



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



Fiscal Year 2009 Skilled Nursing Facility Prospective Payment System (SNF PPS) Final Rule

The FY 2009 SNF PPS Final Rule projects that Medicare payment rates for Skilled Nursing Facilities (SNFs) will increase by \$780 million dollars compared with those in FY 2008. The boost in payments is the result of a 3.4 percent increase in the annual market basket calculation of the cost of goods and services included in a skilled nursing facility stay. The temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS remains in effect.

CMS delayed the proposed recalibration of payment rates intended to correct a FY 2006 case mix weight projection error during the conversion to the RUG 53 classification model. Although recalibration was delayed, CMS noted that they will continue to evaluate the error and fully expect to implement an adjustment in the future.

When a SNF may bill at the default payment rate

SNFs are required to submit resident assessment data according to an assessment schedule. When the SNF fails to comply with the assessment schedule, it must file a late assessment in order to be paid. A late assessment occurs when the ARD for the Medicare-required assessment is set outside of the prescribed assessment window. In this situation, CMS pays a “default rate”— a reduced payment made in lieu of the full SNF PPS rate that would have been

paid had the resident been assessed in a timely manner up to the ARD of that late assessment; the established RUG rate from the late MDS then can be billed for the rest of that billing cycle for that MDS. Noncompliance with the schedule is determined by the assessment reference date (ARD) on the resident PPS MDS. In order to bill the default code, the SNF must prepare a late MDS with an ARD date that is a day prior to the date of discharge from Medicare Part A. If a Medicare Part A resident is discharged, the last allowable ARD would be the “last covered day.” If the ARD is chosen after discharge, then the MDS is late, and payment will not be made.

There are 5 specific circumstances that permit Medicare default rate payment when an MDS was not completed:

1. The stay is less than 8 days within a spell of illness
2. The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial
3. The SNF is notified on an untimely basis of the revocation of a payment ban
4. The beneficiary requests a demand bill
5. The SNF is notified on an untimely basis or is unaware of a beneficiary’s disenrollment from a Medicare Advantage plan.

CMS strongly encourages SNFs to follow the Medicare-required MDS schedule in any instance where there is even a possibility of Medicare payment (Medicare Secondary Payer, Medicare Advantage, payment ban scenarios); otherwise, the SNF risks being paid at the default rate. If a SNF has performed an “OBRA” MDS rather than the supplemental SNF PPS schedule for Medicare-required MDSs during this period which also happens to fall within the window for a Medicare-required MDS, the OBRA MDS can be used for Medicare payment purposes as well.

Instructions relating to Medicare Secondary Payer denials in the Provider Reimbursement Manual and revocation of payment bans in the Medicare Claims Processing Manual have allowed SNFs to use the most recent MDS that was completed in accordance with the OBRA MDS Assessment schedule in order to receive payment under the Medicare program. CMS revised these policies to allow the OBRA required 14-day MDS for billing all days



of covered care associated with a Medicare-required 5-day and 14-day MDS. This is the case even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. For covered days associated with the Medicare-required 30-, 60-, or 90-day MDS, the SNF must have an MDS that falls within the window of the Medicare-required MDS in order to receive full payment at the RUG level in which the resident grouped. If no MDS was completed, the SNF may submit a claim requesting payment at the default rate.

The policy revisions recognize that the level of resources used by a resident changes throughout the stay, and that the OBRA 14-day MDS is less likely to represent the beneficiary's clinical status later in the stay. The policy also applies to situations where the SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage program.

If the SNF fails to submit an MDS for circumstances other than the five listed on the prior page, there is no payment available. When no payment will be made the SNF must nonetheless submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

In situations where the SNF fails to assess the beneficiary and fails to issue the proper Notification of Non-Coverage, the SNF 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. Services that would have been payable to the SNF as Part A benefits cannot be billed to the contractor (Fiscal Intermediary, Medicare Administrative Contractor or Carrier) as Part B services.

The Role of Rehabilitation Service Evaluations in SNFs

For Medicare to cover rehabilitation services in a SNF the services must be directly and specifically related to an active written treatment plan that is developed before the start of rehabilitation services. The plan must be based upon an initial evaluation performed by a qualified therapist (after SNF admission and before the start of rehabilitation services in the SNF) and must be approved by the physician after any needed consultation with the qualified therapist.

This means that the evaluation must have been performed for each discipline and the plan of treatment developed in

order to include minutes for each discipline under Section P ("Special Treatments and Procedures") of the Resident Assessment Instrument (MDS), and also to project minutes under Section T ("Therapy Supplement for Medicare PPS") of the Resident Assessment Instrument. Section T of the MDS is completed for Medicare 5-day MDSs and in certain cases, when a beneficiary is readmitted to the SNF, whereas Section P is completed for each Medicare-required MDS. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of rehabilitation services in the SNF.

To view The SNF PPS FY 2009 Final Rule go to http://polaris-group.com/news_releases.asp. Once on this site your FY 2009 Part A RUG Rates can be purchased by clicking on Publications and Products and following the links to Part A PPS RUG Rates.

Resident Assessment Instrument MDS 2.0 Manual Update

CMS released July 2008 updates to the MDS 2.0 User's Manual. A concluding update to MDS 2.0 is anticipated in 2008 and then CMS will focus on the MDS 3.0 Manual. Key changes in the July 2008 updates include:

- Incorporation of the missed MDS, default rate billing and therapy evaluation clarifications provided in the 2009 SNF PPS Final Rule.
- Chapter 2, Section 2.2, page 2-11—Guidelines for Determining the Need for a SCSA (Significant Change in Status Assessment) for Residents with Terminal Conditions: "While the need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment, CMS encourages facilities to complete an SCSA due to the importance of ensuring that a coordinated plan of care between the hospice and nursing facility is put into place.
- Chapter 3, Section G1(A), page 3-81 add: To code a resident as a "4" (Total Dependence) in G1hA, the resident would have to be totally dependent in eating, drinking and be non-participatory in the TPN, IV or tube feeding administration. If the resident participated in the act of drinking and/or eating and was totally dependent in the TPN, IV or tube feeding,



the facility must evaluate all of the methods that food and fluids are being provided to the resident to determine the resident's level of self-performance.

- Chapter 3, Section R2b, page 3-212: The term "backdating" means to give or assign a date to a document that is earlier than the actual date.
- Chapter 3, Section R2b, page 3-212: Use the actual date that the MDS was completed, reviewed and signed as complete by the RN Assessment Coordinator. This date will generally be later than the date(s) at AA9 which documents when portions of the assessment information were completed by assessment team members.

To view the entire July 2008 MDS 2.0 Manual updates go to http://polaris-group.com/news_releases.asp.

**Fee-For-Service
Expedited Determination Notices**

The Notice of Medicare Provider Noncoverage (CMS-10123) and the Detailed Explanation of Noncoverage (CMS-10124) have been renewed by the Office of Management and Budget (OMB). The new expiration date is July 31, 2011. Both notices and the corresponding instructions for completing the notices have undergone slight revisions. Instruction on when to issue the notices have not change. CMS is expected to announce a transition period after which the notices with June 30, 2008 expiration date will no longer be valid.

The revised notices and corresponding instructions are available at: http://polaris-group.com/news_releases.asp.

Q & A
"Where No Question Goes Unanswered!"

- Q. Are stamped physician signatures acceptable on Medicare Certifications?
- A. No. Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamped signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. Noted Exception: Facsimile of original written or electronic signature are acceptable for the certification of terminal illness for hospice. (Source: Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1)

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

Topic	Date
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
Rvsd. Surveyor Guidance—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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