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 a healthcare industry consultant with a penchant for bridging clinical, financial and compliance needs in an easy-to-understand, fun way.

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

-List all commercial interests. Note if you are employed by a company, you have a commercial interest in that company.

- The Alliance Training Center
- Medpass

2016 MDS 3.0 Updates for Skilled Nursing Facility Leadership

PRESENTED BY

LEAH KLUSCH
EXECUTIVE DIRECTOR
THE ALLIANCE TRAINING CENTER
ALLIANCE, OHIO
330-821-7616
leahklusch@tatci.com

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

Chances are ……..

- Based on my experience…
  - Admissions department has not seen the MBPM chapter 8
  - Updated definitions and coverage guidelines are not being used
  - Audits on Part A cases have not been done for Compliance
  - Documentation guidelines are not being used
  - Certifications are not signed and dated properly and stored carefully – originals?
  - Doctors orders for services do not match the first day of service you are billing for.
  - Coverage of skilled service does not match the requirements – for example: supervision of PTAs and COTAs giving therapy……
- **Use this list for a quick audit - then take action**

SO HOW DOES THIS CONNECT…..

- LET'S START WITH MEDICARE PART A –
  - HOW MUCH DO YOU BILL MEDICARE PART A EACH MONTH – PER FACILITY? – Total $
  - THAT IS YOUR RISK FOR POOR DATA - THERAPISTS NOT KNOWING THE COVERAGE GUIDELINES – POOR DOCUMENTATION – BAD COVERAGE DECISIONS
  - DO NOT TRUST CONTRACTORS – "WE HAVE TRAINING!!!!!" WRONG !!!! AUDITS?
  - THIS IS THE FACILITY RESPONSIBILITY – THEY CAN RUN.
  - WE HAVE OUR OWN THERAPY – NOT MUCH BETTER – TRAINING – POLICIES - AUDITS
  - MOST OF WHAT YOU BILL IS FOR REHAB SERVICES – TAKE A GOOD LOOK AT WHAT IS HAPPENIG – REHAB AUDITS ARE NECESSARY – VERY INFORMATIVE AND GOOD COMPLIANCE ACTIVITY.
  - ASK YOURSELF – WHO HAS A COPY OF THE COVERAGE GUIDELINES AND THE RULES – FRONT LINE THERAPY STAFF? THEY NEED IT. They are billing the minutes that create the $ groups.
  - HOW DO THERAPY MINUTES GET ON THE MDS? – WHO SIGNS FOR ACCURACY?

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.

Comprehensive Assessment Completion

- Big issue – do you document Section V 200b2 correctly
- Completion of the formal care plan – after the care plan meeting
- Then and only then can column B of Section V be filled in and the V200c can be signed and dated on the date of the care plan meeting or later.
- THEN AND ONLY THEN CAN THE 14 DAY ASSESSMENT BE TRANSMITTED AND VALIDATED UNLESS YOU DID THE CAAs ON THE FIVE DAY ASSESSMENT.
- PLEASE READ SECTION V IN CHAPTER 3 OF THE RAI MANUAL CAREFULLY – THIS IS AN ACCURACY AND A COMPLIANCE ISSUE.
- BE CAREFUL – VERY COMMON PROBLEM.
- READ MANUAL INSTRUCTIONS VERY CAREFULLY.

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 !!!!!!!!

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.

Section A
Important Dates in this section

Assessment Reference Date – item A2300 – also described in Chapter 2 – very important !!

Medicare Stay item A2400 – new item – remember to know the Medicare coverage criteria and rules-May 2013 Updates

New Items October 2016 – Section GG

- Data Set Available GG0130-Self Care
- Assessments for Admission (Start of PPS Stay only)
- Admission Assessments – Assessment Period days 1 through 3
- Code residents usual performance at the start of the SNF PPS day for each activity using 6 point scale.
- If activity was not attempted at the start of the SNF PPS stay code the reason
- Code the patients end of SNF PPS goals using 6 point scale.

6 Point Scale
Safety & Quality Performance

If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.*

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.

05. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.

04. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

6 Point Scale
Safety & Quality Performance (con't.)

- 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or supports trunk or limb, but provides less than half the effort.
- 02. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** – Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

Activity Not Attempted Codes

If activity was not attempted, code reason:

07. **Resident refused.**

09. **Not applicable.**

88. Not attempted due to **medical condition or safety concerns**.

Self-Care Activities

These are new definitions - Read them carefully!

A. **Eating**: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

B. **Oral hygiene**: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.

C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing or ostomy, include wiping the opening but not managing the equipment.

Mobility Assessment Items

NEW TASKS TO ASSESS

B. **Sit to lying**: The ability to move from sitting on side of bed to lying flat on the bed.

C. **Lying to sitting on side of bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

D. **Sit to stand**: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.

E. **Chair/bed-to-chair transfer**: The ability to safely transfer to and from a bed to a chair (or wheelchair).

F. **Toilet transfer**: The ability to safely get on and off a toilet or commode.

Mobility Assessment Items (con't.)

H1. **Does the resident walk?**

0. **No**, and walking goal is not clinically indicated ➡ Skip to GG0170Q1, Does the resident use a wheelchair/scooter?

1. **No**, and walking goal is clinically indicated ➡ Code the resident's discharge goal(s) for items GG0170J and GG0170K

2. **Yes** ➡ Continue to GG0170J

J. **Walk 50 feet with two turns**: Once standing, the ability to walk at least 50 feet and make two turns. (90° turns)

K. **Walk 150 feet**: Once standing, the ability to walk at least 150 feet in a corridor or similar space. (no turns)

Mobility Assessment Items (con't.)

Q1. Does the resident use a wheelchair/scooter?

→ 0. **No** Skip to GG0130, Self Care

→ **1. Yes** Continue to GG0170R

R. **Wheel 50 feet with two turns**: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

RR1. Indicate the type of wheelchair/scooter used.

1. Manual

2. Motorized

S. **Wheel 150 feet**: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.

SS1. Indicate the type of wheelchair/scooter used.

1. Manual

2. Motorized

- **Only measure wheeling chair - not scooting chairs.**

Admission or Discharge Performance Coding Tips from 2016 Manual for Section GG

- The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted under SNF Part A.
- On the Part A PPS Discharge assessment (A0310H = 1), the Self-Care items in GG0130 are completed only if the Type of Discharge is Planned (A0310G = 1).
- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.
- When coding the resident's usual performance, use the 6-point scale or code the reason why an activity was not attempted.
- At admission, when coding for the resident's discharge goal(s), use the 6-point scale.
- Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's *usual performance* during the assessment period.

Admission or Discharge Performance Coding Tips from Draft Manual for Section GG (Cont'd.)

- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash ("-").

Section GG Functional Ability & Goals – Discharge (End of PPS Stay)

- Item GG0130 -self Care
- Last 3 days of SNF PPS Stay ending on A2400-C
  - (C. End Date of most recent Medicare stay)
- Complete only if A0310G Is not 2-Unplanned Discharge and A0310H – SNF PPS part A Discharge (end of stay)
- And the length of the Part A Stay is greater than 2 days.
- And the discharge is not to an acute care hospital A2100 discharge Status

New Assessment Discharge Tracking Form

- Use when Med A stays & payment source changes
- Elder stays in the facility
- Totally new discharge assessment
- Coded A0310-H
- Always a planned discharge
- Refer to Chapter 2 instructions aout timing & Coding. Pages 2-44 and 2-45

New Assessment Discharge Tracking Form cont'd

- This assessment has GG discharge status coding
- Section J-Falls coding since last assessment
- Section M – Skin Condition since last assessment

ANALYTICS

- ARE VERY HELPFUL
- CAN LOOK AT ALL SEGMENTS OF THE DATA
- ADDITIONAL RISK MANAGEMENT DATA CAN TRACK FALLS, SKIN AND OTHER CLINICAL AND OUTCOME RISK AREAS
- REHOSPITALIZATIONS CAN BE TRACKED AND EVALUATED
- MDS AND BILLING DOCUMENTS CAN BE SCRUBBED PRIOR TO TRANSMISSION TO ELIMINATE ERRORS
- ANALYSIS OF ALL ASPECTS OF THE CARE PROCESS CAN ASSIST STAFF TO EVALUATE OUTCOMES AN PATTERNS OF CARE

Section O
Therapy Services

- First look at criteria for therapy and that includes the active doctor's order at the beginning of the therapy treatment.
- Now we have requirements for four types of minutes to be documented :
  - Individual Minutes
  - Concurrent Minutes
  - Group Minutes
  - Co-Treatment

Section O
Therapy Services

- Therapy start and stop dates are on each form
- Days of therapy remain the same
- Concurrent minutes mean therapy delivered to two residents at the same time – no more – big issue!!!!!
- Respiratory therapy remains the same – looking for manual revision for this- Nurse can deliver therapy and code minutes. Glossary reference for definition pg. Appendix A-19.
- Coding minutes of therapy p.O15-29

Section Z
Assessment Administration

- Only sign the assessment when it is complete – be careful of dates here.
- The rules for electronic signatures must be in line with state and local laws for the same – You must have specific security in the system to prevent use of electronic signatures by other than the individual.
- Item Z0400 is very important –everyone who codes items on the form needs to sign – and date and identify the items they have completed – very important

Section Z
Assessment Administration

- The attestation is a legal responsibility document – It was written to assure accuracy and make MDS documents available for external audit.
- Should be in HR records – "I certify.."

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?????