



An Informational Bulletin Brought To You By Polaris Group

PART B PHYSICIAN FEE SCHEDULE EXTENSION SIGNED INTO LAW

The Senate and House passed a short-term extenders bill that will stop the 21.3% cut in the Medicare Physician Fee Schedule (MPFS), which is the same schedule used to pay for Part B therapies in nursing facilities and replaced it with a 2.2% increase from June 1 through November 30, 2010. President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010", on June 25th.

This law established a 2.2% update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. The Centers for Medicare and Medicaid Services (CMS) has directed Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered June 1, 2010 and later, until the 2.2% increase rates are in the claims processing system. Claims containing June 2010 dates of service which have been paid at the negative update rates will be reprocessed as soon as possible.

In other regulatory news, congress has delayed action on a tax extenders bill that would repeal the delayed implementation of the Resource Utilization Group (RUG-IV).

CMS HOSTED THE FIRST OF THREE NATIONAL PROVIDER CALLS TO DISCUSS ISSUES RELATING TO THE IMPLEMENTATION OF MDS 3.0 AND RUG-IV

CMS currently is creating the payment infrastructure needed to incorporate the combination of features mandated by the Patient Protection and Affordable Care Act (PPACA) and will apply interim payment rates, effective October 1, 2010, that reflect not only

the use of MDS 3.0 but also the new RUG-IV system in its entirety as finalized in the FY 2010 SNF PPS final rule. CMS will then retroactively adjust the rates to reflect a Hybrid RUG-III system, which incorporates RUG-IV's specific revisions on concurrent therapy and the look-back period within the framework of the existing 53-group RUG-III system, along with the use of the MDS 3.0.

CMS continues to monitor the legislation pending in Congress that would repeal section 10325 of PPACA and eliminate the need to adjust payments retroactively.

RUG IV includes the following changes:

- The number of RUG categories will increase from 53 to 66
- Special Care category will split into two separate categories: Special Care High and Special Care Low
- Impaired Cognition and Behavior categories will combine into one category: Behavioral Symptoms and Cognitive Performance
- Revised qualifiers to classify into Rehabilitation Plus Extensive Services, and Clinically Complex categories
Adjustments to activities of daily living (ADL) index:
 - RUG-IV ADL score ranges from 0 to 16, whereas RUG-III ADL score ranges from 4 to 18
 - Revisions to the eating component ADL score to better categorize the residents who receive feeding assistance.
- Revisions to calculation of therapy minutes (CMS noted that the actual therapy minutes should be reported on the



MDS and the grouper will apply the proper concurrent and group therapy methodologies)

- Modified look-back period for items in section P1a of the MDS 2.0, Special Treatments and Procedures, to include only those services provided while patient is a resident of the SNF.

CMS will hold two additional provider calls in August to explain payment issues related to the transition from RUG-III to RUG-IV and the additional changes needed to install the hybrid RUG-III grouper.

CMS PUBLISHES PROPOSED GUIDANCE FOR SEASONAL, H1N1 FLU PREVENTION

The Centers for Medicare and Medicaid Services (CMS) issued a proposed guidance that would update and replace previous infection control guidance for the seasonal and H1N1 flu.

The published guidance focuses on the importance of vaccination and steps to minimize the potential for exposure, such as respiratory hygiene, management of ill healthcare workers, droplet and aerosol generating procedure precautions, surveillance, and environmental controls. The guidance applies to all healthcare facilities, including nursing homes, hospitals and home health.

<http://edocket.access.gpo.gov/2010/pdf/2010-15015.pdf>

History and Purpose of the Recovery Audit Contractor Program (RAC)

To meet the requirements of the Improper Payment Information Act for annual review of areas susceptible to significant improper payments, the centers for Medicare and Medicaid Services (CMS) developed a variety of tools to reduce payment errors. One part of this effort was the advent of the Recovery Audit Contractors.

After a three-year demonstration period which focused

on Medicare Parts A and B, the Recovery Audit Contractors successfully corrected a total of more than \$1 billion in overpayments from providers and underpayments refunded to providers. Of the \$1 billion in RAC recoveries, approximately \$119 million were recovered from skilled nursing facilities. Because of the success of the demonstration program, Congress authorized the Recovery Audit Contractor program to become permanent.

The Recovery Audit Contractors have three primary responsibilities:

- Conduct data analysis from the Medicare Common Working file
- Review Medical records to further analyze claims
- Identify and correct improper payments (overpayments and underpayments)

The RACs will search for payments made to providers for services rendered that may not be supported by evidence-based care. The goal for recouping funds is \$10.8 billion from Medicare payments to health care providers. Approximately \$500 million of this, or 5%, is anticipated to be recovered from skilled nursing facilities.

There are two types of RAC reviews that are used in the audit process: the Automated and the Complex. For an automated review, no medical records are needed, only the claims. A complex review requires the medical record.

For more information or assistance with RAC prep...please visit our website http://www.polaris-group.com/news_releases.asp



MDS CORNER



As of June 29, CMS has released updated versions of sections of the *RAI User's Manual* for the MDS 3.0. These revised sections are as follows:

- ⇒ Chapter 1
- ⇒ Chapter 2
- ⇒ Chapter 3
- Introduction
- Section A: Identification Information
- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section D: Mood
- Section E: Behavior
- Section F: Preferences for Customary Routine and Activities
- Section G: Functional Status
- Section H: Bladder and Bowel
- Section I: Active Diagnoses
- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section L: Dietary/Oral Status
- Section N: Medications
- Section P: Restraints
- Section Q: Participation in Assessment and Goal Setting
- Section S: Reserved for State Defined Items
- Section V: Care Area Assessment (CAA) Summary
- Section X: Correction Request
- Section Z: Assessment Administration
- ⇒ Chapter 4
- ⇒ Chapter 5
- ⇒ Appendices B, C, E, D, and G

For updated sections, please visit <http://www.cms.gov/NursingHomeQualityInits/> (click on MDS 3.0 Training Materials)

Q & A

“Where No Question Goes Unanswered!”

Q. If a Medicare Part A resident is gone on leave of absence and stays out overnight, does the MDS schedule start over?

A. No, the MDS schedule would continue.

WEBINAR TRAININGS

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

<u>Topic</u>	<u>Date</u>
MDS 3.0-Part I: Basics and More	7/19
MDS 3.0-Part II: Clinical Nurses Sections	7/20
MDS 3.0-Part III: Interviews & MDS Coding	7/21
MDS 3.0-Part IV: Care Area Assessments	7/22
RUG-IV-Part 1: Qualifiers & MDS Coding	7/23
RUG-IV-Part 2: Medicare MDS Requirements	7/26

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

MDS 3.0/RUG-IV PUBLIC SEMINARS

- 7/13 St. Louis**
- 7/15 Chicago**
- 7/27 Minneapolis**
- 7/29 Denver**
- 8/3 Houston**
- 8/5 Philadelphia**

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