



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. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in health care consulting, puts Polaris Group in a limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.



Exceptions to Therapy Caps Restricted July 1, 2008

The below information is correct as of the date written.

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except services billed by hospital outpatient departments. The 2006 Deficit Reduction Act enacted further exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions through June 30, 2008.

Effective July 1, 2008, exceptions to therapy caps are restricted to medically necessary services billed by the outpatient departments of hospitals. Use of the KX modifier to bypass contractor therapy cap edits will not be permitted for therapy service dates of July 1, 2008 and later on bill types 22x and 23x. The financial limits on outpatient therapy services for calendar year 2008 are \$1,810 for combined physical therapy and speech-language pathology services; and \$1,810 for occupational therapy services.

A beneficiary who is not a resident in a certified part of a skilled nursing facility (bill type 23x) will be able to obtain medically necessary services from the outpatient department of a hospital. Consolidated billing requirements prevent a beneficiary who resides in a certified part of a facility (bill type 22x) from receiving Medicare covered services from the hospital outpatient therapy department.

Now is the time to determine which resident have—or soon will—exceed the 2008 Therapy Caps. Timely notification to each beneficiary regarding financial liability beginning July 1, 2008 will protect the both the facility and the beneficiary.

Providers are advised to notify beneficiaries of the therapy financial limitations at the first therapy encounter. Beneficiaries should be informed that they are responsible for 100% of the costs of therapy services above each respective therapy limit.

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department. Although the use of the Notice of Exclusion from Medicare Benefits (NEMB) form is not a Medicare requirement, use of it, or a similar form designed to inform beneficiaries of the therapy financial limitation is advised.

Extension of the Therapy Cap Exception Process for all settings except hospital outpatient departments requires Congressional and Presidential intervention. Polaris Group is monitoring legislative action and will provide updates as information becomes available. There are bills in Congress trying to address this situation.

Charges to Hold a Bed During Skilled Nursing Facility (SNF) Absence

The Centers for Medicare and Medicaid Services (CMS) published Transmittal 1522 to update the Medicare Claims Processing Manual, Chapter 1, General Billing Requirements, Section 30.1. This revision incorporates language regarding charges to hold a bed during a Skilled Nursing Facility (SNF) absence that was inadvertently omitted when the Internet Only Manual was published.

Charges to a beneficiary for admission or readmission to a Skilled Nursing Facility (SNF) are not allowable. However, when temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF. Under the Social



Security Act (SSA), Section 1819 (c)(1)(B)(iii) and the Code of Federal Regulations 42 CFR Section 483.10(b)(5)-(6), a SNF must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge.

Social Security Act, Section 1819

c) Requirements Relating to Residents' Rights

(1) General rights

(B) Notice of rights and services.—A skilled nursing facility must:

(iii) inform each resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this title or by the facility's basic per diem charge.

Note that SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if Medicare requirements are met.

Bed-hold payments are readily distinguishable from payments made prior to initial admission, in that the absent individual has already been admitted to the facility and has established residence in a particular living space within it. Similarly, bed-hold payments are distinguishable from payments for readmission, in that the latter compensate the facility merely for agreeing in advance to allow a departing resident to reenter the facility upon return, while bed-hold payments represent remuneration for the privilege of actually maintaining the resident's personal effects in the particular living space that the resident has temporarily vacated.

One indicator that post-admission payments do, in fact, represent permissible bed-hold charges related to maintaining personal effects in a particular living space (rather than a prohibited charge for the act of readmission itself) would be that the charges are calculated on the basis of a per diem bed-hold payment rate multiplied by however many days the resident is absent, as opposed to assessing the resident a fixed sum at the time of departure from the facility.

Under §1819(c)(1)(B)(iii) of the Act and 42 CFR 483.10(b)(5)-(6), the facility must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge. For these optional payments, the facility should make clear that the resident must affirmatively elect to make them prior to being billed. A facility cannot simply deem a resident to have opted to make such payments and then automatically bill for them upon the resident's departure from the facility.

The updated Medicare Claims Processing Manual, Chapter 1, Section 30.1.1.1 can be viewed at www.polaris-group.com.

Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Effective July 1, 2008, Medicare will begin implementation of a new program for purchasing DMEPOS. For Medicare beneficiaries whose permanent residence is in 1 of 10 Metropolitan Statistical Areas (MSAs) affected by the first phase of this program, only contract suppliers, in most instances, will be eligible to provide competitive bid items and receive payment from Medicare. This program will expand to 70 additional MSAs in 2009.

The 10 MSAs affected by the first phase of this program include:

- Charlotte-Gastonia-Concord, North Carolina and South Carolina
- Cincinnati-Middletown, Ohio, Kentucky and Indiana
- Cleveland-Elyria-Mentor, Ohio
- Dallas-Fort Worth-Arlington, Texas
- Kansas City, Missouri and Kansas
- Miami-Fort Lauderdale-Miami Beach, Florida
- Orlando-Kissimmee, Florida
- Pittsburgh, Pennsylvania
- Riverside-San Bernardino-Ontario, California
- San Juan-Caguas-Guaynabo, Puerto Rico

Any Medicare Fee-for-Service (FFS) provider in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary may be affected by this program. This includes DMEPOS suppliers, physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists). Those who refer or order DMEPOS for Medicare beneficiaries are described as "referral agents".

While new payment rules may not impact referral agents directly, they may impact your patients. If your patients reside in one of the Competitive Bid Areas (CBAs), they must use a Medicare contract supplier for competitive bid items, unless they are willing to be responsible for full payment of these items. This means that some of your patients may have to change from a non-contract supplier



to a contract supplier. Certain suppliers that rent DMEPOS that were not awarded contracts may be “grandfathered” under this program and may be able to continue to supply certain DMEPOS items/services should the beneficiary choose to continue to receive these items from a grandfathered supplier.

The competitive bidding program will be implemented for the following product categories:

- Oxygen supplies and equipment
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories
- Mail-order diabetic supplies
- Enteral nutrients, equipment and supplies
- Continuous positive airway pressure (CPAP), respiratory assist devices, (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Negative pressure wound therapy (NPWT) pumps and related supplies and accessories
- Walkers and related accessories
- Support surfaces (Group 2 mattresses and overlays (Miami MSAs only))

CMS Medicare Learning Network (MLN) Matters article “Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)” can be viewed at: www.polaris-group.com.

Q & A
“Where No Question Goes Unanswered!”

- Q. Can a resident ever use the days remaining in a benefit period if they discharge from a SNF Part A stay before day 100?
- A. A resident may be readmitted to a Part A SNF stay without a new qualifying hospital stay if they require daily skilled care for the same condition within 30 days of the day of discharge. If another condition arises during the 30 days, the beneficiary would need a new 3 day qualifying hospital stay. For days 31 to 60 after discharge, the beneficiary would need a new qualifying hospital stay whether or not the need for skilled services relates to the original condition treated. In either case, the beneficiary would only have the days remaining in the initial 100 day benefit period. available. After 60 days without hospital admission or daily skilled service in the SNF, the beneficiary would qualify for a new 100 day benefit period.

TELECONFERENCE TRAININGS

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

Live Teleconference Trainings

<u>Topic</u>	<u>Date</u>
ADR Part 2	6/17
ICD9 Coding Part 2	6/18
QA Audits that Work	6/19
ADR Part 3	6/24
Case Management	6/25
MDS Basics for TILE Nurses	6/26
Pain Management	7/1
MDS Fundamentals	7/8
MDS Accuracy for RUG	7/9
Coding ADLs and Therapy	7/10
RAPS and Care Plans	7/15
Medicare Part A Basics	7/16
Skilled Medicare Nursing Documentation	7/17
PPS and Case Management of MDS	7/22
QI/QM Report Review	7/23
F-Tag Review	7/24
Survey Process and Preparation	7/29
Writing a POC	7/30
MDS for Administrators	7/31

*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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