



POLARIS PULSE

20 YEARS

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



MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT, 2008

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. Key provisions significant to Post Acute Care providers is outlined below:

- 1. Physician Pay** - As a result of the new law, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate reduction of -10.6 percent is retroactively replaced with the fee schedule rates in effect from January – June, 2008, which reflected a 0.5 percent update from 2007 rates. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments.
- 2. Therapy Caps** - The law also reinstated the therapy caps exceptions process as of July 1st. Medically necessary therapy services, in excess of the therapy caps, will continue to be paid by Medicare in accordance with the exceptions process. Claims submitted with the therapy cap exception modifier will be processed as soon as the payment rates have been activated. Claims submitted without the modifier, and rejected or denied, can be resubmitted with the modifier for reimbursement.

Before this legislation was enacted, CMS instructed outpatient therapy service providers to not submit the KX modifier on claims for services furnished on or after

July 1, 2008. Outpatient therapy service providers may resume submitting claims with the KX modifier for qualifying therapy services that exceed the cap on or after July 1, 2008. Providers that submitted some claims without the KX modifier that would qualify for an exception should resubmit these claims appending the KX modifier so they may now be processed and paid. The Medicare Improvements for Patients and Providers Act of 2008 extends the effective date of the exceptions process through December 31, 2009.

If a beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

- 3. DME** - The Durable Medical Equipment Competitive Bidding Program, which affects only Medicare beneficiaries in traditional fee-for-service in 10 competitive bidding areas, has been delayed. Medicare beneficiaries may use **any** Medicare-approved supplier for Durable Medical Equipment. If a beneficiary changed suppliers when this new program started (July 1, 2008), they can either continue to use the new supplier or choose another supplier. The original DME payment rates in effect prior to July 1 are reinstated retroactively. The DME Competitive Bidding areas are: (1) Charlotte-Gastonia-Concord, NC-SC, (2) Cincinnati-Middletown, OH-KY-IN, (3) Cleveland-Elyria-Mentor, OH, (4) Dallas-Fort Worth-Arlington, TX, (5) Kansas City, MO-KS, (6) Miami-Fort Lauderdale-Miami Beach, FL, (7) Orlando-Kissimmee, FL, (8) Pittsburgh, PA, (9) Riverside-San Bernardino-Ontario, CA, and (10) San Juan, PR.

CMS Posts MDS 3.0 RAND Report

The Centers for Medicare and Medicaid Services created a national project to create version 3.0 of the Minimum Data Set (MDS). The revision aimed to improve the clinical relevance and accuracy of MDS assessments, increase the voice of residents in assessments, improve user satisfaction and increase efficiency of report. CMS contracted with the RAND Corporation for the MDS 3.0 Development and National Evaluation.



The final national testing of MDS 3.0 was conducted in 71 Community Nursing Homes in 8 states and 19 Veterans Administration Nursing Homes. The national test examined agreement between assessors (reliability); validity of new cognitive, depression, and behavior items; response rates for interview items, user satisfaction and feedback on changes; and time to complete the assessment.

Major findings include:

- **Accuracy:** MDS 3.0 items showed either excellent or very good reliability even when comparing research nurse to facility-nurse assessments. For items that were validated against criterion measures, the MDS 3.0 performed better than MDS 2.0.
- **Resident Voice:** MDS 3.0 successfully included resident voice. The majority of residents were able to complete interview sections. Staff members reported that items provided useful clinical insights; analyses showed improved validity for cognitive and mood items.
- **Clinical Relevance:** Nurses who used MDS 3.0 reported that the revisions were more clinically relevant and useful than MDS 2.0; items used in other clinical settings showed either excellent or very good reliability with low rates of missing responses when tested in MDS 3.0.
- **Efficiency:** MDS 3.0 improved assessments while decreasing time to complete. The average time for completing the MDS 3.0 was 45% less than the average time for MDS 2.0 based on the same sample.
- **Crosswalk:** Although MDS 3.0 improved detection of clinical problems, items could be mapped to MDS 2.0 payment cells in a manner that avoided significant shifts in payment.

Conclusions: Improvements incorporated in MDS 3.0 produced a more efficient assessment; better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, including items recognized in other care setting is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including use of more valid items, direct inclusion of resident reports; improved clarity of retained items, deletion of poorly performing items, form redesign, and briefer assessment periods for clinical items.

The full RAND Report can be viewed by going to: www.polaris-group.com

Revision of the Requirements for SNF Denial of Payment for New Admissions (DPNA)

CMS may impose a DPNA when a facility is not in substantial compliance with requirements of participation.

Medicare policy indicates that beneficiaries admitted before the effective date of a DPNA situation and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and **are not subject to the denial of payment upon return.**

Medicare instructions indicate that SNFs should append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply. However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations.

Therefore, CMS is updating DPNA instructions to require SNF providers to append the new occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable.

In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a LOA, the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

Effective January 1, 2009, when a SNF that is under a payment ban needs to submit a claim for a Medicare beneficiary readmission that is not subject to the payment ban, the SNF must use occurrence span code 80 for reporting prior same-SNF stay dates. The definition of "Prior Same-SNF Stay Dates for Payment Ban Purposes" is: The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital. (Previously, SNFs used condition code 57 for this purpose, but that code does not apply to all payment ban situations.)



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In situations where the beneficiary's SNF admission is subject to the payment ban, but the provider fails to issue the proper beneficiary liability notice, the provider is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable co-payment amounts from the beneficiary. These days will be charged against the patient's utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the provider liability billing instructions. In essence, the SNF needs to file a covered bill with the FI or A/B MAC using occurrence span code 77 that indicates the facility is liable for the services in situations where the SNF failed to issue the proper beneficiary liability notice and any applicable co-payments will be charged to the beneficiary's Part A benefit period. In addition, the SNF needs to file a non-payment bill for non-covered Part A services using condition code 21 that indicates beneficiary liability. Remember that services that would have been eligible for Part A benefits in the absence of sanctions may not be billed as Part B charges to Medicare.

Source: CMS Transmittal 1555 can be viewed by going to:
www.polaris-group.com

Q & A

"Where No Question Goes Unanswered!"

- Q. What does condition code "58" on the SNF fee-for-service inpatient SNF claim indicate?
- A. Skilled nursing facilities (SNFs) submit the first fee-for-service inpatient claims with condition code '58' to indicate:
- A patient disenrolled from a Medicare Advantage Plan, and
 - The 3-day prior stay requirement was not met.
- Claims with condition code '58' will not require the 3-day prior inpatient hospital stay.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following
CEU approved teleconference trainings
Live Teleconference Trainings

Topic	Date
How to Prevent F314 Pressure Ulcer Program	8/5
"Super" Supervisor—Part I—Communication Skills	8/6
Implement an Effective QA Program	8/7
Bowel and Bladder Management	8/12
MDS Basics for TILE Nurses	8/12
Supervisory Skills-Part II Coaching to Improve Staff	8/13
Quality Indicator Survey (QIS)	8/14
Fall Prevention and Management	8/19
Documentation Basics for RUG 34	8/19
Anatomy of a Chart	8/20
Survey Process, Preparation & Management	8/21
Revised Surveyor Guidance for Nutrition & Sanitary	8/21
Managing New Admissions and Acute Episodes	9/4
Part I Medicare Billing Part A&B	9/4
Culture Change	9/10
Accidents and Supervision	9/11
Part II Medicare Practicum Part A&B	9/11
Anatomy of a Chart	9/16
Part III No Pay Bills	9/16
Behavior Assessments Care Plan	9/17
MDS for TILES Nurses	9/17
Public Quality Measures	9/18
New Sanitation Survey Protocol	9/23
MDS 3.0	9/24
Documentation for RUG 34	9/24
Taming the Care Plan Monster	9/25
Part IV Consolidated Billing	9/25

Please join us in our Teleconferences.
For further information regarding these seminars, please contact the
Seminar Department at: 800-275-6252 ext. 233
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