



*An Informational Bulletin Brought To You By Polaris Group*

## **Congress Passes Legislation to Avoid 21.2% Medicare Cut Thru May 31, 2010.**

On April 15, 2010, President Obama signed into law the "Continuing Extension Act of 2010". This legislation extends through May 31, 2010, the zero percent update to the Medicare Physician Fee schedule (MPFS), which is the same schedule used to pay for Part B therapies in nursing facilities. The zero percent update to the MPFS was in effect for claims with dates of service January 1, 2010 through March 31, 2010. The law is retroactive to April, 2010.

CMS has instructed Medicare contractors to begin processing claims under the new law for services provided by physicians, non-physician practitioners and other providers paid under the MPFS. Most claims with dates of service April 1 and later were held by Medicare in anticipation of congressional action.



### **CMS Becomes More Stringent with Documentation and Signature Requirements**

Two recent CMS publications, "Improper Medicare Fee-For-Service Payments Report of November 2009" and Transmittal 327, issued March 16 2010, indicate that the organization is tightening its requirements for the documentation required to support medical necessity and mandated signatures on prescriptions and orders for services.

The November 2009 report includes specific details of the type and percentage of errors found in claims as determined by reviews performed under the CERT (Comprehensive Error Rate Testing) program.

The more stringent review criteria for review of claims

selected for the November 2009 report resulted in increases in the error rates due to:

- ⇒ Records from the treating physician not submitted or Incomplete
- ⇒ Missing evidence of the treating physician's intent to order diagnostic tests
- ⇒ Medical records from the treating physician did not substantiate what was billed
- ⇒ Missing or illegible signature on medical record documentation

Additional details related to signatures were published in Transmittal 327 of the Medicare Program Integrity Manual. The signature guidelines apply to reviews conducted by Medicare Administrative Contractors (MACs), CERT Contractors and Recovery Audit Contractors (RACs).

Medicare requires that services provided/ordered by authenticated by a legible identifier. The method used for authentication may be a handwritten or electronic signature. Rubber-stamp signatures are not acceptable. Providers are urged to review their documentation prior to submission in order to ensure that all services and orders are signed appropriately. If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead to a decision that the medical necessity for the service billed has not been substantiated.

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



April 22, 2010  
Celebrate Earth Day!



## MDS Corner

### Updates from MDS 3.0 Train-the-Trainer conference



- ⇒ If the RUG-IV delay is implemented as outlined in healthcare reform, CMS will develop a modified RUG-III system to work with the MDS 3.0.
- ⇒ CMS is in the process of creating this modified system however it would not be ready for the October implementation of the MDS 3.0.
- ⇒ CMS continues to lobby for the RUG-IV implementation on October 1, 2010, as originally planned.
- ⇒ Updated versions of the MDS 3.0 Item Sets and RAI User's Manual are expected to be published in late May or early June.
- ⇒ Updates to Appendix P and PP of the State Operations Manual are expected in early August. This change will address modifications to the survey process while the QM/QI reports are not available.
- ⇒ The updated RAI User's Manual will change the timeframe to conduct the Resident Mood Interview (PHQ-9). Although recommended, the interview will no longer have to be conducted the day before or the day of the ARD, but rather anytime during the assessment look back window.
- ⇒ Facilities will have to manually trigger the Return to Community Care Area Assessment (CAA) until the first update, which is likely to occur in January 2011. After the first update, this CAA will trigger automatically based on MDS coding.
- ⇒ The updated *RAI User's Manual* will change the MDS transmission date for the admission, annual, significant change in status, and significant correction to prior comprehensive assessments. The RAI User's Manual released in January lists the transmission date for these assessments as no later than the MDS/Care Area Assessment (CAA) completion date + 14 days. The revised manual will change the transmission date for these assessments to be no later than the care plan completion date + 14 days. The care plan must be completed within seven calendar days after the MDS and CAA completion date.
- ⇒ When completing Section O0400 of the MDS 3.0, providers should record the total minutes each

therapy discipline (speech-language pathology, occupational therapy, and physical therapy) were administered to the resident for each mode of delivery (individual, concurrent, and group therapy). The software will later apply the 25% cap for group therapy minutes and cut the total minutes recorded for concurrent therapy in half.

- ⇒ The ARD for a discharge assessment will be the day of discharge. (A200)
- ⇒ Quality Indicator Surveys (QIS) will continue as planned.
- ⇒ CMS posted new versions of the MDS 3.0 subsets on its Web site April 9, 2010.

## OIG Reports on Unimplemented Recommendations

The office of Inspector General (OIG) released its Compendium of Unimplemented Office of Inspector General Recommendations March 11, 2010. This report highlights a variety of OIG recommendations that had not been fully implemented as of September 30, 2009.

The following unimplemented recommendations are related to nursing facilities;

- ⇒ Ensure That States Properly Maintain Nurse Aide Registries
- ⇒ Update Nurse Aide Training Curriculum
- ⇒ Ensure that hospice claims for beneficiaries in nursing facilities comply with Medicare coverage requirements
- ⇒ Ensure that Part B payments are appropriate for beneficiaries' medical equipment during non-Part A nursing facility stays
- ⇒ Ensure that Medicare Part D excludes payments for drugs for beneficiaries in Part A skilled nursing facility stay
- ⇒ The OIG report also includes a list of priority recommendations; one of these priority recommendations was to ensure the appropriate processing of denial of Medicare payment remedies for noncompliant nursing facilities.

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



## CMS Announces Series of Nationwide RAC 101 Calls

April 28, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call, 1-877-251-0301

May 4, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call for Home Health and Hospice Providers, 1-877-251-0301

May 5, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call for DMEPOS, 1-877-251-0301

May 12, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call for Physicians, 1-877-251-0301

### Q & A

“Where No Question Goes Unanswered!”

Q. Could you explain when to restart the Part A MDS schedule if a resident goes to the ER.

A. If a Medicare resident is admitted to an acute care facility and later returns to the SNF, the Medicare assessment schedule is restarted with the Medicare Readmission/Return assessment followed by the 14-Day, 30-Day, etc. A Discharge Tracking form, return anticipated and a Reentry Tracking form, would precede this. If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted, the Medicare assessment schedule is not restarted. However, there are payment implications, since the day preceding the midnight on which the resident was absent from the facility is not a covered Part A day. This is known as the “midnight rule.” The Medicare schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment “clock” is adjusted by skipping that day in calculating when the next Medicare assessment is due.

### TELECONFERENCE TRAININGS

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

Topic	Date
MDS 3.0-Part I: Basics & More	5/4
ICD-9 Coding-Part I: The Basics	5/7
MDS 3.0-Part II: Clinical Nursing Sections	5/5
ICD-9 Coding-Part 2: Coding Rules for SNFs	5/14
MDS 3.0-Part III: Interviews & MDS Coding	5/18
MDS 3.0-Part IV: Care Area Assessment	5/19
RUG-IV-Part 1: Qualifiers & MDS Coding	5/20
RUG-IV-Part 2: Medicare MDS Requirements	5/27

*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](http://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 date: May 21st at 1:00 PM EST**

**Learn more and register for demo online:**

[www.polaris-group.com](http://www.polaris-group.com)

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**Contributors:**

Debora Philips, RN, AAS  
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