



POLARIS

PULSE

20 YEARS

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008.

and enthusiasm that we milestone and thank clients for their Twenty years in with a niche in consulting, puts



It is with great pride celebrate this each of our valued continued support. business, especially health care Polaris Group in

limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.

Assignment of Providers to MACs

Background

Since October 1, 2005, CMS will not accept an individual provider's request to move from one FI to another FI. However, a provider that was joining or leaving a Medicare chain (undergoing a change of ownership), was permitted to move from one FI to another FI in connection with that change of ownership.

In September 2007 CMS informed all FIs and A/B MACs that it would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There is one exception for a small subset of chains. They are "qualified chain providers" (QCPs), and are discussed.

CMS implemented this freeze on movement of providers in order to support the process of transferring workload from legacy carriers and FIs to A/B MACs. CMS needs to stabilize chain configurations, provider assignments, and claim histories in anticipation of the MAC implementation. CMS also seeks to limit the number of transitions to which each provider is subjected during the process.

CMS' Approach for Assigning Providers, Physicians, and Suppliers to MACs

A. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located.

B. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the DME MAC contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides.

C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

D. Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS.

E. The Geographic-Assignment Rule

On November 24, 2006, CMS published a final regulation setting forth the "geographic assignment" rule for the balance of Medicare providers, physicians, and suppliers. The regulation (at 42 CFR 421.404) directs that Medicare providers, physicians, and suppliers will generally be assigned to the A/B MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the entity's covered services for the geographic locale in which the entity is physically located. The A/B MACs will be contracted to serve all Medicare benefit categories not discussed above within their jurisdictions.

An exception exists for qualified chain providers (QCPs). A QCP may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC whose jurisdiction includes the QCP's home office.

A few providers that meet the "provider-based" criteria of 42 CFR 413.65 may present an additional exception to the geographic-assignment rule. Provider-based entities (other than home health and hospice (HH+H) providers) will be assigned to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the main ("parent") provider is physically located.



The Process of Moving Providers to MACs

The General Case

All existing providers with a Medicare claims history will remain with their current FI/MAC assignments until their workload is transferred to an A/B MAC.

New providers (also known as “initial enrollments”) will be assigned to the FI or MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider’s covered services for the geographic locale in which the provider is physically located. An exception exists for a “Multi-Provider Complex/Sub-Unit” relationship (ref: 42 CFR 483.5(b)). Visit our website for more regulatory information at www.polaris-group.com An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the “geographic assignment rule.” Each such case is fact-specific and will be treated on an individual basis.

As each MAC contract is awarded, the new MAC will take over the workload performed by the carriers and FIs that serviced the state(s) in the given MAC jurisdiction. The Part A and Part B workload segments for each of the states in the given MAC jurisdiction will be moved one-by-one in the 12 months following the award. The specific requirements associated with workload transfers will be directed through formal CMS transmittals.

Out of Jurisdiction Providers

An “out-of-jurisdiction provider” (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with Items A – E above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

Many legacy Part A workload segments may include a number of OJPs. Examples of how an OJP may have been assigned to the given Part A segment include:

1. Individual “provider nominations.” or
2. Chains being granted “single FI” status.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after all 15 A/B MACs have been implemented. Some providers will need to submit or update their Medicare enrollment record before being reassigned.

When CMS starts the overall transfer of OJPs, the timing of each individual OJP move will be dependent on the then-current implementation status of the health Insurance General

Ledger Accounting System (HIGLAS), the status of the Enterprise Data Centers, and any other factors affecting the ability of the destination MAC to accept the OJP and its Medicare claims history.

Jurisdiction #	States Included in Jurisdiction	MAC Awards that have been announced
1	American Samoa, CA, Guam, HI, NV, North Mariana Islands	Palmetto
2	AK, ID, OR, WA	
3	AZ, MT, ND, SD, UT, WY	Noridian
4	CO, NM, OK, TX	Trailblazer
5	IO, KS, MS, NE	Wisconsin Physician Services (WPS)
6	IL, MN, WI	
7	AR, LA, MS	
8	IN, MI	
9	FL, PR, U.S. V.I.	
10	AL, GA, TN	
11	NC, SC, VI, WV	
12	DE, DC, MD, NJ, PA	Highmark
13	CT, NY	National Government Services (NGS)
14	ME, MA, NH, RI, VT	
15	KY, OH	

Cooperative Self-Disclosers May Avoid Integrity Obligations

Inspector General Daniel R. Levinson issued An Open Letter to Health Care Providers announcing that the Office of Inspector General (OIG) for the Department of Health and Human Services has refined the requirements of the OIG Provider Self-Disclosure Protocol, under which health care providers can voluntarily report fraudulent conduct affecting Medicare, Medicaid, and other Federal health care programs.

The Self-Disclosure Protocol provides guidance to health care providers who voluntarily disclose Federal health care program compliance issues that the provider believes potentially violate Federal criminal, civil, or administrative laws for which exclusion or civil monetary penalties are authorized. According to the Open Letter, providers who disclose in good faith, fully cooperate with OIG, and provide requested information in a timely manner will generally not be required to enter into Corporate Integrity or Certification of Compliance Agreements with OIG.

“A provider’s submission of a complete and informative disclosure, quick response to OIG’s requests for further



information, and performance of an accurate audit are indications that the provider has adopted effective compliance measures,” said Inspector General Levinson. “Accordingly, when we negotiate the resolution of OIG’s applicable administrative monetary and permissive exclusion authorities in exchange for an appropriate monetary payment, we generally will not require the provider to enter into a Corporate Integrity Agreement or Certification of Compliance Agreement. We believe this presumption in favor of not requiring a compliance agreement appropriately recognizes the provider’s commitment to integrity and also advances our goal of expediting the resolution of self-disclosures.”

The Open Letter sets forth four additional Self-Disclosure submission requirements:

1. A Complete description of the conduct being disclosed
2. A description of the provider's internal investigation or a commitment regarding when it will be completed
3. An estimate of the damages to the Federal health care program and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate
4. A statement of the laws potentially violated by the conduct

This information must be included in addition to the Basic Information described in the Self-Disclosure Protocol. The provider must be in the position to complete the investigation and damages assessment within 3 months after acceptance into the Self-Disclosure Protocol.

For a copy of the Open Letter go to www.polaris-group.com, click on News & Information, Press Releases.

Q & A

“Where No Question Goes Unanswered!”

- Q. Is it acceptable to use V Codes on a Skilled Nursing Facility’s UB-04 Claim submitted for Medicare billing?
- A. Yes, V codes are appropriate on a SNF Medicare claim when used according to Official Coding Guidelines. The Medicare Claims Processing Manual, Chapter 6, SNF Inpatient Part A Billing directs that SNFs enter the ICD-CM code for diagnoses in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by HIPAA, including any applicable guidelines regarding the use of V Codes. The code must be the full ICD-CM diagnosis code, including all five digits where applicable.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following **CEU approved** teleconference trainings

Live Teleconference Trainings

Topic	Date
Medicare Part A Basics	5/1
Master Section G Coding	5/6
Survey Process, Preparation & Management	5/7
Medicare Documentation & Skilling Criteria	5/8
Right Coding Sections K, P & T	5/13
Writing a Plan of Correction	5/14
Cut Letters & Generic Notices	5/15
Sections I, J, O & W—Right Coding for Revenue	5/20
Using Your Quality Measure/Indicator Reports	5/22
MDS 3.0—Now and Future	5/28
Implement an Effective QA Program	5/29

***Please join us in our Teleconferences .
For further information regarding these seminars, please contact the Seminar Department at: 800-275-6252 ext. 233 or register at: www.polaris-group.com***



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