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?
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.
- PAYMENT – WHAT ARE YOU BEING PAID FOR AND THE INTEGRITY OF YOUR SUBSTANTIATING DATA AS WELL AS THE BILLING PROCESS?
- NEW ANALYTICS – CMS & GAO REPORTS

PROVIDERS CAN NOT ELIMINATE ALL RISK BUT NEGATIVE OUTCOMES CAN BE MINIMAL OR ELIMINATED WITH PROACTIVE APPROACHES, TRAINING AND POLICY DEVELOPMENT. THE INDUSTRY IS NOT READY FOR THIS ORGANIZED OVERSIGHT AND MORE AUDITS OF THE DATA BASE AND RELATED DOCUMENTS.

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 ELIGIBILITY
- REVIEW PROVIDER AGREEMENTS – PART A MEDICARE – INSURANCE & OTHER CONTRACTS
LET’S TAKE A LOOK............

• The current document was updated in October 2015 with many pages of coverage guidance and also significant information about claims review requirements for documentation.
• The new guideline for Maintenance Therapy is also included as well as expanded guidelines for Skilled Nursing and Skilled Therapy services.
• Certification rules and signature guidelines
• All administrators should have this document and use it when questions come up to define the covered services and documentation requirements.
• Many facilities use outdated coverage guidance – bad idea – terrible idea!

USE THE MEDICARE BENEFIT POLICY MANUAL (CHAPTER 8) FOR ORIENTATION, INSERVICES, DOCUMENTATION GUIDELINES AND COVERAGE DECISIONS.
• DOCUMENT THE SECTIONS OF CHAPTER 8 IN YOUR DOCUMENTATION NOTES OR UTILIZATION MINUTES TO CONFIRM COVERAGE.

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 – TRAININGS – POLICIES –
      AUDITS
    • MOST OF WHAT YOU BILL IS FOR REHAB SERVICES – TAKE A GOOD LOOK AT WHAT IS
      HAPPENING – REHAB AUDITS ARE NECESSARY – VERY INFORMATIVE AND GOOD
      COMPLIANCE ACTIVITY.
    • ASK YOURSELF – WHO HAS A COPY OF THE COVERAGE GUIDELINES AND THE RULES
      – MOST LIKELY THERAPY STAFF THEY NEED IT. They are billing the minutes that
      create the $ groups.

WHO IS RESPONSIBLE FOR:

• THE MDS CODING AND ACCURACY IN THE FACILITIES?
• TRAINING?
• AUDITS?
• DATA BASE ACCURACY FOR INTERNAL AND EXTERNAL REVIEW?

R.N. Assessment Coordinator

• Is required
• Person must be aware and able to identify how they manage the assessment
  process
• Signature on section Z that the assessment is complete – What does this
  mean?
• Know the practice guidelines for nurses in your state
• LPN/LVN can not assess in most states – they gather information and report
• Should not be writing assessment notes in the chart – document observations
  and report facts
New Items October 2016 – Section GG

- Draft of Data Set Available GG0130 Self Care
- Assessments for Admission (Start of PPS Stay)
- 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.

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.
Self-Care Activities

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.

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Section GG Item GG0170 - Mobility

- Admission assessment only
- Assessment Period days 1 through 3
- Use of Usual Performance terminology
- Code if activity was not attempted
- Code admission performance and end of SNF PPS stay goal

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Mobility Assessment Items

- **Sit to lying**: The ability to move from sitting on side of bed to lying flat on the bed.
- **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.
- **Sit to stand**: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
- **Chair/Bed-to-chair transfer**: The ability to safely transfer to and from a bed to a chair (or wheelchair).
- **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. Yes, and walking goal is clinically indicated  
      Code the resident’s discharge goal(s) for items GG0170Q and GG0170K.

   J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
   K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Q1. Does the resident use a wheelchair/scooter?
   0. No  
      Skip to GG0130, Self Care
   1. Yes  
      Continue to GG0170R, Wheel 50 feet with two turns.

   R1. Indicate the type of wheelchair/scooter used.
      1. Manual
      2. Motorized

   S1. Indicate the type of wheelchair/scooter used.
      1. Manual
      2. Motorized

Coding information from October 2015

LTCH Quality reporting Manual Section

GG
1. On the admission assessment, code the patient’s usual performance using the 5-point scale, or code the reason an activity was not attempted, as well as the patient’s discharge goal(s) using the 5-point scale. Instructions about coding discharge goals are provided below.

2. Record the patient’s usual ability to perform each activity. Do not record the patient’s best performance and do not record the patient’s worst performance, but rather record the patient’s usual performance during the assessment period.

3. Do not record the staff’s assessment of the patient’s potential capability to perform the activity.

4. If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.

5. If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.
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

Coding of Self Care Items

- Same as an Admission
- 6 Point Scale
- Activity not attempted code
- Code only discharge performance
- "Usual Performance” definition - Record the patient’s usual ability to perform each activity. Do not record the patient’s best performance and do not record the patient’s worst performance, but rather record the patient’s usual performance during the assessment period.

Section GG Functional Abilities Discharge

- GG0170 Mobility
- Same as an admission
- Performance code only
- Activity not attempted code
- Same performance activities
MDS 3.0 Changes: Quality Measures Documentation
Requirements for Nursing Leadership

Current Situation with Section GG
April 2016

• RAI Manual has not been released for this Section.
• Long Term Care Hospital Manual is released
• LTCH Section GG is very similar to MDS 3.0 Section GG
• New performance scale begin discussions with team members about difference in
  ADL's and performance coding.
• Data collection forms may be necessary for documentation in the medical record
  – therapy notes.
• Preplanning and training are important.

Coding Conventions

• There are several standard conventions to be used when
  completing the MDS assessment, as follows:
  • The standard look back period for the MDS 3.0 is 7 days, unless otherwise stated.
  • A different coding convention will be used for only Section GG in the MDS:
    • Section GG uses a 3 day assessment period within the first 72 hours of admission
      and within the last three days before discharge. Section GG is the only MDS section
      using this assessment period timeframe.
    • Section GG requires reporting the resident’s “usual” performance of an activity. All
      other MDS sections require coding that is based on the “rule of three.”

Glossary of Terms

• Admission Assessment and Planned Discharge Assessment: Assess based on
  direct observation, the patient’s self report, family reports, and direct care staff
  reports documented in the medical record during the 3 day assessment period.
  Admission Assessments are completed as close to the actual time of admission
  as possible. Do not record the staff’s assessment of the patient’s potential
  capability to perform an activity.
• Discharge Goal(s): established at the time of admission and during the three-
  day admission assessment period, this/these is/are based on the admission
  assessment, discussions with the patient and family, the clinician’s professional
  judgement and the clinician’s professional standards of practice. At least one
  functional status goal is reported on the admission assessment to meet Quality
  Reporting Program requirements. Do not record the staff’s assessment of the
  patient’s potential capability to perform an activity.
• Usual: Done, found, or used most of the time or in most cases. The patient’s
  ability during the assessment period to perform an activity with or without
  assistance is determined by discussion or review of available information about
  the patient’s ability to perform an activity during the period examined. The usual
  is not the patient’s best or worst performance nor is it the patient’s most dependent
  or independent performance.
MDS 3.0 Changes: Quality Measures Documentation
Requirements for Nursing Leadership

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 AND PATTERNS OF CARE

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 whom 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 readmission measure and considers all outpatient ED visits except those that lead to an inpatient admission (which are captured by the readmission 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

- 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.

Question and Answer

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