



# POLARIS PULSE®

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

## Medicare Payment Advisory Commission (MedPAC) Recommendations to Congress

The Medicare Payment Advisory Commission (MedPAC) made the following recommendations in the March 2007 MedPAC Report to Congress:

1. Congress should eliminate the update to payment rates for fiscal year 2008:
  - Skilled Nursing Facilities (SNF)
  - Home Health Services (HH)
  - Long-Term Care Hospital Services (LTCH)
2. Congress should update payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2008.

### SNF Summary

#### Are Medicare Payments Adequate in 2007?

According to the March 2007 MedPAC report:

- Medicare payments more than cover the costs of providing SNF care to beneficiaries in 2007.
- Beneficiaries have good access to SNFs, especially if they need rehabilitation therapies.
- Beneficiaries who need certain expensive services (IV Antibiotics, high cost drugs, wound care, for example) may experience delays in finding SNF care.
- Two outcome measures for Medicare SNF residents show declining quality:
  - Facility rates of avoidable re-hospitalizations increased
  - Discharges to the community decreased

### Volume of Services

As a result of a shift toward the higher

rehabilitation case-mix groups. The average therapy case-mix index (CMI) has increased and the average nursing CMI has slightly declined among freestanding SNFs. This means that as Medicare spending on SNF services increases overall, the program is paying for relatively more therapy and relatively less nursing and other items, like drugs, included in the nursing portion of the base rate. The program still spends more on the nursing portion than on the therapy portion of the base rate, but the share of the program's SNF dollar going to therapy payment is growing.

The increasing use of therapy suggests that the population of SNF patients may be changing and adds cause for measuring the value of therapy. MedPAC previously recommended measuring functional status at admission and discharge to assess whether patient status improves, however the program does not currently collect data to enable such an assessment.

### Quality of Care

MedPac considers rates of discharge to the community and potentially avoidable re-hospitalizations for any of five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis and electrolyte imbalance) to capture important outcomes related to quality of care for SNF residents.

Avoiding unnecessary re-hospitalization is important because the primary treatment goal for many SNF residents is stabilization of medical or post surgical problems following an acute hospitalization. Reducing hospitalization for any of the five conditions requires the use of

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preventative measures in the SNF to avoid declining health, the early detection of signs and symptoms of worsening health, and prompt intervention by nursing staff and a physician when needed. Using this measure for reporting may also encourage SNFs not to take patients who are not ready for discharge from the hospital.

### **How Should Medicare Payments Change in 2008?**

MedPAC's recommendations to Congress includes eliminating the update to SNF payment rates for fiscal year 2008. According to MedPAC increasing payments to all SNFs will not necessarily improve quality since facilities would receive payment regardless of their quality and therefore have no incentive to invest in efforts to improve quality. MedPAC estimates Medicare margin at 11% for 2007.

### **Integrated Post Acute Care (PAC) System**

Post Acute Care reform mandated by the Deficit Reduction Act (DRA) includes the purchase of high-quality care in the least costly post acute care setting. Currently there are three primary barriers to an integrated PAC system:

***Inaccurate case-mix measurement***—SNF, HHA and LTCH case mix measures do not accurately reflect the resources used to treat certain types of patients. As a result the measures do not track differences in the costs of care.

***Incomparable data on the quality and outcomes of care***— Medicare currently requires three of the four PAC settings to use a patient assessment tool that is distinct from the other settings (MDS for SNF, OASIS for HH, and IRF-PAI for Inpatient Rehab Facilities).

***Lack of evidence-based standards***—Because few standards to determine appropriate care are available, beneficiaries may not receive medically necessary, high quality care in the least costly PAC setting consistent with their clinical conditions.

The DRA requires CMS conduct a demonstration that supports PAC payment reform. Beginning January 2008, CMS will conduct a demonstration project to develop a PAC assessment instrument for use at the time of hospital discharge. The instrument will gather patient assessment and cost information across all PAC settings. A report on this demonstration is not scheduled to be delivered until July 2011.

While CMS envisions an integrated system and has taken key steps toward developing one, it is years away from implementation. In the meantime, services furnished in PAC settings will likely continue to be paid for under the respective Prospective Payment Systems.

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### **UB04**

The National Uniform Billing Committee (NUBC) approved the UB04 as the replacement for the UB92. Effective March 1, 2007 institutional claim filers such as hospitals, skilled nursing facilities and hospices can begin using the UB04, with a transitional period between March 1 and May 22, 2007 during which time either the UB92 or the UB04 may be used.

Beginning May 23, 2007, all institutional paper claims must be submitted on the UB04. The UB92 will not longer be acceptable, even as an adjustment claim, after May 22, 2007.

The UB04 incorporates the National Provider Identifier (NPI). While most of the data usage descriptions and allowable data values have not changed on the UB04, many UB92 data locations have changed and bill type processing will change.

Data elements in the CMS uniform electronic billing specifications are consistent with the UB04 data set and definitions are identical. Revenue coding system is also the same for both the paper UB04 and the electronic specifications. In some situations, the electronic record contains more characters than the corresponding item on the paper form.

CMS is accepting valid NPIs on the UB04 between March 1 and May 23, 2007. The NPI is

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required as of May 23, 2007.

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**SNF Consolidated Billing  
April 2007 Update**

The following chemotherapy administration-related HCPCS codes are being added to Major Category III, EXCLUSIONS, effective for claims with dates of service on or after January 1, 2007.

- 96521—Refilling and Maintenance of Portable Pump
- 96522—Refilling and Maintenance of Implantable Pump or Reservoir for Drug Delivery, Systemic (e.g. intravenous, intra-arterial)
- 96523—Irrigation of Implantable Venous Access Device for Drug Delivery Systems

**NOTE**

Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims that are brought to their attention.

**SOLUTION CENTER Q&A**  
“Where No Question Goes Unanswered”

**Q:** Are therapy minutes required to be documented in the resident’s clinical record?

**A:** The Centers for Medicare and Medicaid Services (CMS) requires documentation of all therapy minutes. This is not the time the therapist spends with the patient, but a record of the time the patient spends receiving therapy. The actual minutes of treatment must be documented in the patient's records and submitted to the Fiscal Intermediary (FI) upon request for review. The treatment time can be documented per modality or documented in the record as time in and time out (excluding rest breaks). This documentation supports the number of units billed in relation to minutes of therapy received. Failure to provide documentation of minutes to support billed units could result in claim denial.


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<u>Topic</u>	<u>Date</u>
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UB04	4/10
Medicare Basics Nursing Document.	4/11
ADR Part One	4/12
No Pays Bills	4/17
ADR Part Two	4/19
New Pharmacy Rules	4/24
ABNs and Generic Notices	4/25
ICD-9 Coding	4/26
Therapy In’s and Out’s of Medicare	4/27

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