

**October 2008
SNF Open Door Forum Call
Summary**

ANNOUNCEMENTS:

1. Public Health Waivers issued for Hurricanes Gustav and Ike

Two types of waivers were issued:

- 1135 Waiver applies to all different types of Medicare provider
- 1812 Waiver relaxed requirements related to 3 day hospital qualifying stay and the 100 day benefit period for people needing Skilled Nursing Facility care.

Both waivers remain in effect for the entire 90 day period of the declared Public Health Emergency. All procedures implemented at the time the waivers were enacted remain in effect until the below dates

- Gustav Waivers
 - Louisiana, Texas, Mississippi and Alabama went into effect on August 31 and remain in effect until November 29, 2008
- Ike Waivers
 - Texas waivers went into effect on September 11 and remain in effect until December 10, 2008
 - Louisiana waivers went into effect on September 13 and remain in effect until December 12, 2008

2. MDS 3.0 Update

Draft Data Specifications, Draft Item Set and Draft Data Dictionary have been released by CMS. CMS anticipates Final MDS 3.0 and instruction manual will be posted the Spring 2009. To view the updated Draft MDS 3.0 go to http://www.polaris-group.com/news_releases.asp.

3. 2009 Consolidated Billing Annual Update

CMS will post the 2009 Consolidate Billing HCPCS file update by early December 2008.

4. Flu Season

A Reminder that the 2008 – 2009 Flu Season has started. CMS encourages flu vaccination for nursing facility employees as well as residents.

5. Therapy Caps

Reminder that Therapy Caps apply to Part B services provided at locations other than hospital outpatient departments. There is one cap for PT and SLP combined and one for OT. Dysphagia services are included in the caps. The 2009 cap amount will be announced in the upcoming Physician Fee Schedule Final Rule that is due out early November 2008.

6. Local Coverage Determinations and Medicare Administrative Contractors

Medicare Administrative Contractors are not required to go through the public comment period required for the development of a new Local Coverage Determination (LCDs). During the LCD consolidation period, MACs must follow the award Cycle's Statement of Work (SOW).

- Cycle 1 SOW requires the awarded MAC consolidate LCDs to the least restrictive.
- Cycle 2 SOW requires the awarded MAC consolidate LCDs to the most clinically appropriate.

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Medicare MAC Jurisdictions

Cycle	J*	MAC Award	States Included in MAC Jurisdiction
1	1	Palmetto GBA	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
1	2	National Heritage Insurance Corp (NHIC)**	Alaska, Idaho, Oregon, and Washington
1	3	Noridian	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
1	4	TrailBlazer	Colorado, New Mexico, Oklahoma, and Texas
1	5	Wisconsin Physician Service (WPS)	Iowa, Kansas, Missouri, and Nebraska
2	6	Pending	Illinois, Minnesota, and Wisconsin
1	7	Pinnacle Business Solutions, Inc. (PBSI)**	Arkansas, Louisiana, and Mississippi
2	8	Pending	Indiana and Michigan
2	9	First Coast Options Inc. (FCSO)	Florida, Puerto Rico, and U.S. Virgin Islands
2	10	Pending	Alabama, Georgia, and Tennessee
2	11	Pending	North Carolina, South Carolina, Virginia and West Virginia
1	12	Highmark Services, Inc.	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
1	13	National Government Services (NGS)	Connecticut and New York
2	14	Pending	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
2	15	Pending	Kentucky and Ohio

*J = Jurisdiction ** Protest Filed

7. Medicare Secondary Payer

Skilled Nursing Facilities are required to screen for Medicare Secondary Payer (MSP) situations. The screening is required on admission to Medicare Services.

8. Initial SNF Physician Certification

Follow up to questions posed on prior ODF call:

- a. Is it acceptable for the initial SNF Physician Certification be signed by the physician at the hospital where the qualifying hospital stay occurred?

The wording in the applicable law appears less restrictive than corresponding CMS manual instructions.

- The law, SSA Section 1814(a)(2), merely provides for signature by a physician.
- The implementing regulations at 42 CFR 424.20(e)(1) specifies that the certification must be signed by a physician responsible for the case, a physician authorized by the physician responsible for the case, or a physician available in case of an emergency

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who has knowledge of the case. All would appear to allow for the signature by the hospital physician.

- The Internet Only Manual, Publication 100-1, Chapter 4, Section 40.1 is more restrictive, specifying signature only by the attending physician or physician on SNF staff with knowledge of the case.

Manual instructions provide fewer options; however, the regulation has the force of law. Although signature by a physician on staff of the SNF is the preferred option, the law does allow for initial certification signature by the physician at the hospital.

- b. Please define “as soon thereafter as reasonable and practicable” as it relates to initial certification timeliness.
- 42 CFR 424.20(b)(1) requires the initial certification be obtained at the time of admission or as soon thereafter as reasonable and practicable. 42 CFR 424.11(d)(3) permits certification on a delayed basis. CMS has not specified what would be a reasonable and practicable timeframe. The determination of what is reasonable and practicable is a matter of individual contractor (Fiscal Intermediary / Medicare Administrative Contractor) discretion.

QUESTIONS AND ANSWERS

Consolidated Billing

- Q. Part B supplier claims are being denied due to Consolidated Billing, yet the only claims with the same service dates are No Pay Claims. Are the edit problems being corrected?
- A. SNF No Pay Claims should not prevent payment of Part B supplier claims. If carriers are denying claims due to a SNF claim in the system, email Jason Kerr (jason.kerr@cms.hhs.gov) with the concern. Jason will forward the concern to the appropriate carrier. No payment claims should not prevent Part B supplier claim from being paid.
- Q. It frequently occurs that the Common Working File (CWF) is checked to confirm that a resident is not in a SNF Part A stay, only to find out at the time of billing that, in fact, the resident was. How quickly is the CWF updated to prevent this from occurring? Does Medicare have an appeals process appropriate for when the CWF incorrectly indicates the beneficiary is not in a SNF stay?
- A. SNFs are required to submit claims on a monthly basis. The CWF would not update until after the SNF submits the first claim. The service provider should always seek the information directly from the beneficiary and facility prior to providing the service. Eligibility status on the CWF has a legitimate lag from the time of first SNF day to contractor receipt of the first claim. All suppliers must ask the beneficiary status question at the time the appointment is made and when the resident arrives at the office as there may be a status change.

Medicare transaction with the SNF is based on prospective payment for global services. The contract between the SNF and the supplier of service is a free market business transaction. Medicare is not involved and there is not Medicare Appeals process for this scenario. A supplier may contact the regional office who then might contact the SNF on the supplier's behalf. The recourse available to CMS is related to conditions of participation and termination of SNF Provider enrollment.

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SNFs and suppliers must have prior arrangements; which would be prudent to reduce to writing so that both parties are on the same page as to who gets paid by whom, when and what reimbursement. See MLN Matters Article 3592 for details regarding consolidated billing arrangements required between SNFs and suppliers. To view MLN Matters 3592 go to http://www.polaris-group.com/news_releases.asp

- Q. SNF Part A residents receive Chemotherapy at the physician's practice. Some SNFs state that under Consolidate Billing they are not responsible for Chemotherapy reimbursement and are declining payment of appropriate claims. What information is available to a SNF to know what is and is not excluded from CB?
- A. Again, suppliers must make arrangements for payment in advance. This is a general recurring issue related to SNFs and suppliers that is broader than just chemotherapy. CMS publishes the list of consolidated billing exclusions and major category descriptions annually, with quarterly updates as needed. The information is available on CMS website.

MDS 3.0

- Q. Is the MDS 3.0 implementation target still October 2009, when will STRIVE (Staff Time and Resource Intensity Verification Project) data be released and have the STRIVE recommendations impacted the draft MDS 3.0?
- A. CMS is staying with the October 2009 implementation timeline. A Draft manual will be coming out, but no specific date at this time. CMS is aware of the training needs and tight time constraints and is working on developing training materials. CMS will be working with contractors and stakeholders, including professional associations, to get the information out and train on the MDS 3.0 requirements.

STRIVE recommendations are not part of the Draft MDS 3.0, however, CMS went through and added almost all items that might be added based on STRIVE. CMS may later chose to not use some of the items, but do not expect to try to add anything.

Miscellaneous

- Q. When will the final Tag F309 – Pain Surveyor Guidance revisions be out and is there an anticipated date for the final SNF ABN?
- A. The revised surveyor guidance related to Pain is expected by the end of this year. No one is available to provide update on the SNF ABN at this time.
- Q. Will there be an update to the surveyor manual regarding demand bill notification?
- A. CMS is working on new material and will be issuing a Survey & Certification letter. At this time continue to use the demand bill notifications currently in place.
- Q. Please address what protections are in place when a facility attempts to provide the Expedited Generic Notice via phone but does not reach the responsible party and does not receive a return call. When attempts to reach by phone are unsuccessful the notice is mailed with return receipt requested. The current Q&A indicates the required 48 hour notice begins when the letter is accepted, which may be later than the identified last covered day. Please address the provider, beneficiary and Medicare liability when notice is delayed in spite of best efforts of the provider.
- A. No one available to respond to the questions at this time. Will provide response on future ODF call.

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- Q. When will the Hospice for Long Term Care Clarifications be available from CMS?
A: Clarifications are not yet available. CMS will provide response on future ODF call.
- Q. Update on the 5 Star Rating Program requested.
A. The program is targeted for implementation by the end of this year. CMS will allot considerable time to the 5 Star Programs on the next SNF call.
- Q. Has CMS issued guidance on insidious weight loss?
A. CMS has not issued guidance to look specifically at insidious weight loss. There is a long standing practice to look at unplanned and avoidable weight loss in survey process. Insidious weight loss is not addressed as such in the interpretive guidance.
- Q. Question addresses State initiated appeals. Publication 100-4, Chapter 29, Section 310.4 (d) instructs that the medical records must be requested from the state. When the state fails to provide the records, the facility is denied reimbursement. Is it possible to close the loop hole?
A. No one available to address on the call. CMS will address on future calls. Providers are encouraged to utilize the current appeals process in the meantime.