



An Informational Bulletin Brought To You By Polaris Group

## Congress Repeals Medicare Therapy Caps

On Friday, February 9, 2018, the *Bipartisan Budget Act of 2018 (HR 1892)*, which includes a permanent repeal of the longstanding cap on Medicare Part B rehabilitation therapy services was signed into law. Section 5020 of the bill permanently repeals the annual payment cap on Medicare Part B outpatient therapy services, including physical therapy (PT), speech-language pathology (SLP) and occupational therapy (OT) as of January 1, 2018.

The new law continues the requirement that a KX modifier be included on claims over the current exception threshold of \$2,010 either for PT/SLP or for OT services. The modifier continues to serve as attestation by the therapist that the therapy services are medically necessary. The new law also lowers the threshold above which claims may be subject to targeted manual medical review, going from a threshold of \$3,700 to \$3,000.

In repealing the Therapy Cap, Congress offset the new spending by making cuts to home health and skilled nursing, along with a 15% payment reduction for outpatient therapy services furnished by a physical or occupational therapy assistant beginning in 2022.

To read a breakdown of the entire bill from the House Committee on Rules: [http://polaris-group.com/news\\_releases.asp](http://polaris-group.com/news_releases.asp)



## Monthly OIG Work Plan Updates

The OIG announced that they have published the OIG Work Plan for FY 2018-2019, however, this is not the typical OIG work Plan. This work plan provides a 2-year framework for the audits, inspections, evaluations, and investigative activities planned in support of OIG's vision, mission, and strategic goals and objectives.

The OIG is no longer publishing an annual work plan. They will be updating their website monthly with work plan items to ensure that it more closely aligns with the work planning process. The OIG Work Plan monthly update includes the addition of newly initiated work plan items, which can be found on the OIG Recently Added Items page.

The OIG work plan is now an evolving document, which will be revised and updated, as necessary, to ensure that OIG oversight operations remain relevant, timely, and responsive to priorities.

### 2018 OIG Monthly updates listed below:

#### Potential Abuse and Neglect of Medicare Beneficiaries (Jan. 2018)

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. The OIG 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.

### **Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores in Medicare Advantage (Jan. 2018)**

Under Medicare Part C, the Centers for Medicare & Medicaid Services (CMS) makes advanced monthly payments to Medicare Advantage (MA) organizations for each beneficiary enrolled. CMS risk adjusts these payments based on beneficiaries' demographic information and clinical diagnoses from the prior year to pay MA organizations more for beneficiaries with higher expected costs. MA organizations submit to CMS encounter data, which are records of services provided to beneficiaries, including all diagnoses. Currently, CMS includes diagnoses from health risk assessments, which are visits to evaluate a beneficiary's health risks, and chart reviews, which are records based on MA organizations' review of beneficiaries' medical records, when calculating risk scores and risk-adjustment payments. This is allowed regardless of whether these diagnoses are supported by another service rendered to the beneficiary during that year. This study will determine the extent to which diagnoses solely generated by health risk assessments and chart reviews were associated with higher risk scores and higher MA payments. In addition, this study will determine the extent to which diagnoses removed by chart reviews were associated with lower risk scores and lower MA payments.

### **Review of Statistical Methods within the Medicare Fee-For-Service Administrative Appeal Process (Feb. 2018)**

Medicare program integrity contractors are authorized to use statistical sampling to identify and recover improper payments. Providers may contest these statistical estimates through the administrative appeals process. If a statistical estimate is overturned during the administrative appeals process, then the provider is liable for any overpayment upheld in the sample rather than the full, extrapolated total. The difference between these amounts is often substantial. The Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) are responsible for the first two levels of the appeals process and thus play a critical role in deciding which extrapolations will be upheld. The OIG will determine

whether the MACs and QICs are reviewing statistical estimates in an appropriate and consistent manner as part of the fee-for-service appeal process.

To read the FY 2017-2018 Work Plan; [http://polaris-group.com/news\\_releases.asp](http://polaris-group.com/news_releases.asp)

### **Newly Revised Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage**

CMS released a newly revised Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN), along with separate newly developed instructions for form completion. The revised SNFABN has the requirements from the denial letters and looks very similar to the ABN with three different options. CMS will be discontinuing the five SNF Denial Letters and the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF) form. Since the NEMB-SNF was used as a voluntary notice for care that is never covered by Medicare, CMS will continue to encourage SNFs to issue the revised SNFABN in this voluntary capacity. Chapter 30, Section 70 of the Medicare Claims Processing Manual revisions will be forthcoming. The revised SNFABN will be mandatory for use on **May 7, 2018**. During the interim, SNFs may continue to use the old version of the SNFABN, the Denial Letters or the NEMB-SNF; however, it is recommended that the revised SNFABN be used as soon as possible.

For the revised SNFABN and the form instructions: [http://polaris-group.com/news\\_releases.asp](http://polaris-group.com/news_releases.asp)





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**POLARIS PULSE**

**Polaris Group Solution Center  
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**Question:**

If the physician writes no reduction to medication in reference to the pharmacy consultant requesting a dose reduction for an antipsychotic medication can we use that to code N0450D, yes that the physician documented GDR as clinically contraindicated?

**Answer:**

No, because the RAI states the physician must include the clinical rationale for why an attempted dose reduction is inadvisable and the clinical rationale should be based on the fact that tapering the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident’s function, well-being, safety, and quality of life.

**Question:**

Our residents are telling us they were told by the Social Security office to not give anyone their Social Security number when they provide their new Medicare cards with the new numbers that are being assigned this year. Our system won’t accept us coding all ones or all zeros for the Medicare number on the MDS under A0600 Social Security and Medicare numbers. We even tried a sequence of numbers. Is there anything you can recommend we use?

**Answer:**

According to the RAI if there is no social security number available for the resident then that section can be left blank.

**Question:**

I have someone coming up on their 90th day and the dietitian is asking if we should combine it with a quarterly. Do I need to do a quarterly if the patient is discharging from the building?

**Answer:**

If the resident is in the facility greater than 92 days from the admission comprehensive assessment ARD then yes a quarterly is due. The OBRA assessments still need to be completed for the Medicare patients if they meet the OBRA assessment timeframes. You can combine the 90 day PPS MDS with the Quarterly as long as both assessments meet the ARD rules for both assessments.

**2018 WEBINAR TRAININGS**

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

	<u>Date</u>
<b><u>RAC Audit Training</u></b> RAC Audits - Do’s & Don’ts!	3/13
<b><u>RCS-1: In’s &amp; Out’s Training</u></b> *Hot New Topic Resident Classification System-1: Introduction	3/15
<b><u>Medicare Rules &amp; Nursing Doc Training</u></b> Medicare Rules & Nursing Documentation: Got Skill?	3/19
<b><u>SNF Denial Letters Training</u></b> Denial Letters & Expedited Review Notices for LTC	3/20
<b><u>Medicare Part A Basics Training</u></b> Medicare Part A Basics	3/26

*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](http://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:**

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

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