On March 31, 2014 the U.S. Senate passed another temporary Sustainable Growth Rate (SGR) "doc fix" bill, "Protecting Access to Medicare Act of 2014", that averts the 24% Medicare Physician Payment Cuts. The SGR, or sustainable growth rate formula, is the formula the physician fee schedule payment established under Medicare. This is the same schedule used to pay for Medicare Part B therapy services in nursing facilities. In addition, this same bill delays the transition to ICD-10 under the Medicare program for one year.

Some of the Key provisions affecting Nursing facilities:

**Physician Payment Update**
- Prevents a 24% cut in reimbursements for physicians and providers treating Medicare patients on April 1, 2014 and replaces it with a 0.5% update (through December 31, 2014) and a 0% update from January 1, 2015 until April 1, 2015.

**Extension of Therapy Cap Exceptions Process**
- Extends through March 31, 2015, the therapy cap exception process for beneficiary annual limits set for Calendar Year (CY) 2014 at $1,920 for occupational therapy (OT), or for a combination of physical therapy (PT) and speech language pathology (SLP). It also extends the existing manual medical review process for all patients that exceed the $3,700 threshold for either OT or for both PT and SLP services.

**Delay in Transition from ICD-9 to ICD-10 Code Sets**
- Delays the transition to ICD-10 under the Medicare program for 1 year to October 1, 2015.

**Skilled Nursing Facility Value-Based Purchasing Program**
- Establishes a skilled nursing facility (SNF) value-based purchasing (VBP) program by October 1, 2019. The SNF VBP program will be based off of individual SNF performance on a hospital readmission measure. No later than June 2021, MedPac shall submit to Congress a progress report.

**Extension of Two-Midnight Rule**
- Delays enforcement of the Medicare two-midnight payment policy for hospitals until March 2015.

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**SNFs Receive Annual PEPPER Report**

CMS introduced a new annual report in 2013 for Skilled Nursing Facilities (SNFs) called a "Program for Evaluating Payment Patterns Electronic Report" (PEPPER). PEPPER data is shared with both Medicare Administrative Contractors (MACs) and the Medicare Recovery Auditor Contractors (RACs), to be distributed annually to Skilled Nursing Facilities. This report details your specific Medicare claims data in certain targeted areas and compares your facility to other SNFs Nationally, by State, and by Jurisdiction. Facilities received their first PEPPER report at the end of August 2013.

CMS recently announced that the 2014 SNF PEPPER reports are scheduled for distribution between May 5, 2014 and May 12, 2014. Free-standing SNFs will have access to the PEPPER report electronically via secure portal on www.PEPPERResources.org.

Please note these requirements:

1. Access to the PEPPER will be restricted to the provider's Chief Executive Officer, President, or Administrator. Corporate offices and/or facility management companies will need to obtain PEPPERS from each individual provider in their organization.
2. Requestors will be required to enter their 6-digit CMS certification number (also referred to as a provider number or PTAN). This is not the same number as the tax identification number or national provider identification number.
3. For verification purposes, requestors will be required to enter either a patient control number (found at form locator 03a on the UB04 claim form) OR a medical record number (found at form locator 03b on the UB04 claim form) for a fee-for-service Medicare patient who received services at the provider during a specified time period (either the "From" or "Through" date on the claim is during the time period) (TMF will determine this time period closer to report distribution).

Effective January 1, 2014, copies of the 2013 SNF PEPPER reports were no longer available from TMF Health Quality Institute (TMF). Providers must wait for the May 2014 release. For more information, visit http://pepperresources.org/PEPPER/PEPPERDistribution.aspx.
CMS Plans for Increased Survey & Certification Activity in FY 2015

In its proposed budget for FY 2015, the Centers for Medicaid & Medicare Services (CMS) are seeking increased funds for survey-related activities. CMS notes that about 91% of the requested funding will go to State survey agencies (SAs) for completing mandatory inspections of long term care facilities. The agency uses approximately 7000 surveyors across the US to determine compliance with Federal regulations. In FY 2013, SAs cited nearly 90% of Medicare-participating nursing homes with deficiencies. Each facility received approximately 6 deficiencies. In FY 2015, CMS anticipates completing over 24,000 initial and recertification surveys and over 51,000 complaint visits.

CMS explains that part of the increased budgetary request is related to the “continued expansion in the role that survey and certification plays in addressing issues of national importance such as reducing the use of anti-psychotics and improving dementia care in nursing homes, reducing infections, pressure ulcers and other healthcare-associated conditions.”

CMS has re-proposed for FY 2015 a “revisit survey user fee” that would give CMS the ability to revisit providers to ensure that they have implemented their plans of correction for cited deficiencies and are in substantial compliance. This fee would only apply to providers that had serious quality of care or safety deficiencies and would serve as incentive to other providers to quickly address their deficiencies.

While CMS is developing standards and working to measure performance, it also stated in its budgetary document that it will have three specific measurements that will impact long term care facilities, including:

Decrease the Prevalence of Pressure Ulcers in Nursing Homes - An increased focus has been placed on reducing pressure ulcers, including updated survey guidance and Regional Office follow-up with States on their progress.

Percentage of States that Survey Nursing Homes at Least Every 15 Months - CMS had a goal in FY2012 of 97% of states completing all of their surveys, which it failed to meet. It noted that employee furloughs and hiring freezes prevented this percentage from being met. The agency’s FY 2015 goal is for 97% of states to survey nursing homes at least every 15 months, which requires a state to complete 100% of its surveys.

Improve Dementia Care in Nursing Homes by Decreasing the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication - CMS will also be introducing a new performance measure to improve dementia care in nursing homes and reduce the use of anti-psychotic medications.

This measure stems from the Partnership to Improve Dementia Care in Nursing Homes, an initiative that has been underway for some time now.


CMS Announces Long-term Care Providers Achieved 15% Antipsychotic Reduction Goal,

Long-term care facilities have reduced antipsychotic medication use by more than 15% through the National Partnership to Improve Dementia initiative, according to a new report from the Centers for Medicaid & Medicare Services (CMS).

The National Partnership to Improve Dementia Care in Nursing Homes was formally launched in 2012, with the primary goal of reducing the prevalence of antipsychotic prescribing for dementia care by 15% within a year. The initiative joined public and private organizations that educated providers and offered resources to help them transition residents off of antipsychotics. While it took longer than a year to achieve this reduction, the goal was met in the fourth quarter of 2013, according to an interim CMS report.

Items included in this interim report:
- Provides a detailed history of the National Partnership
- Presents current data trends for antipsychotic use and enforcement activity by State and CMS Region
- Describes and catalogues specific contributions of various partnering organizations
- Summarizes Partnership activities to date
- Explores reasons to explain the early progress of the initiative
- Outlines future goals and next steps.

The national prevalence of antipsychotic use among long-stay nursing home residents has decreased 15.1% from the fourth quarter of 2011, the report states. The overall antipsychotic prescribing rate for this population was 20.2% in the fourth quarter of 2013.

To read the complete report: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html
CMS Changes Management of the Coordination of Benefits (COB) to the Benefits Coordination & Recovery Center (BCRC)

Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

CMS has changed the management of the Coordination of Benefits (COB) to the Benefits Coordination & Recovery Center (BCRC). The key change is that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC) and there is a new contact, address and Web address information that is associated with this process and the BCRC. Providers are now mandated to report any payer that may be primary to Medicare.

That BCRC contact information is:

Telephone: 1-855-798-2627 (8AM to 8PM Eastern Time)
Fax: 1-405-869-3307 (address fax to Medicare-MSP General Correspondence)

Mailing Address: Medicare-MSP General Correspondence
P.O. Box 138897 Oklahoma City, OK 73113-8897

Question:
If the patient is discharged off Part A or from the facility on the 7th day of the COT, is the COT required?

Answer:
No. The RAI says, "In cases where a resident is discharged from the SNF on or prior to Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the required. If a SNF chooses to complete the COT OMRA in Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the required. If a SNF chooses to complete the COT OMRA in Day 7 of the COT observation period, then no COT OMRA is required.

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