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CMS Issues Contingency Plan for the National Provider Identifier (NPI) Rule

All covered entities, other than small health plans), must be in compliance with the HIPAA National Provider Identifier (NPI) Rule by May 23, 2007. Small health plans must be in compliance by May 23, 2008. This article addresses the Centers for Medicare & Medicaid Services' (CMS) contingency plan for covered entities with a May 23, 2007 compliance date.

Compliance means the NPI must be used to identify providers on all HIPAA covered transactions, including Medicare Part A and Part B billing to Fiscal Intermediaries and Carriers. Beginning May 23, 2007, covered transactions that are transmitted containing only legacy identifiers (identifiers in use today) or containing both legacy identifiers and NPIs would be noncompliant. With the May 2007 deadline drawing close, the Department of Health and Human Services (HHS) has received a number of inquiries expressing concern over the health care industry's state of readiness. In response, HHS outlined its approach to enforcement of the NPI rule.

Enforcement Approach

CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement. When CMS receives a complaint alleging that a covered entity has failed to comply with the NPI rule, CMS will notify the entity in writing that a complaint has been filed.

Following notification from CMS, the entity will have the opportunity to:

- 1) Demonstrate compliance
- 2) Document its good faith efforts to comply with the standards, and/or
- 3) Submit a corrective action plan.

Good Faith Policy

CMS's enforcement approach will utilize the flexibility granted in section 1176(b) of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under section 1176(b), HHS may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period. HHS has the authority under the statute to extend the period within which a covered entity may cure the noncompliance "based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities, each of whom is required to comply with HIPAA, and that noncompliance by one covered entity may put the second covered entity in a difficult position. CMS intends to look at the covered entities' good faith efforts to come into compliance with the NPI standards when determining whether reasonable cause for the noncompliance exists and the extent to which the time for curing the noncompliance should be extended.

For the 12 month period after the compliance date, CMS will not impose penalties on covered entities that deploy contingency plans if they have made reasonable and diligent efforts to become compliant and, in the case of health plans, to facilitate the compliance of their trading partners. If a health plan demonstrates active outreach/testing efforts, CMS will allow the plan to continue processing payments to providers.

In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrated progress. A covered entity may end its contingency plan at any

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time prior to May 23, 2008, but cannot continue it after that date.

Indications of good faith might include, but is not limited to:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, the trading partner(s) to test transaction(s) with the covered entity whose compliance is at issue.
- In the case of such a health plan, concerted efforts in advance of the May 23, 2007 and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community.
- For a health care provider, having obtained an NPI and having the ability to use it on HIPAA transactions.

Health care providers should be able to demonstrate that they took actions to become compliant prior to the May 23, 2007 compliance date, including obtaining an NPI. If CMS determines that reasonable and diligent efforts have been made, the cure period for noncompliance would be extended at the discretion of CMS. CMS will continue to monitor the covered entity to ensure that their sustained efforts bring progress towards compliance. If continued progress is not made, CMS will step up their enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should document such efforts in the event of a complaint being filed. This flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the 12 month transition to the NPI standards, as well as on the availability and quality of patient care.

Working Towards Compliance

HHS encourages covered entities to intensify their efforts toward achieving compliance with the NPI requirements during the few remaining months before the May 23, 2007 deadline.

Successful implementation will require the attention and cooperation of all health plans, clearinghouses, and all providers that conduct electronic transactions. HHS plans to reassess industry readiness on the May 23, 2007 compliance

date, and throughout the 12 month contingency plan period.

Medical Review of Skilled Nursing Facility Part A Claims

On March 30, 2007, CMS posted revisions to the Medicare Program Integrity Manual, Chapter 6 , Medical Review of Skilled Nursing Facility (SNF) Claims. Effective with the introduction of the 9 new RUG III categories on January 1, 2006, the paper Matrix currently found in this section became outdated. Beginning April 30, 2007, Medicare Contractors (Fiscal Intermediaries and Program Safeguard Contractors) must use a new, automated MDS QC System Software to review and calculate correct RUG values for Part A SNF claims with dates of service beginning January 1, 2006. According to CMS Transmittal 196, the tool has been piloted and contractors have been trained on its use. This transmittal *does not* apply to the review and adjustment of SNF swing-bed claims.

Medicare Contractors will utilize the MDS extract tool to obtain electronic copies of MDS assessments from the state repository. The MDS data will be imported into the MDS QC Software System and converted to a readable format. The Medical record will then be reviewed. Using the MDS QC tool, the reviewer will make coding changes as necessary to the provider submitted MDS. The claim will be paid according to the RUG-III value calculated by the MDS QC tool, and any applicable overpayments will be recouped.

When an MDS is not found in the National repository, contractors shall deny the claim, with the two following exceptions:

1. When the beneficiary dies or is discharged on or before day 8 of SNF admission or readmission, the contractor will pay the claim at the default rate if coverage criteria are met and skilled services provided were reasonable and necessary.
2. There may be cases where the contractor receives a demand bill for which no associated MDS was transmitted to the state repository because the provider did not feel that the services were appropriate for Medicare payment. If the contractor determines that coverage criteria are met and medically

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necessary skilled services were provided, the contractor shall pay the claim at the default rate for the period of covered care when an associated MDS is not located in the repository. If the 14-day State (OBRA) assessment has an assessment reference date within the assessment window of either the Medicare 5-day or 14-day assessments, it may be used as a basis for billing the days associated with one of those Medicare required assessments.

In addition to validating that all technical and medical necessity requirements are met, the FI must confirm:

- All MDS assessments corresponding to the Claim's reimbursement period have been transmitted to the State Repository. *Claims for which the MDS has not been transmitted and accepted into the State Repository **SHOULD NOT** be submitted to Medicare for payment.*
- SNF must have complied with the assessment schedule. The contractor will pay the default rate for the days of a patient's care for which the SNF is not in compliance with the assessment schedule.

Want to learn more about SNF Medical Review process? Polaris Group is offering a three-part ADR teleconference training series:

- Part 1: The What, When, How and Why of ADRs (4/12)
- Part 2: How to Survive a Medicare Chart Review (4/19)
- Part 3: The Appeals Process—What You Need to Know for Success (date to be announced).

SOLUTION CENTER Q&A

“Where No Question Goes Unanswered”

- Q: How is the therapy cap amount calculated? Is the beneficiaries co-insurance included in the amount?
- A. The amount subject to the therapy cap includes the total of the amount received by the provider, the beneficiaries co-insurance amount and any beneficiary deductible that is not yet paid at the time therapy is billed. The physician fee screen should be used when calculating the beneficiary's cap amount.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following **CEU approved** teleconference trainings
Live Teleconference Trainings

Topic	Date
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
Part B 2007	4/27
F-Tag Review	5/1
Master ADL Coding	5/2
MDS Fundamentals	5/3
Survey Prep and Management	5/8
Sections K, P, and T	5/9
Case Management for PPS	5/10
Super Supervisor	5/15
Sections I, J, O, and W	5/16
Activities Protocol and Psychosocial Grid	5/17
Feedback on Performance	5/22
MDS for Administrators	5/23
Behavior Assessments, Monitors, Care Plans	5/24

*Please join us in our Teleconferences .
 For further information regarding these seminars,
 please contact the
 Seminar Department at:
 800-275-6252 ext. 233
 Or register at: www.polaris-group.com*



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