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The Healthcare Bulletin

Observation and Assessment of Patient's Condition

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized. (Source: *Medicare Benefit Policy Manual, Chapter 8, Section 30.2.3.2*)

Medicaid Fraud and Abuse

Effective January 1, 2007 the Deficit Reduction Act of 2005 imposes new requirements on healthcare-related entities that receive more than \$5 million in state Medicaid payments. The new requirements are now "a condition of payment." The Centers for Medicare and Medicaid Services will establish a Medicaid Integrity Program that will operate in a similar fashion to the Medicare Integrity Program. (Source: *Deficit Reduction Act of 2005*)

PPS and Grace Days

Grace days may be used for Medicare assessments without incurring financial penalty. These may be used in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to capture more fully therapy minutes or other treatments. (Source: *CMS Resident Assessment Instrument User's Manual Appendix A, Page A-5*)

Coverage of Outpatient Rehabilitation Therapy Services Revised

The revised outpatient rehabilitation therapy services are effective January 1,

2007. These important changes include definitions, documentation requirements, and instruction for therapy above the caps. (Source: *Medicare Benefit policy Manual Chapter 15, Section 220*)

SNF Admissions and Medicare Advantage Plans

SNF providers must obtain pre-authorization before admitting a patient covered by a Medicare Advantage Plan. The Plans may refuse to pay if the facility does not receive approval prior to admission of the patient.

No Pay Bills

No pay bills are required to enable The Centers for Medicare and Medicaid Services (CMS) to keep track of the beneficiary's benefit period. For example, if a prior facility has not submitted no pay bills, the common working file (CWF) will not have accurate information to determine a beneficiary's benefit status. A new benefit period will be opened erroneously.

Medicare Administrative Contractors

As contracts with Medicare Part A fiscal intermediaries, Part B carriers, and DME regional carriers expire, the contractors signed for those function will be known as Medicare Administrative Contractors (MAC). The MACs will perform claims processing and related functions for the Medicare program, however more efficiently. CMS will ensure its MAC contracts focus on three critical areas, customer service, operational excellence, and financial management. (Source: *Medicare Prescription Drug Act, Section 934*).

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