



POLARIS PULSE®

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

Physician Fee Schedule 2007—Final Rule

Starting next year, the Medicare program will pay physicians more for the time they spend talking with Medicare beneficiaries about their health care and will pay for a broader range of preventive services. The changes, which will become effective January 1, 2007, are included in the Medicare Physician Fee Schedule (MPFS) final rule released by the Centers for Medicare & Medicaid Services (CMS).

CMS projects that it will pay approximately \$61.5 billion to over 900,000 physicians and other health care professionals in 2007 as a result of the payment rates and policies adopted in this rule. This new spending figure reflects current law requirements to reduce payment by 5 percent to account for the combined growth in volume and intensity of physician services.

Therapy Caps and CCI Edits

The rule establishes that the therapy caps will remain in effect, but without the exception process for expenses incurred beginning January 1, 2007. The dollar amount of each therapy cap in CY 2007 will be \$1780. Under the statute, the exception process will not apply to therapy services after December 31, 2006.

CMS does not have the authority to extend the exceptions process beyond the December 31, 2006 statutory expiration date. Extension of the exception process will require Congressional intervention. It is unknown at this time if Congress will consider extending the exceptions process for the Therapy Caps in 2007.

Preventive Services

Modifications to coverage for Preventive Services coverage effective January 1, 2007 include:

- Adding preventive ultrasound screening for abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the Welcome to Medicare physical.

- Expanding the number of beneficiaries who qualify for bone mass measurement due to long term steroid therapy.
- Eliminating a potential financial barrier to the use of the colorectal cancer screening benefit by exempting it from the Part B deductible requirement.

Additional Provisions

The 2007 PFS Final Rule also:

- Codifies the provision that adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the Federally Qualified Health Center benefit.
- Caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments.
- Includes further guidance on how drug manufacturers should address particular issues related to their reporting requirements.
- Amends the public consultation process for developing payment amounts for new clinical laboratory tests.
- Adopts supplier standards for independent diagnostic testing facilities (IDTFs).
- Continues the temporary intravenous immune globulin pre-administration-related services fee into 2007.
- Includes regulations affecting ambulance payment policy under the ambulance fee schedule.
- Reinforces requirements for Part B billing for Blood Glucose Testing in Nursing Homes.

2007 Medicare A and B Deductible and Coinsurance Rates

For Calendar Year (CY) 2007, the following rates are applicable for Medicare Part A Deductible and Coinsurance amounts:

For more information, please contact your Polaris Group representative.

Deductible = \$992.00 per benefit period
 Acute Hospital Coinsurance:
 \$248.00 a day for days 61 – 90 per benefit period
 \$496.00 a day for day for Lifetime Reserve Days

SNF Coinsurance:
 \$124.00 a day for days 21 – 100 per benefit period

For CY 2007, the following rates are applicable for Medicare Part B Deductible and Coinsurance:

Deductible = \$131.00 per year
 Coinsurance = 20%

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary.

Comprehensive Error Rate Testing (CERT) Documentation Request Response

The Center for Medicare and Medicaid Services shortened the time that providers have to produce medical records in response to Comprehensive Error Rate Testing (CERT) contractors' documentation requests from 90 to 75 days. The new CERT call/letter schedule takes effect with initial documentation requests made on November 1, 2006 or later. If the provider has not responded by the 76th day, CMS will automatically deem the claim at issue as erroneous and will act to recoup the Medicare funds.

About the CERT Program

The CERT Program calculates the paid claims error rate for Medicare claims submitted to Fiscal Intermediaries, Carriers, and Durable Medical Equipment Regional Carriers. CMS receives in excess of 2 billion claims per year. CERT randomly selects a statistical sample of these claims for review to determine whether the claims were properly paid.

The CERT Documentation Contractor is responsible for requesting and receiving the medical record documentation from providers. The CERT Documentation Contractor call center attempts to make an initial telephone contact with the provider to explain the program and follows up with a faxed or mailed medical record request letter.

New CERT Contractor Call / Letter Schedule

Effective with initial documentation requests sent November 1, 2006 and after:

- Day 0: Initial Call and send letter or fax 1
- Day 30: Call 2 and send letter or fax 2
- Day 45: Call 3 and send letter or fax 3

Day 60: Send letter 4

Day 76: If no medical records received, an error will be applied and the Medicare reimbursement will be recouped.

Letter 4, frequently called the OIG letter, notifies the provider that failure to send the requested information may result in a referral to the fraud unit and to the Office of the Inspector General which may exclude the provider from participation in Medicare and Medicaid. It is anticipated that CMS will take the deadline very seriously as the Medicare fee-for-service error rate has historically been attributable in part to providers' failure to comply with contractor documentation requests.

Part B Billing for Blood Glucose Testing in Nursing Homes

Associated Hospital Services recently posted the results of a post payment review for CPT code 82962 – Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use in a Skilled Nursing Facility (SNF). The results are as follows:

- **Of 219 claims reviewed by clinical staff**
- **> 0 claims were allowed as billed**
- **> 219 claims were denied as billed (100%)**

The reasons for denials were:

- Documentation did not support the medical necessity of the services billed.
- Documentation did not support the number of services billed.

To be covered, blood glucose monitoring services must be ordered by a physician and used in the active management of the beneficiary's specific condition. Medicare reimbursement for these tests require that the service meet the reasonable and necessary. For a laboratory service to be reasonable and necessary it must not only be ordered by the physician but the ordering physician must also use the result(s) in the management of the patient's specific medical condition.

Transmittal No. AB-00-108, Dec. 1, 2000 states implicitly that laboratory result must be reported to the physician promptly in order for the physician to use the result and instruct continuation or modification of patient care; this includes the physician's order for another laboratory test. A standing order for intermittent blood glucose testing and/or sliding scale

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insulin injections are examples of non-covered laboratory services when they do not meet the ordering physician's utilization requirements.

Documentation to support the medical necessity for the services billed includes, but is not limited to:

- > Physician order(s) for blood glucose monitoring
- > Documentation of the medical necessity for each test billed- this may include nurse's notes and/or physician progress notes
- > Results of each blood glucose billed
- > Documentation of physician notification of each result and the corresponding medical management
- > Detailed itemization of charges billed
- > History and physical supporting the diagnosis of diabetes
- > Documentation to support all services provided incidental to the blood glucose service

While CMS does not require a specific format for information to be documented, service information contained in medical records should be clear, concise, and structured in a way that clearly identifies and supports the services provided during a patient encounter. The medical record must also clearly identify who is rendering the services.

Do you have your NPI?

(National Provider Identifier)

Don't risk disruption to your cash flow. HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use the NPI to identify covered entities in standard transactions beginning May 23, 2007. Small health plans must use only the NPI no later than May 23, 2008. Learn how to apply by visiting the CMS website at www.cms.hhs.gov/NationalProvIdentStand/.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: If a resident used Lifetime Reserve Days during the most recent hospitalization are the available SNF benefit days affected?

A: No, Lifetime Reserve Days apply to acute hospitalization only. The SNF benefit is not impacted by the use of reserve days.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following *CEU approved* teleconference trainings

Live Teleconference Trainings

| Topic | Date |
|--------------------------------------|-------------|
| Survey Process, Prep and Management | 11/9 |
| Right Coding Sections K, P & T | 11/14 |
| Managed Risk—Event/Incident | 11/16 |
| New Activity Protocol & Psychosocial | 11/28 |
| Behavior Assessment & Care Planning | 11/30 |

*Please join us in our Teleconferences .
 For further information regarding these seminars,
 please contact the
 Seminar Department at: 800-275-6252 ext. 233
 Or register at: www.polaris-group.com*



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