November 29, 2018

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An Informational Bulletin Brought To You By Polaris Group

CMS Issues CY 2019 Medicare Physician Fee Schedule Final Rule

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) issued the Final Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS), which would take effect January 1, 2019. The final rule updates Medicare Part B payment policies, payment rates and quality provisions for services under the Medicare PFS. This is the same fee schedule used to pay for Medicare Part B therapy services in nursing facilities. The final 2019 PFS conversion factor is $36.05, a slight increase above the CY2018 PFS conversion factor of $35.99.

Key items that impact nursing facilities per the CMS fact sheet:

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

The data from the functional reporting system was to be used to aid CMS in recommending changes and reforming of Medicare payment for outpatient therapy services that were subject to the statutory therapy caps. Going forward, the functional status reporting data that would be collected may be even less purposeful because the Bipartisan Budget Act of 2018 repealed the therapy caps while imposing protections to ensure therapy services are furnished when appropriate. As a result, CMS is finalizing their proposal to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapy Assistants

CMS is finalizing their proposal to establish two new modifiers – one for Physical Therapy Assistants (PTA) and another for Occupational Therapy Assistants (OTA) – when services are furnished in whole, or in part by a PTA or OTA. However, CMS is finalizing the new modifiers as "payment" rather than as "therapy" modifiers, based on comments from stakeholders. These will be used alongside of the current PT and OT modifiers, instead of replacing them, which retains the use of the three existing therapy modifiers to report all PT, OT, and Speech Language Pathology services, that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps. CMS is also finalizing a standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

KX Modifier Attestation Amount

- The KX Modifier attestation amount for CY 2019 is $2,040.
- Manual Medical Review amount for CY 2019 remains at $3,000.

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)

This final rule also addresses a subset of changes to the Medicare Shared Savings Program for ACOs proposed in the August 2018 rule. CMS is finalizing the following policies.

- A voluntary 6-month extension for existing ACOs whose participation agreements expire on December 31, 2018, and the methodology for determining financial and quality performance for this 6-month performance year from January 1, 2019, through June 30, 2019.
- Allowing beneficiaries who voluntarily align to a Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO if the clinician they align with is participating in an ACO.
- Revising the definition of primary care services used in beneficiary assignment.
- Providing relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 and subsequent years.
- Reducing the Shared Savings Program core quality measure set by eight measures; and promoting interoperability among ACO providers and suppliers by adding a new CEHRT threshold criterion to determine ACOs' eligibility for program participation and retiring the current Shared Savings Program quality measure on the percentage of eligible clinicians using CEHRT.

To read the complete Physician Fee Schedule Final Rule: http://polaris-group.com/news_releases.asp

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CMS Provides Clarification to Physician Certification Requirements

In June 2018, CMS published a clarification in their Medicare General Information Manual, Chapter 4, Physician Certification and Recertification of Services (Certification for Extended Care Services). The clarification added the word "daily" to the initial certification required content. To avoid claim denials or survey deficiencies, providers should ensure the word "daily" is added to their initial Physician Certification process for both Medicare and Managed Care.

40.2 - Certification for Extended Care Services (Rev.114, Issued: 03-16-18, Effective: 06-19-18)

The certification must clearly indicate that post-hospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF (or for a new condition that arose while in the SNF for treatment of that ongoing condition). Alternatively, under the regulations at 42 CFR 424.20(a)(1)(ii), the initial certification can simply affirm that the individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required SNF level of care, as provided in the regulations at 42 CFR 409.30 (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1, for a discussion of the administrative level of care presumption under the SNF PPS). Certifications must be obtained at the time of admission, or as soon thereafter, as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for post-hospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

November OIG Update

Involuntary Transfer and Discharge in Nursing Homes

The involuntary transfer or discharge of a resident of a nursing home can be unsafe and a traumatic experience for the resident and his or her family. To address these concerns, Congress passed the Nursing Home Reform Act of 1987 to protect residents against involuntary transfer and discharge. However, data from the National Ombudsman Reporting System show that from 2011 through 2016, the Long-Term Care Ombudsman Program, established to advocate for older Americans by the Older Americans Act of 1965, cited complaints related to "discharge/eviction" more frequently than any other concern. In addition, the media has recently highlighted the rise in nursing home evictions. CMS estimates that as many as one-third of all residents in long-term care facilities are involuntarily discharged. The OIG will determine the extent to which State long-term care ombudsmen address involuntary transfers and discharges from nursing homes and the extent to which State survey agencies investigated and took enforcement actions against nursing homes for inappropriate involuntary transfers and discharges. The OIG will also examine the extent to which nursing homes meet CMS requirements for involuntary transfers and discharges.

CMS Provides Updated PDPM Webpage

The new SNF – Patient-Driven Payment Model (PDPM) webpage is now available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

This website includes a variety of educational and training resources to assist providers in preparing for the PDPM implementation date of October 1, 2019. Resources include:

- FAQs
- Fact Sheets
- PDPM Training Presentation
- Implementation tools (including PDPM GROUPER logic)

Additionally, CMS will also be conducting a **SNF PPS – PDPM National Provider Call on Tuesday, December 11, 2018, from 1:30pm to 3:00pm EST.**

For additional PDPM Resources: http://polaris-group.com/news_releases.asp

For more information, please contact your Polaris Group representative.

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
Does the dietary director have to complete a new assessment when a patient readmits from the hospital to the facility?

Answer:
No, as long as there have not been any changes. According to the State Operations Manual, it says under F636 Resident Assessment "Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave".)

Question:
We have a resident who is under a Medicare Advantage plan for skilled therapy and will be discharging on day sixteen. I had set the ARD for the 14 day PPS MDS for day 15. Should I set the 14 day ARD and the Medicare end date (A2400C) on day 15 of the stay?

Answer:
When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.

Question:
If I have a Medicare Part A resident that expired in the facility. Do I complete the NPE (Medicare Part A PPS discharge) and a death in the facility tracking form?

Answer:
No. You would only complete the death in the facility tracking form.

2018 WEBINAR TRAININGS
Polaris Group is pleased to offer the following
CEU approved live Webinars

	Date
PDPM Introduction Training **Hot New Topic* Introduction to Patient Driven Payment Model	12/4
Medicare Review Training Medicare Review & Eligibility Basics for Billers	12/6
GG Coding for Function Scores **Hot New Topic*	12/11
ICD-10 Coding for PDPM Training **Hot New Topic* ICD-10 Coding Tips for PDPM	12/12
MDS/RUG to Claim Training MDS/RUG to Claim for Billers	12/18

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

2019 LTC Dates

POLARIS GROUP LTC TRAINING INSTITUTE

Comprehensive 3-day training workshops to implement a compliant and successful Medicare program

SNF Billing Basics
February 19-21 Orlando, FL
April 16-18 St. Louis, MO

Medicare & PPS/PDPM & SNFQRP Compliance
February 26-28 Las Vegas, NV

Advanced Billing
March 19-21 Las Vegas, NV
May 21-23 Dallas, TX

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