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Managing FY 2012 PPS MDS Changes

CMS provided clarification regarding use of the term “day of discharge”. The term “day of discharge” can serve two distinct purposes. The day of discharge may refer to the day the resident leaves the facility, as discussed in Chapter 2 of the MDS RAI manual and as captured within Item A2000 on the MDS. “Day of discharge” may also refer to the resident’s discharge from Medicare Part A, which is captured in Item A2400C on the MDS. As noted in Chapter 2 of the MDS RAI manual, it is possible that these two dates, that is the date of facility discharge and the date of Part A discharge, may not be the same, such as in cases where a resident uses all of his or her 100 entitled SNF benefit days but remains in the facility for some time after that point. It is also possible that the dates listed in A2000 and A2400C may be the same, such as in cases where the resident leaves the facility prior to exhausting their SNF benefit or if the resident were to expire during the course of the Part A stay.

OMRAs, Discharge MDSs, and Interviews

Residents That Remain in the Facility

Change of Therapy (COT) and Discontinuation of Medicare: For residents who remain in the facility after their Medicare stay, when the residents last covered day under Medicare is also the day of the COT check and there is a change in RUG, the COT OMRA is required. Put another way, if A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if there was a change in RUG level.

End of Therapy (EOT) and Discontinuation of Medicare: If the patient remains in the facility after skilled rehab is discontinued and the patient remains on skilled care for more than three days, the EOT OMRA would be required.

Residents That Discharge From the Facility

COT and Discharge MDS: This scenario applies only to residents that will be discharged from the facility at the conclusion of their Medicare stay. When the date of discharge is equal to the Change of Therapy 7th day date, it is not required (but allowed) that the facility combine the COT OMRA with the Discharge MDS. However, if

the RUG level on the day of discharge is greater than the current RUG level at the time of the COT 7th day check, the MDS should be completed as a Change of Therapy/ Discharge MDS. This increases the RUG level back to the first day of the COT look back period. If the RUG level at the time of the COT Check is less than the current RUG level, the facility should not combine the Change of Therapy and the Discharge MDS. The facility should complete only a Discharge MDS.

EOT and Discharge MDS: When the day of discharge is equal to the third day without rehab, then no EOT OMRA is required. The facility is required to complete just the Discharge MDS.

Interviews and COT OMRAs

CMS further clarified that for COT OMRAs the interview portions of the MDS may be done one or two days after the ARD. However, this should be a rare occurrence. If the facility is monitoring the COT Checks daily, most of the interviews should be completed timely.

CMS also went on to remind us that we should not routinely dash interview items or substitute the staff assessment for the patient interview due to logistical concerns or when a recent interview has been conducted. All efforts should be made to interview residents in a timely fashion.

Key Items Regarding Change of Therapy (COT) OMRAs

- Applicable to all residents receiving therapy who are Medicare Part A residents.
- A COT observation period is a successive seven (7) day window in which a review of therapy days and minutes is conducted.
- If a COT ARD (day 7) falls on the day of discharge from the facility you are **NOT** required to combine the COT with the Discharge MDS.
- If the ARD of a scheduled PPS assessment is set on or prior to Day 7 of the COT observation period, then no COT OMRA would be required.



- A Review of therapy days and minutes is required every (7) days beginning the day following the ARD of the resident's last PPS assessment used for payment. (The exception to this is during an EOT-R when the COT observation period begins on the resumption date listed on Section O of the MDS-00450B).
- The COT is reset with each scheduled MDS ARD or completed COT OMRA.
- Once services through the seventh (7) day are recorded, the team will review therapy days and minutes and make the determination if the level of delivery is consistent with previous RUG level achieved.
- The ARD for the COT will always be day seven (7).
- The COT OMRA will apply to a higher or lower RUG level.
- The COT OMRA will apply when a patient is receiving therapy but due to case mix the RUG level falls into a non-rehab RUG.
- When a RUG level changes either up or down, the payment will change **backward** (effective the first day of the observation period for the COT).

Effect of Leave of Absence on PPS Assessments

- For scheduled assessments, the Medicare assessment scheduled is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, a resident leaves the SNF at 6 p.m. on Wednesday (Day 27) and returns to the SNF on Thursday at 9 a.m. Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.
- For unscheduled assessments, days during which a resident experiences an LOA must be counted toward the ARD for a given unscheduled assessment.
 - ⇒ EOT OMRA example: A resident did not receive therapy Monday, Tuesday, and Wednesday. He went to the emergency room at 9 p.m. Wednesday and returned to the facility at 10 a.m. Thursday. Whether or not therapy is provided on Thursday, an EOT OMRA would be required with an ARD set for Monday, Tuesday, or Wednesday.
 - ⇒ COT OMRA example: The ARD for a 30-day assessment was set for Nov. 7. The resident went

to the ER at 11 p.m. November 9, returning at 2 p.m. November 10. Day 7 of the COT observation period would remain November 14.

Medicare Therapy Cap Exception Process Expires December 31, 2011

On January 1, 2012 three changes will be implemented to Medicare Part B services unless congress acts prior to December 31, 2011.

- Sustainable Growth Rate (SGR) – Medicare Part B payment reduction of 27.4%.
- Therapy Cap Exception Process expires.
- Therapy Cap limit goes from \$1,870 to \$1,880.

Medicare Part B therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses was \$1,870 in 2011 and is \$1,880 in 2012. For occupational therapy services, the limit was \$1,870 in 2011 and is \$1,880 in 2012. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

In 2006 Congress mandated that the Centers for Medicare & Medicaid Services (CMS) develop an "exceptions process" for Medicare beneficiaries with certain conditions who exceeded the cap on Part B therapy services. Congress has extended authority for continued use of this exceptions process multiple times. The most recent extension of the therapy caps exceptions process was included in **the Medicare & Medicaid Extenders Act of 2010, which will expire on December 31, 2011.**

Recently, the House of Representatives passed HR 3630 "The Middle Class Tax Relief and Job Creation Act of 2011" by a vote of 234 to 193. The bill updates the Medicare Physician Fee Schedule Sustainable Growth Rate (SGR) for 2012 and 2013 by 1% -- negating a scheduled 27.4% reduction in payments to providers, including Part B therapy services provided in nursing facilities under the physician fee schedule. The bill also provides a 2-year extension of the therapy cap exceptions process. This will now go to the Senate who could draft a different bill with a different approach. Action from the Senate is expected late next week.



**Medicare Claims Processing Issue
Related to Part B Services for Skilled
Nursing Facility (SNF)**

A claims processing issue was identified that has affected payment of some Part B claims for SNF residents for dates of service from Saturday, October 1, 2011 through Monday, November 21, 2011.

Some Part B claims for SNF residents submitted to Medicare during October and November 2011 have been erroneously denied by Medicare’s claims processing system. In other instances, the claims processing system has paid and then identified a Medicare “overpayment” on these claims in error.

If you submitted a Part B claim for a SNF patient, you may receive a system-generated Demand Letter from Medicare, or you may see a notification for a payment offset on your Remittance Advice.

Your Medicare Claims Administration Contractor is working with CMS to remedy this problem in the claims processing system so that appropriate payment adjustments can be made. They are asking providers not to appeal these claims at this time. Because these are erroneous adjustments in Medicare’s claims processing system, submitting an appeal may slow down the correct adjustment of your claim.

Your Medicare Claims Administration Contractor will notify you when the adjustment process for these claims is initiated and keep you updated so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted.

Q&A
“Where No Question Goes Unanswered!”

Q: Is oxygen used in the SNF billable to Part B?

A: The definition of DME in §1861(n) of the Social Security Act (the Act) provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also. (See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Service,” §110.)

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Contributors:

- Debora Philips, RN, RAC-CT
- Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA
- Marty Pachciarz, RN, RAC-CT
- Deborah Moss, RN, MHS, RAC-CT
- Susan Dickson, RN, RAC-CT

Editor:

Chuck Cave, BS, CHC

Production Manager:

Cindy Hernandez