Mandatory Payment Reduction in the Medicare Fee-for-Service Program

The Budget Control Act of 2011 requires mandatory across-the-board reductions in Federal spending, also known as “sequestration”. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013.

Under the sequestration order original Medicare provider payments will be cut by 2 percent beginning April 1, 2013, as part of the spending reductions required by the Budget Control Act of 2011. The cuts will be applied to provider payments for services administered under original Medicare Part A (hospital insurance) and original Medicare Part B (medical insurance), as well as “contractual payments to Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D)”, according to the Congressional Budget Office (CBO). Payment reductions must be made at a uniform rate across all programs and activities subject to a sequestration order.

The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor (MAC). These reductions will be effective April 1, 2013 unless Congress takes action to eliminate the mandatory payment reductions.

CMS Issues Interim Instructions for Manual Medical Review Process for 2013

The Centers for Medicare and Medicaid Services (CMS) issued interim guidance on how the manual medical review process will be implemented in 2013 for outpatient therapy claims that exceed $3,700.

From October 1, 2012, through December 31, 2012, CMS used a prior approval process at $3,700 under which providers would submit a request to their Medicare Administrative Contractors (MAC) for approval of up to 20 visits. With the request, providers would include information from the patients’ medical record to support the need for the additional visits.

For 2013, CMS has replaced the prior approval process with prepayment review, at least for the interim. Under prepayment review, when the patient reaches $3,700 in outpatient therapy services, the MAC will send the provider an additional development request (ADR) asking him or her to submit documentation so that the MAC can determine whether the services are medically necessary. Typically under Medicare, MACs have 60 days to make a determination. However, CMS has requested that with regard to the therapy cap manual medical review process, MACs decide within 10 days of receipt of the documentation whether the services exceeding $3,700 will be paid.

CMS currently is working on a long-term strategy for the manual medical review process.

Providers should consult their MACs' websites for specific information about submitting documentation in response to an ADR.
OIG Conducts Recent Review of Skilled Nursing Facilities

A recent Office of Inspector General (OIG) report found that Skilled Nursing Facilities (SNFs) often did not meet quality-of-care requirements. Skilled Nursing Facilities (SNF) are required to develop a care plan for each beneficiary and provide services in accordance with the care plan, as well as to plan for each beneficiary's discharge. OIG studies and investigations found that SNFs had deficiencies in quality of care, did not develop appropriate care plans, and failed to provide adequate care to beneficiaries.

This study was based on a medical record review of SNF stays from 2009. The reviewers determined the extent to which SNFs developed care plans that met Medicare requirements, provided services in accordance with care plans, and planned for beneficiaries' discharges as required. Reviewers also identified examples of poor quality care.

OIG concluded that for 37 percent of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found examples of poor quality care related to wound care, medication management, and therapy.

OIG recommends that CMS: (1) strengthen the regulations on care planning and discharge planning, (2) provide guidance to SNFs to improve care planning and discharge planning, (3) increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable, (4) link payments to meeting quality-of-care requirements, and (5) follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care. CMS concurred with all five of the OIG recommendations.

Drug-resistant Bacteria Spreading in Healthcare Facilities

The Centers for Disease Control and Prevention is concerned about an increase in CRE infections in patients receiving inpatient medical care, such as in hospitals, long-term acute care facilities and nursing homes. CRE, which stands for carbapenem-resistant Enterobacteriaceae, are a family of germs that are difficult to treat because they have high levels of resistance to antibiotics. Klebsiella species and Escherichia coli (E. coli) are examples of Enterobacteriaceae, a normal part of the human gut bacteria, that can become carbapenem-resistant.

CRE are lethal bacteria that pose a triple threat:
- Resistance: CRE are resistant to all, or nearly all, the antibiotics we have - even our most powerful drugs of last-resort.
- Death: CRE have high mortality rates – CRE germs kill 1 in 2 patients who get bloodstream infections from them.
- Spread of disease: CRE easily transfer their antibiotic resistance to other bacteria. For example, carbapenem-resistant klebsiella can spread its drug-destroying weapons to a normal E. coli bacteria, which makes the E.coli resistant to antibiotics also. E. coli is the most common cause of urinary tract infections in healthy people.

Healthy people usually do not get CRE infections. In healthcare settings, CRE infections most commonly occur among patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators (breathing machines), urinary (bladder) catheters, or intravenous (vein) catheters, and patients who are taking long courses of certain antibiotics are most at risk for CRE infections.

CDC released a CRE prevention toolkit and fact sheet with in-depth recommendations to control CRE transmission in hospitals, long-term acute care facilities, and nursing homes. CRE can be carried by patients from one health care setting to another. Therefore, facilities are encouraged to work together, using a regional “Detect and Protect” approach, to implement CRE prevention programs.
The number of CRE infections grew seven-fold in the last 10 years, with hospitals and long-term care facilities in 42 states reporting cases.

The CDC released resources to help nursing homes and other facilities with CRE prevention and control. CDC website for resources to help nursing homes; [http://www.cdc.gov/hai/organisms/cre/cre-toolkit/f-level-prevention.html#facility-measures](http://www.cdc.gov/hai/organisms/cre/cre-toolkit/f-level-prevention.html#facility-measures)

**Termination of the Common Working File Eligibility Provider Query**

CMS is transitioning away from the use of the Common Working File (CWF) and related systems for querying the eligibility of Medicare beneficiaries. The discontinuation of these systems will begin in April 2013.

Specifically, querying for Medicare eligibility via the Multi-Carrier System (MCS, also known as PPTN) and the ViPS Medicare System (VMS, also known as VPIQ) will be terminated April 2013; and eligibility querying via the FISS Data Direct Entry (DDE, also known as HIQH, ELGA, ELGH, or HUQA) application will be terminated soon after. The DDE application will still continue to be available for the use of submitting and correcting claims.

Replacing those systems for eligibility querying is the HIPAA Eligibility Transaction System (HETS). The HETS Help page on the CMS website describes how to get started using this system.

Other options available for providers;
- Use your Medicare Contractor’s Interactive Voice Response system.
- Use your Medicare Contractor’s Eligibility Internet Portal (Note: not all contractors have established a portal)
- Contract with a software vendor for the use of an eligibility tool/service. Below we have listed several software vendors.
  - ZirMed - [https://public.zirmed.com/](https://public.zirmed.com/)

*For additional information, please visit our website at [www.polaris-group.com/news_releases.asp](http://www.polaris-group.com/news_releases.asp)*