Home care agencies push for new billing rule

Home care agencies say a new rule under consideration by the Department of Health would make it easier to get reimbursed for physician-ordered services. Under current public health law in New York, home care agencies have 30 days from the time a patient is admitted to get a doctor to sign off on the necessary paperwork. But it’s often difficult to meet that deadline, a challenge the state Home and Community Based Care Workgroup attributed in part to the rise in transient doctor-patient relationships. The rule would extend the deadline to “12 months after admission to the agency, or prior to billing, whichever is sooner,” in an effort to align state and federal requirements. “We appreciate the state’s support for a sensible timeline that has worked under Medicare,” said Joanne Cunningham, president of the Home Care Association of New York State, in a statement. “This proposal ensures that providers and physicians can focus on the initiation or modification of the care itself.” The rule applies to licensed home care services agencies and certified home health agencies. It’s open for public comment for 45 days from when it was posted (Wednesday, Feb. 10).

Fewer hospital beds in NYC

The state Public Health and Health Planning Council released its 2015 annual report yesterday, showing the net effect of all the certificate-of-need applications it reviewed last year. The report showed New York City hospitals reduced their bed count by 87 in 2015, with the biggest reduction, 43, in psychiatric beds, followed by a 31-bed decrease in chemical-dependency detoxification beds. The category with the most additions was neonatal intensive care. The PHHPC reviewed city hospitals’ request for 47 additional NICU beds last year. Statewide, the net reduction in hospital beds was 102. In all, PHHPC approved 170 projects for New York City providers that were worth a combined $854.9 million. That’s less than half the $1.9 billion approved in 2014. The value of projects reviewed for Hudson Valley providers, $871.8 million, was more than seven times as large in 2015 than in 2014.

DOH issues evaluation RFP

The state Department of Health, in partnership with the nonprofit Health Research Inc., is seeking proposals for a $2.5 million, 34-month contract to evaluate the State Health Innovation Plan. In addition to conducting a cost-benefit analysis of the Advanced Primary Care model and an overall evaluation of the project, the successful bidder will assess the value-based payment models, workforce initiatives and health IT that go into implementing SHIP, according to the request for proposals. The evaluator also must look at whether state initiatives like DSRIP conflict with the plan in any way. SHIP is funded through a $100 million State Innovation Models grant awarded to New York at the end of 2014. Its goals are based around the “triple aim” of improving health outcomes and quality of care, and generating $5 billion to $10 billion in savings by lowering costs. The centerpiece of SHIP is a pilot of the Advanced Primary Care model, which accounts for about two-thirds of the funding. Proposals are due in March, and data collection will begin as early as the first quarter of 2017.

AT A GLANCE

OVERPAYMENTS: CMS issued a final rule on requirements for reporting and returning overpayments for Medicare Parts A and B. It established that providers are responsible only for returning overpayments identified within six years of the date the payment was received. The rule also clarifies that an overpayment must be reported either 60 days after it was identified or at the time the corresponding cost report was due, whichever comes later. Read the rule here.

WHO’S NEWS: Dr. Manish Sharma started as chairman of emergency medicine at Forest Hills Hospital in January. He was previously associate chairman of emergency medicine at New York-Presbyterian/Queens. Dr. Mark Tang became associate chairman of emergency medicine at Forest Hills on Jan. 1.

SCHEDULE: Pulse will not publish on Feb. 15, Presidents Day.