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CMS Issues FY 2017 SNF PPS Final Rule

On July 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the SNF PPS final rule outlining fiscal year (FY) 2017 Medicare payment policies and rates for the Skilled Nursing Facility Prospective Payment System (SNF PPS), the SNF Quality Reporting Program (SNF QRP), and the SNF Value-Based Purchasing (SNF VBP) Program.

The FY 2017 final policies are summarized below:

Updates to Payment Rates under the SNF Prospective Payment System (PPS)
CMS projects that aggregate payments to SNFs will increase in FY 2017 by $920 million, or 2.4 percent, from payments in FY 2016. This estimated increase is attributable to a 2.7 percent market basket increase reduced by 0.3 percentage points, in accordance with the multifactor productivity adjustment required by law.

Changes to the SNF Quality Reporting Program (QRP)
The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) added Section 1899B to the Social Security Act that requires SNFs to report data on measures that satisfy measure domains specified in the Act. Section 1899B also requires that these measures be aligned with measures implemented for Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). This final rule adopts three measures to meet the resource use and other measure domains and one measure to satisfy the domain of medication reconciliation. SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the annual market basket percentage update factor for fiscal years beginning with FY 2018.

The quality measures finalized for the FY 2018 payment determination and subsequent years to meet the resource use and other measure domain are as follows:

- Medicare Spending Per Beneficiary - Post-Acute Care (PAC) SNF QRP
- Discharge to Community – PAC SNF QRP
- Potentially Preventable 30-Day Post-Discharge Readmission – SNF QRP.

The quality measure finalized for the FY 2020 payment determination and subsequent years to meet the medication reconciliation domain is:

- Drug Regimen Review Conducted with Follow-Up for Identified Issues

Policies and procedures associated with public reporting are also being finalized, including the reporting timelines, preview period, review and correction of assessment-based and claims-based quality measure data, and the provision of confidential feedback reports to SNFs.

SNF Value-Based Purchasing (VBP) Program
Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) authorizes the establishment of a SNF VBP Program beginning with FY 2019 under which value-based incentive payments are made to SNFs based on performance.

This final rule specifies the SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure as required by law. The SNFPPR assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital.

In the final rule, CMS has also finalized additional policies related to the SNF VBP Program including:

- Establishing performance standards;
- Establishing baseline and performance periods;
- Adopting a performance scoring methodology; and
- Providing confidential feedback reports to SNFs.

To read the complete FY 2017 SNF PPS Final rule: http://polaris-group.com/

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CMS Targets Social Media Use in Nursing Homes

The Centers for Medicare and Medicaid Services (CMS) published a memo Aug. 5, 2016, to state nursing home survey agency directors regarding protecting resident privacy and prohibiting mental abuse related to photographs and audio/video recordings by nursing home staff. This memo is in response to recent media reports regarding inappropriate posting to social media of pictures of nursing home residents. Within 30 days of the memo, surveyors are to implement changes to address these issues.

As stated in the memo, current regulations already prohibit unauthorized pictures or videos that are used in a manner that demeans or humiliates a nursing home resident. In addition, current regulations require facilities to maintain policies regarding appropriate treatment of residents and training of staff about such policies. Nursing homes are required to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported within prescribed timeframes and thoroughly investigated and that corrective action is taken.

CMS advises that "each nursing home must review and/or revise their written abuse prevention policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident. This would include using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media."

"Each nursing home must establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation," the memo reads. "The nursing home management must assure that all staff are aware of reporting responsibilities, including how to identify possible abuse and how to report any allegations of abuse."
Within 30 days of the CMS memo, surveyors are expected to, during the next standard survey of a facility request and review nursing home policies and procedures related to prohibiting nursing home staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident. All nursing homes will be surveyed for the inclusion and implementation of such policies.

To read the complete memo…link to http://polaris-group.com/

Proposed Physician Fee Schedule Includes New Physical Therapy Evaluation Codes

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2017 proposed rule that updates payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS), effective January 1, 2017. This is the same schedule used to pay for Part B therapy services in nursing facilities.

CMS proposed new physical therapy and occupational therapy evaluation codes for 2017 as part of the Medicare Physician Fee Schedule proposed rule.

There are three new physical therapy and occupational therapy evaluation codes and one new physical therapy and occupational therapy re-evaluation code. The codes are based on the amount of time and complexity involved in the evaluation.

The table below identifies the new physical therapy codes for 2017 and gives the long-form description of each code.

New CPT Code	CPT Long Form Descriptor
97X61	**Physical therapy evaluation: low complexity,** requiring these components: • A history with no personal factors and/or comorbidities that impact the plan of care; • An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; • A clinical presentation with stable and/or uncomplicated characteristics; and • Clinical decision-making of low complexity using a standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 20 minutes are spent face-to-face with the patient and/or family.
97X62	**Physical therapy evaluation: moderate complexity**, requiring these components: • A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care;

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	• An examination of body systems using standardized tests and measures in addressing a total of three or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; • An evolving clinical presentation with changing characteristics; and • Clinical decision-making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 30 minutes are spent face-to-face with the patient and/or family.
97X63	**Physical therapy evaluation: high complexity**, requiring these components: • A history of present problem with three or more personal factors and/or comorbidities that impact the plan of care; • An examination of body systems using standardized tests and measures addressing a total of four or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; • A clinical presentation with unstable and unpredictable characteristics; and • Clinical decision-making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 45 minutes are spent face-to-face with the patient and/or family.
97X64	**Re-evaluation of physical therapy, established plan of care**, requiring these components: • An examination, including a review of history and use of standardized tests and measures is required; as is a • Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 20 minutes are spent face-to-face with the patient and/or family.

These new codes are all untimed codes, and when recording time for Medicare, the minutes allocated for the evaluation are tallied as part of the "total treatment minutes," which includes timed codes and untimed codes. CMS has proposed the same payment for each code. Although CMS is proposing a single payment for the three evaluation codes, it will be assessing the usage of each code via the claims system.

To read the complete CY 2017 Proposed Physician Fee Schedule: http://polaris-group.com/

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Part 3 UB04 Review	10/18
Part $ No Pay & benefits Exhaust	10/19
Part 5 Consolidating Billing	10/20
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Part 7 Medicare Beneficiary Notices	11/9
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Medicare Secondary Payer **New Topic*	
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October 11-13 Las Vegas, NV

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