PATHFinder

A Troubleshooting and Information Newsletter for McKesson Customers

January • Volume 20 • Issue 1

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Release 14.0 offers exclusive features

Release 14.0 features a number of new features, including the medication profile updates for all customers who did not upgrade their medication profile in Release 13.5.

PLEASE NOTE: The Spring 2017 regulatory release, which is targeted for March 2017, will be Release 13.5.3 and is our last planned 13.x release. Release 13.5.3 will NOT include the features described in this article. All customers will need to update to the Release 14.x platform prior to the Summer 2017 regulatory release.

Here's a summary of several features introduced in Release 14.0:

Doc Center

Doc Center adds support for documents related to entities (personnel, physician, payer and facility) as well as new access points to the Doc Center application from those corresponding parts of the application. A new Doc Center icon has been added to personnel information, physician information, insurance payers and facilities information. The icon is located at the end of the icon bar at the top of each area.

With Release 14.0, any agency using Doc Center has the option to use

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Icon Keys

Home Health

Home Health & Hospice

Hospice

BUSINESS CARE CONNECTIVITY

Release 14.0 offers exclusive features

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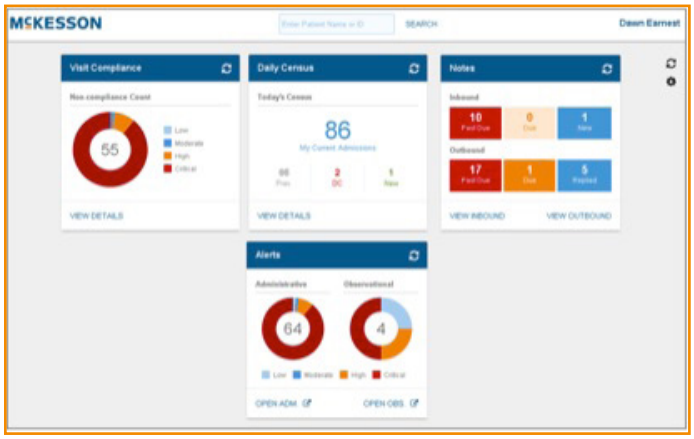
SQL Server FileStream to store encrypted documents. One utility will set up the FileStream database and a second utility will migrate the files into the FileStream database. These are technical processes and will not create any change in Doc Center functionality or user processes. Any agency implementing Doc Center after Release 14.0 will implement FileStream and Doc Center at the same time, and therefore, will not need to perform the migration process.

Figure 1



Home Pages

Home page templates are available for clinical managers ***(see Figure 1)*** and field clinicians. This release introduces the daily census widget and the visit compliance widget for clinical managers. ***(See the September 2016 edition of PATHFinder for more detail on the clinical manager home page.)***

Medication profile for clinical explorer IPU (inpatient unit)

As a part of the effort to provide a single clinical solution within McKesson Homecare™ and McKesson Hospice™, the medication profile has been redesigned for clinical explorer home health, hospice and hospice IPU explorer admissions. The updated design improves patient safety, optimizes workflow efficiency, and meets or exceeds industry standards across multiple platforms.

In Release 13.5, the conversion to the redesigned medication profile applied to those agencies without an IPU. Release 14.0 includes functionality to support agencies with an IPU. ***(See the September 2016 edition of PATHFinder for more detail on the medication profile updates to support IPU's.)***

Mileage Advisor

Release 14.0 adds the McKesson Homecare™ Mileage Advisor web transaction detail report to McKesson Homecare and McKesson Hospice. This report displays the number of transactions for address verification, mileage calculation, directions to home and total transactions for a specified date range.

Windows 10 tab control

Currently, the third party tab control screens within McKesson Homecare™ and McKesson Hospice™ cause certain applications to close automatically after five minutes. We've corrected the issue with a phased approach over several releases. With this release, the replacement of tab control on all screens is complete.

Resources available

For a comprehensive list of all items included in Release 14.0, please check the Worklist Search on InfoCenter and filter by the release number.

Detailed release documentation, educational materials and a recording of the release overview webinar are available so that you can begin training your staff on the new features.

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.

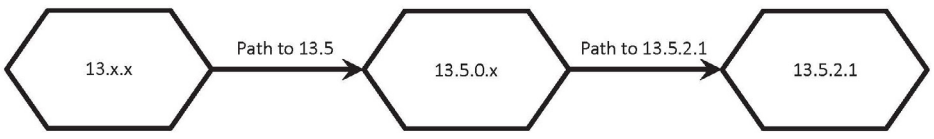
Release	ESD?
Winter Regulatory Release 13.5.2	Yes
Hotfix 13.5.2.1	Yes
Winter 2016 Medication Update	Yes
Insight 9.9.1.1	No
PPS Rate Update 2017	Yes
MobileCare 3.5	No
Telephony 13.1	No
Web Chart 13.5.0.2	No
MobileCare: Checkpoint 1.0	No
Base Release 14.0	No
Insight 10.0	No

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?
Insight 9.9.2	In Development	No
Medication Interface	In Development	No
Telephony 13.2	In Development	No
Telephony 13.2	In Development	No

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 then 13.5.2.1. This process will ensure the Horizon Client is properly installed on the new machine. Alternatively, Rapid Deployment will also load all appropriate software in the correct order for newly staged devices.

Regulatory Calendar 2016/2017

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
R3559CP Hospice	Medicare Program; FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements	10/01/2016	MLN article not provided Final Rule
CR 9729 Change Request 9729 updates the hospice payment rates, hospice wage index, and Pricer for FY 2017. The CR also updates the hospice cap amount for the cap year ending October 31, 2016. These updates apply to Pub 100-04, Chapter 11, and section 30.2.			
R3537CP Hospice	Billing of Vaccine Services on Hospice Claims	10/03/2016	MM9052 Click here
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. WL113162 addresses vaccination billing claim format for our customers.			
R3502CP Hospice	Making Principal Diagnosis Codes Mandatory for Notice of Election (NOE) to be Accepted	10/03/2016	MM9575 Click here
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 BOTH	Claim Status Category and Claim Status Codes Update	10/03/2016	MM9550 Click here
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.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R3597CP BOTH	Healthcare Provider Taxonomy Codes October 2016 Code Set Update	10/01/2016 OR 01/03/2017	MM9659 Click here
CR 9659 Change Request 9659 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference file. MACs that have the capability to do so will implement the October 2016 HPTC set as early as October 1, 2016, for claims received on or after October 1, 2016. All MACs will implement the HPTC set by January 3, 2017. Note to McKesson customers: Ensure your agency required HPTC codes are up to date. The solution does pull Taxonomy codes for physicians and for the providers to the claims.			
R17P232 BOTH	Provider Reimbursement Manual - Part 2, Provider Cost Reporting Form and Instructions	10/07/2016	MLN not available
Provider Reimbursement Manual - Part 2, Provider Cost Reporting Forms and Instructions, Chapter 32, Form CMS-1728-94 has been updated. Ensure your staff responsible for cost reporting is aware of the manual update.			
R3560CP BOTH	Correction of Remark Code Information	10/17/2016	MM9641 Click here
CR 9641 Change Request 9641 is to update Chapter 30 of Pub. 100-04 to make corrections to Remittance Advice Codes, and general punctuation and grammar corrections. All Remittance Advice messaging must follow a prescribed set of rules. Specifically, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), and the designated Standards Development Organization (SDO).			
R29QIO HHA	QIO Manual Chapter 3 “Memoranda of Agreement for Case Review”	10/21/2016	MLN not available
Transmittal 29 updates Quality Improvement Organization Manual Chapter 3 *Memoranda of Agreement for Case Review. Subsection 3015*: Home Health Agencies (HHAs) and Skilled Nursing Facilities (SNFs) Memoranda of Agreement (MOA). Ensure your agency QIO entity is aware.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R1711OTN BOTH	Medicare Appeals System (MAS) Level 1 Part A and Home, Heath, Hospice (HHH) Onboarding Effort	11/29/2016	MM9683 MLN not available
Background: In 2014, the Centers for Medicare & Medicaid Services (CMS) worked with specific Part A Medicare Administrative Contractors (MACs) for the implementation of the Level 1 Medicare Appeals System (MAS) effort under Change Request (CR) 8354. This effort is to onboard the remaining Part A and Home, Health, Hospice (HHH) MACs. The MACs will begin utilizing MAS to perform redeterminations and reopenings in accordance with CMS regulations and policy. The functionality to support the Level 1 process will be implemented by December 31, 2016. Each MAC contractor is implementing MAS in a phased in approach, beginning January 1, 2017 through April 30, 2017 as agreed upon with CMS. The remaining Part A MACs are: ▪ CGS Administrators, LLC. ▪ First Coast Service Options ▪ National Government Services (NGS) ▪ Palmetto Government Benefits Administrator, LLC			
R1721OTN BOTH	Adding a Foreign Language Tagline Sheet to Medicare Summary Notices (MSNs)	12/05/2016	MLN not available
Adding a Foreign Language Tagline Sheet to Medicare Summary Notices (MSNs)			
R3538CP Revised	JW Modifier: Drug Amount Discarded/Not Administered to any Patient	1/01/2017	MM9603 Click here
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.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
CMS1648 F R3624CP HHA	CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements CMS-1648-F	01/01/2017	Click here
This final rule updates the Home Health Prospective Payment System (HH PPS) payment rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor; effective for home health episodes of care ending on or after January 1, 2017. This rule also: Implements the last year of the 4-year phase-in of the rebasing adjustments to the HH PPS payment rates; updates the HH PPS case-mix weights using the most current, complete data available at the time of rulemaking; implements the 2nd-year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment to account for estimated Casemix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between CY 2012 and CY 2014; finalizes changes to the methodology used to calculate payments made under the HH PPS for high-cost "outlier" episodes of care; implements changes in payment for furnishing Negative Pressure Wound Therapy (NPWT) using a disposable device for patients under a home health plan of care; discusses our efforts to monitor the potential impacts of the rebasing adjustments; includes an update on subsequent research and analysis as a result of the findings from the home health study; and finalizes changes to the Home Health Value- Based Purchasing (HHVBP) Model, which was implemented on January 1, 2016; and updates to the Home Health Quality Reporting Program (HH QRP).		
OASIS C2 HHA	Outcome Assessment Instrument 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/ HHA Hospice Both	Description	Effective Date	Reference
R156DEMO MACS	Affordable Care Act Bundled Payments for Care Improvement Initiative - Recurring File Updates Models 2 and 4 January 2017 Updates	01/01/2017	MM9775 MLN not available
Directives to MACs regarding the Affordable Care Act Bundled Payments for Care Improvement Initiative - Recurring File Updates Models 2 and 4 January 2017 Updates.			
R3617CP BOTH	Implementation of New Influenza Virus Vaccine Code	1/03/2017	MM9793 Click here
Change Request (CR) 9793 which informs MACs about the changes to instructions for payment and edits for the Common Working File (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. Make sure that your billing staffs are aware of these changes. It is important to note that MACs will hold institutional claims with code 90674 with dates of service on or after January 1, 2017, through February 20, 2017, until the Fiscal Intermediary Shared System (FISS) changes are implemented on February 20, 2017. Medicare will issue further instructions on how to handle claims for code 90674 with dates of service from August 1, 2017, through December 31, 2016.			
R3599CP BOTH	Claim Status Category and Claim Status Codes Update	01/01/2017	MM9680 Click here
(CR) 9680 Change Request 9680 updates, 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 Acknowledgement transactions.			
R3577CP BOTH	New Condition Code To Use When Hospice Recertification Is Untimely and Corrections to Hospice Processing Problems	01/01/2017	MM9590 Click here
CR 9590 Change Request 9590 creates a new condition code for hospices to use to identify when an occurrence span code 77 period is caused by a late recertification of the terminal illness. It also corrects a number of problems in hospice claims processing. Effective for claims on or after 01/01/2017. Make sure that your billing staffs are aware of these updates.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R3617CP BOTH	Implementation of New Influenza Virus Vaccine Code	01/01/2017	MM9590 Click here
A. Background: This change request (CR) provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. **B. Policy:** Effective for claims processed with dates of service on or after August 1, 2016, influenza virus code 90674 will be payable by Medicare. This new code will be included in the 2017 annual HCPCS update. Instructions shall be forthcoming for Part A and Part B Medicare Administrative Contractors (A/B MACs) to providers on how to handle bills for this new influenza virus vaccine product between August 1, 2016 and December 31, 2016. The new influenza virus vaccine code 90674 will then be implemented with the January 2017 release for dates of service on or after August 1, 2016.			
R3655CP MACS	Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System	01/01/2017	MM9376 Click here
CR 9736 Change Request 9736 informs MACs about the implementation of a separate payment for home health agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. In addition, CR9736 will do the following: · Implement changes to the methodology used to calculate outlier payments to HHAs and · Create new G codes associated with registered nurse (RN) and licensed practical nurse (LPN) visits in the home health setting.			
R3618CP HHA	Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement	01/01/2017	MM9771 Click here
CR 9771 Change Request 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R3674CP OPPS	January 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.0	01/01/2017	MM9892 Click here
CR 9892 Change Request 9892 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/.			
SE1631 Hospice	Sample Hospice Notice of Election Statement	N/A	N/A
In MLN Matters Special Edition Article, SE1628, the Centers for Medicare & Medicaid Services (CMS) details the requirements for and provides further guidance to hospices on election statements. Model Medicare Hospice Election Statement language is included at the end of this article.			
SE1628 Hospice	Documentation Requirements for the Hospice Physician Certification/Recertification	N/A	MLN not available
The article provides information on specific elements that are required for a physician certification and recertification as stated in the "Medicare Benefit Policy Manual," **Chapter 9**, Section 20.1- Timing and Content of Certification. The intent is to provide guidance on the requirements for a valid physician certification and recertification. The examples provided in the article are for illustration purposes only and do not in any way imply this is the only acceptable format. Hospice providers may choose to design their own forms or format, so long as all requirements of a valid physician certification are met.			
HHA	Continuation of the Home Health Probe and Educate Medical Review Strategy	Episodes beginning on or after 08/01/2016	Click here
CMS announced December 16, 2016 in transmittal 1635 to HHA's that MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting Round 2 of medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in **CMS-1611-F**.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R274FM	New Physician Specialty Code for Hospitalist	04/01/2017	Click here
CR 9716 Change Request 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.			
R3618CP HHA	Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement	01/01/2017	MM9771 MLN not available
The transmittal provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. The attached Recurring Update Notification in the SE (see link) applies to Chapter 10, section 20.			
R3661CP BOTH	Claim Status Category and Claim Status Codes Update	04/01/2017	Click here
CR 9769 Change Request 9769 informs MACs about system changes to update, 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. Make sure that your billing staffs are aware of these changes.			
R3660CP MACs	Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update	04/01/2017	MM9774 Click here
CR 9774 Change Request 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and 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 and PC Print software if they use that software.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R3665CP MACs	Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)	04/01/2017	MM9767 Click here
Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.			
R3629CP HHA	Denial of Home Health Payments When Required Patient Assessment Is Not Received	04/01/2017	MM9585 Click here
CR 9585 Change Request 9585 directs MACs to automate the denial of Home Health Prospective Payment System (HH PPS) claims when the condition of payment for submitting patient assessment data (OASIS) has not been met. *McKesson will improve message text for claim message 549 Assessment must be accepted. This will provide notice to HHA's regarding OASIS assessments for Medicare PPS episodes are submitted in the required time frame so the claims are not rejected.* **Make sure that your billing staffs are aware of this change.**			
R3630CP HHA	Correcting Editing for Condition Code 54 and Updating Remittance Advice Messages on Home Health Claims	04/01/2017	MM9826 Click here
CR 9826 Change Request 9826 informs MACs about corrections to Medicare systems to require condition code 54 on Home Health (HH) appropriately. The system edit that enforces proper reporting of condition code 54 should only set when no skilled visits are reported by the provider. Currently, the edit is also setting when skilled service lines are denied during review. CR9826 also updates remittance advice coding combinations to ensure compliance with industry standards. CR9826 contains no new policy.			

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Number/ HHA Hospice Both	Description	Effective Date	Reference
R1758OTN MACs, FISS, CWF	Updates for the Shared System Maintainers to implement the Social Security Number Removal Initiative (SSNRI)	04/01/2017	MLN not available

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within 4 years of enactment. Centers for Medicare and Medicaid Services (CMS) will be establishing a new Medicare Beneficiary Identifier (MBI) that will replace the HICN on the Medicare card. The MBI must be submitted on claims, translated to the HICN for processing, and translated back to the MBI for outgoing communications. These changes will be implemented in several phases. The maintainers shall submit business requirements for a July 2017 implementation CR for CMS approval, in Microsoft Word, no later than December 15, 2016. *McKesson will begin preparation for SSNRI in 2017 to fully support the transition period which begins 04/01/2018.*

Telephony release focuses on incremental improvements

By Charlie Batutis, Technology/Connectivity Product Manager

To help ensure we continue to address customer and internal stakeholder input regarding McKesson Homecare™ Telephony, we plan bi-annual Telephony maintenance releases. We collectively determine priorities in an effort to balance progress between maintenance (including security updates and fixes for problems with current features) and creating new functional capabilities. Several important changes will be made in Telephony Release 13.2 across all segments of the tool.

In the area of maintenance, we started by addressing a few security vulnerabilities discovered as part of a comprehensive review by McKesson's Chief Technology Office.

Improvements include:

- Closing a vulnerability that allows an expired user password to be reset without current password validation
- Addressing Common Weakness Enumeration (CWE) 257 by eliminating the use and storing of weakly encrypted passwords
- Addressing Common Weakness Enumeration (CWE) 603 by eliminating the use of client side password authentication

Additional activity in the maintenance realm includes behind-the-scenes work that fixes an issue with the current "Prompt for Care Plan" feature not suppressing care plan information when configured to do so.

New functionality includes:

- In conjunction with increasing industry focus around electronic visit verification (EVV) in the home visit space, we recognize the benefit of preserving the integrity of time related visit information with the intent of stemming fraud, waste and abuse. In response to agency feedback, we've created a method for agencies to prevent field staff from manually adjusting arrival/departure times. While still leveraging the existing capabilities of Telephony Automatic Number Identification (ANI) to provide the location-based verification, this new feature provides another layer of verification for agencies that choose a more rigid visit logging model for their field clinician population.
- For scheduled visits, all Telephony users will hear the scheduled duration of a visit when logging an arrival call. Providing this information helps ensure the caller is aware of the approved service duration target.

We'll continue to collect feedback for future Telephony system releases to help ensure the plan for the next release builds on previous efforts to deliver the highest priority items for Telephony customers.

Get a sneak preview of the new document manager

By Deb McWhirter, Product Manager

The new document manager will help you to manage and track clinical documents more efficiently. You'll be able to filter the list by docsys, organization, patient, physician, physician group, document status (ready to send, outstanding, incomplete, checked in, sent), document type (initial certification, recertification, etc.) and dates (creation, completion, begin, printed, checked-in, sent). Additional filters will include: author, plan, team, admission type, delivery method, and follow-up code.

You'll be able to take action on multiple documents at one time such as printing/sending/faxing, marking sent, checking-in, following up, exporting a list, and marking inactive ***(see Figure 1)***.

You'll also be able to take action on a single document such as changing the physician, changing an interim order, checking in a document, marking a document inactive, unlocking a document and undoing check in ***(see Figure 2)***.

This functionality is targeted to be included in Release 14.1. Look for webinars coming this spring!

Figure 1

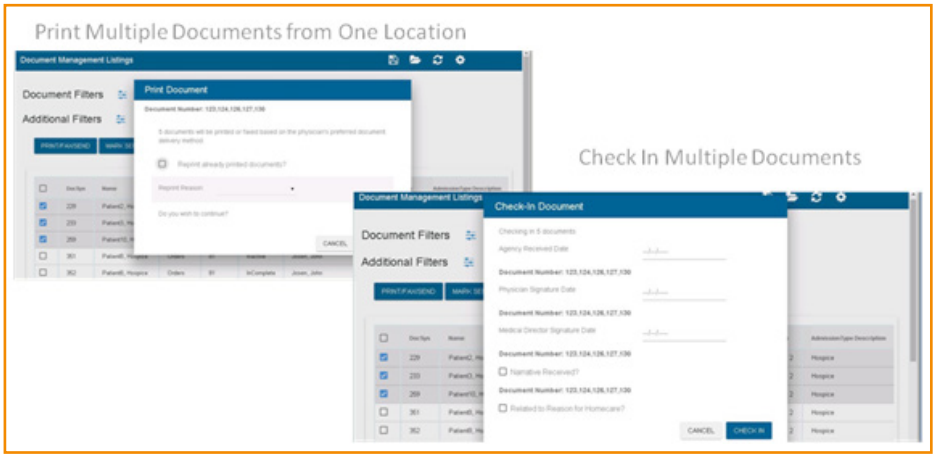
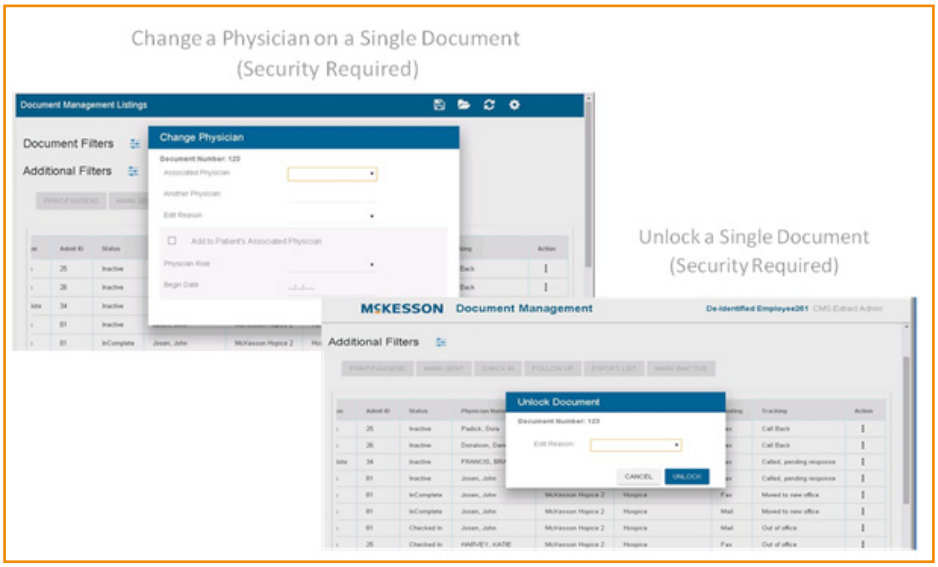


Figure 2



New forms editor to ease creation of customized signature forms content

By Diana Robertson, RN, Senior Business Systems Analyst

Completing electronic signature forms on the tablet device will be a reality in 2017. A cornerstone of that project will be the new forms editor, which will be available with the phase 1 release of clinical mobility.

This new, web-based tool will offer your agency the ability to build signature forms from compliant core McKesson consent and acknowledgement content, as well as the ability to create custom, agency-specific content. The new forms editor includes question and answer types that will allow data capture on signature forms. While the first phase is limited to consent forms, future phases will accommodate assessment forms creation. Because planning is still underway, watch for more information on implementation and education.

Like the McKesson Homecare MobileCare™ and CheckPoint™ management console, the new forms editor will be McKesson hosted. This will allow McKesson core content to be updated, providing new content to the library of forms, questions and text elements. This approach enables us to be more responsive to your agency with enhancements and regulatory changes.

Building from the ground up

The application will make building agency-specific forms easier than before. The forms editor user will build "from the ground up". Plan your form by selecting from the library of McKesson's standard content or create new questions/text elements, to suit your needs. This will lay the foundation. Next, you'll create and name the form, adding questions by dragging and dropping them onto the form and dragging them into position. Once the questions/text elements are on the form, you may select the settings for each question. These settings will allow you to employ form-specific defaulted answers, set whether a question should be required, and identify triggers that will hide questions when certain answers are selected.

Introduction to the new forms editor

Home Page & Menu Options

Once you have accessed the application via the log-in screen, you'll be directed to the Home Page ***(Figure 1)***. The home page lets you access the menu options for planning and creating forms and editing existing forms. The menu is collapsible to provide you a full screen view, if desired ***(see Figure 1)***.

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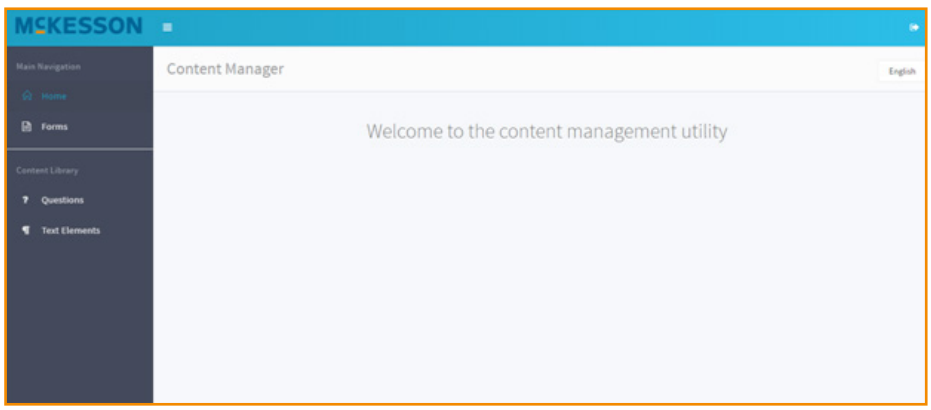
Figure 1



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The home page menu on the left is where you'll select the available features:

- Forms ***(see Figure 2)*** – Where existing forms can be reviewed and you can choose the following actions:
  - Edit or review history
  - Delete – with appropriate rights
  - Copy – to copy an existing form for editing
  - Publish – the process used to move a completed form into production
  - Preview – to confirm how the form will look on the tablet
  - Forms builder – Where the questions & text elements will be configured and settings identified
- Content Library – Where the individual questions and text elements are found.
  - Questions – Where you can search for existing questions ***(see Figure 3)***, edit, copy, delete or create new ones.

Figure 2

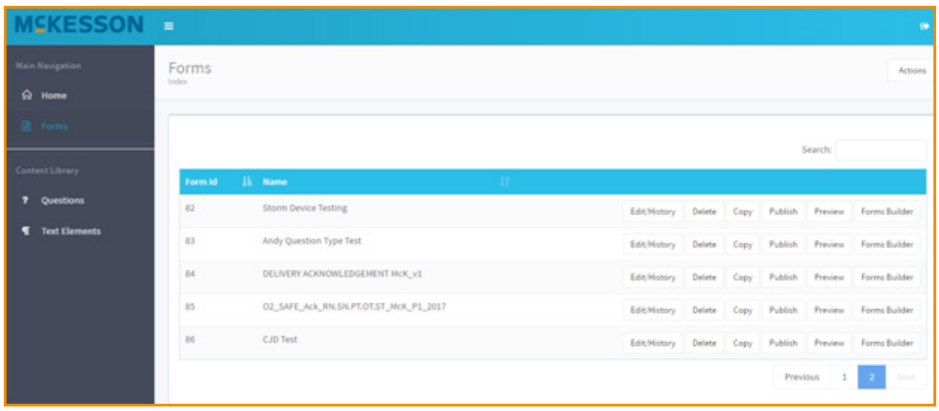
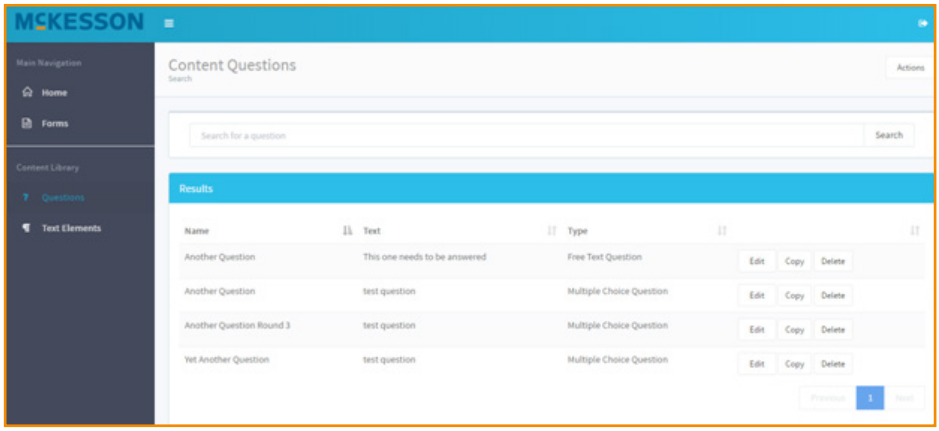


Figure 3



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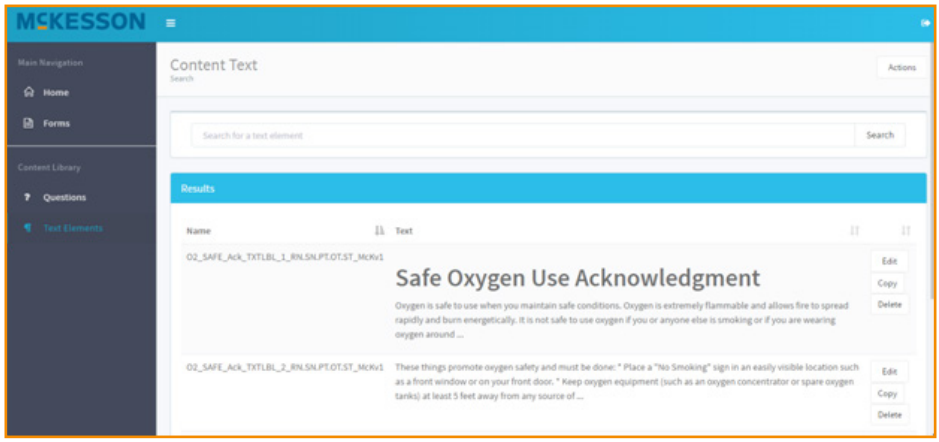
There are several question types available for use on signature forms.

- Question Types:
  - Yes/No questions
  - Numeric whole number
  - Numeric decimal number
  - Multiple choice question
  - Multiple choice with multiple answers allow
  - Free text question
  - Date question
  - Signature entry

For text elements ***(see Figure 4)***, formatting options will help the clinician and the patient, clearly identify and review the different sections of the form.

- Text Element formatting options:
  - Headers
  - Bold
  - Italics
  - Bullet lists
  - Numbered lists
  - Default type selection

Figure 4



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Figures 5a and 5b show an example of a signed form on the tablet.

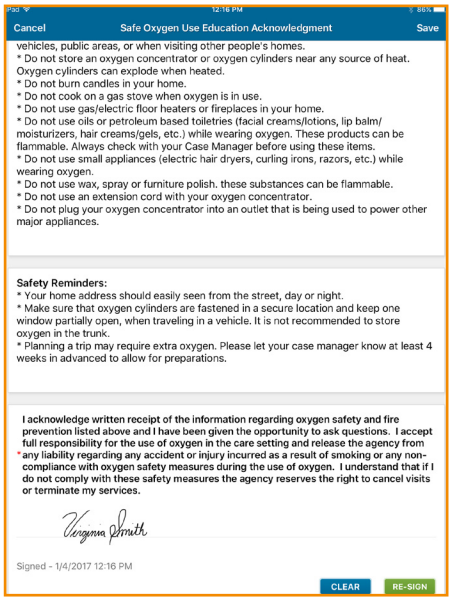
Planning your implementation of signature forms on the tablet

Agencies planning to implement signature forms with mobile clinical phase 1 can begin now to prepare for success. We recommend the following steps:

- Develop a forms team of internal stakeholders. Include a project lead and an executive sponsor who will be responsible for the project.
  - Be sure to include your McKesson Account Executive for additional support.
- Prepare an inventory of your existing consents and other paper and electronic signature forms.
  - Be sure to identify current state, as well as gaps and needs.
  - Identify any state-specific or unique form needs that may require custom build.
  - Prioritize based on your agency's needs.
- Collect agency and organization level identifying information that may be needed on headers or default fields.

Figure 5a

Figure 5b



We recognize that ensuring your success with our new mobile clinical solution requires a user-friendly method to create compliant and, if needed, custom electronic signature forms for the tablet. Please reach out to your Account Executive with questions about preparations and look for more detail about mobile clinical phase 1 in the coming months.

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: Does 13.5.2.1 include 13.5.2?

Q: Will a non-cumulative version of 13.5.2.1 be made available?

A: The Winter 2016 Regulatory Hotfix will only be available as a 13.5.2 cumulative update. Agencies that do not want to install two regulatory releases may choose to place 13.5.2 in TEST and then upgrade that environment to 13.5.2.1 for final testing. After they pass all testing they can choose to only install 13.5.2.1 in Production and send the final ESD to field devices.

Q: Does either 13.5.2 or 13.5.2.1 include a Java update so it is compatible with the version required for the Java grouper?

A: Neither 13.5.2 nor 13.5.2.1 include an update to the Java runtime that agencies need if they choose to use the 3M Java-based Grouper. However, the requirements for Java have not changed since the Fall Regulatory Release. Only Java 7 and 8 are supported and Java 6 cannot be installed in any environment that will be used to lock OASIS assessments.

Q: We did not revert to the Java Grouper. Should we be concerned or were the issues with the .NET Grouper fixed with 13.5.2?

Q: How do I know what grouper I should be using?

A: The version of the .NET Grouper in v13.5.2 is a completely new version built by ABILITY, the same company that builds our OASIS scrubber. The new .NET Grouper has been tested to ensure that it returns the same HHRG and HIPPS as the Java Grouper. In the end, the choice of which one to use is an agency decision.

Q: With all of the releases, we have got checked lists to test the update with our system. Are we going to be getting them for this update?

A: The install documentation found on InfoCenter for 13.5.2 includes UAT documentation for agencies to use when testing the release.

Q: On the possible Transfer Error for Field Devices with an excessive case load, is the IIS fix on the field laptop or server?

A: The fix is made to a setting for IIS on the Web Transfer Server.

Q: What setting has to be changed for Connection customers for Java?

Q: Just so I understand clearly, for agencies that reverted back to the Java Grouper, when we install 13.5.2.1, the system config option will NOT switch to the .Net grouper. We will have to manually switch back in order to use the ABILITY .Net grouper?

A: The setting as shown in the presentation will be available to both Connection and stand-alone customers. Once the setting is changed, the new value to flow out to laptops on their next transfer. This setting will not be changed from its current value by either 13.5.2 or 13.5.2.1. Agencies that wish to change the Grouper setting will need to follow the manual steps outlined in the documentation.

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Q&A with the Technical Resource Team

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Q: Will the Update_Suggested_Visit_Contents_OASIS_C2.sql and the Retire_or_Activate_assessment.sql scripts be run automatically for Connection Customers or do they have to place a support call?

Q: Are the scripts you mentioned in V13.5.2 or V13.5.2.1?

A: The scripts are included with both v13.5.2 and the v13.5.2.1 hotfix. The Update_Suggested_Visit_Contents_OASIS_C2.sql script will be ran for all Connection agencies 11pm CST on December 31, 2016. The OASIS C2 assessments will be delivered as active by the 13.5.2 upgrade and the Retire_or_Activate_assessment.sql script will not be needed to make them available to users. Connection agencies wanting to retire the OASIS C1 assessments will need to place a support call to request the script be run.

Q: Which interface are the new frequencies in the Medication Update for?

A: The new frequencies are only for the new Medication Profile introduced in v13.5. Any agency that was exempted until v14.0 will not see these new frequencies until after they upgrade.

Q: For the medication utility clean up, the SQL script correctly identifies utility medications. Why can't this script be enhanced to add an end date for that utility medication and change status to D(iscontinued)?

A: When the script was being created we chose to not make the decision of the end date for the agency and let the clinical department at the agency follow their process to set the correct date.

Q: If we install 13.5.1.2 do we still have to push a separate PPS Rate Update ESD or is it included?

A: The 13.5.2.1 hotfix includes both the PPS Rate Update and the 13.5.2 content. If your agency decides to only install v13.5.2.1, only one ESD will be required to update laptops.

Q: 13.5.2 is required for Insight 9.9.1.1? Is this correct?

A: Insight 9.9.1.1 is essential a release supporting security changes coming in v14.0. Agencies may choose to install this release early and it is supported with v13.5.1 and 13.5.2.x.

Q: What is meant by 'Late December' target GA for 13.5.2.1?

A: We expect v13.5.2.1 to be released to GA during the week of December 19th.

Q: If we upgrade only to 13.5.2 but not the Hotfix, would it be advisable to drop all our cases, in order to avoid the transfer error?

A: The error can be corrected with a change to a setting in IIS. Any agency that upgrades to 13.5.2 and receives the error can contact McKesson Support to have the setting modified manually until they can finalize their 13.5.2.1 upgrade plans.

Q: v13.5.2.1 is compatible with all versions of JAVA 8?

A: The main application does not utilize Java and if an agency chooses to use the new ABILITY

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Grouper that is based on .NET the version of Java on their machines will not be of concern. The Java-based Group provided by 3M will support all current versions of Java 7 and 8.

Q: If you run the Retire Activate Script do you just put it in Activate mode and will it update the new assessments or do you have to list Assessments numbers you need activated for Jan 1?

A: The script has four functions. Agencies should first run it in one of the two "report" modes to get a listing of the assessments in their system that are active or retired. They then run the script in one of two update modes to activate or retire the assessments they specify in the script.

Q: Will you be delivering a hotfix to replace the version of java on the laptops to support the new grouper?

A: Maintaining the version of Java on servers, workstations, and laptops is the responsibility of each agency. If your agency has other third-party applications that require versions of Java that
are not supported with the Java Grouper, switching to the .NET Grouper using the instructions provided will be required.

Q: If another application my clinicians use on their laptop is not compatible with the .net version, how will that affect install?

A: The versions of .NET operate independently. This allows your laptops to have v1.0, 2.0, 3.0, 3.5, 4.5, and 4.6.1 all installed to support any applications the need them. This is one of the advantages of using the .NET Grouper or the Java Grouper.

Q: On InfoCenter Discussion Forum, if you choose instant or batch for emails, does the message sent include the original question?

A: The email will include a section of the message, but not the entire message or string. This is to make reading the email, especially the batch version, easier.

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.

Troubleshooting Historical Diagnosis on claims after loading v13.5.1 (KB 1024682)

With the V13.5.1 release, the admission and historical diagnosis codes that were active during the specified billing range will pull to the claim. The Diagnosis Code (DtaDia) option will default to O-Admission Diagnosis Onset for the Medicare Hospice claim format (5IHSv1).

Page 33 of the Functional Release Guide for V13.5.1 states:

- Active diagnosis codes for the admission will pull to the claim:
  - When the onset date is on or before the end date of the billing period, or
  - The exacerbation date is on or before the end date of the billing period.
  - If both are blank, the admission diagnosis will be reported on the claim.
- Historical diagnosis is reported on the claim, when:
  - The onset date is on or before the end date of the billing period, or
  - The exacerbation date is on or before the end date of the billing period.
  - If both are blank, the diagnosis will be reported on the claim.
- Historical diagnosis will not appear on the claim if:
  - Already listed as an active diagnosis code on the claim.
  - Marked in Error or if the end date is prior to the billing period.

Agencies should treat diagnosis codes as a 'Diagnosis Set'. When the diagnosis codes used or the order of the diagnosis needs to change for any reason, the entire set should be moved to historical with an appropriate end date. The new diagnosis set (even if they are the same codes in a slightly different order) should then be added to the active tab with updated exacerbation (or onset) dates.

If a Medication Order is marked in Error in the Orders Summary screen, does this discontinue the medication in the medication profile? (KB 1024540)

No. Marking a medication order in error does not discontinue the medication or prevent the medication from showing as an Active medication.

You can click the Create Order for Signature link in the Medication Profile to create a new Interim order for the medication.
To discontinue a medication, perform the following steps:

1. Enter the Expected Stop Date
2. Enter the Discontinue Reason (required),
3. Then tab out of the Discontinue Reason field to enable the Next button at the bottom.
4. Click Next
5. Then select Yes or No for Interim Order for Signature
6. Then click Done to discontinue the medication.

It should then drop off of the Active Medications list.

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Support FAQs

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Why does a medication show up in the active medications list, even though an end-date has been entered in the medication wizard? (KB 1024539)

When selecting a medication in the new medication profile, by default it opens the medication management wizard to the Dosage screen where you can end-date a dosage and enter a new dosage. Entering an end date on this screen does not discontinue the medication.

To discontinue the medication, perform the following steps:

1. Click the Previous button at the bottom to go to the medication information screen.
2. Enter the Expected Stop Date.
3. Enter the Discontinue Reason (required).
4. Then tab out of the Discontinue Reason field to enable the Next button at the bottom.
5. Click Next.
6. Then select Yes or No for Interim Order for Signature.
7. Then click Done to discontinue the medication.

It should then drop off of the Active Medications list.

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

McKesson Homecare™ and McKesson Hospice™ PATHFinder

McKesson Corporation
1550 E. Republic Road
Springfield MO 65804
Phone: 800-800-5403
Fax: 417-841-1872

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