November 7, 2012

POLARIS PULSE 20 YEARS

An Informational Bulletin Brought To You By Polaris Group

CMS Issues Final 2013 Physician Fee Schedule Rule

On November 1, 2012 the Centers for Medicare and Medicaid Services (CMS) released the final 2013 Medicare Physician Fee Schedule. This is the same schedule used to pay for Part B therapy services in nursing facilities. This final rule sets the therapy cap amount on outpatient therapy services, updates the 2013 payment amount for physician, physical therapist, and other health care professionals; and revises other payment policies.

The final rule includes a 26.5% across-the-board reduction to Medicare payment rates for physicians, physical therapists, and other professionals due to the flawed sustainable growth rate (SGR) formula. Since 2003, Congress had enacted legislation preventing the reduction every year. CMS announced that it is "committed to fixing the SGR update methodology and ensuring these payment cuts do not take effect." Excluding the 26.5% projected SGR payment cut; the aggregate impact on payment of changes in the rule for outpatient physical therapy is a positive 4% in 2013.

The Final rule set the therapy cap amount on outpatient therapy services for 2013 at $1,900 for occupational therapy and $1,900 for physical therapy and speech therapy combined. The therapy cap exceptions process will expire on December 31, 2012 unless Congress acts to extend it.

As required by the Middle Class Tax Relief Jobs Creation Act of 2012, CMS will begin to collect data on claim forms about patient functional status for patients receiving outpatient physical therapy, speech therapy, and occupational therapy beginning January 1, 2013. Therapists will be required to report new G codes accompanied by modifiers on the claim form that convey information about a patient's functional limitations and goals at initial evaluation, every 10 visits, and at discharge. This data is for informational purposes and not linked to reimbursement. Until July 1, 2013, claims will be processed regardless of the inclusion of functional limitation codes. Beginning July 1, 2013, all claims must include the functional limitation codes in order to be paid by Medicare.

In addition, the final rule includes a new policy to pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. The changes in care coordination payment and other changes in the rule are expected to increase payment to family practitioners by 7% and other primary care practitioners between 3 and 5% if Congress prevents the required 26.5% reduction in the Medicare physician fee schedule.

The final rule with comment period will appear in the November 16 Federal Register.

Click Here to Read the Final Rule

Medicare Secondary Payer

Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "Coordination of Benefits" when assigning responsibility for first and second payment.)

The term "Medicare Secondary Payer" is sometimes confused with Medicare supplement. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the *primary payer*. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program.

Responsibilities of Providers Under MSP
As a Part A institutional provider:

- Obtain billing information prior to providing services. It is recommended that you use the Centers for Medicare & Medicaid Services' (CMS') questionnaire, or a questionnaire that asks similar types of questions; and
- Submit any MSP information to the intermediary using condition and occurrence codes on the claim.

As a Part B provider:

- Follow the proper claim rules to obtain MSP information such as group health coverage through

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employment or non-group health coverage resulting from an injury or illness;

- Inquire with the beneficiary at the time of the service if he/she is taking legal action in conjunction with the services performed; and, submit an Explanation of Benefits (EOB) form with all appropriate MSP information to the designated carrier.

We have provided you with several questions and answers regarding MSP:

Question: Can my software create an MSP claim?
Answer: Most software can't create MSP claims and the biller's can't hand enter them into the Direct Data Entry (DDE).

Question: Medicare was billed as secondary. Now the primary insurance is stating that Medicare should be primary and the primary insurance company is requesting their payment back. What do I need to do?
Answer: Medicare does not consider a situation where Medicare processed a claim in accordance with the information on the claim and consistent with the information in the Medicare systems of records. A third party mistakenly paid primary when it alleges that Medicare should have been primary constitutes as 'good cause' to reopen a claim. There is a 'within one year of the initial determination' clause which allows claim to be reopened and adjusted, but claims beyond one year cannot be reopened.

Question: When filing Medicare Secondary Payer (MSP) claims, facilities have been instructed to include value codes 80 and/or 81. What are these two codes?
Answer: With the implementation of UB-04, Value Codes 80 and 81 are defined as follows:
Value code 80 - covered days. The number of days covered by the primary payer as qualified by the payer.
Value code 81 - non-covered days. Days of care not covered by the primary payer.
Use these value codes to indicate the covered and non-covered Medicare days (not the covered and non-covered days as determined by another payer) on Medicare claims submitted electronically via the 837I or in hard copy format if an Administration Simplification Compliance Act (ASCA) waiver is on file, including MSP or conditional claims.

For additional education on MSP Claims watch for future Polaris Group Billing Seminars.

Updates to Common working file

The Common Working File (CWF) is a single data source for Fiscal Intermediaries and Carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the fee for service (FFS) claims processing system where full individual beneficiary information is housed. CWF meets CMS' core requirements for claims processing: 1) beneficiary entitlement to Part A/B, 2) accurate deductible & coinsurance, 3) appropriate services, 4) benefits on the claim are available, and 5) Medicare Secondary Payer information is correct. CWF also performs limited part A/B crossover editing to insure services are not paid twice on different types of claims.

- Effective for claims processed on/after October 1, 2012, change request 7260 implemented a requirement for Medicare systems (FISS/MCS) to return claims when the beneficiary's name does not match the health insurance claim number (HICN) on the Common working file (CWF). These claims will be handled as follows:

- Part A claims will be returned to provider (RTP)
- Part B claims will be returned as unprocessable

Provider action
If you receive a remit indicating the patient/insured health identification number and name do not match, you must advise the patient or his/her representative to contact their local Social Security office to have their files updated. Once the update has been made, you may submit a new claim for processing.

- Prior to Oct 1, the area on the CWF related to therapy services reflected the amount that the resident had remaining before they exceeded the $1880 therapy cap. As of Oct. 2012 the CWF was updated to include all Part B therapy provided to a beneficiary year to date and now reflects the amount of therapy APPLIED (APL) in other words PAID on the recipients behalf. Physical Therapy and Speech Therapy totals are combined under the area PT $xxxx.00 APL and Occupational Therapy totals are OT $xxxx.00 APL.

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!"

The following questions were received from clients through Polaris Group's Solution Center Hotline:

Question: We have a patient that is on Part A and now the physician has ordered him to receive 15 treatments of Palliative outpatient radiation treatments in the hospital. Are these included in our consolidated billing?

Answer: Radiation is a Category 1 and is excluded from consolidated billing. These services must be provided on an outpatient basis at a hospital, including a critical access hospital only, not by a SNF, and are excluded from SNF PPS and CB for beneficiaries in a Part A stay.

Question: I keep getting a warning of 3616aincorrect RUG value and I don't know what that means.

Answer: 3616a was generated when the system changed from RUG III to RUG IV so this is a software issue. Contact your software company to make sure they have completed all the updates to your system.

2012 WEBINAR TRAININGS

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

Topic	Date
Part B Therapy Programs	11/15
Preventing Hospital Readmissions	11/29
DON TRAINING SERIES	
Recruitment & Retention	11/1
Staffing, Scheduling & Budgeting	11/8
MEDICARE DENIALS TRAINING	
Additional Development Requests	11/6
Responding to Denials & Appeals—Part II	11/7
TRADITIONAL SURVEY MGMT SERIES	
Survey Process-Tasks 1-5	11/13
Survey Tasks 5-7 & Staff Prep	11/20
Writing a Plan of Correction	11/27
QUALITY MEASURES TRAINING SERIES	
All About the New Quality Measures	11/14
Overcome 5 Star Anxiety	11/28

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

POLARIS GROUP LTC TRAINING INSTITUTE

A comprehensive 3-day training workshop to implement a compliant and successful Medicare program

Medicare Training Workshop for LTC

Current 2012 Dates, Locations:
(click on each city for hotel and registration information)

December 4 - 6: Orange County, CA

POLARIS PULSE is an informational newsletter distributed to **POLARIS GROUP** clients. For further information regarding services or information contained in this publication, please contact **POLARIS GROUP** corporate headquarters at 800-275-6252.

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