time and said she never directed anyone to commit fraud, according to the newspaper.

"When criminals cheat and steal from [home care] programs, they not only steal from the taxpayers, but they steal from the most vulnerable members of our community," U.S. Attorney **Scott Brady** says in a release.

In Virginia: A home health agency owner in Virginia has been indicted on Medicaid fraud charges in a $4.5 million scheme, reports *NBC 4 News*. **John Ndunguru**, president of **Mercy Services of Health** in Springfield, is accused of submitting Medicaid claims for patients who were not approved for long-term care.

Prior to the indictment, the attorney general raided Mercy's offices and seized computers and documents, the news station says. Court documents also allege forged physician signatures, missing documentation, and missing background checks for aides. The agency services about 90 patients and employs about 100 aides, a staffer told *NBC 4*.

In St. Louis: A home care aide has pleaded guilty to submitting false time sheets to Medicaid for home care services, for times he was actually traveling or working another job. In one instance, **Demagio Smith** was on a Caribbean cruise, the DOJ says in a release. Five others have already been convicted or pleaded guilty in the case.

"Home health care is a more convenient alternative to skilled nursing facilities, and it saves tax dollars because it is less expensive," the **FBI's Richard Quinn** says in a release. "People who abuse and cheat the system take money away from those who truly need the services." ❖

Compliance

Beware These Gift-Giving Taboos At Holiday Time

Remember, Medicare is a whole different world when it comes to gifting to your associates.

Giving gifts to those you work with may seem like a natural way to share holiday cheer this time of year — but be careful you're not inviting fines or even criminal charges under updated guidelines.

Background: Showering lavish gifts on referring physicians, other healthcare associates, business partners, vendors, and/or patients can get you into hot water with the feds. Additionally, the last year's enforcement results highlight that the **HHS Office of Inspector General** has put gift-giving at the top of its target list, levying substantial penalties for providers bunking federal laws. So it is important to remember that depending on the value and circumstances of your gift, the feds can — and do — bring major fines for gift-giving violations under the Anti-Kickback Statute (AKS) and the Stark Law.

Though the temptation to celebrate the season with gift-giving can be overwhelming, it's wise to check yourself and follow the rules. Under the AKS, even if you have the very best of intentions, gifts suggest a financial obligation — and that's a no-no.

"Gifts from health care providers to referral sources, patients, vendors, and colleagues can create unintentional sticky situations," cautions attorney **Patricia Hofstra** with **Duane Morris** in Chicago.

AKS: Remember that the AKS is a criminal law and violating the gift-giving rules outlined under the regulation is considered a crime. "It is a felony to offer, provide, request, or accept any payment if one purpose is to influence payments under a federal healthcare program," stresses attorney **David Glaser** with **Fredrikson & Byron** in Minneapolis. "Paying referral sources is a big problem."

This is particularly important for Medicare and Medicaid providers, as AKS is tied up with federal healthcare programs. Enforcement activity also shows that providers who frequently incentivize

referrals with big holiday payouts may face both civil and criminal indictments — and exclusion from state and federal healthcare programs down the line.

"Significantly, the AKS applies to both the giver and recipient; thus, soliciting or receiving gifts from vendors or other providers may expose the recipient to liability," explains attorney **Kim Stanger** of **Holland & Hart** in legal analysis of the statute. "The OIG has suggested that 'nominal' gifts would not create much AKS risk, but offers no guidance as to what is 'nominal'."

"In some industries, it is acceptable to reward those who refer business to you," OIG reminds. "However, in the federal healthcare programs, paying for referrals is a crime."

Stark: Ethically speaking, if you give extravagant presents to referring physicians or their family members over the holidays, that's a violation of the physician self-referral law, or Stark for short. "Gifts create a financial relationship under Stark," advises Stanger.

"Accordingly, Stark would prohibit the physician from referring patients to the giver for certain designated health services payable by Medicare or Medicaid, and would prohibit the giver from billing for those services, unless a regulatory exception applies." He adds, "Stark violations may result in civil penalties, repayments, and False Claims Act [FCA] liability."

Use Good Judgement When Giving

Though you may need to put the kibosh on any luxurious gift baskets that you were planning to give your favorite docs or vendors, you can still offer a token of appreciation and holiday spirit. "Certain small gifts such as pens or coffee mugs are permissible, other larger gifts are not," Hofstra counsels.

In fact, the feds allow some holiday cheer — however, they don't really go into detail. "The OIG has suggested that 'nominal' gifts would not create much AKS risk," Stanger notes. "But, [the agency] offers no guidance as to what is 'nominal'."

To be on the safe side, it's wise to keep your gift-giving in line with the federal requirements.

Beneficiaries: The government determines that Medicare providers may give gifts with a retail value equaling $15 per gift or $75 annually per beneficiary. Giving cash to these patients also triggers the Civil Monetary Penalties Law (CMPL) and suggests that these gifts may be looked at as a way to influence beneficiaries. "As with the AKS, the CMPL does not apply to private pay patients, although state kickback, rebate, or fee splitting statutes may apply," reminds Stanger.

Referring physicians: Regulation 42 CFR 411.357(k) outlines the non-monetary compensation limits under the Stark Law as well as certain medical staff incidental benefits, notes the CMS Consumer Price Index-Urban All Item (CPI-U) guidance. Medical staff incidental benefits refer to things as varied as meals and transportation, according to national law firm **Hall Render** in online analysis.

Adjusted annually for inflation, the CY 2018 limits are $407 for non-monetary compensation and $34 for medical staff incidentals. Next year, there's a slight bump of 2.3 percent. In 2019, $416 will be allowed for non-monetary compensation and

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Rebecca L. Johnson, Executive Editor (888) 234-5896
Leesa A. Israel, BA, CPC, CUC, CEMC, CPPM, CMBS, AAPC Fellow, AAPC MACRA Proficient
Vice President, TCI Content & Online Tools
leesai@supercoder.com
Bulk Sales (800) 508-1316 ext 2313

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less than $35 for each occurrence of medical staff incidentals.

See the CMS breakdown at www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html.

Vendors: Don't forget that the vendors you deal with fall under referral territory, too. "The AKS may also apply to gifts offered by vendors: it prohibits providers from soliciting or receiving such gifts as a reward or in exchange for referring federal program business to the vendors," Stanger writes in analysis.

Watch The Rules On Accepting Gifts, Too

You should exercise similar caution when it comes to accepting gifts, whether they come from referral sources, colleagues, or patients, suggests attorney **Ross Lanzafame** with **Harter Secrest & Emery** in Rochester, New York.

Gifts from colleagues and patients can be particularly problematic, Lanzafame worries. "Although the gift may appear innocent, the act of giving and accepting a gift can potentially create a conflict of interest for the recipient," he points out.

Here's the problem: "When someone gives a gift, the social construct within which we generally operate is that the gift will in some way be reciprocated. It is the polite thing to do," Lanzafame explains. "This social construct can potentially tempt the recipient to make decisions not motivated by objective factors, but rather based on the subjective in order to reciprocate."

While it won't be a popular decision, "my rule of thumb, as difficult as it may be, is not to accept gifts," Lanzafame says. "Consider advising patients and colleagues who desire to give gifts to make a donation to some public charity instead."

Tip: If you don't have an agency compliance policy that includes your gift-giving procedures, you should add that to your holiday to-do list. "Health care providers should consult with counsel and exercise caution when giving gifts during the holidays, or at any time, to avoid the appearance of impropriety and potential prosecution for legal and regulatory violations," Hofstra counsels. ❖

Note: Find a more in-depth look at the fraud and abuse laws that govern healthcare and gift giving at https://oig.hhs.gov/compliance/physician-education/01laws.asp.

Industry Notes

Check Out Your New Hospice Compare Measure

Attend upcoming webinar for more info.

Hospices' scores for the newest Hospice Compare measure are now on display for all to see.

Medicare has updated its Hospice Compare website, the **Centers for Medicare & Medicaid Services** noted in a Dec. 4 message to providers. "In addition to the Hospice QRP measures that are currently displayed on Hospice Compare, the following new quality measures will be displayed with data collected Q2 2017 — Q4 2017: Hospice and Palliative Care Composite Process Measure — Comprehensive Assessment at Admission (NQF #3235)," CMS said in the message.

Reminder: The new measure streamlines the seven Hospice Item Set-based measures that comprise it: Treatment Preferences (NQF #1641); Beliefs/Values (NQF #1647); Pain Screening (NQF #1634); Pain Assessment (NQF #1637); Dyspnea Screening (NQF #1639); Dyspnea Treatment (NQF #1638); and Bowel Regimen (NQF #1617).

Users have the option to expand the composite measure to see the individual measure scores. Near the bottom of the page, the site offers users a chance to "View more information about the 7 measures that make up the HIS Comprehensive Assessment Measure."

Hospices that would like to learn more about the measure now on display can consult a new resource from Medicare. The "Hospice Comprehensive Assessment QM Background and Methodology Fact Sheet … provides information on the background of this measure, how this measure is calculated, and how providers can use their CASPER QM reports to understand their hospice's performance on this measure," CMS notes.

Resource: The fact sheet is at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html.

You can also tune in to a webinar on the new measure on Dec. 13. Registration for the session, which also covers the new 4.5-month data correction deadline, is at https://engage.vevent.com/index.jsp?eid=3536&seid=1296.

• Illinois agencies are waiting on pins and needles to see when the Review Choice Demonstration actually will start — and it looks like that waiting may go on a bit longer.

The **Centers for Medicare & Medicaid Services** has said it will not implement the pre-claim review demo until it gets Paperwork Reduction Act approval for the program. "So, December 10th is still our targeted start date for providers to begin making their choice selections for the demonstration, but that could be subject to change, depending on … when we get that approval," a CMS official said in a Nov. 13 education call about RCD. "When we do get that approval, we'll announce the date when provider can begin making their choice selection and the date where reviews under the demonstration will start."

HHAs' worries that RCD will proceed just as the worst of the holiday season – and staffing shortages – hit may find some comfort in the CMS staffer's comments in the call. "We want to make sure that Home Health Agencies have ample time to make their choice selection and **Palmetto** needs time as well to finalize in their system, making sure that everyone is in the right choice and documentation will go to the correct place and the systems are set up appropriately," she said. "We also understand that holidays are coming up soon and we … will be sensitive to that as we finalize some of our start dates."

Newly posted links to a transcript and recording of the Nov. 13 call are at www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-11-13-HH.html.

• You might not get the result from your claim adjustment that you were hoping for, if a newly reported glitch is impacting it.

"Reason code 30909 is incorrectly being applied to adjustment type of bills," HHH Medicare Administrative Contractor **CGS** says in its claims processing issue log. "Affected claims will be suspended in status/location S M0909."

For now, home health agencies must sit tight — and their claims must stay in suspension. "No provider action is required at this time," CGS informs providers. "Until this issue is resolved, affected claims will be suspended in status/location S M0909."

• Good news: The threshold that will allow you to bring an appeal before an Administrative Law Judge will stay the same in 2019. "The amount that must remain in controversy for Administrative Law Judge (ALJ) hearing requests filed on or before December 31, 2018 is $160," HHH Medicare Administrative Contractor **Palmetto GBA** says on its website. "This amount will remain at $160 for ALJ hearing requests filed on or after January 1, 2019."

However, the same isn't true for the AIC level for federal court appeals. "The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2018 is $1,600," Palmetto says. "This amount will increase to $1,630 for appeals to Federal District Court filed on or after January 1, 2019."

• Beware a new payment glitch hitting hospice claims. "Hospice claims are incorrectly rejecting with reason code C7080 indicating that one or more line item date of service overlaps with another claim," HHH Medicare Administrative Contractor **CGS** reports on its website. The MAC has reported the issue to the Common Working File contractor, and there's no action providers can take at this time. ❖