



POLARIS PULSE



An SPECIAL EDITION Bulletin Brought To You By Polaris Group

Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in healthcare consulting, puts Polaris Group in limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.



Polaris Group Update on Therapy Caps—July 2008

It appears that congress has failed with implementing legislation that will prevent the therapy caps from being re-instituted effective 7/1/08. There is still legislation pending that could change this, but it looks like it will not be voted on in time. There is strong speculation that legislation will be passed after the July 4th recess that could possibly go retro to July 1, 2008. As a reminder, three things will occur July 1, 2008.

1. **Therapy Caps will be back in place**
2. **Therapy exception process to the Caps will no longer be valid**
3. **10.6% reduction in Part B fee screens will take effect.**

What you should you do?

1. Today through Tuesday inform and work with the therapy vendor / department to establish a plan that will take effect this coming Tuesday.
2. The plan should include looking at the current Part B caseload to determine if the resident has already hit the therapy cap anytime since January, If so they need to be informed that Medicare will no longer pay for their Part B therapy services unless received in an out-patient, off site, hospital based clinic. NOTE: From a reimbursement standpoint, if the resident is in a Certified Bed, consolidated billing applies and the facility would have to pay the cost. This is only true for patients who are NOT in a certified bed. Issuing an NEMB will help the facility to be protected should the claim be denied.
3. Prior to any new resident being picked up on Part B they should be screened for where they are in regards to the therapy cap limit. This limit is calendar year not provider based so any therapies received in an alternative location count towards the current year cap limit.
4. If the legislation is not enacted before 7/31/08 you will need to set up new fee screens in their charge masters to correctly book revenue.

Here is some additional information for you. **Any facility with Polaris Group hotline access can call the hotline anytime to get additional information.**

2008 Therapy Caps:

- \$1,810 Physical Therapy and Speech Language Pathology Combined
- \$1,810 Occupational Therapy
- Cap amount includes beneficiary deductible and co-payment amounts in addition to provider reimbursement
- Financial limits on therapy services includes dollars spent toward the caps beginning January 1, 2008
- Use of KX modifier to bypass contractor therapy cap edits **not permitted** for therapy service dates of July 1, 2008 and later
- It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits can be obtained at a hospital therapy department and is Part B reimbursable if the patient DOES NOT reside in a Medicare Certified bed. If the resident is in a Medicare Certified bed consolidated billing rules apply and the facility or patient would be responsible for any amount over the cap, depending on how this information was communicated.
- Although the use of the Notice of Exclusion from Medicare Benefits (NEMB Form CMS 20007) is not a Medicare requirement, the CMS Medicare Claims Processing Manual advises it be used for beneficiary notification.
- A sample reason for denial statement includes: "Medicare will not pay for physical therapy and speech-language pathology services (or occupational therapy services, if OT cap met) over \$1,810 during Calendar Year 2008"

Polaris Group will keep you informed about this over the next few weeks.

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• POLARIS PULSE is an informational newsletter distributed to
 • POLARIS GROUP clients. For further information regarding
 • services or information contained in this publication, please contact
 • POLARIS GROUP corporate headquarters at 800-275-6252.

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NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you (**Estimated Cost: \$**_____).

Medicare will not pay for: _____
_____;

1. Because it does not meet the definition of any Medicare benefit.

2. Because of the following exclusion * from Medicare benefits:

- | | |
|---|--|
| <input type="checkbox"/> Personal comfort items. | <input type="checkbox"/> Routine physicals and most tests for screening. |
| <input type="checkbox"/> Most shots (vaccinations). | <input type="checkbox"/> Routine eye care, eyeglasses and examinations. |
| <input type="checkbox"/> Hearing aids and hearing examinations. | <input type="checkbox"/> Cosmetic surgery. |
| <input type="checkbox"/> Most outpatient prescription drugs. | <input type="checkbox"/> Dental care and dentures (in most cases). |
| <input type="checkbox"/> Orthopedic shoes and foot supports (orthotics). | <input type="checkbox"/> Routine foot care and flat foot care. |
| <input type="checkbox"/> Health care received outside of the USA. | <input type="checkbox"/> Services by immediate relatives. |
| <input type="checkbox"/> Services required as a result of war. | <input type="checkbox"/> Services under a physician's private contract. |
| <input type="checkbox"/> Services paid for by a governmental entity that is not Medicare. | |
| <input type="checkbox"/> Services for which the patient has no legal obligation to pay. | |
| <input type="checkbox"/> Home health services furnished under a plan of care, if the agency does not submit the claim. | |
| <input type="checkbox"/> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997. | |
| <input type="checkbox"/> Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need). | |
| <input type="checkbox"/> Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital. | |
| <input type="checkbox"/> Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF. | |
| <input type="checkbox"/> Services of an assistant at surgery without prior approval from the peer review organization. | |
| <input type="checkbox"/> Outpatient occupational and physical therapy services furnished incident to a physician's services. | |

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**