



An Informational Bulletin Brought To You By Polaris Group

CMS POSTS MEDICARE PREMIUMS & DEDUCTIBLES FOR CALENDAR YEAR (CY) 2012

The U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), released a Fact Sheet, announcing the Medicare premium rates and deductibles for 2012 for Medicare, Parts A, B and D.

Below you will find a comparison of Calendar Year (CY) 2011 to Calendar Year (CY) 2012.

PART A - Inpatient

SKILLED NURSING FACILITY CARE

Beneficiary pays:

Co-payments days 21st through 100th day

CY 2011 = \$141.50

CY 2012 = \$144.50

INPATIENT HOSPITAL CARE (ACUTE)

Beneficiary pays:

Deductible:

CY 2011 = \$1,132.00

CY 2012 = \$1,156.00

Co-payments days: 61st through 90th day

CY 2011 = \$283.00

CY 2012 = \$289.00

Lifetime Reserve Days:

60 days with co-payment

CY 2011 = \$566.00

CY 2012 = \$578.00

PART B -

Physician and Other Outpatient Services

(such as therapy services in a SNF)

PHYSICIAN & OUTPATIENT SERVICES

Deductible:

CY 2011 = \$162.00

CY 2012 = \$140.00

20% coinsurance amount after of allowed charges

Standard Monthly Premium:

CY 2011 = \$115.40

CY 2012 = \$99.90

To read the entire article, [click here](#)

CMS ISSUES 2012 PHYSICIAN FEE SCHEDULE FINAL RULE

On November 1st, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. This is the same schedule used to pay for Part B therapies in nursing facilities. The physician pay rates will be cut by 27.4 percent starting Jan. 1, 2012, **unless Congress intervenes to change the underlying law like they have done in previous years.**

CMS projected that total payments under the MPFS in CY 2012 will be approximately \$80 billion.

Listed below are key items that have an impact on nursing facilities:

- The Physician Fee Schedule sets the therapy cap on outpatient services provided in nursing facilities at \$1,880 beginning January 1, 2012, which is \$10 more than the cap that is in place for 2011.
- The current therapy cap exception process will expire on December 31, 2011, unless Congress acts to extend it, which they have done several times in past years.
- In 2011, Medicare applied the Multiple Procedure Payment Reduction (MPPR). This is a reduction to the practice expense portion of the payment for a therapy procedure when more than one unit or procedure is provided to the same patient on the same date of service. The MPPR of 25% for services furnished in an institutional setting remains unchanged.

To read the entire Final Rule, [click here](#)



Nursing Facility Compliance Program Implementation

With the passage of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education Reconciliation Act of 2010 (the Healthcare Reform Law), Congress for the first time has mandated that a broad range of providers, suppliers, and physicians adopt a compliance and ethics program. The Healthcare Reform Law's compliance program mandates are divided into two categories: (1) nursing facilities and (2) all other providers/suppliers. The nursing facility compliance program provisions in the Healthcare Reform Law are far more detailed and contain the implementation timeline detailed below;

- ◆ By **December 31, 2011**, the Secretary shall establish and implement a quality assurance and performance improvement (QAPI) program for nursing facilities that will address best practices.
- ◆ Within one year following the promulgation of the Secretary's QAPI program regulations (no date is specified for such regulations), a nursing facility must submit a plan to HHS to meet such standards and implement such best practices.
- ◆ By **March 23, 2012**, the Secretary of HHS, working jointly with OIG, must promulgate regulations for "an effective compliance program" for nursing facility operating organizations.
- ◆ Those regulations "may" include a model compliance program and, with respect to specific elements of the program, "shall" vary with the size of the operating organization for organizations that operate five or more facilities. Larger organizations are expected to have a more formal program, and requirements may "specifically apply to the corporate level management of multi-unit nursing home chains." In other words, the nursing facility compliance program regulations should contain an element of scalability and proportionality.
- ◆ By **March 23, 2013**, skilled nursing facilities and other nursing facilities must have "in operation" a compliance and ethics program that meets the Law's criteria.
- ◆ By **March 23, 2013**, the HHS Secretary shall have completed "an evaluation" of the compliance and ethics programs that nursing facilities will be required

to establish. Nursing facilities are not required to have in operation those compliance and ethics programs until the very same day the Secretary's evaluation is supposed to be completed.

- ◆ Sometime after **March 23, 2013**, the Secretary must submit an evaluation report to Congress with recommendations on changes to the regulatory requirements for nursing facility compliance programs.

For nursing facilities, the Healthcare Reform Law specifies certain "required components of a compliance and ethics program" that include:

- ◆ Compliance standards and procedures for employees and other agents "that are reasonably capable of reducing the prospect" of criminal, civil, and administrative law Medicare and Medicaid violations.
- ◆ The assignment of overall compliance program oversight to "high-level personnel" with "sufficient resources and authority" to assure such compliance.
- ◆ The exercise of "due care" not to delegate "substantial discretionary authority" to individuals whom the nursing facility knew or should have known had a "propensity to engage in criminal, civil, or administrative violations."
- ◆ The effective communication of compliance standards and procedures to all employees and agents, including training programs or published materials.
- ◆ The adoption of reasonable monitoring and auditing systems reasonably designed to detect compliance violations by employees and other agents and a mechanism for employees and agents to report violations without fear of retribution.
- ◆ The consistent enforcement of appropriate disciplinary mechanisms, including for failure to detect an offense.
- ◆ Following detection of an offense, reasonable responses to include steps to prevent further similar offenses, including any modifications to the compliance program.
- ◆ The periodic reassessment of its compliance program to identify modifications necessary to reflect changes within the nursing facility organization and its facilities.



CMS Makes Changes to the Process for Leave of Absence

In a recent release, CMS made changes to the process for handling a Leave of Absence (LOA). A Leave of Absence can have a direct impact on a patient's Medicare assessment schedule for both scheduled and unscheduled MDSs and has direct billing implications. CMS defines an LOA as a period away from the center which does not require completion of either a discharge assessment or an entry tracking record. This occurs when a patient has a:

- ◆ Temporary home visit or leave of at least one night; or
- ◆ Hospital observation stay less than 24 hours and the hospital do **not** admit the patient.

Leave of Absence and Scheduled MDSs

A patient may experience brief Leaves of Absence for many reasons. The most common is when the patient has a less than 24 hour hospital visit and is not admitted to the hospital. If a patient is out of the center over a midnight, but for less than 24 hours, and is not admitted to an acute care center, the Medicare assessment schedule is not restarted. However, there are payment implications: the day preceding the midnight on which the patient was absent from the nursing home is not a covered Part A day. This is known as the "midnight rule." The Medicare assessment schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment clock is adjusted by skipping that day in calculating when the next Medicare assessment is due.

Leave of Absence and Unscheduled MDSs

In the case of unscheduled PPS assessments, the ARD of the relevant assessment is not affected by the LOA because the ARDs for unscheduled assessments are not tied directly to the Medicare assessment calendar or to a particular day of the patient's stay.

In the case of an EOT OMRA, the EOT OMRA must be performed if a patient does not receive therapy for three consecutive calendar days, which may include days during which the patient experienced a LOA. In the case of an COT OMRA, the COT OMRA does not move and remains 7-days after the ARD since it is not a regularly scheduled MDSs. Based on these rule changes, it is also possible to have an ARD set for an LOA day. It is also possible to capture items on the MDS that were provided on the LOA day.

2011 WEBINAR TRAININGS

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

<u>Topic</u>	<u>Date</u>
<u>Medicare Billing Part 4</u>	11/21

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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