



***FY 2012 and FY 2013 Medicare Rules  
for IRH/Us, SNFs, and LTCHs:  
Expanded Perspectives***

***AMRPA 9<sup>th</sup> Annual Medical Rehabilitation  
Conference  
September 26-28, 2011  
South Beach, FL***



*Carolyn C. Zollar J.D.  
Vice President for Government Relations  
& Policy Development  
[czollar@amrpa.org](mailto:czollar@amrpa.org)*

## *What We Will Discuss*

1. Bundled Payments for Care Improvement Initiative
2. Bundling and CCH Pilots
3. FY 2012 IRF PPS Final Rule
4. FY 2012 SNF PPS Rule
5. FY 2012 LTCH PPS Rule
6. Cahaba Reviews





# *Medicare Participating Post-Acute Providers as of 2011*

<b>Type of Provider</b>	<b><u>1990</u></b>	<b><u>1996</u></b>	<b><u>2000</u></b>	<b><u>2004</u></b>	<b><u>2006</u><sup>4</sup></b>	<b><u>2008</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>
Skilled Nursing Facilities	10,508	15,553	14,825	14,929	15,006 <sup>5</sup>	15,041 <sup>5</sup>	15,067	15,715
Home Health Agencies	5,793	9,886	7,528	7,341	8,587	9,382	10,945 <sup>6</sup>	11,605 <sup>7</sup>
Rehabilitation Facilities (Hospitals and Units)	813	1,048	1,128	1359 <sup>3</sup>	1,229	1,195	1,189	1,169
Long-Term Care Hospitals	90	185	253 <sup>1</sup>	317	393	393	428	436
CORFs	191	403	516 <sup>2</sup>	638	627	517	401	336

1) As of February, 2001, CMS

2) As of April 1, 2002, CMS

3) As of May, 2004, CMS

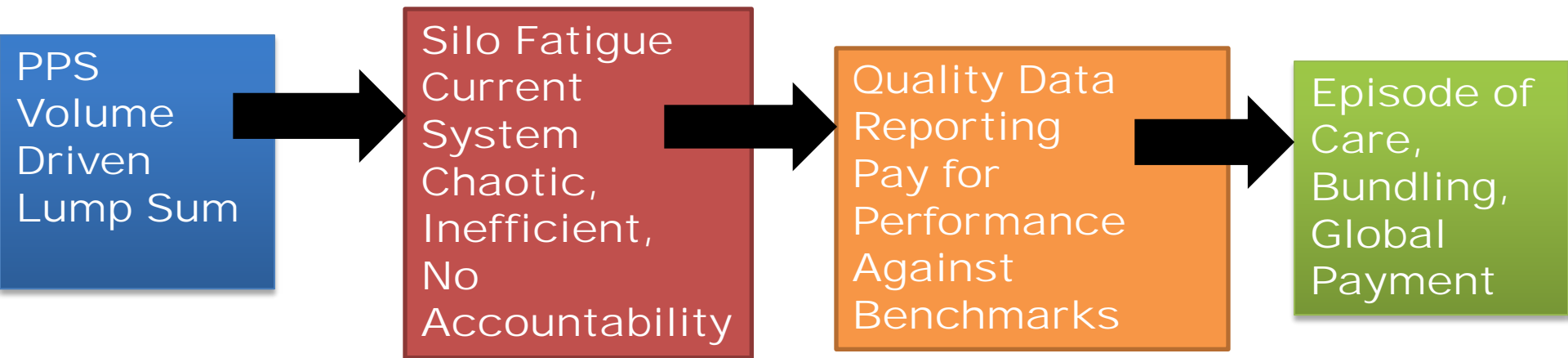
4) As of August, 2006, CMS

5) MedPAC June, 2009 Data Book

6) As of May, 2010, CMS

7) As of May, 2011, CMS

# Conceptual Changes in the ACA



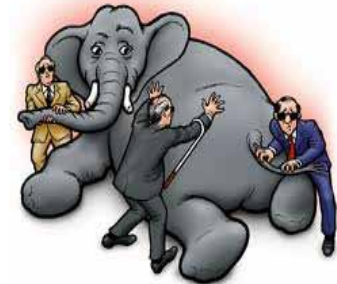
***\$ Cuts***



***Quality***



***Payment and  
Delivery Reform***





# Volume Driven Services

## FY 2014

- IRF PPS
- IPPS
- SNF PPS
- LTCH PPS
- MPFS
- ACO cont.
- IRF/LTCH Quality Payment for Reporting Starts
- ICD 10 Starts
- Bundling Pilot Starts\*
- CCH Pilot Starts\*
- VBP PAC Report Due

Accountability

Global Payment



*Therefore for FY 2012 to 2014  
IRF + LTCH  
Payment Can Be Reduced*



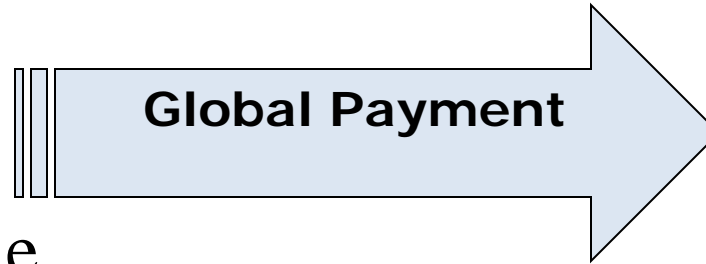
P = Standard Payment Rate -((MB-reduction)  
(Productivity Adjustment Starting in FY 2012)-  
(Quality Reporting Incentive -2% Starting in FY  
2014))

Payment May be Further Reduced in the Future  
by Application of the Hospital Acquired Condition  
Policy and Value Based Purchasing Policies



## *And Beyond FY 2013*

- All Rules Continue
- Demonstrations Continue
- ACOs
- Medical Homes
- Health Care Reform: Expanded Patient Base?
- Start of VBP Pilot for PAC Hospitals





## *Building For Tomorrow*

- ACO
- Bundling Initiatives
- Bundling and CCH Pilots
- Other Initiatives
- How Are You and How Are Local Providers Responding?



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Represents Phase I
- Key Documents on Innovations Center Website:  
<http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>.
- Four Models:
  - Model 1: Acute Only
  - Model 2: Acute and PAC
  - Model 3: PAC
  - Model 4: Acute Only with Prospective Payment



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Phases II and III: No Further Information Yet
  - Model 5: Prospective Payment for EOC Acute and PAC
  - Model 6: Prospective Payment PAC Only
  - Model 7: Retrospective Payment Chronic Care
  - Model 8: Prospective Payment Chronic Care



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Questions Can be e-Mailed to [BundledPayments@cms.hhs.gov](mailto:BundledPayments@cms.hhs.gov).
- Letters of Intent/ Applications Deadlines Due
  - Model 1- September 22, 2011/October 21, 2011
  - Models 2-4 - November 4, 2011/March 15, 2012
  - First Awards for Model One Anticipated Spring 2012



# *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Criteria for Awards/ Points
  - Model Design 20
  - Financial Model 40
  - Quality of Care and Patient Centeredness 25
  - Organizational Capabilities 15



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Mandatory Minimum Quality Measures Listed
  - Taken from Hospital Inpatient Quality Reporting Program (Hospital IQR)
  - All Required for Model 1; Designated Ones for Models 2-4
  - Applicants Can Propose Additional Measures and Applications Require Others to be Addressed as Well
- Waivers Must Be Requested by Each Applicant/ No Blanket Waivers Mentioned
- Payment is FFS with Reconciliation / Gainsharing Allowed for Most Models



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Applicants Identify the MS DRG Based Conditions to be Included
- Contracts for 3 Years/ Possible 2 Year Extension
- Applicants Must Show Ability to Bear All Financial Risk
- CMS Will Use Evaluation Contractor
- Awardees to Evaluate Beneficiaries/CMS May Require CARE Tool or Subset of Measures



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- CMS Mentions Need to Assure Patient Choice, No Restrictions on Necessary Care
- CMS Will Analyze Service Utilization Data During the Project, Patterns of Care and Compare to Baseline and A Comparison Group



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Beneficiary Protections and Notification Procedures to be Included in Applications
- Reasons for Termination Outlined Including Restricting Access to Medically Necessary Care
- CMS “Will Look Favorably” Upon Applications That:
  - Offer Greater than Stated Discounts
  - Coordinate with Medicaid, Private Payers, and Multi-Payer Collaboratives to Redesign Care



## *CMS Announces New Bundling Payments for Care Improvement Initiative: Reactions*

- First, Do No Harm
  - Vulnerable Populations Need Special Protections
  - Preservation of Provider Choice Must Be Absolute
- Preserve Access to IRH/Us
- Should IRB Review Be Required?
- Need to Monitor Beneficiary Notice
- Monitor / Evaluate Denial of Medically Necessary Care
  - Monitor Referrals to Inappropriate Sites of Care
  - Extra Emphasis on Patient Rights/ Appeals/ Hotline?
  - Application Review Panel for Patient Concerns



## *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Critical Provider Incentives Hazy or Where is the Brass Ring?
  - Echos of ACO Proposed Rule
  - Medicare Discounts Mandatory (Plus ALL ACA FFS Cuts and Potential BCA Cuts)
- Must Bear All Financial Risk if Costs Exceed FFS Payment – Reconciliation for Discounted Payment
- May Incur Additional Costs to Coordinate Care, etc. with No Additional Funds Provided
- Cynically, Are These Wired Awards?



# *CMS Announces New Bundling Payments for Care Improvement Initiative*

- Does Not Reflect Implementation of the CCH Concept nor National Bundling Pilot, Sec. 3023
- On the Plus Side.....
  - Provides Insight into CMMI's Strategy and Thinking for Major Component of the ACA Third Leg (Moving to Bundled then Global Payment)
    - Examples: Definitions of EOC, Bundling, Global Payment
  - Provides Options for Perhaps Larger Systems with All Components
  - Others



## *AMRPA Positions*

- First, Do No Harm
  - Protect Concerns of Patients
  - Preserve Access to IRH/Us and Rehabilitation Services
- Seek Clarity and Upfront Agreement on Waiver of Regulations
- Emphasize Need to Implement CCH Pilot



## *AMRPA Position Papers*

- Focus on Critical Aspects of Quality Measures, Monitoring and Risk Adjustment
- Distribute/ Discuss AMRPA Position Papers:
  - CCH Bundling Pilot
    - “The Continuing Care Hospital Pilot: Recommendations for Implementation and Executive Summary”, August, 2011*
  - National Bundling Pilot
    - “American Medical Rehabilitation Providers Association Position Paper on a National Pilot Program on Payment Bundling”, July, 2011*



# *Affordable Care Act of 2010: Building for Tomorrow*

- **Continuing Care Hospital Pilot**
  - Start by 1/1/13
  - 5 Years
- **Bundling Pilot**
  - Starting by 1/1/13
  - HHS Submits Plan to Congress 1/1/16 to Expand Program
  - Mentions the CARE Assessment Instrument
  - 5 Years

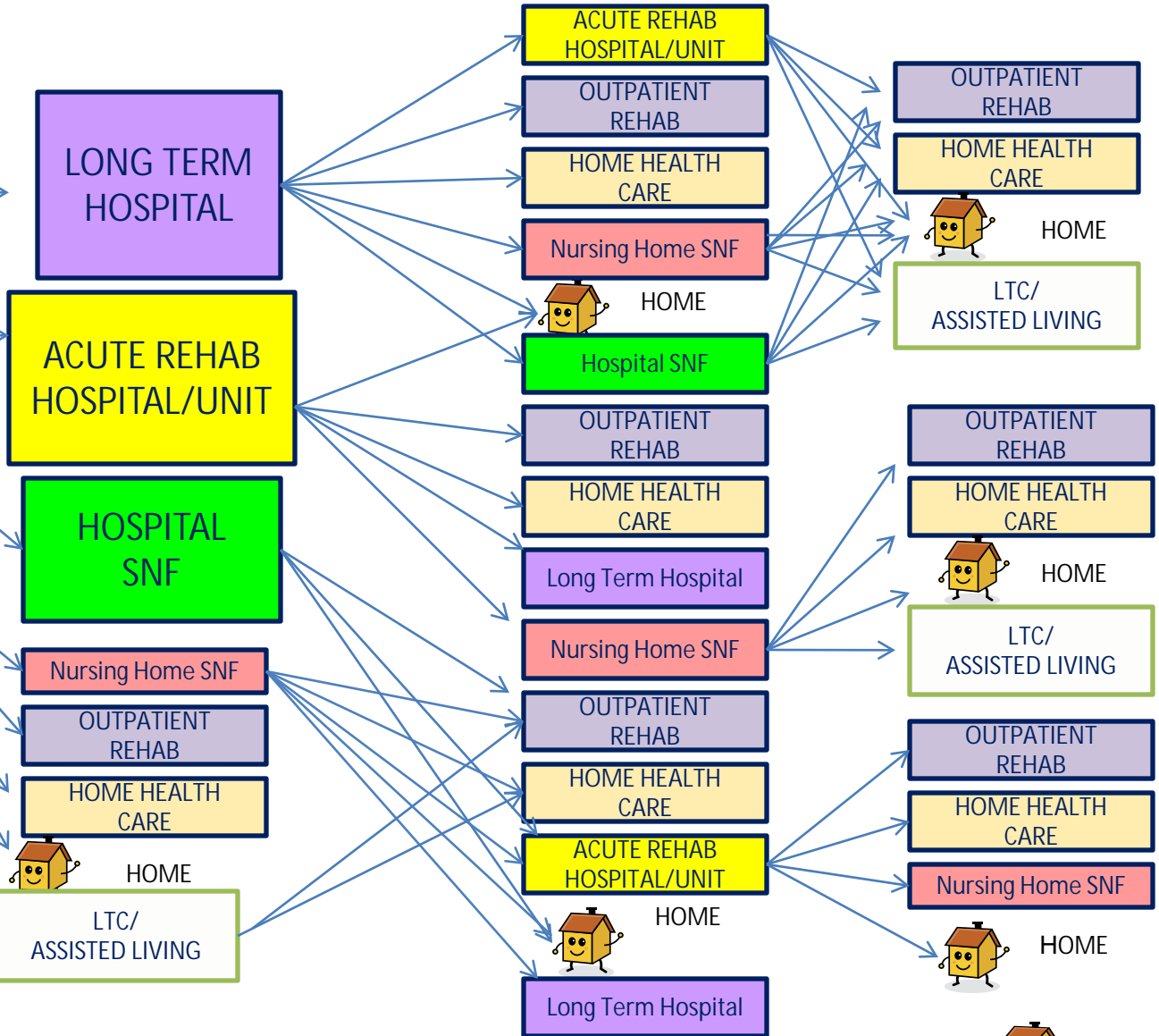


# *AMRPA Advocacy*

- **Continuing Care Hospital/Bundling**
- **Committee Documents**
  - *The Continuing Care Hospital Pilot: Recommendations for Implementation, August 2011*
  - *AMRPA Position Paper on National Pilot Program on Payment Bundling, July 2011*

# Current Delivery System

Patient



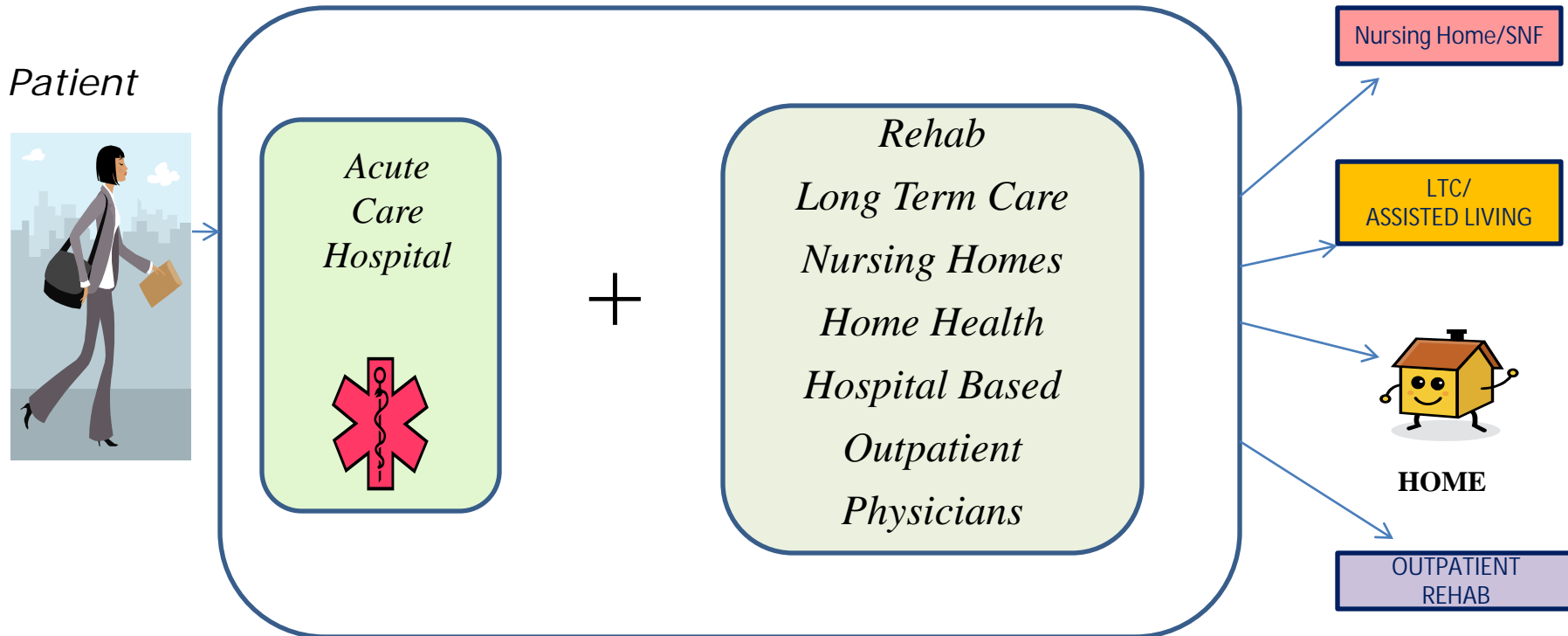
Revised 5/14/10

KEY	Nursing Home SNF	LTC/ ASSISTED LIVING	HOME HEALTH CARE	OUTPATIENT REHAB	Long Term Hospital	ACUTE REHAB	Hospital SNF



# Acute Bundle of Care

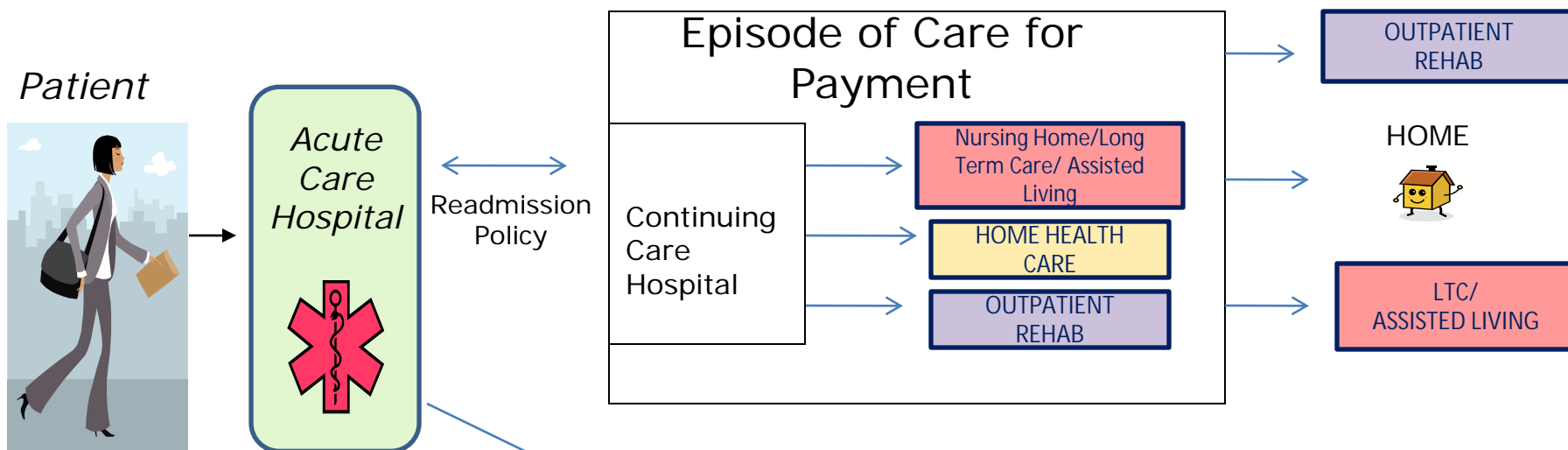
For the Acute Care Admission  
and 30 Days Post Discharge



- *ACH of ACO/"Entity" Receives Payment*
- *Bundled, Bid, Other Payment*
- *Non-entities at risk*
- *Non entities negotiate for payments*

**Revised 7/2/2010**

# CCH Creates a Bundled PAC Episode for Delivery System and Payment Reform

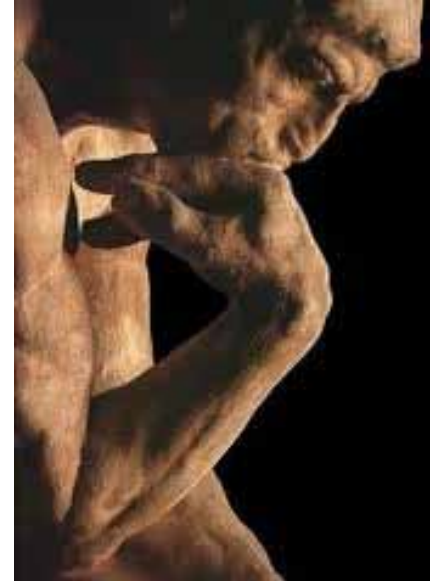


- *Case Mix Adjusted CCH Rate*
- *CCH Site Neutral*
- *Virtual or Real CCH “Bundle”*
- *For Readmissions: Shared Payment Reduction*

**Revised 5/14/10**

## *Acute and PAC Bundling*

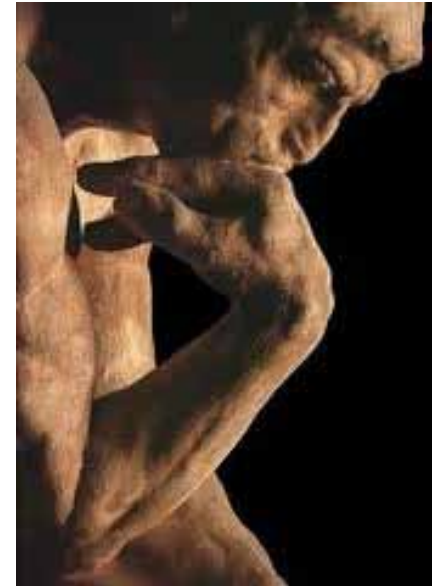
- Numerous Issues Mentioned in Opening Session:
  - Ethics
  - Bundle Holder
  - Definition of the Bundle
    - Access
    - Patient Choice
- See Position Papers





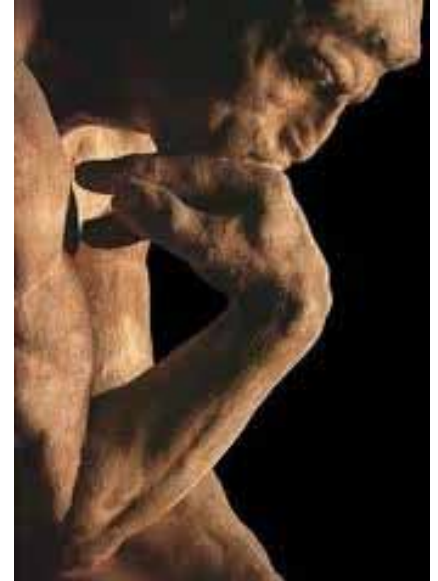
## *AMRPA Advocacy: Continuing Care Hospital*

- Includes IRF, Hospital Based SNF, LTCH Levels of Care
- Hospital Stay Plus 30 Day Episode
- Virtual or Real
- Contract for Post CCH Hospital Services



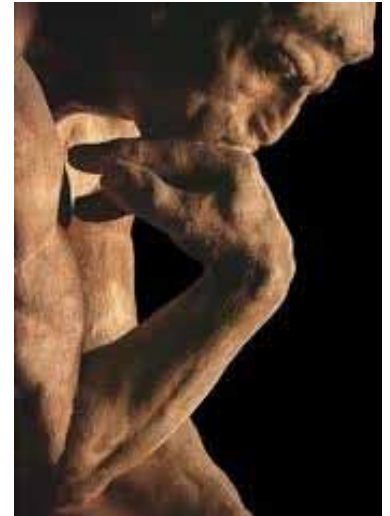
## *CCH Implementation Issues*

- Similar to Acute-PAC Bundling
- Common Management
- Patient Care and Safety Standards
- EOC
  - Time Frame
  - Services
  - Costs
  - Payment Amount (Method)
  - Classification



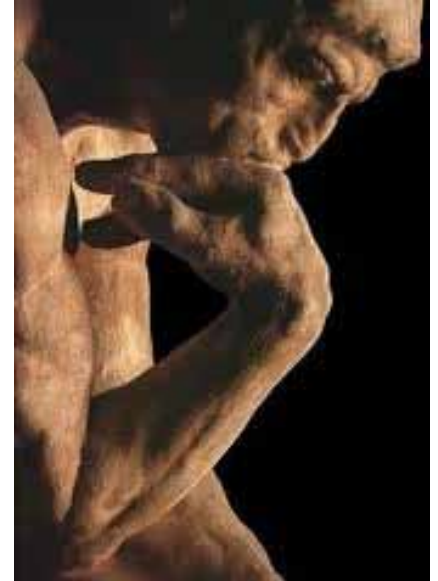
# *CCH Implementation Issues*

- Bundle Holder
- Real or Virtual
- Assessment Tool
- Data on Patients, Provider Costs, Federal Payments
- Quality Metrics
- Regulatory and Statutory Waivers



# *CCH Implementation Issues*

- Coordination of Benefits
- Special Payment Policies
- Some or All Conditions
- Evaluation Criteria





## ***FY 2012 PAC PPS RULES:***

- FY 2012 IRF PPS
- FY 2012 LTCH PPS
- FY 2012 SNF PPS

# *IRF-PPS FY 2012 Final Rule*

- Classification Criteria
- Quality Measures
- Payment System Changes





## *FY 2012 IRF PPS Rule:*

# *“Classification Criteria for Payment Under the Inpatient Rehabilitation Facility Prospective Payment System”*

- Section Completely Revised New 42 CFR 412.29
- CMS Moves All the Classification Criteria Formerly in 42 CFR 412.23(b) Here; Revises 412.23(b)
- No Changes to the Following Criteria:
  - Have A Hospital Provider Agreement
  - Except For “New” IRFs or “New” IRF Beds Defined In (c), Meets The 60% Rule



## *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (c) for New IRFs and New Beds, the Provider Must Provide A Written Certification It Will Meet the 60% Rule
  - For New IRFs, Applies Until End of First 12 Month Cost Reporting Period
  - For New Beds, Applies Until End of Cost Reporting Period During which New Beds were Added



## *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (c)(1) New IRFs
  - A Provider Not Paid as an IRF for At Least 5 Years
  - Considered New From Point it First Participates in Medicare Until End of First Full Cost Reporting Period
- Payment: Start of Hospital CRP Presumed To Be When Starts as New Medicare Facility and Is Paid Then



# *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29(c)(2) New IRF Beds
  - Must Meet State Certificate of Need and State Licensure Laws
  - May Be Added One Time During a CRP and Considered New for Balance of CRP
- Full 12 Month CRP Must Elapse Between Delicensing or Decertification of IRF Beds and Addition of New IRF Beds; RO to Verify, Approve
- New Beds Included in 60% Rule Compliance Calculations At Time Added to the IRF



# *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (c)(3)(4) Change of Ownership or Leasing, Mergers
  - Current Excluded Status Can Be Maintained if New Owner Accepts Assignment of Prior Owner's Provider Agreement and Continues to Meet All Payment Requirements.
  - If New Owner Doesn't Accept Assignment, then Is Terminated from Medicare and Must Reapply
  - If IRF Doesn't Continue to Meet Requirements, Loses Status and Is Paid under MS-DRGs



# *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (d) Preadmission Screening- Amended
  - New Language Added:  
“the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.”



# *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (e) Close Medical Supervision – Reorganized and Rewritten (changes underlined)

(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.



## *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (f) Use of Personnel- Separated from Medical Supervision, New

(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.



## *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29 (g) Director of Rehabilitation – Combines Language for IRF Hospital and Units Directors with Respect to Time, No Other Changes
  - (g) Have a director of rehabilitation who-
    - (1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;
- 412.29 (h) – Plan of Treatment- Reorganized; No Change



## *CMS Moves All the Classification Criteria To Revised 42 CFR 412.29*

- 412.29(i) Interdisciplinary Team Approach – Adds Discharge Planning
  - (i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.
- 412.29 (j) Retroactive Adjustments – If New IRFs or Beds Don't Meet 60% Rule, Payment Adjusted Retroactively



# *CMS Revises Classification Criteria at 42 CFR 412.25(b)*

- 42 CFR 412.25 Excluded Hospital Units: Common Requirements – (a) Basis for Exclusion - No Changes
- 412.25 (b) Changes in Size of Excluded Units –Reframed
  - Unit Size Can Be Changed Anytime During a CRP With 30 Days Advance Notice to FI/ MAC and RO Approval
  - Payment Can Start Immediately If Attestation Form Filed and all Other Requirements for Adding Beds are Met
- Year Conversion Waiting Period Gone and 42 CFR 412.30 Removed



## *CMS Moves the Classification Criteria*

- Payment for New IRF Units And Beds
- A New IRF Unit Can Start Being Paid under the IRF PPS at the Start of a CRP.
- Example:
  - The hospital’s CRP is July 1, 2012 through June 30, 2013
  - The hospital completes all paperwork, necessary licensure and approvals, and starts treating patients in the area that it intends to use as an IRF unit starting on April 1, 2012.
  - The patients the hospital treats in that “unit” April 1, 2012 through June 2013 are paid for under the acute care hospital inpatient prospective payment system (IPPS).
  - Beginning July 1, 2013, the “unit” officially becomes an IRF unit of the hospital and can be paid under the IRF PPS.



## *CMS Moves the Classification Criteria*

- Therefore for New Units:
  - New **units** will be able to begin being paid under the IRF PPS at the start of the hospital's next cost reporting period, as long as the hospital submits the required attestation forms for the 60% rule during which they are paid under the IPPS and have to demonstrate that they meet the 60% rule.



## *CMS Moves the Classification Criteria*

- Therefore for New Unit or IRF Beds:
  - New IRH/U **beds** will be able to begin being paid under the IRF PPS when they are first added to the freestanding IRH/U or unit (which can be one time, at any time during a cost reporting period), as long as the hospital submits the required attestation form for the new beds. The new beds can start being paid under the IRF PPS as soon as they are added, assuming that the requirements for adding beds are met.

# *AMRPA Quality Committee*



## **Visionary Committee**

### **Sorting Criteria:**

- Selected measures will fit into one of the following categories and represent:
  - Absence of adverse events;
  - Achievement of positive outcomes; or
  - Demonstrate effectiveness/efficiency
- Meetings with CMS, MedPAC, Participation on NQF and MAP





# *CMS's Final Quality Measures for FY 2014 Reporting*

- **Catheter-Associated Urinary Track Infection (CAUTI)**
  - Collected For All Patients Without Regard to Payer
- **Pressure Ulcers That Are New or Worsened**
  - Using Data Items from Pressure Ulcer for Section M, MDS 3.0
  - CMS Will Revise the IRF PAI
  - Medicare FFS and Medicare Advantage Patients
- Data Will Be Collected from 10/1/2012 to 12/31/2012
- Information on Data Submission Will Be Posted by 1/31/2012



# *CMS's Final Quality Measures for FY 2014 Reporting*

- **All Cause Readmission with Risk Adjustment**
  - Look at NQF 0329
  - Look at IPPS Readmission Policies, AMI, HF and PN
- AMRPA Concerns
- To Be Completed Late 2011?
- Collected for Medicare FFS Patients
- Issues Included Planned, Unplanned, Related Definitions, or Which Facility Credited With the Readmission



## *IPPS Readmissions Policy: Any Precedent for IRFs Here?*

- Three Measures: AMI, HF, PN; More Later
- Excess Readmissions Carry A Payment Penalty
- No Policy on Readmission Rates for All Patients -  
Would Include IRH/U Readmissions
- National Rates for Medicare Patients:
  - AMI 19.8%
  - HF 24.8%
  - PN 18.4%
- National Rate 30 Days Post 19%
- Goal: Reduce Readmissions by 20%



# *CMS's Proposed Quality Measures for FY 2014 Reporting*

- **Possible Future Measures**
  - See Table 13 for Possible Future Measures in the Appendix



## *FY 2012 Final IRF PPS Rule: Snapshot*

- Payment Rate From Adjusted FY 2011 - \$13,860 to \$14,076
- Updated CMS Weights and LOS
- Labor Share – From 75.271 to 70.199 (FY 2008 Market Basket)
- Average Est. Weight Per Discharge FY 2012 -1.141
- Outlier Threshold From FY 2011 - From \$11,410 to \$10,660
- Urban National Average Cost-to-Change Ratio (CCR) is 0.520
- Rural National Average CCR is 0.669



## *Facility Adjusters: No Changes*

- CMS Proposed to Change the Methodology for Calculating LIP, Teaching, Rural
- From Weighted Historical Approach to Non Weighted
- Result is Drops in LIP and Teaching Exponents
- AMRPA Filed Strong Objections
- CMS Will Analyze Data for Another Year
- See Susanne Seagrave, CMS, Sept 28 AM



## *Impact of the Rule and Denials Well Known And Further Documented By MedPAC and eRehabData®*

- Medicare FFS Patients Declining; No FFS Increase Post 60% Rule as Expected
- Cost Per Day and Per Discharge Increasing
- Non Medicare Including Medicare Advantage Patients Increasing
- Number of Beds Closing Faster Than Facilities Closing
- Drop in Payments
- Number of Units Still Declining
- Look At The Numbers

# *Medicare's Coverage Criteria: How Are You Doing?*



*Federal Register  
August 7, 2009*

*No Changes in FY 2012  
IRF PPS Rules*

# *CMS Concerns*

1. Hospitals Without Physicians
2. No Check Lists – Providers
3. No Check Lists – MACs
4. Documentation in the IRF patient medical record must:
  - Support medical necessity
  - Be complete and legible
  - Not be presented as check off lists
5. CMS Held Provider Education Call with Dr. McKinney, Cahaba Medical Director, August 23
6. See What Susanne Seagrave has to Say at AMRPA Fall Conference





# *CMS Quiz from Chronic Care Policy Group*

True or False:

Medicare is looking to deny a claim based on a technicality.

Answer: **FALSE**



## *CMS Quiz from Chronic Care Policy Group*

True or False:

An email (with no attachment) dated prior to the IRF admission that states that the rehabilitation physician “Agrees with the admission decision” is sufficient to document the rehabilitation physician’s review and concurrence with the preadmission screening.

Answer: FALSE



# *CMS Quiz from Chronic Care Policy Group*

True or False:

As long as all of the correct boxes are checked on the preadmission screening form indicating that the patient meets all of the Medicare coverage requirements, Medicare contractors will consider the IRF admission reasonable and necessary.

Answer: **FALSE**

## *Good Example of Meeting PAS*

Patient A requires, can tolerate, and can reasonably be expected to benefit from 3 hours of therapy per day/5 days per week.

Yes, this patient is expected to meet this requirement because he/she has cerebral artery occlusion with comorbidities of pneumonia, dysarthria, and ataxia . He/she is able to ambulate 100 feet with mod assist, and we expect that with an intensive course of therapy will improve to the point that he/she can return home with a walker within 3 weeks.

## *Bad Example*

Patient A requires, can tolerate, and can reasonably be expected to benefit from 3 hours of therapy per day/5 days per week.

Yes   X  

No \_\_\_\_\_



# *CMS Quiz from Chronic Care Policy Group*

Quiz:

The information presented in the preadmission screening must be consistent with the other information provided in the patient's medical record, or a plausible explanation be given for why they differ, in order for the preadmission screening to support the IRF admission.

Answer: TRUE



# *CMS Quiz from Chronic Care Policy Group*

## Quiz:

To meet the post-admission physician evaluation requirement, a rehabilitation physician may sign-off on an evaluation that was performed by a trusted physician assistant.

Answer: FALSE



# *CMS Quiz from Chronic Care Policy Group*

## Quiz:

To meet the physician visit requirement, a rehabilitation physician can simply document that the patient's vital signs and blood pressure are stable and that the patient can continue the prescribed course of therapy.

Answer: FALSE



## *CMS Quiz from Chronic Care Policy Group*

### Quiz:

To meet the physician visit requirement, documentation may simply show that a comprehensive assessment of the patient's medical and functional status led the rehabilitation physician to conclude that the patient was progressing nicely and should therefore continue with the prescribed course of therapy.

Answer: TRUE



# *CMS Quiz from Chronic Care Policy Group*

Quiz:

Group therapy may count towards the intensive rehabilitation therapy requirement if the patient's benefit from this type of therapy is well-documented in the patient's medical record and it is not provided merely for the convenience of the staff.

Answer: **TRUE**

# *DOCUMENT IT!*

- Strategies and Procedures
  - Pop Up Time Coded System to Alert When Next Steps Necessary After Admission?
  - Be Careful However
- Checklists
  - Required Elements for the Record
  - Documentation To Be Included
- Internal Audits • External Audits
- Be Legible and Clear, Or You May Be Denied
- Clear Writing or Electronic Recording





## *FY 2012 LTCH PPS*

- Recalibrated MS-LTC-DRG weights,
- Recalculated Geometric LOS, 5/6<sup>th</sup> of GLOS for Short Stay Outlier Payments
- See Table 11
- Adopted Revised and Rebased RPL as Was Done for IRF PPS Rule
- Payment Rates Subject to Same Reductions in Market Basket and Productivity Adjustment So Update Factor is 1.8%
- Adopted Proposal to Establish Budget Neutrality Requirement for Wage adjustment and Labor Share



## *FY 2012 LTCH PPS*

- Standard Payment Rate is \$40,222.05
- Adopted Three Pay for Reporting Quality Measures
  - Catheter Associated Urinary Tract Infections (CAUTI)
  - Central Line Catheter Associated Bloodstream Infections (CLABSI)
  - Pressure Ulcers that are New or Have Worsened
- Collected via CARE Tool Item Subset which is Identical to MDS 3.0 Section M



## *FY 2012 LTCH PPS*

- Submission Requirements, etc Be Posted by 1/31/2012
- Data Collection to Begin October 1, 2012
- List of Potential Quality Measures
- Times Lines for FY 2015 Submission to Follow Calendar Year
- Included MA Patients 25 day LOS Determination Effective 1/1/2012
- Modified Regulations Pertaining to MMSEA Moratorium



## *FY 2012 SNF PPS*

- Recalibrated Case Mix Adjustment; Result is Net 11.1% Decrease
- Increased Use of Individual and Group Therapy
- Productivity Adjustment Also; Increase in Federal Rates of 1.7%
- Cases Shifted to Higher Paying Rehab RUGs IV – “Exceeded Expectations” (CMS)
- Removed Line of Sight Supervision of Therapy Students
- Made Changes to MDS 3.0 Assessment Schedule and Other Medicare- Required Assessments



## *FY 2012 SNF PPS Group Therapy*

- Group Therapy Documentation Minutes Allocation Changed
- Therapy Provided Simultaneously to Exactly 4 Patients w/o Regard to Payer, Performing Same or Similar Activities
- Cannot Exceed 25% of a Patient's Time Per Week
- Changed Documentation Requirements

# Medicare Compliance Review Contractors



**MAC**



**RAC**



**CERT**



**ZPIC**



**MIC**



# *Cahaba and Highmark Start Pre Payment Reviews*

- Cahaba: Alabama, Georgia and Tennessee
  - 42 CFR 405.921(b)(2) Specifies Content for Initial Determination
  - CMS Used Cahaba M.D. ad Speaker on Provider Education Call 8/23/11
  - Now Requesting Additional Cases in Misc. Category
  - Denial Results Show Repetitive Pattern





# *Cahaba Published Results: CMGs A2001-A2004*

## Q **Technical Denials/ Findings**

- Physician signature was dated, but is not timed to validate physician review and concurrence of preadmission screen prior to IRF admission.
- E-mail was submitted to substitute for physician signed preadmission. E-mail does not indicate what documents were reviewed by the physician to approve/concur with admission. Time and date of e-mails does not always correspond with the time and date of the clinician screener (e-mail approval is prior to the date/time clinician screener signs for completion of the preadmission screen).



# *Cahaba Published Results: CMGs A2001-A2004*

## ○ **Technical Denials/ Findings**

- Overall plan of care was not individualized as defined by CMS. 3 hours/day 5 days/wk or 15 hours over 7 days or 90 min of PT and 90 min of OT does not meet CMS intent for individualized plan of care.
- Physician signature on overall plan of care or on progress notes was not always timed to validate time requirement met as established by CMS.



# *Cahaba Published Results: CMGs A2001-A2004*

## ○ **Technical Denials/ Findings**

- Physician's plan of care indicated therapy services 3 hours/day over 5 days/wk, but services were provided over 7 days to total the 15 hours or were provided at greater than 3 hours/day for 3-4 days/wk. (this usually occurred when the week included a weekend during the middle of the week) There was no documentation of a reason (based on the patient's needs) for the change from the physician's plan. (example from record reviewed- 3hr/day 5 days/wk or 15 hr/wk due to late admit- this does not support change in # days based on the patient's need)



# *Cahaba Published Results: CMGs A2001-A2004*

## Q **Technical Denials/ Findings**

- Documentation did not always clearly indicate a rehabilitation physician face-to-face visit at three times per week as required. Visits by Physician Assistants or nurse practitioners are not a substitute for rehab physician visits.
- Signature on the preadmission screen and post-admission physician evaluation did not meet time requirements. Example would be from a patient admitted on April 24, 2010 and the preadmission screen is not signed by the rehab physician until April 27, 2010. The post admission history and physical was not completed until April 26, 2010.
- Interdisciplinary team meeting requirements for once weekly were not always met.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- Potential risk for clinical complications as documented on preadmission screen (fall, DVT, infection, unsteady gait, decreased balance, need for post-op wound/incision care, or continued antibiotic meds, etc) does not raise the patient's needs to the level which would require inpatient care or observation.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- No detailed justification for IRF admission on the preadmission screen or on the post-admission physician evaluation. The documentation will state that the patient requires intense services of inpatient rehabilitation and direction by rehabilitation physician and 24 hour rehabilitation nursing care however no details are documented to support this statement. Another example is that the preadmission evaluation indicated that the patient required IRF admission for pain management, but per post-admission physician evaluation, there is no muscle or joint pain.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- The evaluations did not include a complete assessment of the patient's current functional status to validate the need for intense therapy program or for multiple therapy disciplines. An example to support this is that the documentation had an assessment from the acute hospital record of gait, however no assessment documented of current ADL or dressing status or no functional assessment.
- Functional status as documented on preadmission screen would not support the need for an intense therapy program or for multiple therapy disciplines. An example would be that the documentation states that the patient had the ability to walk 100 feet with an assistive device stand-by assist and ADL's required minimal assistance.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- No evidence of hands-on functional assessment by the rehabilitation physician on the post-admission evaluation or on any of physician visit notes. The documentation was a repeat of the preadmission screen functional information or it would be documented to “see therapy evaluations” on the post-admission physician evaluations. Some evaluations did not have any functional assessment at all. The physician daily notes would state to “see therapy notes” regarding patient's functional status.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- The documentation in the record indicated discrepancy between the post admission physician evaluation which would state no change from preadmission screen and the therapy evaluation would indicate a change from the preadmission screen with no explanation of discrepancy. It would appear that the patient was responding without therapy intervention.



# *Cahaba Published Results: CMGs A2001-A2004*

- q **Admission Did Not Appear Reasonable and Necessary**
- Therapy services for debility to address strength & endurance would not require the intensity of an inpatient rehabilitation program. Documentation indicates repetitious exercises and no documentation of skilled intervention. Documentation indicates walking with the patient to increase walking distance and no indication of training or instruction to validate skilled intervention was provided.
- Documentation in some records would indicate that 15-30 minutes of the 3 hour day time was used as application of ice which is not a skilled procedure.
- The documentation in the preadmission screening, post admission physician evaluations and therapy evaluations did not support the need for more than one therapy discipline.



# *Cahaba Published Results:*

## *CMGs A0801-A0806*

### Q **Technical Denials/ Findings**

- Physician signature was dated, but is not timed to validate physician review and concurrence of preadmission screen prior to IRF admission.
- E-mail was submitted to substitute for physician signed preadmission. E-mail does not indicate what documents were reviewed by the physician to approve/concur with admission. Time and date of e-mails does not always correspond with the time and date of the clinician screener (e-mail approval is prior to the date/time clinician screener signs for completion of the preadmission screen).
- Overall plan of care was not individualized as defined by CMS. 3 hours/day 5 days/wk or 15 hours over 7 days or 90 min of PT and 90 min of OT does not meet CMS intent for individualized plan of care.



# *Cahaba Published Results:*

## *CMGs A0801-A0806*

### Q **Technical Denials/ Findings**

- Physician signature on overall plan of care or on progress notes was not always timed to validate time requirement met as established by CMS.
- Physician's plan of care indicated therapy services 3 hours/day over 5 days/wk, but services were provided over 7 days to total the 15 hours or were provided at greater than 3 hours/day for 3-4 days/wk. (this usually occurred when the week included a weekend during the middle of the week) There was no documentation of a reason (based on the patient's needs) for the change from the physician's plan. (example from record reviewed- 3hr/day 5 days/wk or 15 hr/wk due to late admit- this does not support change in # days based on the patient's need)



# *Cahaba Published Results:*

## *CMGs A0801-A0806*

### Q **Technical Denials/ Findings**

- Documentation did not always clearly indicate a rehabilitation physician face-to-face visit at three times per week as required. Visits by Physician Assistants or nurse practitioners are not a substitute for rehab physician visits.
- Signature on the preadmission screen and post-admission physician evaluation did not meet time requirements. Example would be from a patient admitted on April 24, 2010 and the preadmission screen is not signed by the rehab physician until April 27, 2010. The post admission history and physical was not was not completed until April 26, 2010.
- Interdisciplinary team meeting requirements for once weekly were not always met.



# *Cahaba Published Results:*

## *CMGs A0801-A0806*

- q **Admission Did Not Appear Reasonable and Necessary**
- Potential risk for clinical complications as documented on preadmission screen (fall, DVT, infection, unsteady gait, decreased balance, need for post-op wound/incision care, or continued antibiotic meds, etc) does not raise the patient's needs to the level which would require inpatient care or observation.



## *Cahaba Published Results: CMGs A0801-A0806*

- q **Admission Did Not Appear Reasonable and Necessary**
- No detailed justification for IRF admission on the preadmission screen or on the post-admission physician evaluation. The documentation will state that the patient requires intense services of inpatient rehabilitation and direction by rehabilitation physician and 24 hour rehabilitation nursing care however no details are documented to support this statement. Another example is that the preadmission evaluation indicated that the patient required IRF admission for pain management, but per post-admission physician evaluation, there is no muscle or joint pain.



# *Cahaba Published Results:*

## *CMGs A0801-A0806*

### q **Admission Did Not Appear Reasonable and Necessary**

- The evaluations did not include a complete assessment of the patient's current functional status to validate the need for intense therapy program or for multiple therapy disciplines. An example to support this is that the documentation had an assessment from the acute hospital record of gait, however no assessment documented of current ADL or dressing status or no functional assessment.
- Functional status as documented on preadmission screen would not support the need for an intense therapy program or for multiple therapy disciplines. An example would be that the documentation states that the patient had the ability to walk 100 feet with an assistive device stand-by assist and ADL's required minimal assistance.



## *Cahaba Published Results:* *CMGs A0801-A0806*

- q **Admission Did Not Appear Reasonable and Necessary**
  - No evidence of hands-on functional assessment by the rehabilitation physician on the post-admission evaluation or on any of physician visit notes. The documentation was a repeat of the preadmission screen functional information or it would be documented to “see therapy evaluations” on the post-admission physician evaluations. Some evaluations did not have any functional assessment at all.
  - The documentation in the record indicated discrepancy between the post admission physician evaluation which would state no change from preadmission screen and the therapy evaluation would indicate a change from the preadmission screen with no explanation of discrepancy. It would appear that the patient was responding without therapy intervention.



# *Cahaba Published Results: CMGs A0801-A0806*

- q **Admission Did Not Appear Reasonable and Necessary**
- Repetitious therapy services to address strength & endurance would not require the intensity of an inpatient rehabilitation program. Documentation indicates repetitious exercises and no documentation of skilled intervention. Documentation indicates walking with the patient to increase walking distance and no indication of training or instruction to validate skilled intervention was provided.
- Documentation in some records would indicate that 15-30 minutes of the 3 hour day time was used as application of ice which is not a skilled procedure.



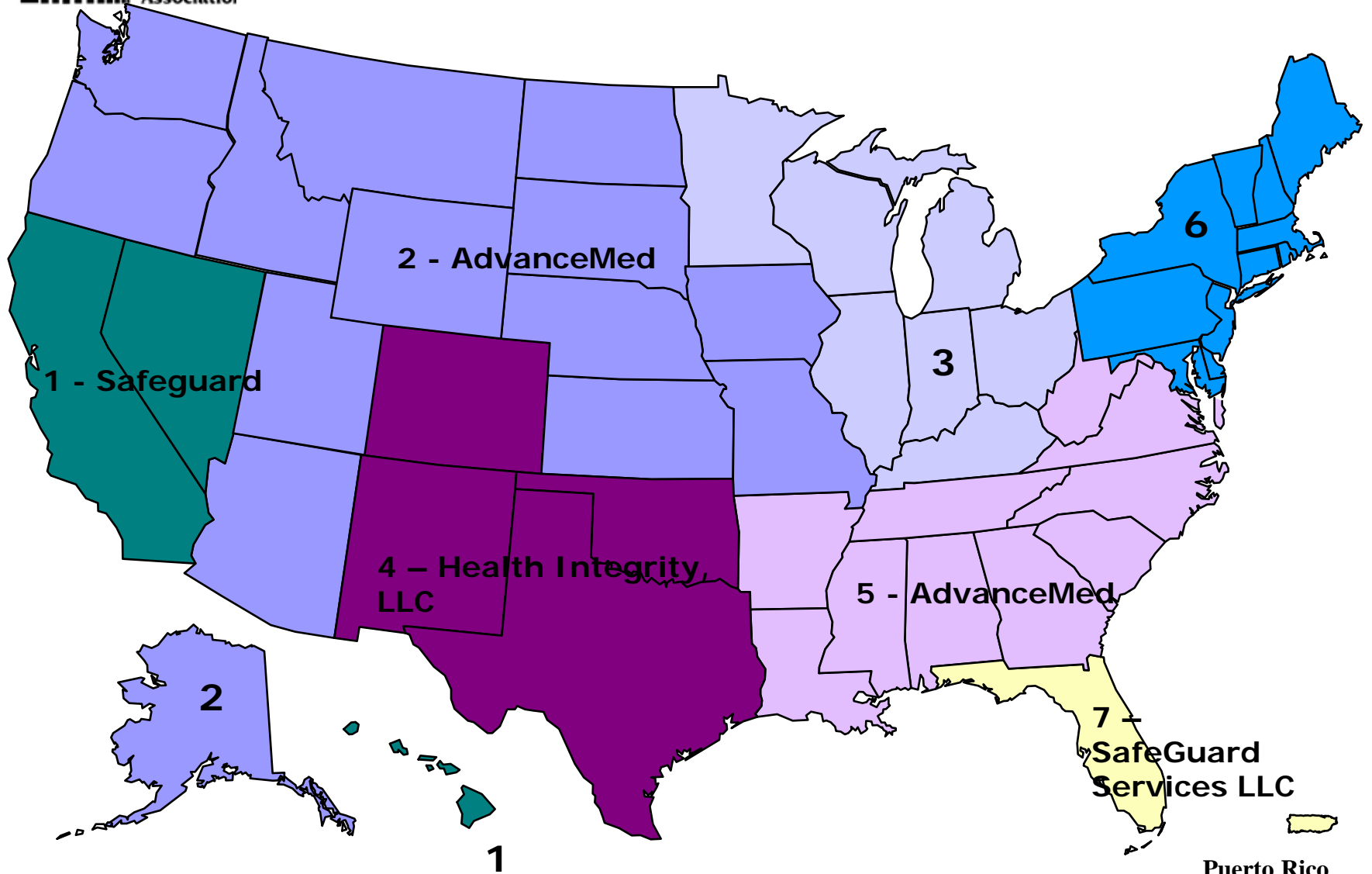
# *Denials Due To Documentation Not Submitted On Time*

- **Cahaba Recommends Review of the Following:**
- In addition to denials technical denials and denials due to documentation indicating admission to the inpatient rehabilitation facility, denials were also due to documentation not being submitted within the required time. To eliminate 56900 denials, please review the following elements to ensure appropriate and timely record processing:
  - Print screen the ADR letter and attach the copy to the front of the requested medical documentation
  - Send requested information to the address on the ADR letter
  - Do NOT send certified mail or overnight mail
  - Include ALL requested documentation outlined in the ADR
  - Submit the above information via regular mail in a timeframe to ensure the MAC receives the information by the 45<sup>th</sup> day after the date of the request.



American  
Medical  
Rehabilitati  
Providers  
Association

# ZPIC Zone Alignment



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Puerto Rico  
U.S. Virgin Islands<sup>96</sup>

\*Other territories of Zone 1 include American Samoa, Northern Marianas Islands and Guam

## *AMRPA Actions*

- eRehabData® Appeals Database
- Appeal Denials Checklist: “How To Appeal”;
- Supporting FAIR Fund
- Calls with RAC Staff
- AMPRA Member Calls with RAC Staff



# *Questions?*





# *Contact Information*

Carolyn C. Zollar J.D.

V.P. for Government Relations & Policy Development  
American Medical Rehabilitation Providers Association

1710 N Street N.W.

Washington, D. C. 20036-2907

Toll-free: 888-346-4624

Phone: 202-223-1920

Fax: 202-223-1925

E-mail: [czollar@amrpa.org](mailto:czollar@amrpa.org)



# *APPENDIX*



# *CMS Announces New Bundling Payments for Care Improvement Initiative*

MODEL FEATURE	MODEL 1 – Inpatient Stay Only	MODEL 2 – Inpatient Stay plus Post-discharge Services	MODEL 3 - Post-discharge Services Only	MODEL 4 – Inpatient Stay Only
<b>Eligible Awardees</b>	<ul style="list-style-type: none"> <li>• Physician group practices</li> <li>• Acute care hospitals paid under the IPPS</li> <li>• Health systems</li> <li>• Physician-hospital organizations</li> <li>• Conveners of participating health care providers</li> </ul>	Physician group practices Acute care hospitals paid under the IPPS Health systems Physician-hospital organizations Post-acute providers Conveners of participating health care providers	Physician group practices Acute care hospitals paid under the IPPS Health systems Long-term care hospitals Inpatient rehabilitation facilities Skilled nursing facilities Home health agency Physician-hospital organizations Conveners of participating health care providers	Physician group practices Acute care hospitals paid under the IPPS Health systems Physician-hospital organizations Conveners of participating health care providers
<b>Payment of Bundle and Target Price</b>	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment



# *CMS Announces New Bundling Payments for Care Improvement Initiative*

<b>MODEL FEATURE</b>	<b>MODEL 1 – Inpatient Stay Only</b>	<b>MODEL 2 – Inpatient Stay plus Post-discharge Services</b>	<b>MODEL 3 - Post-discharge Services Only</b>	<b>MODEL 4 – Inpatient Stay Only</b>
<b>Clinical Conditions Targeted</b>	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
<b>Types of Services Included in Bundle</b>	Inpatient hospital services	<ul style="list-style-type: none"> <li>• Inpatient hospital and physician services</li> <li>• Related post-acute care services</li> <li>• Related readmissions</li> <li>• Other services defined in the bundle</li> </ul>	Post-acute care services Related readmissions Other services defined in the bundle	Inpatient hospital and physician services Related readmissions
<b>Expected Discount Provided to Medicare</b>	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration



# *CMS Announces New Bundling Payments for Care Improvement Initiative*

<b>MODEL</b> <b>FEATURE</b>	<b>MODEL 1 – Inpatient Stay Only</b>	<b>MODEL 2 – Inpatient Stay plus Post-discharge Services</b>	<b>MODEL 3 - Post-discharge Services Only</b>	<b>MODEL 4 – Inpatient Stay Only</b>
<b>Payment from CMS to Providers</b>	Acute care hospital: IPPS payment less pre-determined discount Physician: Traditional fee schedule payment (not included in episode)	Traditional fee-for- service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for- service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment
<b>Quality Measures</b>	All Hospital IQR measures and additional measures to be proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs.		

## *What Did The Q And A Answer on Coverage Criteria?*

- **Physician Extenders - CMS spent considerable time in clarifying the use of physician extenders.**
- **Physician extenders may:**
  - Conduct the preadmission screening if they are licensed or certified and if they are appropriately trained and qualified to assess the patient's medical and functional status, assess the risk for clinical and rehabilitation complications and assess other aspects of the patient's condition both medically and functionally.

## *What Did The Q And A Answer on Coverage Criteria?*

- **Physician Extenders May *cont'd***
  - Draft the reasoning/justification for the admission and make recommendations to the rehabilitation physician. However the rehabilitation physician must review and concur with the findings and result of the PAS. In defining physician extenders CMS references Section 1861(s) (2) (K) of the Social Security Act. This subparagraph references specifically physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with a physician.

## *What Did The Q And A Answer on Coverage Criteria?*

- **Physician Extenders May *cont'd***
  - Complete the history and physical (H&P), however the rehabilitation physician must visit the patient and complete the other required parts of the post admission physician evaluation within 24 hours of admission.
  - Work in collaboration with the rehabilitation physician to assist the rehabilitation physician in developing the overall plan of care for the rehabilitation physician's approval and signature.
  - Work in collaboration with the physician to generate the admission orders.
  - See also §1861(aa) (5), (6) regarding the definition of clinical nurse specialist and collaboration respectively.

## *What Did The Q And A Answer on Coverage Criteria?*

- **Residents**
- **CMS also addresses in part how residents may be used to meet the coverage criteria as well; however some others areas are not yet clear. Residents may:**
  - Conduct the preadmission screenings if they meet the criteria CMS has set for training, assessment of the patient’s condition and risk for complications and other medical and functional aspects of the patient’s condition and other tasks qualified physician extenders may perform as noted above.
  - Complete the H&P. In discussing its position that physician extenders and residents may complete the H&P it states that the “usual Medicare regulations” apply without a specific reference.

## *What Did The Q And A Answer on Coverage Criteria?*

- **Residents may *cont'd***
  - Issue admission orders (as distinct from reviewing and concurring with the preadmission screening assessment) in that CMS states “Any licensed physician may generate the admission orders. It does not have to be a rehabilitation physician.” CMS also states that a physician extender, working in collaboration with the physician, may generate the admission orders.
  - Per conversations with CMS, residents may not lead team meetings or conduct the required rehabilitation physician three visits per week or other rehabilitation physician required responsibilities, unless the supervising rehabilitation physician is present. CMS sees residents as physicians in training.

# *Examining Post-Acute Care From New Perspectives*

- 20% of all Medicare beneficiaries hospitalized at least once a year
  - Admitted for a wide range of reasons including medical, surgical, functional diagnoses
- About 35% will be discharged to PAC:
  - 41.1% à SNF
  - 37.4% à Home Health
  - 10.3% à IRF
  - 9.1% à Outpatient/ ambulatory therapy
  - 2.0% à LTCH

*Source: Gage et al. (2009). Examining post-acute care relationships in an integrated hospital system, ASPE*



# *FY 2012 IRF PPS Final Rule: Market Basket Rebasing and Revision*

- Market Basket Rebasing and Revision Update
  - From FY 2002 to FY 2008 Cost Reports
  - Done Every 6-7 years
  - Decrease in Labor Related Weights – Why?
  - Increases in Others Such as Utilities
- Market Basket for FY 2012 is 2.9%
  - Reduced by ACA MB Reduction of 0.1%
  - Reduced by Productivity Adjustment of – 1.0%



# *FY 2012 IRF PPS Final Rule: Productivity Adjustment*

- Productivity Adjustment
  - Required by ACA; Same for Acute, LTCH, Other Providers
  - Equals the 10 Year Moving Average of Changes in Annual Economy Wide Private Non Farm Business Multi-Factor Productivity
  - How Long Can Hospitals Decrease Productivity?
    - An Illusion?



## ***FY 2012 IRF PPS Final Rule: Labor Share and Wage Index***

- Labor Share – Reduced; Impact Depends on Your Wage Index
  - Reflects Change of Methodology in Accounting for Local Labor Costs
  - From 75.271 to 70.199
- Wage Index – Calculated Using Same Methodology as Used Since FY 2009 Rule

## *Table 13—Possible Future Measures And Topics For The IRF Quality Reporting Program*

*Overarching Goal: Safety and Healthcare Acquired Conditions:  
Avoidable Adverse Events and Serious Reportable Events \**

- Unplanned acute care hospitalizations.
- Falls with major injury.\* \*\*
- Falls with major injury per 1,000 days.
- Incidence of venous thromboembolism (VTE), potentially preventable.\*
- Poly-pharmacy related injury.
- Medication errors.\*
- Stage III and IV pressure ulcers.\*\*



## *Table 13—Possible Future Measures And Topics For The IRF Quality Reporting Program*

### *Overarching Goal: Safety and Prevention*

- VTE Prophylaxis.
- Patient Immunization for Influenza.
- Patient Immunization for Pneumonia.
- Staff Immunization.

### *Overarching Goal: Safety and Healthcare Acquired Conditions— HAIs*

- Surgical site infections.
- Multidrug resistant organism infection.



## *Table 13—Possible Future Measures And Topics For The IRF Quality Reporting Program*

*Overarching Goal:* Better, Person Centered-Care: Care Coordination/Care Outcome

- Functional Change: Change in Motor Score.
- Change in Cognitive Function: Change in Cognitive Score.
- Communication.
- Percent of patients whose individually stated goals were met.
- Care Transitions Measure–3 (CTM–3).
- Discharge Outcome/Discharge disposition:
  - Home.
  - Assisted Living.
  - Nursing Home.
  - LTCH.
  - Hospital.
  - Hospice.



## *Table 13—Possible Future Measures And Topics For The IRF Quality Reporting Program*

- Patient Preferences for care, treatment and management of symptoms by healthcare providers.

*Overarching Goal:* Better, Person Centered-Care: Symptom Management

- Percent of patients on a scheduled pain management regime on admission who report a decrease in pain intensity or frequency.
- Percent of patients with pain assessment conducted and documented prior to therapy.
- Percent of patients who self-report moderate to severe pain.
- Percent of patients with dyspnea improved within one day of assessment.



## *Table 13—Possible Future Measures And Topics For The IRF Quality Reporting Program*

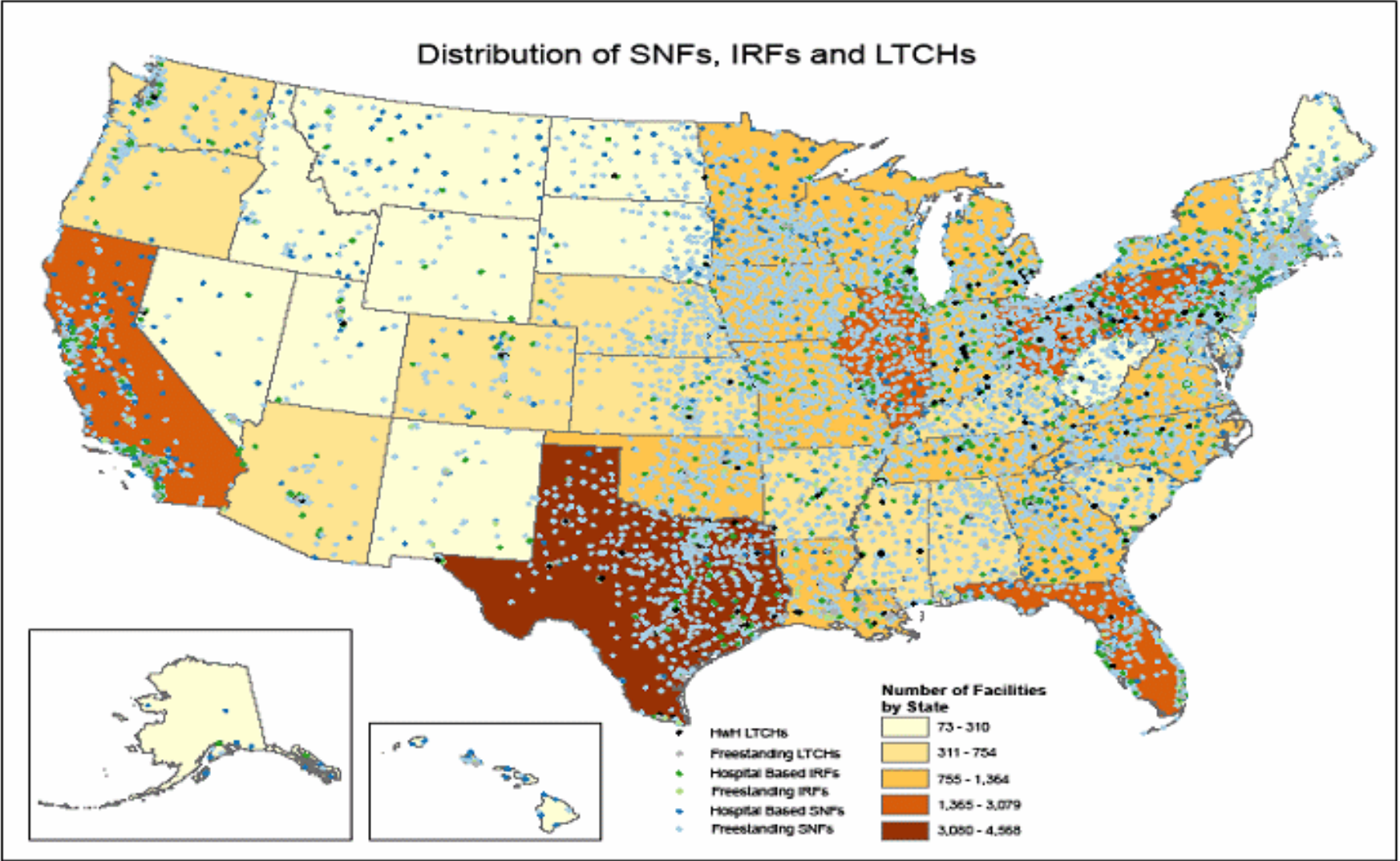
*Overarching Goal:* Better, Person Centered-Care: Experience of Care

- Patient Survey, for example, Hospital Consumer Assessment of Healthcare Providers & Systems.
- Percent of patients for whom care delivered was consistent with patient stated care preferences.

\* Consistent with NQF Serious Reportable Events.

\*\* Consistent with Healthcare Acquired Conditions (HAC) Prevalence Measure.

# Distribution of Freestanding Versus Hospital-Based SNFs, IRFs, and Freestanding and HWH LTCHs in 2007



# ZPICs To Date

ZPIC	Zone	Parts A, B, HH + H, DME
<b>Safeguard Services</b>	<b>1</b>	California, Nevada, American Samoa, Guam, Hawaii, Mariana Islands
<b>AdvanceMed Corp.</b>	<b>2</b>	Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri
	<b>3</b>	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
<b>Health Integrity</b>	<b>4</b>	Texas, Oklahoma, Colorado, New Mexico

# ZPICs To Date

ZPIC	Zone	Parts A, B, HH + H, DME
<b>AdvanceMed Corp.</b>	<b>5</b>	West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, Louisiana
	<b>6</b>	Pennsylvania, New York, Maryland, Washington D.C., Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, Vermont
<b>SafeGuard Services</b>	<b>7</b>	Florida, Puerto Rico, Virgin Islands

## *PSCs To Date*

<b>PSC</b>	<b>Task Order Name</b>	<b>Jurisdiction</b>
<b>AdvanceMed Corporation</b>	<b>Ohio / Kentucky /Minnesota PSC</b>	<u>Part A&amp;B</u> : Kentucky and Ohio
		<u>Part A</u> : Minnesota
<b>Cahaba Safeguard Administrators</b>	<b>North Carolina PSC</b>	North Carolina Cost Report and Medical Review Activities for Part A Facilities
<b>Cahaba Safeguard Administrators</b>	<b>Alabama</b>	<u>RHHI</u> : Montana, Wyoming, Utah, Colorado, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, West Virginia

# PSCs To Date

PSC	Task Order Name	Jurisdiction
<p><b>Computer Sciences Corp.</b></p>	<p><b>Western Integrity Center (WIC)</b></p>	<p><u>Part A:</u> North Dakota, Alaska, Washington, Oregon, Utah, Montana, Wyoming, Idaho, Arizona, South Dakota, Iowa</p>
		<p><u>Part B:</u> Alaska, American Samoa, Arizona, Guam, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Montana, Idaho, Wyoming, Utah</p>
<p><b>IntegriGuard, LLC</b></p>	<p><b>NE, KS, MO &amp; WPS</b></p>	<p><u>Part A &amp; B:</u> Nebraska, Kansas, and Missouri</p>
		<p><u>Part A:</u> BI work currently performed by WPS</p>

## *PSCs To Date*

PSC	Task Order Name	Jurisdiction
<p><b>Safeguard Services (SGS)</b></p>	<p><b>New England Benefit Integrity Support Center (NE - BISC)</b></p>	<p><u>Part B:</u> Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut, DC, Delaware, Maryland</p>
		<p><u>Part A:</u> New Hampshire, Rhode Island, Vermont, Maine, Massachusetts, Connecticut, DC, Maryland, Delaware</p>
		<p><u>RHHI:</u> Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, DC, Maryland, Delaware, Pennsylvania</p>

## *PSCs To Date*

PSC	Task Order Name	Jurisdiction
Safeguard Services (SGS)	California Benefit Integrity Center (CAL - BISC)	<u>Part B:</u> California
Safeguard Services (SGS)	Eastern Benefit Integrity Center	<u>Part A and B:</u> New York and New Jersey
Safeguard Services (SGS)	PENN-Benefit Integrity Center	<u>Part A and B:</u> Pennsylvania
Safeguard Services (SGS)	Region D - Durable Medical Equipment (DME) PSC	<u>DME:</u> Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Mariana Islands, and American Samoa

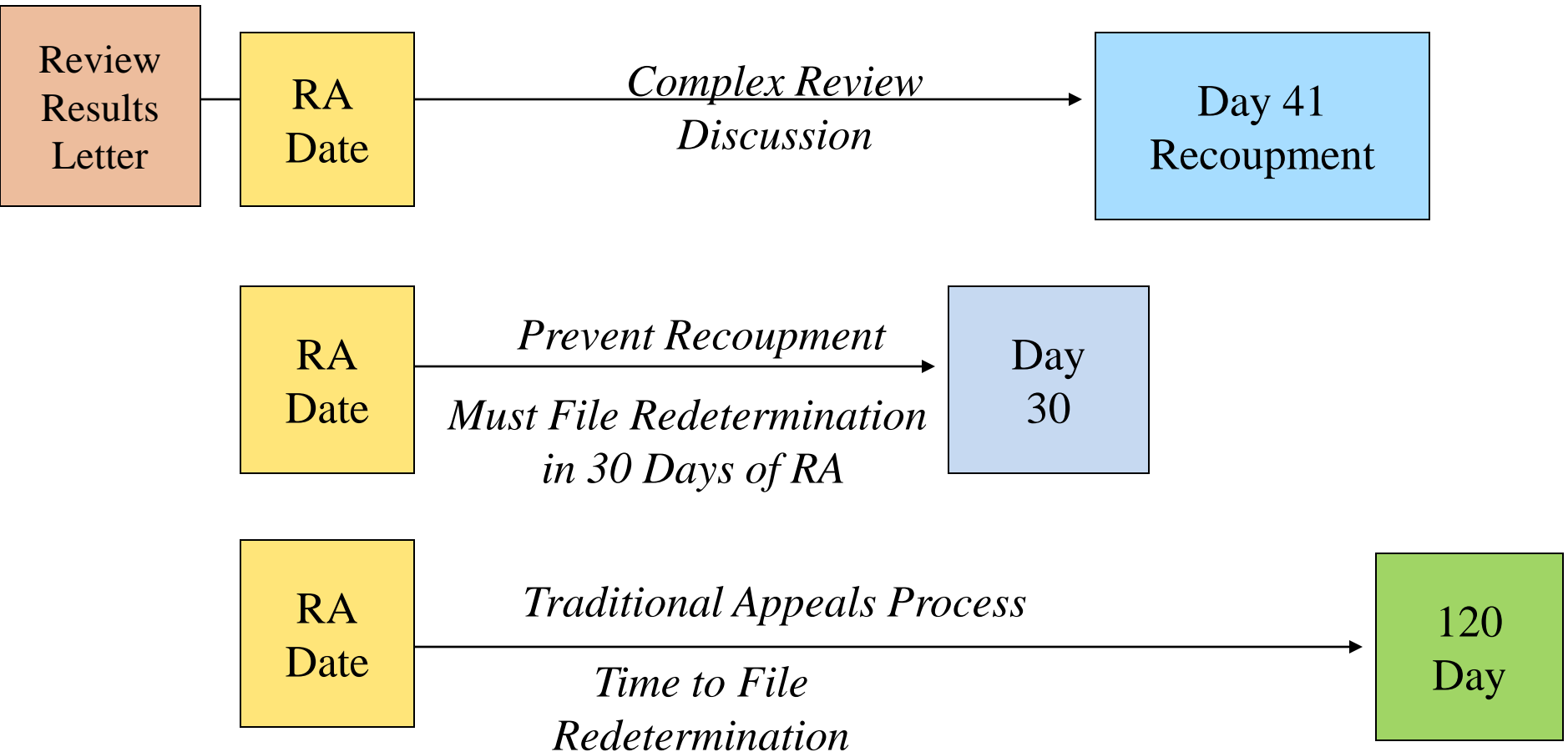
## *PSCs To Date*

PSC	Task Order Name	Jurisdiction
<p><b>TriCenturion</b></p>	<p><b>Region A/B - Durable Medical Equipment (DME) PSC</b></p>	<p><u>DME</u>: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia, West Virginia, and Wisconsin.</p>

## *PSCs To Date*

PSC	Task Order Name	Jurisdiction
<p><b>Trustsolutions, LLC</b></p>	<p><b>UGS Workload, WPS Workload, ASF Workload</b></p>	<p><u>Part A:</u> American Samoa, California, Guam, Nevada, Hawaii, Mariana Islands, Michigan, Wisconsin, Illinois, and Indiana</p>
		<p><u>Part B:</u> Minnesota, Wisconsin, Michigan, Illinois, and Indiana</p>
		<p><u>RHHI:</u> American Samoa, Mariana Islands, Oregon, California, Nevada, Idaho, Arizona, Hawaii, Guam, New Jersey, New York, Wisconsin, Michigan, Minnesota, Alaska, and Washington, Illinois, Indiana, Kentucky, Ohio</p>

# Three Timelines



# *Traditional Appeals Process*

<b>Level of Denial</b>	<b>Time in Which to File Response (Provider)</b>	<b>Time in Which to Make a Decision (FI, AIC, ALJ, etc)</b>	<b>Amount in Controversy Required</b>
Initial ADR Request (Probe, Post Payment Review)	Usually 30 Days	N/A	N/A
Rebuttal	15 Days From Denial	15 Days	N/A
1. Redetermination of Initial Denial (Probe, Payment Review, LCD or RAC)	120 Days From Date of Receipt of Remittance Advice From FI	MAC Has 60 Days	N/A
2. Reconsideration by QIC	180 Days From Date of Receipt of Letter of Denial of Determinations	QIC Has 60 Days	None
3. ALJ Hearing	60 Days From Date of Receipt of QIC Decision	ALJ Has 90 Days	\$130
4. Department Appeals Board/MAC	60 Days After Date of Receipt of ALJ Notice <sup>1</sup>	90 Days	No Mention
5. Federal District Court	60 Days to File	None	\$1,300

<sup>1</sup> Medicare assumes receipt 5 days from date of notice

<sup>2</sup> These amounts are adjusted based on the Medicare component of the CPI



# *Current Appeals Rules*

- Interim Final Rule Issued 3/8/05
- Corrections 6/30 and 8/26/05
- Final Rule 12/9/09, Effective 1/8/10
- All Days Are Calendar Days
- If Due Date Falls on Sat, Sun, Holiday – “Roll Over”
- Time Frames Not Changed
- Terms – Clarifies “Final”, “Bundling”, “Decision”, “Dismissal”, “Remand” etc.



## *CMS Issuances on Recoupment*

- Final Rule, 9/18/09 Section 935(f) MMA, Effective 11/16/09
- Transmittal 141, September 2008 Rule is the Same
  - Business Judgment on Recoupment
  - To Prevent Recoupment Must File for Redetermination in 30 vs. 120 Days
  - To Prevent Recoupment Must File for Reconsideration in 60 vs. 180 Days



## *Nationwide Switch to ICD-10*

### *MLN Matters® Number: SE1019*

- CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures) at the same time.
- ICD-10-CM diagnoses codes will be used by all providers.
- ICD-10-PCS procedure codes will be used only for inpatient hospital procedures.
- **Help with Converting Codes**
- The General Equivalence Mappings (GEMs) can be used to convert from ICD-9-CM to ICD-10-CM/PCS and vice versa.
- The GEMs are a translation dictionary.
- ICD 9 to ICD 10 IRF PPS Conversion Report Still Expected Fall 2011



## *Nationwide Switch to ICD-10*

- **Frequently Asked Questions (FAQs) –**

Access <http://www.cms.gov/ICD10/> select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”.



## *New Podcasts Available from Four Popular CMS ICD-10 National Provider Calls*

- CMS has created podcasts from four popular National Provider Calls on ICD-10.
  - [“CMS ICD-10 Conversion Activities”](#) – Wednesday, May 18, 2011
  - [“Preparing for ICD-10 Implementation in 2011”](#) – Wednesday, January 12, 2011
  - [“Basic Introduction to ICD-10-CM”](#) – Tuesday, March 23, 2010
  - [“ICD-10-CM/PCS Implementation and General Equivalence Mappings \(Crosswalks\)”](#) – Tuesday, May 19, 2009



## *The ICD-10-PCS GEM Mappings and Reimbursement Mappings are Coming Soon:*

- 2012 ICD-10 PCS GEM Mappings Will be Posted in October 2011
- 2012 ICD-10 PCS Reimbursement Mappings Will Be Posted in December 2011