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Skilled Nursing Facility (SNF) Payment Rates for Fiscal Year 2008

The Centers for Medicare and Medicaid Services' (CMS) Fiscal Year (FY) 2008 Final Rule was placed on display August 1, 2007. The Final Rule includes a 3.3% market basket increase representing approximately \$690 million for fiscal 2008. That same day, the House of Representatives approved H. R. 3162 that, if approved by the Senate and signed by the President, will eliminate FY 2008 increase to SNF payment rates. Congress' actions are consistent with the recommendations set forth in the March 2007. The Medicare Payment Advisory Commission's (MedPAC) Report to Congress.

The Final Rule was published in the Federal Register on August 3, 2007. Additional key points include:

- The SNF market basket base year was revised to reflect Medicare allowable costs from Fiscal Year (FY) 2004 cost reports and two new allowable cost categories were added: professional liability insurance and postage.
- The market basket's pharmaceutical cost weight will include an adjustment for Medicaid drug expenditures.
- Administrative presumption of coverage for the upper 35 RUGs is maintained for FY 2008.
- Consolidated Billing requirements are maintained without changes to major category exclusions.
- The temporary increase of 128% in the per diem adjusted payment rates for SNF residents with AIDS remains in effect.

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- Effective for FY 2008 and subsequent years, a 0.5 percentage point threshold (currently 0.25%) will be used to determine whether a forecast error adjustment is appropriate.

In addition to freezing FY 2008 payment rates at the 2007 level, H. R. 3162 includes the following sections that have potential for impact on Skilled Nursing Facilities:

- Section 601 provides a two-year extension of the exceptions process for the Medicare therapy caps and requires that HHS conduct a study to develop an alternative or refined payment system for the future.
- Section 606 removes clinical social workers from the skilled nursing facility consolidated billing which allows them to bill for clinical treatment for nursing home residents in nursing homes as do psychologists and psychiatrists.
- Section 502 provides a one percent increase in payment rates for Inpatient Rehabilitation Facility (IRF) services for FY 2008, permanently freezes implementation of the "75 percent" rule at 60 percent; reduces rates for hip and knee replacements and hip fractures and directs research on outcomes, costs and other factors needed to evaluate the value of services provided.

CMS Delays Implementation of NPI Data Dissemination

CMS is extending the period of time in which enumerated health care providers can view their Freedom of Information Act (FOIA) disclosable National Plan and Provider Enumerations System (NPPES) data and make any edits they feel are necessary prior to the initial disclosure of the data. Previously scheduled for implementation on August 1, 2007, the query-only NPI Registry will become operational on September 4, 2007 with the

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downloadable file expected to be ready approximately one week later.

In order to ensure edits are reflected in the NPI Registry and in the first downloadable file when they become operational, health care providers must submit electronic edits no later than Monday, August 20, 2007. Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

Health care provider may refer to the document entitled "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007 for assistance in making their edits.

Contact the Polaris Solution Center for additional information or to receive a copy of the June 20, 2007 publication cited above.

CMS Clarifies Life Safety Code Issues in Nursing Homes

In a recent Survey and Certification Letter to State Survey Agency Directors and State Fire Authorities, CMS provided policy clarification regarding the use of the Fire Safety Evaluation System (FSES) when determining compliance with the Life Safety Code (LSC) where canopies or overhangs are not sprinklered.

The FSES (NFPA 101A, Chapter 4, 2001 edition) can be used to evaluate the level of safety provided for a Health Care occupancy that does not conform to the provisions of "Automatic Sprinklers and Other Extinguishing Equipment" (NFPA 101, Section 9.7). The FSES affords facilities the opportunity to have stronger safety features in other areas to compensate where the facility does not have sprinklers installed. Facilities without sprinklers installed under overhangs or canopies may meet the requirements of NFPA 13 at Section 5-1.1 and 5-13.8.1 temporarily by using the FSES.

NFPA 13 Section 5-1.1 requires "... (1) Sprinklers installed throughout the premises..." An annex note discusses that this standard contemplates full sprinkler protection for all areas.

NFPA 13 Section 5-13.8.1 requires that sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width with an exception for those with noncombustible or limited combustible construction.

Facilities may only use the FSES to comply with sprinklers requirements until CMS regulations

mandate that the facility become fully sprinklered. The FSES is required to be completed annually after each prescriptive survey and submitted as part of the facility's plan of correction. The CMS Regional Office will review the completed FSES annually.

Facilities with existing waiver of the requirement for canopies and overhangs to be sprinklered may continue under the waiver so long as the CMS Regional Office finds that all other applicable requirements in law and regulations continue to be met. Request for new waivers will not be approved. Existing waivers may be continued until CMS regulations require that the facility become fully sprinklered. All waivers are to be reviewed annually by the CMS Regional Office.

The date at which time facilities will be required to be fully sprinklered by installing a sprinkler system in accordance with NFPA 13 will be determined in the final version of CMS' proposed regulation issued as a Notice of Proposed Rulemaking on October 27, 2006.

Source: NFPA website.

The FSES for Health Care Occupancies provides a basis for developing alternatives that achieve a level of safety equivalent to that mandated by the Life Safety Code. The FSES was developed to provide a rational basis for achieving the level of safety intended by the Code without necessarily meeting all of its prescriptive requirements. This can be especially important for existing buildings in which physical conditions may not allow strict compliance or when retroactive compliance may present an economic hardship.

The FSES involves the evaluation and comparison of the risk factors and safety features present or proposed for a healthcare occupancy. The FSES methodology for healthcare occupancies is based on the evaluation of individual "zones," which are generally the spaces separated by floors, horizontal exit barriers, or smoke barriers. The risks of a zone consider the number of people affected by a given fire, the density of the people in the zone, the mobility of the patients, the age of patients, the location of the zone, and the ratio of patients to staff in the given zone.

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In addition to the risk aspects of the FSES, each zone must consider the ability of the building and its fire protection features to provide measures of safety commensurate with the risk. Safety parameters that are evaluated include building construction fire resistance, interior finish, corridor partitions/walls, corridor doors, zone dimensions, vertical openings, hazardous areas, smoke control, egress routes, fire alarms, fire detection, and automatic sprinklers. Redundancy of the safety features is an important aspect of the FSES. By evaluating the redundancy of safety features, the methodology intends to ensure that the failure of a single protection feature or device will not result in major failure of the entire system.

SOLUTION CENTER Q&A
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- Q. Is it possible for a resident to receive both Hospice and Medicare Part A skilled benefits in a Nursing Home? If yes, is the Hospice care included in consolidated billing?
- A. Although infrequent, a Hospice recipient may receive Medicare Part A SNF benefits if it can be clearly demonstrated that skilled nursing care, as defined by Medicare, is needed for a condition unrelated to the terminal condition. The facility should collaborate with the Hospice provider to obtain documentation to support the skilled service is unrelated to the Hospice benefit and to evaluate the appropriateness of Hospice providing ADL care, if in fact that is occurring, as the ADL score may impact the Part A RUG reimbursement. Hospice services for the terminal condition are excluded from consolidated billing and may be billed by the Hospice provider on bill type 81X or 82X. Services unrelated to the Hospice are designated by the presence of condition code 07 on the SNF claim, bill type 21X.

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Pressure Ulcer Management	8/21
MDS for Administrators	8/22
QIS Survey Process	8/23
Medicare Part A&B Billing—Consolidated Billing	8/24
ICD9 Coding—Part 1	9/6
Medicare Skilled Nursing Documentation	9/7
Master ADL Coding	9/11
ICD9 Coding—Part II	9/13
Part B Therapy	9/14
Accidents & Supervision	9/20
Sections K, P, and T	9/25
Sections I, J, O, and W	9/26
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Contributors:
 Gayle Atherton
 Victor Kintz
 Marty Pachciarz

Editor:
 Chuck Cave

Production Manager
 Cindy Hernandez

For more information, please contact your Polaris Group representative.