



An Informational Bulletin Brought To You By Polaris Group

2010 Medicare Physician Fee Schedule Updates

Temporary Delay in Part B Fee Schedule Rate Change

On December 19th, the President signed into law H.R. 3326, the "Department of Defense Appropriations Act, 2010," which includes a zero percent Medicare Part B Fee screen update through February 28, 2010.

This action staves off a 21% pay cut for Part B fee screens scheduled for January 1, 2010. Congress will continue to work in the new year on a physician fee schedule fix to extend beyond the new February 28th deadline.

In anticipation of the two-month freeze of Medicare payments to physicians and other Part B providers, the Centers for Medicare and Medicaid Services (CMS) also instructed its MACs to hold claims for the first 10 business days of January for 2010 dates of service.

This Part B fee screen rate change delay also pertains to the therapy Part B fee screens paid to Skilled Nursing Facilities.

“No Exceptions” to the Caps for Medicare Part B therapy take effect—January 1, 2010

The Therapy cap exceptions process expired on December 31, 2009, which means that the claims filed starting January 1, 2010 will be subject to the \$1,860 hard cap.

Centers for Medicare and Medicaid Services (CMS) have reported that speech-language pathology and physical therapy will continue to share a combined cap of \$1,860, with a separate cap of \$1,860 for occupational therapy. As before, the cap does not extend to services provided in hospitals. Settings impacted by the therapy caps include private practice, rehabilitation agencies, skilled nursing facilities,

comprehensive outpatient rehabilitation facilities, physician offices, and Part B home health agency services.

Congress has included an extension of the therapy cap in both the House and Senate versions of the health care reform legislation but slow debate in the Senate projects a final action on health reform into January or February of 2010. The Senate healthcare reform bill would extend the exceptions process through the end of 2010. The House package would extend it through 2011.

MDS 3.0 Corner



The main objective of the MDS 3.0 is to make the resident assessment process more clinically relevant and reliable. To accomplish this, increased emphasis is placed on the residents themselves by expanding the use of resident interviews.

The interview process applies to: Mental Status; Mood (PHQ-9); Daily Preferences; Activity Preference and Pain Assessment.

We have provided you with interview techniques to assist you in obtaining accurate information during this process.

- Introduce yourself to the resident.
- Ensure the resident can hear you.
 - ⇒ Articulate words clearly;
 - ⇒ If the resident requires a hearing aid, make sure it is in place and working properly;
 - ⇒ Use voice amplifier/headphones if needed;
 - ⇒ Determine if the resident is fluent in English, or may need the assistance of an Interpreter (Language or Signing).
- Find a quiet, private place.

- Sit where the resident can see you in a location with good lighting.
- Establish rapport.
- Explain the purpose of the interview.
- Say and show item responses.
 - ⇒ As resident is saying response, show this response in large print on a paper.
- Ask questions as they appear on the tool.
 - ⇒ Try not to influence the answer.
- Break the questions apart if necessary.
- Clarify using echoing.
- Repeat responses and choices as needed.
- Move on to another question if unable to answer.
- Break up the interview if the resident becomes tired or agitated.
- Do not try to talk a resident out of an answer.
- Record resident’s responses.

If the resident becomes agitated or sorrowful, respond sympathetically. Resident preferences may be influenced by current status and can be challenging to discern.

⇒ May interview family/friend for preferences.

Ending the Interview:

Rules for ending the interview – Failed to “Answer” 3 questions.

- There has been no sensible answers (sensible, logically relevant to question) OR
- There has been no response verbally or in writing to questions up to this point OR
- Combination of no sensible answer or no verbal/written response



The Five Star Quality Rating System

There have been several changes to how the Five-star rating system is calculated.

1. A change in methodology for assigning revisit points: No points are assigned for the first visit, for each subsequent revisit up to four, and then additional

points are assigned up to 85% of the health inspection score for the fourth revisit. Bottom line, more weight is given to these revisits as failure to restore compliance is associated with more serious quality problems.

2. Change in methodology in assigning points for past noncompliance: If the status of the deficiency is "past noncompliance" and the current severity is Immediate Jeopardy, then points associated with G level deficiency are assigned (20 points). Without further clarification from CMS, we believe; that this is in addition to the already assigned points; lending weight to the repeat citation.

3. For the Health Domain, the rating for given facility is held constant unless new health inspection (standard survey or complaint survey), or 2, 3, 4th revisit occurs. The facility's rating will not change from month to month without new survey information from the facility, regardless of changes in the state wide distribution due to new surveys in other facilities.

In addition, in the past, Nursing Home Compare (NHC) Public Measures were posted using 3 quarters worth of data; going forward, NHC will be posting QM from up to 3 Quarters worth of data which will now match what is used for 5 Star.

For additional information, please visit our website at: <http://www.polaris-group.com/news.asp>

Key Points in Responding to an (ADR) Additional Documentation Request



- The Process starts with a request for records (typically electronic rarely will it ever be hard copy).
- Check the on line system (FISS) daily to identify claims needing submission of medical records.
 - ⇒ Screen print Pg 07 which identifies the claim, request date and date documentation due.



⇒ Screen print Pg 08 which identifies the documentation requested.

- All requests for information should be dated when received by the facility.
- Begin collecting information immediately.
- Respond within 30 days to avoid denials.
- Use the ADR request letter as a guide when completing the information for mailing.
- Send all requested records and any additional information needed to support all services billed on the claim.
- Include documentation to support information coded on the MDS.
- Thoroughly review the ADR to ensure that all items requested are submitted completely.
- Do not send part of the records while you are waiting for the rest. The first record submission received will be reviewed as the complete submission.
- Some MACs prefer that each claim is sent in a separate envelope. This also helps to ensure records are not mistakenly co-mingled.
- Attach a copy of the ADR (FISS Pg 07) to the top of the medical records being submitted for each individual claim.
- Make three copies of the information being submitted; retain two at the facility and forward one to the MAC as requested.

Q & A
“Where No Question Goes Unanswered!”

Q. If a resident receiving Medicare Part B Therapy does not use all therapy services to reach their cap, can they carry the additional dollar amount over to the next year?

A. Therapy Caps are based on Calendar year and will not rollover to the next year.

TELECONFERENCE TRAININGS

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

<u>Topic</u>	<u>Date</u>
Get Ready for Rug IV	1/19
Survey Process, Preparation & Management	1/20
Medicare Billing Series Part A&B:	
Part I: Billing Cycle	1/7
Part II: UB04 Completion	1/14
Part III: The “In’s and Out’s”	1/21
Part IV: Consolidated Billing	2/4
ICD-9 LTC Coding Series:	
ICD-9 Coding—Part I The Basics	1/15
ICD-9 Coding—Part II Unique Challenges of SNFs	1/22
MDS to Administrators	2/2
ADL Coding	2/2
Acute Episodes	2/3
MDS 3.0	2/4
Anatomy of a Chart	2/9
Behavior Assessment and Care Plans	2/9
QA Audits That Work	2/10
RUG IV	2/11

Please join us!

For further information, please contact the Seminar Department at: 800-275-6252 ext. 233 or register online at: www.polaris-group.com

Risk Management solutions at your fingertips

- * **Immediate analysis for improving MDS**
- * **Survey outcomes & clinical support applications**
- * **Regulatory research library and manuals**

Apollo RM (risk management web application)

**Demo dates: January 8th at 1:00 PM EST
and February 19th at 1:00 PM EST**

Learn more and register for demo online:

www.polaris-group.com

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