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POLARIS PULSE

An Informational Bulletin Brought To You By Polaris Group

CMS Increases Site Visits to Medicare Providers

The Affordable Care Act (ACA) provided tools to enhance the Centers for Medicare & Medicaid Services' (CMS) ability to screen providers and suppliers upon enrollment and identify those that may be at risk for committing fraud, including the use of risk-based screening of providers and suppliers. In addition to implementing the tools provided by the ACA, CMS is strengthening strategies designed to reinforce provider screening activities by increasing site visits to Medicare-enrolled providers and suppliers, enhancing and improving information technology (IT) systems, and implementing continuous data monitoring practices to help make sure practice location data is accurate and in compliance with enrollment requirements per a February 22, 2016 CMS fact sheet.

A recent report by the Government Accountability Office (GAO) reviewed the implementation of some of CMS' screening procedures that are used to prevent and deter ineligible or potentially fraudulent providers and suppliers from enrolling in the Medicare program. The GAO concluded that, as part of an overall effort to enhance program integrity and reduce fraud risk, effective enrollment and screening procedures are essential to make sure that ineligible or potentially fraudulent providers and suppliers do not enroll in the program and that CMS has taken steps to develop and implement such procedures. The GAO analysis identified areas for improvement in our Provider Enrollment Chain and Ownership System (PECOS) regarding verification of provider and supplier practice locations and physician licensure statuses. Providers and suppliers are required to supply the address of the location from which services are offered on their Medicare enrollment applications.

CMS key strategies:

- **Increase the number of site visits to Medicare -enrolled providers and suppliers.** CMS has the authority, when deemed necessary, to perform onsite review of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements (42 C.F.R. 424.517). Under this authority, CMS has increased site visits, initially targeting those providers and suppliers receiving high reimbursements by Medicare that are located in high risk geographic areas.
- **Enhance address verification software in PECOS to better detect vacant or invalid addresses or commercial mail reporting agencies (CMRAs)**. Starting this year, CMS will replace the current PECOS address verification software with new software that includes Delivery Point Verification (DPV) in addition to the existing functionality. This new DPV functionality will flag addresses that may be vacant, CMRAs or invalid addresses. In most cases, CMRAs are not permitted in the Medicare program. These verifications will take place during the application submission process and may trigger additional ad hoc site visits.
- **Deactivate providers and suppliers that have not billed Medicare in the last 13 months.** Beginning March 2016 and on a monthly basis, CMS will run analysis on enrollment data to deactivate providers or suppliers meeting specific criteria that have not billed Medicare in the last 13 months. Providers and suppliers that may be exempted from the deactivation for non-

billing include: those enrolled solely to order, refer, prescribe; or certain specialty types (e.g., pediatricians, dentists and mass immunizers (roster billers)). This approach will remove providers and suppliers with potentially invalid addresses from PECOS without requiring site visits.

- **Monitor and identify potentially invalid addresses on a monthly basis through additional data analysis by checking against the U.S. Postal Service address verification database.** CMS has started to continuously monitor and identify addresses that may have become vacant or non-operational after initial enrollment. This monitoring is done through monthly data analysis that validates provider and supplier enrollment practice location addresses against the U.S. Postal Service address verification database.

CMS Updates Manual Medical Review Process for Therapy Claims

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, 2015, extended the therapy cap exception process through December 31, 2017 and modified the requirement for manual medical review for services over the $3,700 therapy thresholds. MACRA eliminated the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process. MACRA also prohibits the use of Recovery Auditors (RAC) to conduct the reviews.

On February 9, 2016, CMS announced that it has contracted with Strategic Health Solutions to serve as a supplemental medical review contractor (SMRC) to conduct a "targeted review process" for claims that exceed the $3,700 cap for physical therapy and speech-language pathology combined, and $3,700 for occupational therapy services. Unlike previous years, in which reviews were conducted for all claims exceeding the thresholds, the new approach allows Strategic Health to select only certain claims for review.

- Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of MACRA
- Therapy provided in skilled nursing facilities (SNFs), therapists in private practice, and outpatient physical therapy or speech-language pathology providers (OPTs) or other rehabilitation providers

Of particular interest in this medical review process will be the evaluation of the number of units/hours of therapy provided in a day.

For CY 2015, the limit on the incurred expenses (therapy cap) is $1,940 for physical therapy (PT) and speech-language pathology services (SLP) combined and $1,940 for occupational therapy (OT) services.

Update to the CY 2016 Medicare Physician Fee Schedule Database

The Centers for Medicare and Medicaid Services (CMS) issued an Update to the CY 2016 Medicare Physician Fee Schedule Database. CMS posted the updated file on their website on January 27, 2016.

The CMS transmittal, Change Request 9495 amended the Medicare Physician Fee Schedule (MPFS) payment files in order to correct technical errors in the MPFS update files and to include corrections described in the CY 2016 MPFS Final Rule Correction Notice. Specifically, the Conversion Factor was adjusted to $35.8043 and several Relative Value Units were modified.

Please note that the amended 2016 fees effective January 1, 2016 reflects all changes included in the CY 2016 Medicare Physician Fee Schedule (MPFS) Final Rule (CMS-1631-FC) published in the Federal Register on November 16, 2015 and reflects the Emergency Update to the CY 2016 Medicare Physician Fee Schedule.

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question:
Can we charge Medicare Part A residents for the flu and pneumonia vaccinations while in the Skilled Nursing Facility (SNF)?

Answer:
If the residents are in the SNF under a Medicare Part A stay and they have Medicare Part B then you can bill their Medicare Part B for those vaccinations. CMS says; "Vaccines and Vaccine administration are Major Category IV-Additional Excluded Preventative and Screening Services so these services are covered as Part B benefits and are not included in the SNF PPS".

Question:
If a skilled resident is receiving PT and OT, can they each write treatment frequency orders that are for 3-5 x week and still be considered skilled?

Answer:
In order to be a skilled service therapy has to provide services at a frequency of 5 times a week. If the orders are written 3-5 that would not be considered skilled.

Question:
We have noticed that when Medicare Part A residents go to outside appointments, we often get bills for labs but not for provider visits. I'm just wondering how that portion of consolidated billing works?

Answer:
Under the consolidated billing guidelines, the labs, which are included under consolidated billing, would be the responsibility of the facility because that is the technical component of the visit and the physician can bill their portion to Med Part B for the professional component of the visit.

2015 WEBINAR TRAININGS
Polaris Group is pleased to offer the following
CEU approved live Webinars

	Date
New Regulations October 1 Training	
Overview of Proposed Regulations for SNFs ***New Topic**	Mar 3
QAPI Training Series	
Preparing for QAPI Initiative: Part 1	Mar 9
Quality Assurance (QA) Skill Building QAPU: Part 2	Mar 10
Process Improvement (PI) Skill Building: Part 3	Mar 11
Supervisor Skills Training Series	
"Super" Supervisor	Mar 15
Supervisory Skills: Feedback on Performance	Mar 17
Quality Measures Training	
All About Quality Measures	Mar 21
QAPI to Decrease Hospital Transfers Training	
Using QAPI to Decrease Hospital Transfers	Mar 23
Managed Care Training	
Understanding Managed Care in a SNF Environment *New Topic	Mar 24

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 233
or register online at: www.polaris-group.com

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October 11-13 Las Vegas, NV

SNF Billing Training—Basics & More
March 15-17 Las Vegas, NV
July 12-14 Raleigh, NC
September 13-15 San Antonia, TX

Advanced Billing for SNFs
April 12-14 Chicago, IL
August 16-18 Las Vegas, NV
November 15-17 Orlando, FL

Surviving MAC, RAC & ZPIC Audits
April 27-28 Brentwood, TN
October 5-6 Las Vegas, NV

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