August 23, 2019

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CMS Releases CY 2020 Medicare Physician Fee Schedule Proposed Rule

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) issued the Proposed CY 2020 Medicare Physician Fee Schedule (PFS), which would take effect January 1, 2020. The proposed rule updates Medicare Part B payment policies, payment rates and quality provisions for services under the Medicare PFS. This is the same fee schedule used to pay for Medicare Part B therapy services in nursing facilities.

Summary of key items include:

Conversion Factor

The proposed CY 2020 PFS conversion factor is $36.09, a slight increase above the CY 2019 PFS conversion factor of $36.04.

Outpatient Therapy Services

Repeal of the Therapy Caps and Limitation to Ensure Appropriate Therapy

Beginning January 1, 2018, section 50202 of the Bipartisan Budget Act (BBA) of 2018 repealed the Medicare outpatient therapy caps and the therapy cap exceptions process, while retaining the cap amounts as limitations and requiring medical review to ensure that therapy services are furnished when appropriate. While CMS explained and implemented the changes required in the Bipartisan Budget Act of 2018 (BBA of 2018) in the CY 2019 PFS rulemaking, CMS did not codify those changes in regulation text.

CMS proposes to add a new paragraph to clarify that the specified amounts of annual per-beneficiary incurred expenses are no longer applied as limitations, but as threshold amounts above which services require, as a condition of payment, inclusion of the KX modifier; and that use of the KX modifier confirms that the services are medically necessary as justified by appropriate documentation in the patient's medical records.

CMS also proposes to specify the therapy services and amounts that are accrued for purposes of applying the KX modifier threshold, including the continued accrual of therapy services furnished by critical access hospitals (CAHs) directly or under arrangements at the PFS-based payment rates. CMS is also proposing to amend paragraph (e)(3) in §§ 410.59 and 410.60 for the purpose of applying the medical review threshold to clarify the threshold amounts ($3,000 for PT and SLP services and $3,000 for OT services) and the applicable years for both the manual MR process originally established through section 3005(g) of MCTRJCA and the targeted MR process established by the MACRA, and including the changes made.

Outpatient PT and OT Services Performed by Therapy Assistants

In the CY 2019 PFS final rule, CMS established two modifiers (CQ/CO) to identify therapy services that are furnished in whole or in part by a physical therapy (PT) and occupational therapy (OT) assistants, and set a de minimis 10 percent standard for when these modifiers will apply to specific services. In addition, CMS also established that the 15 percent statutory reduced payment rate for therapy assistant services, effective beginning for services furnished in CY 2022, does not apply to services furnished by critical access hospitals because they are not paid for therapy services at PFS rates.

Beginning January 1, 2020, these modifiers are required by statute to be reported on claims. In this Proposed Rule, CMS is proposing a policy to implement the modifiers as required by statute, and apply the 10 percent de minimis standard, while imposing the minimum amount of burden for those who bill for therapy services while meeting the requirements of the statute.

CMS proposes to make the de minimis 10 percent calculation based on the respective therapeutic minutes of time spent by the therapist and the PTA/OTA, rounded to the nearest whole minute. For purposes of deciding whether the 10 percent de minimis standard is exceeded, CMS offers two different ways to compute this: (1) divide the PTA/OTA minutes by the total minutes for the service; or (2) divide the total time for the service by 10 to identify the 10 percent de minimis standard, and then to add one minute to identify the number of minutes of service by the PTA/OTA that would be needed to exceed the 10 percent standard.

To read the complete CMS CY 2020 Proposed Physician Fee Schedule: http://www.polaris-group.com/news_releases.asp

August OIG Updates

Nursing Homes: CMS Oversight of State Survey Agencies

CMS enters into agreements with State survey agencies (SAs) to conduct surveys to determine whether nursing homes are compliant with Medicare requirements. Recent reports by OIG found problems in SA performance, including not verifying whether nursing homes corrected deficiencies and not investigating complaints in a timely manner. CMS evaluates SA performance in fulfilling their surveying responsibilities, including through Federal monitoring surveys and performance thresholds described in the State Performance Standards System. When there is inadequate SA performance, CMS may impose a sanction or remedy, such as providing for training of survey teams, requiring the SA to submit a corrective action plan, or reducing the State's allotment of Federal financial

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participation. OIG will describe CMS's efforts to work with SAs to improve performance by conducting interviews and reviewing supporting documentation about CMS's monitoring efforts. OIG will also identify any challenges or barriers that may impede CMS's ability to help SAs improve performance.

Medicare Part B Services to Medicare Beneficiaries Residing in Nursing Homes during Non-Part A Stays

Medicare pays physicians, non-physician practitioners, and other providers for services rendered to Medicare beneficiaries, including those residing in nursing homes (NHs). Most of these Part B services are not subject to consolidated billing; therefore, each provider submits a claim to Medicare. Since the 1990s, OIG has identified problems with Part B payments for services provided to NH residents. An opportunity for fraudulent, excessive, or unnecessary Part B billing exists because NHs may not be aware of the services that the providers bill directly to Medicare, and because NHs provide access to many beneficiaries and their records. OIG will determine whether Part B payments to Medicare beneficiaries in NHs are appropriate and whether NHs have effective compliance programs and adequate controls over the care provided to their residents.

Medicaid Assisted Living Services

Medicaid may provide assisted living services to beneficiaries who are medically eligible for placement in a nursing home but opt for a less medically intensive, lower-cost setting. These services may include personal care (e.g., assistance with dressing and bathing), homemaker services (e.g., housecleaning and laundry), personal emergency response services, and therapy services (i.e., physical, speech, and occupational). A 2018 Government Accountability Office report indicated that improved Federal oversight of beneficiary health and welfare is needed in States' administration of Medicaid assisted living services. OIG will determine whether assisted living providers are meeting quality-of-care requirements for Medicaid beneficiaries residing in assisted living facilities and whether the providers properly claimed Medicaid reimbursement for services in accordance with Federal and State requirements.

Revisions to Appendix Q, Guidance on Immediate Jeopardy

On July 31, 2019, CMS revised guidance in Appendix Q of the State Operations Manual (SOM) to reinsert language referring criminal acts to law enforcement.

CMS Memorandum Summary:

- **Core Appendix Q and Subparts** -Appendix Q to the State Operations Manual (SOM), which provides guidance for identifying immediate jeopardy, has been revised. The revision creates a Core Appendix Q that will be used by surveyors of all provider and supplier types in determining when to cite immediate jeopardy. CMS has drafted subparts to Appendix Q that focus on immediate jeopardy concerns occurring in nursing homes and clinical laboratories since those provider types have specific policies related to immediate jeopardy. Appendix Q has been revised to reinsert language referring criminal acts to local law enforcement.
- **Key Components of Immediate Jeopardy** – To cite immediate jeopardy, surveyors determine that (1) noncompliance (2) caused or created a likelihood that serious injury, harm, impairment or death to one or more recipients would occur or recur; and (3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment or death to one or more recipients.
- **Immediate Jeopardy Template** – A template has been developed to assist surveyors in documenting the information necessary to establish each of the key components of immediate jeopardy. Survey teams must use the immediate jeopardy template attached to Appendix Q to document evidence of each component of immediate jeopardy and use the template to convey information to the surveyed entity.

To read the complete CMS Memo; http://www.polaris-group.com/news_releases.asp

Final MDS 3.0 Data Specs for Oct. 1, 2019 Implementation

The FINAL version (V3.00.1) of the MDS 3.0 Data Specifications was posted. This version is scheduled to become effective October 1, 2019. Note that there have been additional revisions since the errata – they can be identified by looking for "post-errata" in the version notes for the items and edits.

In addition, V1.04.0 of the MDS 3.0 CAT Specifications is also scheduled to become effective October 1, 2019. The specification for CAT 12 (Nutritional Status) has been updated in accordance with the changes in V3.00.0 of the MDS 3.0 Data Specifications.

For the complete CMS MDS Spec downloads;

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
If a resident comes in with an indwelling Foley and within the look back period it was discontinued do you check indwelling Foley in section "H" if it was not in for the entire look back period or check if it was even in one day of the look back period?

Answer:
You would code the indwelling catheter if it were used anytime during the look-back period. The RAI says: Check next to each appliance that was used at any time in the past 7 days.

Question:
We have a Medicare Part A patient who went to the oncologist and was prescribed a medication that cost over $2000.00 for 56 tablets. The medication name is Capecitabine and it is an oral chemotherapy medication. Are we responsible for the cost of that medication?

Answer:
Under the consolidated billing guidelines the facility would be responsible for the cost of that medication because it is not excluded according the HCPCS code of J8521. The facility would be responsible for the Medicare allowable rate, which according to the July 2019 ASP Pricing File would be 3.644 per tablet. The Medicare allowable rate for 56 tablets would be $204.07.

Question:
We have a resident who had multiple fractures from the elevator she was in falling about eight stories. Would I mark this as a fall on the MDS?

Answer:
No, because under the definition of a fall it says, "Falls are not a result of an overwhelming external force" so the patient did not fall it was the elevator that fell.

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