Disclosure of Commercial Interests

I have commercial interests in the following organization(s): (or I consult for the following organizations)

List the Name of Your Employer:

-Executive Director

-The Alliance Training Center

-The Alliance Training Center is the headquarters for many services offered to the professionals in long-term care include: educational services, management consultation, facility consultation, and development of specialized and custom training programs.

If consultant for organizations, only list the names of the companies for which you consult.

-List all commercial interests. MedPass

Practical Strategies for Senior Managers to Improve and Maintain Data Accuracy

ACHCA Convocation

April 2-5, 2017

Presented by:
Leah Klusch
Executive Director
The Alliance Training Center
leahklusch@tatci.com

Medicare Update Topics

- Compliance with current rules and structure of the Medicare program
- View of corporate compliance and how Medicare compliance is impacted
- Impact of Medicare Benefit Policy Manual
- Regulatory structure of data base development – All Medicare Payment for SNF services is determined by the MDS 3.0 data base
- CMS releases pertaining to the data base and the Annual Payment Update for FY 2018
- New items for the MDS October 2017

A few words about Section GG coding

- All data on the MDS must be reproducible in the medical record – be sure your back up data for the three day period is in the record.
- Therapy evaluations should not be the only data used for Section GG coding as it is usual performance during the first three or last three days of the Part A stay.
- Self care skills are very hybrid – read definitions carefully
- Section GG and section G for ADLs do not have to match due to different assessment periods.
- Be careful with goal setting on admission – realistic goals at the end of the Part A stay.
- Share manual instructions for Section GG with therapy and care giving staff.

New focus on Data by CMS and Regulatory Agencies

- ORGANIZED APPROACHES TO FRAUD PREVENTION –
- MDS ACCURACY OVERSIGHT – RESULT OF AUDITS AND PAYMENT RETURNS
- INTERAGENCY REPORTING – NOW VERY ACTIVE PROCESS
- NEGATIVE OUTCOMES FOR PROVIDERS CAN BE REGULATORY, FINANCIAL AND LEGAL
- COMPLIANCE IS FOUNDATIONAL – PROVIDERS MUST KNOW THE RULES AND CHANGE BAD HABITS – WHO KNOWS THE RULES FOR FEDERAL PROGRAMS AND REGULATIONS?
- Data Base content – Who monitors this?
- NEW REGULATIONS reinforce CMS position on data accuracy.

FOCUS OF GOVERNMENTAL AGENCIES

- COMPLIANCE – LINK POLICIES AND PROCESSES TO THE COVERAGE GUIDELINES
- REGULATORY STRUCTURE OF FEDERAL AND STATE PROGRAMS – MEDICARE AND MEDICAID
- NEW SURVEY PROTOCOL ON MDS ACCURACY – FITS INTO THE CURRENT CMS FOCUS AND NEW REGULATIONS.
- PAYMENT – WHAT ARE YOU BEING PAID FOR AND THE INTEGRITY OF YOUR SUBSTANIATING DATA AS WELL AS THE BILLING PROCESS?
- NEW ANALYTICS – CMS & GAO REPORTS
- ALL DATA MUST BE SUPPORTED BY THE MEDICAL RECORD.

COMPLIANCE

- COMPLIANCE IS A BIG PICTURE FOR THE ENTIRE ORGANIZATION
- MUST BE HONEST AND OPEN – REVIEW WHERE INVESTMENT IS BEING MADE.
- CAN NOT COVER UP BAD PRACTICE – VERY DANGEROUS
- INTERNAL COMPLIANCE REQUIRES AUDITS TO CONFIRM PRACTICE
- EXCELLENT OPPORTUNITY FOR QAPI PROGRAMS
- HIPPA IS A NEW FEDERAL FOCUS – IMPLICATIONS FOR THE MDS BECAUSE OF DATA USE AND SHARING
- START WITH COMPLIANCE RELATED TO PAYMENT – AND ELIGBILITY
- REVIEW PROVIDER AGREEMENTS – PART A MEDICARE – INSURANCE & OTHER CONTRACTS

Compliance is Serious Business

- Seven elements of a Compliance Program
  - Establish policies, procedures and controls
  - Exercise effective compliance and ethics oversight
  - Exercise due diligence
  - Communicate and educate employees on compliance and ethics
  - Monitor and audit compliance
  - Ensure consistent enforcement
  - Respond to incidents and take steps to prevent future incidents

MEDICARE PROVIDERS

- Agree to operate compliant with current Medicare rules and structure
- Have policies and procedures that follow the Medicare rules and data base creation guidance
- Admit only those individuals that meet the requirements for skilled nursing care
- Have certifications for each stay with proper dates and authorizing signatures
- Create and transmit assessment documents during the stay that document skilled services to create payment levels for billing, the care plan and quality measures.
- Bill only for covered services during the stay
- Maintain documentation in the medical record to document and justify covered care.

Medicare Benefit Policy Manual Chapter 8

- This document contains the definitions of covered services for all Skilled Nursing Services .
- Was last updated in October 2016.
- Is organized by sections to address pre admission requirements, covered skilled nursing and or skilled rehab services, certification requirements.
- Should be part of the operating policies and procedures in the facility.
- Has new documentation guidance for claims review.
- Has definitions used by auditors to define specific coverage for claims as well as documentation to justify payment.

Three Important Sections

- Section 20 of the Medicare Benefit Policy Manual has the specifics of the pre-admission issues. 3 day stay requirements in a variety of settings – definitions of special circumstances and overall coverage rules. The October 2016 update had some additions to this section and should be part of the knowledge base of admissions departments.
- Section 30 of the Medicare Benefit Policy Manual has all of the definitions of coverage, specific requirements for skilled rehabilitation and skilled nursing. It also has the documentation guidance for supporting data to be included in the medical record to justify claims. (this is a recent addition to the content and is very important)

- Section 40 contains the Certification requirement as well as the guidance for who can sign Certifications. Certifications are required before the case can be billed to Part A and must be available with the record for review at an audit or additional documentation request.
- Skilled facilities billing for Medicare Part A services should refer to the definitions in the M.B.P.M. in their policy and procedure statements since this document is the official guidance for coverage of services. I suggest an updated copy of the document be included as an appendix to the facility policy and procedure manual.

Who needs a copy of the M.B.P.M

- Any staff member responsible for making admission, coverage or benefit decisions on a Medicare Part A case as well as facility administration, billing or compliance departments.
- The Utilization Review committee should be careful that coverage decisions during the stay are consistent with the definitions of covered services and that documentation in the record reflects the covered services.
- Internal audits should use the definitions from the Medicare program to identify proper coverage and documentation.
- Compliance officer should be assigned updating the M.B.P.M. when necessary.
- All covered Medicare Part A skilled services are defined in this document.

RISK IS FREQUENTLY DETERMINED FROM THE MDS DATA BASE

- The data from all the MDS documents that are transmitted into the CMS system formulates much of the external review and risk for the skilled nursing facility.
- New in October 2016 the Section GG requirements began to collect admission and discharge performance data for all Medicare Part A cases. This data will demonstrate outcomes for all Medicare Part A cases and establish patterns for each facility .
- MDS data establishes payment levels for billing and patterns of service delivery , length of stay and program utilization patterns. This is currently being reported by the P.E.P.P.E.R. reports.

Next Steps to Compliance – MDS Data Base

- The completion of the MDS data set is directed from the Federal Regulations and further supported by the directions in the RAI Manual of the timeframe of the assessment document.
- Look at the State Operations Manual regulation 483.20 Survey Tags related to Resident Assessment.
- All persons completing MDS assessments or related documents into the facility data base should be aware of the regulatory Tags and the requirements. Your policies should reflect that you are in compliance with the requirements and staff have education related to the content.
- A copy of the Resident Assessment Tags are an attachment to this program.

WHO IS RESPONSIBLE FOR:

- THE MDS CODING AND ACCURACY IN THE FACILITIES?
- TRAINING?
- AUDITS?
- DATA BASE ACCURACY FOR INTERNAL AND EXTERNAL REVIEW?
- INTERNAL ANALYTICS – YOU LOOK AT YOUR DATA!

BE VERY CAREFUL WITH REHAB CODING

- MINUTES OF THERAPY HAVE A VERY SPECIFIC DEFINITION IN SECTION O OF THE RAI MANUAL
- THERAPY MINUTES MUST BE JUSTIFIED WITH NOTES AND THEN CAREFULLY CODED IN THE RECORD TO THE MINUTE – NO ROUNDING OF MINUTES
- THERAPY MINUTES IN SECTION O 400 A,B,C SHOULD BE SIGNED FOR BY THE THERAPY MANAGER OR THE INDIVIDUAL THERAPISTS IN SECTION Z FOR ACCURACY.
- ALL THERAPY MINUTES ON THE MDS MUST BE FOR SKILLED THERAPY SERVICES ONLY AND BE IDENTIFIED BY THE TYPES OF MINUTES DEFINED IN SECTION O.
- CO-TREATMENT AND INDIVIDUAL MINUTES ARE DOUBLE CODED SINCE THE LAST RAI MANUAL REVISION. – THIS IS A PROBLEM TODAY.

SO WHAT DO WE DO NOW?

START NOW WITH DOCUMENTATION OF YOUR ASSESSMENT PROCESS WITH A POLICY AND PROCEDURE THAT IS ACCURATE AND OPERATIONALLY CORRECT.

CHECK THAT ALL MEMBERS OF THE TEAM COMPLETING ITEMS ON THE MDS HAVE THE CORRECT, UPDATED DIRECTIONS FROM THE MANUAL

REVIEW THE SUBSTANTIATING DATA IN THE MEDICAL RECORD – THE CRITERIA IS REPRODUCIBLE – EXACT DOCUMENTATION.

ALL INTERVIEWS NEED TO BE DOCUMENTED IN THE RECORD – ALL 6 INTERVIEWS ON ADMISSIONS !!!!!!!

ATTESTATION SIGNATURES AND DATES NEED TO BE COMPLIANT WITH THE DIRECTIONS.

NO ONE SHOULD TAKE CREDIT FOR ACCURACY OF DATA IN SECTION Z THAT THEY DID NOT CREATE OR SECURE FROM THE RECORD.

SINCE THERAPY MINUTES AND DAYS PRODUCE SIGNIFICANT PAYMENT RISK THEY SHOULD BE ATTESTED TO BY THE THERAPY MANAGER OR A THERAPIST.

DO YOU HAVE A LIST OF ALL THE STAFF INVOLVED WITH THE SCHEDULING AND COMPLETION OF THE MDS PROCESS – THAT INCLUDES TRANSMISSION AND VALIDATION AS WELL AS CORRECTIONS.

WHERE ARE THE MANUALS AND ARE THEY UPDATED TO OCTOBER 2016.

AND NOW…….

- SHOULD WE AUDIT ? GOOD IDEA!!!!!!!!!!
- Audit activities should focus on areas identified in the survey process
- CHECK ON TRAINING
- DO NOT ASSUME STAFF HAVE READ MATERIALS FROM THE MANUAL – CHECK ON THEIR UNDERSTANDING AND COMPLIANCE.
- NO ONE SHOULD EVER SIGN FOR ACCURACY OF DATA THAT THEY ARE NOT COMPLETING OR CREATING.
- THIS NEW SURVEY TASK IS VERY PROBLEMATIC AND RISKY – BE CAREFUL.
- CHECK THAT ALL STAFF DOING DATA ENTRY ON THE MDS HAVE MANUAL INSTRUCTIONS AND DEFINITIONS.
- READ THE REGULATORY TAGS RELATED TO THE ASSESSMENT PROCESS – PAY SPECIAL ATTENTION TO THE PROBES AND SURVEYOR GUIDANCE SECTIONS.

P.E.P.P.E.R. REPORTS

- Very important to review each year to identify patterns of data that my indicate risk areas for the facility.
- These reports only represent a portion of the data that CMS has about your facility compliance, patterns of service delivery and how the data compares to facilities in your state, payment jurisdiction and nationally.
- There will be an open door forum call later this spring related to the 2017 reports.
- Monitor this data – your chance to see how your facility compares to others and if you have data patterns you need to investigate.
- Risk management – Monitor P.E.P.P.E.R. reports.

Skilled Nursing Facility Quality Reporting Program Requirements for Fiscal Year 2018 Reporting Year

- September 2016 CMS published a fact sheet with information related to this program and reflect data collected from your MDS data transmissions from 10/01/16 to 12/31/16.
- This fact sheet is an attachment to this program and contains significant data related to the quality measures and the requirements for data transmission. Providers have until May 15, 2017 to correct or submit the data necessary to calculate the measures.
- References to the requirements for this requirement from the IMPACT Act of 2014 that mandates the SNF QRP are in the document.
- All facilities should audit that the transmissions from 10-01-16 to 12/31/16 are correct and have necessary data to calculate the quality measures . This includes the SNF Part A PPS Discharge Assessment.

CMS Skilled Nursing Facility Quality Reporting Program – September 2016

- Completion of MDS 3.0 Assessments and Information related to the SNF Quality Reporting Program
- Attachment to the program
- This is all related to the data for Section GG – Discharge combinations for Part A PPS cases and the Pressure Ulcer quality measure for the SNF Quality Reporting Program
- Contains all the references to the specific items included and the percentage of items that must be transmitted.

- The Annual Payment Update threshold for F.Y. 2018 is not based on the final calculation of a quality measure, or complete stays. Rather it is based on the determination of the completion of the items necessary to calculate the quality measure, which we note includes the risk adjustment items. The threshold is based on the completion of items on a record regardless of whether the stay has been completed. A provider must have 100% of all the items necessary to calculate the measure on at least 80% of the records submitted that would be used to calculate (and risk adjust) the quality measure.
- References to all the items, and timelines are in the document.
- MDS managers must review this document and related requirements as soon as possible. This includes the warning about missing data and dashes.

NEW ITEMS FOR THE MDS 3.0 October 2017

- The MDS data set will change in October 2017 with the addition of new items in Section N and Section P.
- The RAI Manual supporting these changes has not been released.
- The items and coding directions for the form have been released
- The new MDS will be version 1.15.0 and will begin use October 1, 2017.
- Section N will add 5 new items
- Section P will have a new title and add 7 new items

Section N – new items

- Item N0410H – Opioid – will be coded with other medications received in the last 7 days
- Item N0450 Antipsychotic Medication Review – item title
- Item N0450A – Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment , whichever is more recent?
  - Four options for answers
  - No
  - Yes routine
  - Yes PRN
  - Yes routine and PRN

- Item N0450B – Has gradual dose reduction (GDR) been attempted?
- Options No – Yes
- If Yes then go to item N0450C
- Item N0450C – Date of last attempted GDR
- Item N0450D – Physician documented GDR as clinically contraindicated – options yes or no
- Item N0450E – Date physician documented GDR as clinically contraindicated.

Section P – new items

- Section P - P200 has a new title – Restraints and Alarms
- New item Alarms – Instructions: An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected
- Item P200A – Bed alarm
- Item P200B - Chair alarm
- Item P200C – Floor mat alarm
- Item P200D – Motion sensor alarm
- Item P200E – Wander /elopement alarm
- Item P200F – Other alarm

- The corresponding definitions for the various types of alarms listed on the assessment have not been released at this time and will stimulate a lot of discussion.
- The entire team must focus on alarm use and proper documentation as well as evaluation of the utility of the alarm and alternatives.
- All of these additional items will have RAI Manual directions and definitions for coding. Look for that information in the summer with an implementation of coding October 1, 2017.
- The content of the MDS 3.0 will change as of that date as well.

Overview of Claims-Based Measures

- Measures use Medicare claims, although the MDS is used in building stays and for some risk-adjustment variables.
- Measures only include Medicare fee-for-service beneficiaries.
  - Eventually, encounter data may allow us to include Medicare Advantage enrollees.
- All are short-stay measures that only include those who were admitted to the nursing home following an inpatient hospitalization.
- Measures are risk-adjusted, using items from claims, the enrollment database and the MDS

Percentage of Short-Stay Residents Who Were Re-hospitalized After a Nursing Home Admission

- Development of readmission measures is a high priority for CMS:
  - The Protecting Access to Medicare Act calls for public reporting of readmission measures on Nursing Home Compare.
  - SNF Value-Based Purchasing (VBP) will use a claims-based readmission measure.
- Includes hospitalizations that occur after nursing home discharge but within 30-days of stay start date.
  - Includes observation stays.
  - Excludes planned readmissions and hospice patients.
- A 'stay-based' measure that includes both those who were previously in a nursing home and those who are new admits.

Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community

- For many short-stay patients, return to the community is the most important outcome associated with SNF care.
- Measure uses MDS assessments to identify community discharges and claims to determine whether the discharge was successful.
  - An episode-based measure that looks at whether resident is successfully discharged within 100 days of admission
  - Successful discharge defined as those for which the beneficiary was not hospitalized, was not readmitted to a nursing home, and did not die in the 30 days after discharge.

Percentage of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit

- Better preventative care and access to physicians and nurse practitioners in an emergency may reduce rates of emergency department (ED) visits.
- Outpatient ED visit measure has same 30-day timeframe as the re-hospitalization measure and considers all outpatient ED visits except those that lead to an inpatient admission (which are captured by the re-hospitalization measure).

Percentage of Short-Stay Residents Who Made Improvements in Function

- Measures the percentage of short-stay residents who made functional improvements during their complete episode of care.
  - Based on self-performance in three mid-loss activities in daily living (ADLs): transfer, locomotion on unit, walk in corridor
  - Calculated as the percent of short-stay residents with improved mid-loss ADL functioning from the 5-day assessment to the Discharge assessment
  - Based on Discharge assessment at which return to the nursing home is not anticipated
  - Excludes residents receiving hospice care or who have a life expectancy of less than six months

Percentage of Long-Stay Residents Whose Ability to Move Independently Worsened

- Measures the percentage of long-stay nursing residents who experienced a decline in their ability to move around their room and in adjacent corridors over time.
  - Defined based on "locomotion on unit: self-performance" item.
  - Includes the ability to move about independently, whether a person's typical mode of movement is by walking or by using a wheelchair.
  - Risk adjustment based on ADLs from prior assessment.
- Decline is measured by an increase of one or more points between the target assessment and prior assessment.
- Look at the data in Section G.G. to be used in October 2016.

Percentage of Long-Stay Residents Who Received an Antianxiety or Hypnotic Medication
THIS IS CURRENTLY ON HOLD

- Measures the percentage of long-stay residents in a nursing facility who receive antianxiety or hypnotic medications.
  - Purpose of the measure is to prompt nursing facilities to re-examine their prescribing patterns in order to encourage practice consistent with clinical recommendations and guidelines.
  - No risk adjustment
- Excludes residents who are receiving hospice care or have a life expectancy of less than 6 months at the time of target assessment.
- This QM will have a delay.

YOU CAN MANAGE YOUR RISKS AND HAVE BETTER FISCAL, CLINICAL AND OPERATIONAL OUTCOMES BY FOCUSING ON:

- COMPLIANCE
- DATA BASE CONTENT
- USING ANALYTICS AS A TOOL

- RISK MANAGEMENT – THE NAME OF THE GAME
- PROACTIVE APPROACHES TO MITIGATE OR ELIMINATE RISK
- HIGH RISK DATA RELATED AREAS ARE VERY DANGEROUS
- MANAGERS MUST BE AWARE OF DATA & MONITOR BUILDING DATA PROFILE.
- RISKS ARE GROWING FAST THIS YEAR WITH DATA CHANGES IN OCTOBER AND QM CHANGES IN APRIL.

QUESTIONS?????