



An Informational Bulletin Brought To You By Polaris Group

Therapy Cap Exceptions Process Expires

On December 31, 2017, The Medicare Part B Therapy Cap exceptions process expired. This process allowed all covered and medically necessary services to qualify for exceptions to the Therapy Cap.

As a result, residents receiving Medicare Part B therapy in 2018 will have a “Hard Cap” of \$2,010 for Physical Therapy (PT)/Speech Therapy (SLP) and a “Hard Cap” of \$2,010 for Occupational Therapy (OT). The “Hard Cap” means that once the \$2,010 amount is met for each cap, Medicare will no longer cover therapy services for the 2018 calendar year. Medically necessary therapy services beyond the cap may be paid for privately by the patient/responsible party but this can only occur with a resident/responsible party signed ABN that is provided by the facility.

The "therapy cap" was first adopted in the Balanced Budget Act of 1997. Under this policy, Medicare beneficiaries cannot receive outpatient occupational therapy services, and, separately, physical therapy and speech language pathology services combined, if those services would exceed the "cap" amount, regardless of medical need. Since its adoption in 1997, Congress has only allowed this hard cap on therapy services to take effect four times: in 1999, 2003, 2006, and 2010. At all other times, they either put in place moratoria on the policy, or implemented an exceptions process that allowed access to the needed services.

Key items regarding the Medicare Part B Therapy Cap as of Jan. 1, 2018:

- The therapy cap exceptions process ended Dec. 31, 2017
- Medicare beneficiaries are limited to \$2,010 for physical therapy (PT) and speech - language pathology (SLP) combined, and \$2,010 for occupational therapy.
- Therapy over the cap is statutorily excluded as a Medicare benefit in the absence of an exceptions process.

- The therapy caps apply to all therapy service locations (including skilled nursing facilities), with the exception of hospitals.
- Beneficiaries are financially responsible for all therapy costs over the therapy cap (again, with the exception of services provided in hospitals).
- With the implementation of the hard therapy cap on January 1, 2018, there is no targeted medical review threshold. This is subject to change, pending congressional action
- Providers should issue a mandatory advanced beneficiary notice of non-coverage (ABN) to advise beneficiaries of non-coverage of therapy over the cap.

CMS is taking steps to limit the impact on Medicare beneficiaries by holding claims affected by the therapy caps exceptions process expiration for a short period of time beginning on January 1, 2018. Only therapy claims containing the KX modifier are being held; claims submitted with the KX modifier indicate that the cap has been met but the service meets the exception criteria for payment consideration. Currently if claims are submitted without the KX modifier and the beneficiary has exceeded the cap the claim will be denied.

CMS is not holding any other claims except those affected by the therapy caps. If legislation regarding the therapy caps is not enacted in this short period of time, then CMS will release and process the therapy claims accordingly. Under current law, CMS may not pay electronic claims sooner than 14 calendar days (29 days for paper claims) after the date of receipt, but generally pays clean claims within 30 days of receipt.





Section GG Web-based Training Module

The Centers for Medicare & Medicaid Services (CMS) is offering a web-based training module to address questions submitted by providers during trainings between November 2015 and August 2016 related to Section GG across the Skilled Nursing Facility (SNF), Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), and Home Health (HH) care settings. This training is designed to be used on demand anywhere you can access a browser and includes interactive exercises that allow you to test your knowledge in real life scenarios.

Specific topics for Skilled Nursing Facilities include:

- Lesson 1: Significance of Section GG for Post-Acute Care
- Lesson 2: Assessment and Response Coding Principles
- Lesson 3: Additional Section GG Response Coding Tips
- Lesson 4: Coding GG0130 Items for Skilled Nursing Facilities
- Lesson 5: Coding GG0170 Items for Skilled Nursing Facilities

Click here to access the training: <https://www.cms.gov/medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/gg-training/>

OIG to Review Potential Abuse and Neglect of Medicare Beneficiaries

The OIG announced in Jan. 2018, the review of potential abuse and neglect of Medicare Beneficiaries.

Medicare beneficiaries, including elders and disabled persons, are being treated at inpatient and outpatient medical facilities for conditions that may be the result of abuse or neglect. The Elder Justice Act recognizes an older person's rights, including the right to be free of abuse, neglect, and exploitation. In addition, all 50 States have mandated reporter laws for the reporting of the potential abuse or neglect of elders and vulnerable persons. Prior OIG reviews have shown that there are problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and skilled nursing facilities. By analyzing the treating medical facilities' diagnoses, the

OIG will determine the prevalence of the potential abuse or neglect of Medicare beneficiaries. They will also determine whether the potential abuse or neglect occurred at a medical facility or at another location, such as the Medicare beneficiary's home.

SNF QRP- Full Confidential Feedback Reports Now Available

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) Confidential Feedback Reports/Quality Measure Reports containing the assessment and claims-based IMPACT Act measures are now available via the Certification and Survey provider Enhanced Reports (CASPER) Reporting System.

Assessment-based quality measures:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
- Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Claims-based quality measures:

- Total Estimated Medicare Spending Per Beneficiary Measure
- Discharge to Community-Post Acute Care- SNF QRP
- Potentially Preventable 30-Day Post Discharge Readmission Measure

Please note- CMS has discovered an error in some of the MSPB measure calculations contained in the SNF October 2017 Confidential Feedback/QM reports. The error affects the risk adjustment of the measure. CMS has corrected this issue and the data has been loaded into the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. These facility level quality measures reports are on-demand, user-requested reports in your CASPER folder in QIES. Providers should request an updated version of the report to review the corrected MSPB measure calculation.

To read the SNF QRP help desk quarterly Q&A; http://polaris-group.com/news_releases.asp



**Polaris Group Solution Center
Hotline Q&A
“Where No Question Goes Unanswered!”**

Question:
Since Congress did not extend the therapy cap exception is there anything we need to do related to Medicare Part B notices?

Answer:
Yes. When the Medicare Part B therapy cap exception is not in place/expired the facility should provide the Part B ABN to the beneficiary when the cap is met. This ABN (CMS R-131) notifies the patient of their liability for any Part B therapy services provided after the cap has been met.

Question:
I have a resident who came in Medicare Part A on 12/24/17 and then her payer source changed to Aetna HMO-A on 1/1/18. My question for you is do I need to complete a Medicare Part A PPS Discharge (NPE) when she changed payer source from traditional Medicare Part A to Aetna HMO-A?

Answer:
Yes you would complete a Medicare Part A PPD Discharge (NPE) when switching from traditional Medicare Part A to a Medicare Advantage plan.

Question:
If the patient expires, do I need to complete Section GG?

Answer:
Yes you would complete a Medicare Part A PPD Discharge (NPE) when switching from traditional Medicare Part A to a Medicare Advantage plan. The PPS schedule would start over with the 5 day PPS MDS and January 1st would be day one of the Medicare Advantage stay. The original entry and admission dates would not change.



2018 WEBINAR TRAININGS
Polaris Group is pleased to offer the following CEU approved live Webinars

	<u>Date</u>
<u>Understanding Quality Measures Trainings</u>	
Managed Risk/Event Reporting	2/6
Casper and 5 Star Quality Measures	2/8
De-Mystify IMPACT QMs—Current and Future	2/20
<u>RUG Training Series</u>	
RUG-IV Qualifiers & MDS Coding - Part 1	2/12
COT, SOT, EOT Combinations & More - Part 2	2/21
PPS Systems and Management - Part 3	2/22
<u>Part B Compliance Training Series</u>	
Part B Therapy Programs - Part 3 - Coverage and Billing	2/13
Part B Therapy Programs - Part 4 - Triple Check, Denials & Appeals	2/14

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

 Comprehensive 3-day training workshops to implement a compliant and successful Medicare program

Training Workshops for LTC
Current 2018 Dates & Locations:

<u>Advanced Billing for SNFs</u> May 22-24 Chicago, IL August 21-23 Las Vegas, NV October 16-18 Orlando, FL	<u>SNF Medicare & PPS Compliance</u> February 13-15 Las Vegas, NV May 8-10 Denver, CO November 13-15 New Orleans, LA
<u>Surviving MAC/RAC/ZPIC Audits</u> April 18-19 Las Vegas, NV September 12-13 Tampa, FL	<u>SNF Billing Training</u> March 20-22 Las Vegas, NV June 19-21 Orlando, FL September 18-20 Dallas/Ft. Worth, TX

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