



POLARIS PULSE

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

CMS FAQs Related to Hurricane Katrina

Due to the extraordinary circumstances faced by providers in various states, the Secretary has declared a public health emergency. Health and Human Services Secretary Mike Leavitt invoked the time-limited statutory authority under section 1135(b) of the Social Security Act to permit CMS (and its agents) to waive or modify certain requirements, deadlines and timetables for the performance of required activities. The waivers became effective August 29, 2005 in Louisiana, Mississippi, Alabama, Florida, Texas, Arkansas, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, and Utah.

CMS has established a web page dedicated to providing information to residents and providers impacted by Katrina. The web page includes links to questions that have arisen during the days and weeks following the hurricane. This page is updated regularly and is located at: www.cms.hhs.gov/katrina/. Below are a few of the posted Q&As.

LENGTH OF WAIVER

Q: What is the duration of the waivers granted by Secretary Leavitt under Section 1135(b)?

A: The length of the waiver is the duration of the emergency period, unless the Secretary extends the waiver by notice for additional periods of 60 days, as provided in 1135(e)(2). However, requirements are waived only to the extent necessary to achieve the purposes of the statute. For example: if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, then the waiver of the requirement would no longer apply to that location.

AMBULANCE

Q: What is CMS' policy relating to ambulance

payments for evacuations?

A: Medicare policy provides contractors with discretion to determine Medicare payment for services provided under unusual circumstances. While CMS recognizes it is in the patient's best interest to be evacuated as soon as possible during an emergency, contractors have the responsibility to determine if Medicare payment should be made for the evacuation.

In most cases, mass emergency evacuations billed to Part B are for nursing home patients from ambulance suppliers. Nursing homes are required to have an emergency evacuation plan as a condition of participation. Many will have insurance to cover these situations. If the facility has insurance that will cover the evacuations, Medicare is the secondary payer. If not, contractors should consider the following points prior to making payment:

- Medicare's medical necessity requirements apply in all cases;
- Payment may be made only if the patient was transported to an approved destination; and
- Multiple patient transport payment provisions apply in all cases.

Due to the unusual nature of the services provided during Katrina, contractors should evaluate circumstances relating to the affected beneficiaries and make coverage decisions based on the facts for individual situations. Contractors may have to vary coverage determinations based on a patient's individual situation.

Q: Will Medicare consider such ambulance trips under the consolidated billing requirements for skilled nursing facilities?

A: No, such trips will not be subject to consolidated billing.

For more information, please contact your Polaris Group representative.

REIMBURSEMENT AND COST REPORTS

Q: If providers chose to waive Medicare deductible or coinsurance amounts for victims of the hurricane, may the providers claim these waived amounts on the cost report as bad debt? If so, what documentation will be required in order to satisfy auditors?

A: Providers can waive the coinsurance and deductible amounts and claim bad debt for Medicare patients that they determine to be indigent. The indigence determination must be made on a case-by-case basis. Documentation requirements stated in Provider Reimbursement Manual 1, Chapter 3, Section 312 (C) allow that the “provider should take into account any extenuating circumstances”.

Q: Can a provider affected by this disaster receive an extension to the filing of its cost report?

A: Yes, an affected provider may receive an extension to a cost report’s filing deadline as provided under 42CFR413.24(f)(2)(ii). The request must be reasonable as determined by the specific circumstances by the provider. Provide copies of both denials and approvals to the RO (Regional Office).

Q: Can the 14-day payment floor be temporarily suspended to improve the cash flow of Part A and Part B providers?

A: Cash flow problems can better be resolved through accelerated (Part A providers) or advance (Part B providers) payments rather than through suspension of the mandatory payment floor. Intermediaries have been asked to process immediately any requests for accelerated payments or increases to PIP (Periodic Interim Payments) for providers affected by the hurricane. The intermediaries are also authorized to increase the rate of the accelerated payment to 100% and extend the repayment period to 180 days on a case-by-case basis.

SNF PART A BENEFITS

Q: Can Medicare Part A SNF benefits be provided in the absence of a 3-day prior hospital qualifying stay for people who are being evacuated or transferred as a result of hurricane Katrina?

A: Yes. We understand that it may often be difficult to determine whether the 3-day stay requirement has been met. This policy applies to any Medicare beneficiary:

- Evacuated from a nursing home in the emergency area;
- Discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients;

- Who needs SNF care as a result of the emergency, regardless of whether the individual was in a hospital or nursing home prior to the hurricane.

Providers must document in the medical record both the medical need for the SNF admission and how the admission was related to the crisis created by Hurricane Katrina and its aftermath. Billing instructions will be issued at a later date.

MDS ASSESSMENTS

Q: What are the requirements for filling out an MDS assessment?

A: Under normal circumstances, a nursing facility is required to complete a Minimum Data Set (MDS) within 14 days of admission to the facility to meet OBRA requirements. In the case of evacuations, the evacuating facility should determine by day 15, whether or not residents will be able to return to the originating facility within 30 days or not. In the case that the evacuating facility is unavailable to make this determination, the receiving facility should do so, and act accordingly.

If the resident returns to the originating facility within 30 days, the MDS cycle will continue as though the resident was never transferred. This decision allows facilities to care for patients and avoids the necessity of having the receiving facility to complete many MDSs while the patient is awaiting transfer back to the originating facility.

If the evacuating and/or receiving facility determines that the resident will not return to the evacuating facility within the previously mentioned time frame, the evacuating provider will discharge the resident if possible. The receiving facility will then admit the resident and complete an admission MDS (and/or a 5-day MDS) as per the OBRA/PPS requirements. The MDS cycle will begin as of the admission date. The discharge/admission date must occur within the previously mentioned time frame (i.e. 30 days).

If the resident returns to the originating facility after the allowed time frame, the receiving facility will discharge the resident and the evacuating facility will re-admit the resident. The MDS cycle will be established based on the discharge tracking.

Q: Many Hurricane Katrina victims in nursing homes were evacuated to other nursing homes without their medical history. The national Minimum Data Set (MDS) is the only source of medical record information for many of these residents. What can

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nursing homes that have accepted residents do to obtain information available on the residents' MDS record to assure appropriate care of those residents? In some cases the States affected by the hurricane are unable to provide this information on an "as requested" basis.

A: CMS has compiled a list of all nursing homes that were evacuated, and has compiled a file of critical, clinical information from the MDS records of the residents in those nursing homes in an Excel spreadsheet. Any nursing home that has received evacuees may request access to this file(s). To receive this information, the receiving nursing home should contact the IFMC Help Desk at 1-888-477-7876. When the request is received, IFMC will place the file in the receiving nursing home's shared MDS folder. The report will stay in the receiving nursing home's file for about 30 days.

MEDICARE PREMIUMS AND DEDUCTIBLES FOR 2006

The Medicare Part B monthly premium will be \$88.50 in 2006, an increase of \$10.30 from the current \$78.20 premium.

The Part B deductible will be \$124.00 in 2006, an increase of \$14.00 from the current \$110 deductible.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: Is the new Notice of Medicare Non Coverage (NOMNC) required when a resident is discharged from Medicare Part B Therapy Services in a Nursing Home?

A: When a beneficiary is receiving Medicare Part B Therapy Services, the expedited notice must be given at the time all Part B service is terminated. When the beneficiary is receiving more than one therapy service the SNF is not required to give the expedited notice until all services provided under Part B are terminated. For example, if in addition to receiving PT, OT and ST, the resident is also receiving tube feedings, the NOMNC would not be issued when the last therapy service is discontinued and the tube feeding remains. Conversely, if the resident is not receiving additional Part B services, the NOMNC would be issued when the last therapy service is discontinued. This is true whether the resident's bill type is 22x or 23x.


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<u>Topic</u>	<u>Date</u>
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New Urinary Continence & Catheters Survey	9/27
Part D—New Pharmacy Drug Benefit	9/29
Pressure Ulcer Program & Survey Prep.	10/4
Mastering ADL Coding	10/6
MDS/Case Management for PPS and Accurate Reimbursement	10/11
Right Coding Sections K, P and T	10/13
Managed Risk	10/18
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