



**POLARIS**

**PULSE**

**20 YEARS**

*An Informational Bulletin Brought To You By Polaris Group*

## **Polaris Group Hits 20 Year Anniversary in 2008!**

*Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in health care consulting, puts Polaris Group in a limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.*



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### **OIG Supplemental Compliance Program Guidance for Nursing Facilities**

The Office of Inspector General (OIG) originally published Compliance Program Guidance (CPG) for nursing facilities in 2000. The new Supplemental CPG responds to developments in the nursing facility industry, including significant changes in the way nursing facilities deliver and receive reimbursement for health care services, evolving business practices, and changes in the Federal enforcement environment. This voluntary guidance is intended to help nursing facilities develop compliance programs that address major Medicare and Medicaid fraud and abuse problems related to poor Quality of Care, billing Federal Health Care Programs, and kickbacks.

According to the supplemental CPG, "A successful compliance program addresses the public and private sectors' common goals of reducing fraud and abuse, enhancing health care providers' operations, improving quality of health care services, and reducing their overall cost. Meeting these goals benefits the nursing facility industry, the Government, and residents alike."

A significant goal of the supplemental CPG is fostering quality of care in nursing facilities. The CPG will help compliance professionals address areas such as:

- Staffing
- Resident care plans
- Medication management
- Appropriate use of psychotropic medications
- Resident safety.

In addition, the supplemental CPG emphasizes the importance of submitting accurate claims and discusses issues related to:

- Reporting resident case-mix data
- Therapy services
- Screening for excluded individuals and entities
- Restorative and personal care services.

Nursing facilities are urged to consider the risks of improper kickback payments associated with their business arrangements including those involving free goods and services, as well as those with physicians and suppliers.

### **Benefits of a Compliance Program**

A nursing facility may gain important additional benefits by voluntarily implementing a compliance program including:

- Demonstrating the nursing facility's commitment to honest and responsible corporate conduct
- Increasing the likelihood of preventing unlawful and unethical behavior or identifying and correcting such behavior at an early stage
- Encouraging employees and others to report potential problems, which permits appropriate internal inquiry and corrective action and reduces the risk of False Claims Act lawsuits, and administrative sanctions as well as State actions
- Minimizing financial loss to the Government and taxpayers, as well as corresponding financial loss to the nursing facility
- Enhancing resident satisfaction and safety through the delivery of improved quality of care
- Improving the nursing facility's reputation for integrity and quality, increasing it's market competitiveness and reputation in the community

The OIG recognizes that implementation of a compliance program may not entirely eliminate improper or unethical conduct from nursing facility operations. However, an effective compliance program demonstrates a nursing facility's good faith effort to comply with applicable statutes, regulations, and other Federal health care program requirements, and may significantly reduce the



risk of unlawful conduct and corresponding sanctions.

To view a copy of the guidance, “OIG Supplemental Compliance Program Guidance for Nursing Facilities,” go to: <http://www.polaris-group.com/news.asp>

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### **Recovery Audit Contractor Permanent Program Part 1**

Section 306 of the Medicare Modernization Act (MMA) authorized the Secretary of the Department of Health and Human Services to utilize Recovery Audit Contractors (RACs) to identify improper Medicare payments during a 3 year RAC Demonstration Project. The demonstration ran from March 2005 until March 2008, initially involving the states of California, New York and Florida.. The demonstration was expanded in the summer of 2007 to include Massachusetts and South Carolina.

The demonstration RACs were provided with 4 years of claims data and subsequently received an additional three months of claims data on a quarterly basis. These RACs succeeded in correcting more than \$1.3 billion in improper payments and repaid \$37 million back to providers in underpayments while costing the Medicare program approximately \$178 million in contingency fees.

Section 302 of the Tax Relief and Health Care Act of 2006 makes the Recovery Audit Contractor (RAC) Program permanent and requires the program be expanded to all 50 States no later than 2010. Each of four RACs will be responsible for identifying overpayments and underpayments in approximately 25% of the country.

On October 6, 2008 the Centers for Medicare and Medicaid Services (CMS) announced awards for the four permanent RACs that were scheduled to begin work immediately in select states. However, there has been a protest filed with the Government Accounting Office (GAO) by two unsuccessful bidders for the RAC awards. Under GAO rules, CMS is required to impose an automatic stay for all contract work until a determination is made by the GAO as required under the provisions of the Competition in Contracting Act (CICA) of 1984. Under the CICA, the GAO has 100 days to issue it's decision which means the decision on these protests will be due in early February. The four RAC contracts and any work scheduled to be performed by the awarded contractors are on hold pending the outcomes of the

protest.

CMS initially announced a roll out strategy for RAC audits to begin in additional states beginning March 1 and August 1 or later in 2009. During a recent Open Door Forum call, CMS stressed the fact that the RAC program is not going away. The implementation schedule will have to be adjusted due to the current work stay.

### **How Will RACs Select Claims for Review?**

The permanent RACs will be able to look back 3 years from the date a claim was paid. The demonstration allowed the RACs to go back four years. When the permanent program begins the RACs will not be able to review claims prior to October 1, 2007. Claims and issues to be reviewed will be selected based on each RAC's data mining techniques, OIG and GAO reports, Comprehensive Error Rate Testing (CERT) reports, and the experience and knowledge of the RAC's staff.

Two types of reviews will occur - automated and complex - much like the reviews currently completed by Fiscal Intermediaries (FIs), Carriers and A/B Medicare Administrative Contractors (MACs).

CMS will implement a “new issues” review process. Although the process is not yet well defined, the general intent is outlined below.

For Automated Reviews (duplicate claims, etc):

- The RAC sends a “new issue” review request to CMS for any new issues a RAC wants to pursue for overpayments.
- CMS will review the issue and decide if it is valid
- If approved, the issue will be shared with provider organizations via the RAC website
- A RAC cannot go forward with the review until it is posted to the website
- All demand letters will be sent after CMS has approved the new issue for review

For Complex Reviews (Medical Record Review necessary):

- The RAC will issue a limited number of medical record requests to providers
- Providers will be required to forward the requested medical record when the request is received
- The RAC will review the medical record and then send a new issue review request to CMS
- CMS will then review and decide if the issue is valid
- If approved, the issue is posted to the RAC website



and a wide scale review may begin

- In cases where CMS has not decoded by day 60 whether or not the issue is valid the RAC can issue a limited number of review results letters without CMS approval and web posting

The medical record request process is intended to be similar to the current process for Additional Development and CERT Requests. Failure to submit the requested record within 45 days will result in denial. There will be a web based application which will allow address customization, etc. Providers will be permitted to submit medical records via mailed paper copy, CD or DVD or via fax.

RACs will use the same Medicare policies used by the current contractors including National Coverage Determinations, Local Coverage Determinations and CMS Manuals. The permanent RACs are required to use nurses, therapists, certified coders and a physician contractor medical director. The demonstration RACs were not required to have a medical director on staff.

Watch for Part II—The RAC Collection Process in the next edition of the *Polaris Pulse*.

**Q & A**  
**“Where No Question Goes Unanswered!”**

- Q. Are all medically necessary ambulance transports excluded from consolidated billing (CB) for a Part A resident?
- A. No. Common instances when a medically necessary (MN) ambulance transport is NOT excluded from consolidated billing include:
- Round trip to hospital for services within the general scope of comprehensive care plan unless the service is specifically excluded by CB.
  - Round trip for physician office visit.
  - When service provided is not specifically excluded by CB. For example: Some CT Scans are excluded when performed at the hospital outpatient dept.. - the MN ambulance transport to the hospital would also be excluded. However, if the same CT Scan is performed at a location other than the hospital outpatient dept. neither the Scan nor the round trip ambulance transport to the alternate location would be excluded from CB.

**TELECONFERENCE TRAININGS**  
 Polaris Group is pleased to present the following  
**CEU approved** teleconference trainings  
Live Teleconference Trainings

<u>Topic</u>	<u>Date</u>
Medicare Part A Basics	12/2
QA Audits That Work	12/3
ICD-9 Coding—Part 1— The Basics	12/3
Managing New Admissions & Acute Episodes	12/4
Working the RAPs	12/4
Cut Letters & Generic Notices	12/9
ICD-9 Coding-Part II-Coding Unique Challenges	12/10
How Therapy Affects the Survey Process	12/10
Taming the Care Plan Monster	12/11
Selecting the Correct CPT Code for Therapy	12/11
Medicare Documentation & Skilling Criteria	12/16
MDS 3.0—Now & Future	12/16
Behavior Management—Secrets to Success	12/17
Bowel & Bladder Management	12/18

*Please join us in our Teleconferences .  
 For further information regarding these seminars,  
 please contact the Seminar Department  
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