



An Informational Bulletin Brought To You By Polaris Group

Office of Inspector General Posts Work Plan for Fiscal Year 2012

The Office of Inspector General (OIG) Work Plan for Fiscal Year (FY) 2012 provides brief descriptions of activities that OIG plans to initiate or continue in FY 2012, which runs from October 1, 2011 through September 30, 2012. The following key items are addressed in the FY 2012 work plan for Nursing Homes.

- **Medicare Requirements for Quality of Care in Skilled Nursing Facilities**

OIG will review how Skilled Nursing Facilities (SNFs) have addressed certain Federal requirements related to quality of care. They will determine the extent to which SNFs developed plans of care based on assessments of beneficiaries, provided services to beneficiaries in accordance with the plans of care, and planned for beneficiaries' discharges. OIG will also review SNFs use of Resident Assessment Instrument (RAI) to develop nursing home residents' plans of care.

- **Safety and Quality of Post-Acute Care for Medicare Beneficiaries (New)**

OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to post-acute care. They will evaluate the transfer process and also identify rates of adverse events and preventable hospital readmissions from post-acute-care settings. OIG will focus on three post-acute settings: SNFs, IRFs and long-term-care hospitals.

- **Nursing Home Compliance Plans (New)**

OIG will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in OIG's compliance program guidance.

- **Oversight of Poorly Performing Nursing Homes**

OIG will review CMS's and States' use of enforcement measures to determine their impact on

improving the quality of care that beneficiaries received in poorly performing nursing homes and evaluate the performance of these nursing homes. They will also determine the extent to which CMS and States follow-up to ensure that poorly performing nursing homes implement correction plans.

- **Nursing Home Emergency Preparedness and Evacuations During Selected Natural Disasters**

OIG will review nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors to determine the sufficiency of the nursing homes' plans and their implementation of the plans.

- **Medicare Part A Payments to Skilled Nursing Facilities**

OIG will review the extent to which payments to SNFs meet Medicare coverage requirements. They will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009.

- **Hospitalizations and Rehospitalizations of Nursing Home Residents**

OIG will review the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized and rehospitalized. They will also assess CMS's oversight of nursing homes whose residents have high rates of hospitalization.

- **Questionable Billing Patterns During Non-Part A Nursing Home Stays (New)**

OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit.

Click here to read the work plan:

http://www.polaris-group.com/news_releases.asp



CMS Announces MDS 3.0 FY 2012 Transition RUG Value Calculation Issue

The Centers for Medicare and Medicaid Services (CMS) identified an issue with the calculation of the FY2012 transition RUG values for a small percentage of assessments submitted following the Assessment Submission and Processing (ASAP) system enhancements deployed on September 18, 2011.

The affected assessments were submitted between September 18th and September 28th, 2011.

The issue occurred because the FY2012 transition RUG calculations were utilizing the FY2011 CMI Set Codes rather than the FY2012 CMI Set Codes. As a result, 0.47% of the transition RUGs reported were incorrect. The affected assessments have been identified and the FY2012 transition RUG values for those records have been recalculated.

The system enhancement to correct the issue was deployed Wednesday afternoon, September 28th, 2011. Assessments submitted since the system enhancements are returning the correct FY2012 transition RUG values.

MDS 3.0 Final Validation reports for the affected submissions were created and stored in the affected facility's Validation Report (VR) folder. A notification email will be sent to users who submitted the original submission files containing the affected assessments.

We have attached the letter and file from CMS that will help you determine if any of the MDSs you transmitted were affected by this error. The attachment includes a list of facilities that were affected by the error.

[Click here](#) to read the memorandum



New Health Care Electronic Transactions Standards HIPAA 5010 Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses.

Over 99 percent of Medicare Part A claims and over 96 percent of Medicare Part B claims transactions are received electronically. The current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions and the National Council for Prescription Drug Programs [NCPDP] Version 5.1 for pharmacy transactions) used in these health care transactions lack certain functionality required by the health care industry. Therefore, it is necessary for providers to prepare for new standards in order to continue submitting claims electronically.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current Version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) Version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

All HIPAA covered entities must transition to Version 5010 by **January 1, 2012**. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010 on or after



January 1, 2012. Electronic transactions that do not use Version 5010 are not compliant with HIPAA and **will be rejected**.

To allow time for testing, CMS began accepting electronic transactions using either Version 4010/4010A or Version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011.

[Click here](#) for additional information

Revalidation of Medicare Provider Enrollment Information

The Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled **prior to March 25, 2011**. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are not impacted. Between now and March 23, 2013, MACs will send out notices on a regular basis to begin the revalidation process for each provider and supplier. Providers and suppliers must wait to submit the revalidation **only after being asked by their MAC** to do so.

When you receive notification from your MAC to revalidate:

- ◆ Update your enrollment through Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or complete the 855;
- ◆ Sign the certification statement on the application;
- ◆ If applicable, pay your fee thru **pay.gov**; and
- ◆ Mail your supporting documents and certification statement to your MAC.

[Click here](#) for additional information

Frequently Asked Questions FY 2012

PPS Final Rule

END OF THERAPY (EOT) ,END OF THERAPY RESUMPTION (EOT-R) and Change of Therapy (COT) Other Medicare Required Assessment (OMRA)

If a therapy patient leaves the facility at 8:00 am and returns the next day at 7:00 am is an End of Therapy Resumption (EOT-R) required to be completed?

No, an EOT-R is only applicable when there has been a lapse of therapy services for no more than 5 consecutive calendar days after the last day of therapy, regardless of the reason for the lapse. A leave of absence (skip day) or discharge and readmission would determine the PPS schedule.

If a Part A patient has a break of 3, 4 or 5 days of therapy are these days counted in the available 100 Part A benefit days?

Yes, the patient is still skilled the MDS would generate a non-rehab RUG level. These skilled days would count as days used toward a patients available Part A benefit period.

What happens if you have a 3 day break in therapy services and you proceed with an EOT-R but you don't reach the same RUG level you had previously. What should be done?

In this case, if you resumed therapy on a Tuesday at the same planned therapy intensity (Minutes and days), the payment for the previous rehab RUG level would begin on the day therapy started and this day would also start your count for the seven (7) day COT observation period. So you begin therapy on Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday and Monday at the end of the day you determine the RUG level is not achieved either higher or lower, a COT OMRA would be completed and your payment would change on Tuesday for the lower RUG. In a COT the ARD is always day 7. It is also possible that a regularly scheduled PPS assessment could be required before the 7 day COT review. If that



occurred the payment period for that RUG level would be determined by which assessment was done (14, 30,60, 90 day).

If a three day lapse in therapy services occurs what would skill the patient for nursing?

Each Part A patient has unique nursing needs as per the established care plan. During these unplanned breaks in therapy services, nursing and therapy will continue to document the skilled nursing needs of the patient and the reason for the lapse in therapy. The resident would continue to stay in a Part A skilled bed. The resident is not off therapy cases load.

During a three day break in therapy services, is the facility required to issue a notice to terminate Medicare covered services?

No, when SNF covered services end solely because the beneficiary fails to meet the consecutive days of therapy required (5 days) for a covered stay or the facility does not offer weekend care, the expedited determination notice (NOMNC) or an ABN would not be provided.

Does Change of Therapy (COT) OMRA apply when a rehab RUG level is indexed (over ridden) to a nursing RUG level?

Yes, a facility would be required to complete a COT OMRA for all patients receiving any amount of skilled therapy, including those patients who have index maximized into a non-therapy or nursing RUG level. For example, a patient qualifies for RMC but the index maximizes into a LE2. During the observation period the therapy minutes are increased so that a RV is obtained. A COT OMRA is required because of the change of the index maximization and the increased RUG category

For the complete clarification document, please visit our website: www.polaris-group.com

2011 WEBINAR TRAININGS

Polaris Group is pleased to offer the following *CEU approved* live Webinars

Topic	Date
New SNF Rules Part 1	10/13
New SNF Rules Part 2	10/20
Denial Letters & Generic Notices	10/18
Survey Prep & Process	10/18
Writing a Plan of Correction	10/25
New QM/QI Measures 2012	10/27
MDS Part 1	11/1
MDS Part 2	11/8
MDS Part 3	11/15
MDS Part 4	11/16
RUG IV Part 1	11/2
RUG IV Part 2	11/3
Billing Part A&B-Billing Cycle	11/8
Billing Part A&B-UB04 Completion	11/15
SNF No Pay Billing & Benefit Exhaust	11/17
Billing Part A&B-Consolidated Billing	11/22

Please join us!

For further information, please contact the Webinar Department at: 800-275-6252 ext. 233 or register online at: www.polaris-group.com

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