CLINICAL REIMBURSEMENT ESSENTIALS FOR LEADERS
Using your SNF data

David Rokes, RN
C.E.O.
Post Acute Consulting, LLC
Objectives

- Understand effective strategies and systems implementation to ensure appropriate reimbursement and withstanding audit scrutiny
- Managing Managed Care
- Gain knowledge on the most common areas where reimbursement opportunities are missed
- Understand the importance of the MDS & it’s relationship to Quality Measures
- Be able to define techniques for Denials management and the medical record review process
Clinical Reimbursement Goals

- Increase in Daily Medicare Rates
- Increase in Length of Stay
- Cost Containment
- Ensuring Compliance with State and Federal Regulations
- Process Standardization Throughout Facilities
- Improved Quality Care Through QM Focus
- Denials Prevention
- Increase Profitability of Managed Care
Importance

- Decreased Funding from State and Federal Government
- Implementation of Pay for Performance–Value Based Purchasing
- Govt. Move Toward Bundled Services
  - ACO’s and PACE Type Programs
- Increase in Transparency for Public Reporting
- Provider Relationships
  - Setting yourselves apart from the competition
- Ensuring Appropriate Reimbursement for Services Delivered to Your Residents
- The Recovery Audit Contractors (RAC) are increasing focus in the SNF’s
Program Focus

RUG Score Distribution
- Therapy Categories
- Nursing Categories
- End Split Capture

Length Of Stay

Appropriate Skilled Services and Documentation

Therapy Program Implementation and Oversight

MDS and Medicare Compliance

Implementation of Metric Tracking Tools

QM Tracking and Management
Skilled Nursing Facility Primary Payment Sources

- Medicare Part A
- Managed Care
- Commercial Insurance
- Managed Medicare Part C
- Medicaid
- Private Pay
- Long Term Care Insurance
Daily Skilled Management
Daily Focused meeting with PPS/Managed Care team

- Nursing, Rehab, Business Office, Social Services, etc.

Meeting should take no longer than 1 minute per skilled resident

Effective way to monitor reason for skilling on a daily basis and update any changes in condition and/or treatment

Process leads to clean month end close and effective Medicare management
Establish reasons for skilling

**Rehab**
- # of disciplines to be involved
- Estimated time frame to meet goals
  - Nursing
- Any treatments requiring daily skilled monitoring
  - Infections, Wound Treatment, Cardiac Issues, Behavior Monitoring and Medication Adjustment, etc.

**Teaching Needs**
- Diabetic Teaching
- Colostomy
- Medication Regimen
- Wound Care, etc.
Discharge Plan

- Estimated Length of Stay
  - This is just an estimation, may vary greatly from the time of actual discharge
- Final Discharge Destination
  - Home, ALF, Another SNF etc.
- Discharge Barriers
  - Level of Function needed to reach D/C destination
  - Any Community Services
  - Medication/O2 management
  - Home management (e.g., stairs, ability to care for self at home, meal preparations)
Reason for admission to hospital and continued need for skilled care in the SNF

Use V-codes when applicable

- For Ortho aftercare
  - Use appropriate code to specify area to be treated
  - Remember we do not treat the actual fracture we are treating the aftermath

Medical Codes

Therapy Codes
ICD–9 codes (cont.)

• Be sure to have the most current ICD–9 code book as these are frequently updated
  • This will be the last year of updates to ICD–9; ICD–10 will be implemented in October of 2015
• Codes should paint a picture of why the resident is skilled
• Use only codes that relate to why the resident is currently in a Part A stay
  • i.e., if resident has HTN that is stable and not affecting current treatment do not include
Make sure the codes support the services billed on the UB-04

- If in a rehab category there should be therapy charges (only exception may be period pending an OMRA)

Readjust codes as needed

- New onset of disease while in a Part A stay
- Newly diagnosed pneumonia, code should be on correlating month’s UB-04
- If issues resolved they should be deleted from the next month’s bill
Daily Management

ICD–9 Codes (cont.)
- Watch for benign codes
  - I.e., IDDM without complications (250.00) vs IDDM with renal manifestations (250.4 and follow with 5th digit when necessary) etc.
  - Updated ICD–9 codes should be communicated to the Business Office when they occur instead of waiting until the end of the month
  - This can be one of the biggest hold-ups at month end close
  - At least weekly
- Track Diagnosis and ICD–9 codes on log
  - UB–04 only records the number codes

ICD–10
- Coming
- October 2015
- Announced early 2014 that they would delay Oct 2014 roll–out for 1 more year
RUGS–IV Management

- These are critical to capture an appropriate picture of treatments being delivered
- Watch Look Back Periods for treatments delivered
  - 7 days (IV fluids, Therapy Minutes, ADL tracking, etc.)
  - 14 days (IV medications, Blood Transfusions, Oxygen, etc.–While a resident)
- 14 days (Behaviors)
- Know your Assessment Date Range for MDS Completion
- Monitor ADL index

Watch your ARD’s (Assessment Reference Dates)
RUGS–IV Management

Extensive Service Qualifiers

- Must be while a resident
- Ventilator or Respirator
- Tracheostomy Care
- Isolation for Active Infectious Disease
MDS Cycle

• Discuss where they are in the MDS cycle daily
  • ARD
  • Status of completion (daily meeting is a good format to “remind” disciplines of need to complete)
• Date of Transmission
  • Must be transmitted within 14 days of completion (some states require a shorter time frame)
  • **MDS’ must be transmitted and accepted into the State/CMS database prior to billing**
• Some FI/MAC’s are now cross referencing the MDS repository when UB–04’s are submitted
MDS Cycle

- LOA’s
  - If resident is out for MLOA for <24 hours (and not admitted to the hospital) and not in the bed at midnight, that day cannot be billed for and the MDS cycle is readjusted by one day, you do not need to start a new MDS cycle
  - If out greater than 24 hours or <24 hours but admitted to the hospital then a new Medicare cycle must be started
  - An exception to this rule can be a “social leave”, a new cycle does not need to be started upon return, but the facility cannot bill for the days that “the head is not in the bed” at midnight (use caution in these situations as it may jeopardize Medicare coverage)
RUGS–IV Management

OMRA’s (Other Medicare Required Assessment)

- End of Therapy OMRA and a Start of Therapy OMRA
- End of Therapy OMRA
  - Required only if the resident was in a Rehabilitation RUGS–IV Classification and will continue to need Part A SNF–level services
  - If last RUG score was in a clinical category an OMRA is not required
  - May be set day 1–3 after completion of all therapy. Payment changes on First Non–Therapy Day
- Start of Therapy OMRA
  - When a resident returns to Therapy 5–7 days/week
  - ARD is set 5–7 days after therapy starts
OMRA’s (2)

Change in Therapy (COT) OMRA

- Needed whenever there is a change in therapy level that would result in a change in RUG-IV level using RTM (Reimbursable Therapy Minutes) rather than just total minutes reported on the MDS.
- Must monitor residents on a rolling 7 day cycle beginning the day after the previous assessment reference date.
  - For example, if a 14 day MDS ARD is set on day 14, then the facility must monitor minutes delivered days 15 through 21. If a decrease in RTM’s is noted then the COT would be performed. Payment would change on day 15 to the new RUG-IV level. Then reassess on day 28.
  - ARD would be set on the 7th day resulting in payment change.
Skilled Nursing Services

- IV medications, IV therapy, and IM injections
  - SQ Injections are not deemed skilled

- Feedings account for 51% of daily calories or 26% of daily calories and 501cc

- NG tube, G tube, J tube feedings

- Nasopharyngeal and tracheotomy aspiration
Suprapubic catheters

Insertion, irrigation, and replacement of urinary catheters has been deleted

Application on dressing involving prescription medications and aseptic techniques

Pressure or stasis ulcers

2 or more of any stage and treatment

Any Stage III or IV pressure ulcer and treatment
Reasons to Skill

• Management and Evaluation of a Care Plan
  • Are you establishing and/or monitoring the treatment regimen to meet the resident’s physical and emotional needs?
  • Do needs require licensed staff to manage them?
  • Are the total sum of unskilled services requiring skilled management?
• Are you providing the nursing process of observation, assessment, planning, implementation and evaluation?
• Risk of complicating factors, high probability of relapse
  • Is the resident’s condition stabilized?
Reasons to Skill

- Observation and Assessment
  - Is there the likelihood of a change in the resident’s condition?
  - Are skills of a licensed nurse required to monitor and evaluate the possible for a modification to treatment?
  - Is there a need to initiate medical procedures (labs, radiology, blood gases, etc.)?
  - Does the physician think there is a high likelihood of a change in condition?
• Observation and Assessment (cont.)
  • Is there a need to observe for therapeutic effects and/or adverse side effects of drug dosage adjustments or newly prescribed medications i.e. Coumadin, antibiotic therapy, new or adjusted steroid therapy, chemotherapy, pain medications, cardiac medications, psychotropic medications
  • Is the resident dehydrated, electrolyte imbalance
  • Are you performing daily assessment for: neurological, respiratory, cardiac, pain/sensation, gastro-intestinal, nutritional, circulatory, genito-urinary, musculoskeletal/mobility, skin
Daily Management

Teaching and Training Activities
- Self-Administration of:
  - Injectable Medications
  - Complex Range of Medications
  - G-tube Feedings
- New Diabetic (Medications, dietary changes, foot care)
- Self Catheterization
- Skin/Wound Treatments
- Prosthesis Care, Care of Splints, braces, orthotics
- Maintenance of Central Lines, Suprapubic tubes
- New colostomy or ileostomy care

Reasons to Skill
Skilled Rehab

1. Must be directly and specifically related to an active written treatment designed by the M.D. after any needed consultation with a qualified therapist
   • Signature must be obtained prior to billing Medicare
2. Must be of level of complexity that requires the judgment, knowledge and skills of a qualified therapist
   • 3. Assessment based on patients restoration potential in a “reasonable and generally predictable” period of time
   • 4. Services are necessary for establishment of a safe and effective maintenance program
Daily Management

Rehabilitation Needs
- At least 5 days per week
- Watch for Dialysis patients, rehab must be at least 5 separate days a week to meet skilled criteria
- Caution: Watch for residents falling into RM category who do not receive therapy 5 separate days a week
- Therapy must be delivered for at least 15 minutes a day to code on the MDS (this does not need to be all at once)
- As of October 2013 MDS now tracks distinct calendar days

Reasons to Skill
Daily Management

Reasons to Skill

- Rehabilitation Needs:
  - Count only therapy delivered in the facility or with the facilities therapists (i.e. home eval/treatment)
  - Count only actual treatment time—Reimbursable Therapy Minutes
  - Group therapy cannot exceed 25% of the time in the 7-day observation period
  - Number of Disciplines Involved
  - Monitor minutes delivered on a daily basis as a team when they are in the assessment date range
  - Appropriate amount of disciplines and minutes for the assigned RUG score
Restorative Nursing

- Rehab Low with therapy involvement
  - Therapy 3 days a week for at least 15 minutes a visit and restorative 6 times a week in qualifying areas for at least 15 minutes in each (they do not need to be 15 consecutive minutes)
  - This makes more sense for the LTC resident in that the actual transition plan will be over to nursing
- Know if your M.A.C. allows for restorative as a stand alone skill
  - Probably no more than 2 weeks
  - Must have 6x/week in 2 areas at least 15 minutes each, licensed progress notes (can be written by R.A. and countersigned by nurse), and care plan
  - Must have goals for continued improvement
  - Recommend an MD order is in place but not required
Documentation Guidelines

The key to success is appropriate/accurate documentation!
ADL Score

Daily Management

- One of the most inaccurate areas in the DAVe audits
  - Facilities tend to under code this area
- Remember to include care delivered around the clock
  - Many residents require increased levels of care at night
- Monitor ADL care given by all disciplines
  - In therapy, activities, esp. with the Nursing Assistants on all shifts
- Code for actual care delivered not what you think the resident is capable of doing
Daily Management

ADL Score

- Bed Mobility (0–4 Points)
- Eating (0–4 Points)
- Toilet Use (0–4 Points)
- Transfers (0–4 Points)
- One incorrect coding of an ADL category from limited to extensive assist or number of assist required can cost over $150/day
Ancillary Management

- Areas to monitor:
  - DME/Dressings/Medical Supplies
  - Pharmacy Costs
  - Lab, X-Ray and Radiology
  - Physician Visits
    - Facility responsible for technical component not professional component
  - Transportation Costs
Excluded services when performed in outpatient hospital setting:

- Cardiac Catheterization
- CT Scans
- MRI/MRA
- Radiation Therapy
- Angiography
- Venous Procedures
- Lymphatic Procedures
- Ambulatory Surgery involving the use of an Operating Room
- Certain Chemotherapy Drugs and Administration Services
- Dialysis and ambulance transport
- Physician Professional Services
- Certain Emergency Room Services
- **Reviewing PET Scans for possible exclusion**
Use the **SNF Consolidated Billing Annual FI/MAC Update File** (formerly the SNF Help File) on the CMS website to help find what the facility is liable for or whether the physician or service provider can bill separately.

Reimburse at the Medicare Allowable Rate with the correlating HCPCS code, also available on the CMS website, not the actual amount charged with mark-up (which can be over 1000%)

- **CMS actually only pays 80% of this rate**

The provider should know ahead of time on your intention to pay at the Medicare Allowable Rate to avoid any confusion after the services have already been rendered (include with Provider Agreement or Continuity Form).
DAILY MEETING

- Keep the meetings brief and to the point
  - Divert unnecessary non-team related conversations

- Expect team members to come prepared with the information they are expected to provide

- Wait until weekly meeting to elaborate if needed (i.e. ICD-9 code changes, future discharge plans)

- Have log updated and available for the month end close process
Ongoing Management

Continue to monitor residents in their 30 day window for any presence of returned skilled needs

- Number of days available after the part A stay
- Return to Part A without a hospital stay

Monitor for 60 day break in skilled needs to see when the resident is eligible for a new benefit period/spell of illness
Monitor the status of “non-coverage letters”, SNF ABN forms

- Generic Notice (CMS Form 10123)
  - Beneficiary has 48 hours to request an expedited appeal
- Detailed Notice (CMS Form 10124)
  - Will be requested by QIO if appeal requested by beneficiary
  - Keep MDS cycle going if QIO review or demand bill is requested or CMA review is anticipated

SNF ABN form is available on CMS website (Form # CMS-10055) [www.cms.hhs.gov/medicare/bni](http://www.cms.hhs.gov/medicare/bni) for Part A

- CMS is still working on final draft (will probably be different from current form available on the website)
- The intention is to replace all of the other forms (determination for continued stay, determination upon admission, etc.)
Reconciliation with Business Office, MDS Coordinator, and Therapy Department

- Verify:
  - Certification/Recertification are updated (including therapy certs) SNF care must be certified upon admit, within the first 14 days and then every 30 days thereafter
  - Have MDS’ been transmitted and accepted into the state data base
  - MDS Info on UB–04: ARD’s, RUGS–IV Classification, days in each category, correct HIPPS codes
  - Therapy Charges (Do they support the RUG score?)
  - Ancillary Charges (Are they appropriate?, Were they delivered?)
ANY QUESTIONS?
The Managed Care Process

By David Rokes, RN
CEO
Post Acute Consulting, LLC
Objectives

Attendees will understand:

- Preadmission requirements
- Post Admission Process
- Contract Review
- Outliers and Delivery of Services
- Weekly Managed Care Billing Reconciliation
We have seen an increase in all managed care products over the last several years.

Expect to see increases particularly in Managed Medicare Products (A.K.A. Medicare Part C) throughout the next decade.

Increase in DSO of Managed Care products.
Authorization Process

Preauthorization

- Needs to be completed prior to admission by facility designee
- Verify that a contract is in place with the provider and levels in contract
- Cost-Out medications and treatments
- Rate should be verified and initial authorization prior to residents arrival at facility
- Verification Of Benefits
- Copy of Common Working File when indicated
Admission Process

Upon Admission

- Screening form* should be completed in its entirety
- Form should be distributed to Business Office, MDS Office, Rehab Department, Social Services, etc.
- Soft File should be created by delegated Managed Care representative in facility. i.e. MDS, CRC, RNAC, Social Services, etc.
- Get a copy of the residents Managed Care Card
  - Very important to ensure you have the correct billing office to expedite payment
# Contract review

**Ensure that you have a copy of all contracts**

**Review levels available**
- Ensure residents authorization is appropriate for services to be delivered
- Verify rates via contract
- Therapy Allowances per contracted level

**Outliers**
- Pharmacy
- DME
- Are there specific transportation benefits in the resident’s policy?

**I recommend reviewing on an annual basis**
Responsibility of facility designee

- Update Managed Care representative as requested and with any change in level of care
- Negotiate appropriate level to serve the resident’s needs
- Get all authorizations in writing when appropriate
- All conversations and paperwork should be documented and maintained in the resident’s soft file and saved after discharge
Daily Management

Daily review of resident status

- All residents should be reviewed on a daily basis
- Any changes should be communicated to the case managers
  - Change in rehab level of care
  - Medical changes
  - Medication changes
- Progress towards discharge
- External Appointments
Weekly Management

Weekly billing reconciliation
- Review with the team on weekly basis the level of services being delivered support the payment level

Purpose of reviewing weekly is because billing does not wait until the end of the month as Medicare Part A does

Get pharmacy bills
- To review outliers that can be billed separately
  - I.e. Many insurances over up to a set $ amount per day and IV meds excluded
MAO HIPPS Code Reporting

- CMS starting to require that HIPPS codes be reported on the UB-04 for all Managed Medicare Products
  - Was to be implemented December 1\textsuperscript{st}, 2013 after the July 1\textsuperscript{st} deadline was moved.
  - Full implementation went into effect July, 1\textsuperscript{st} 2014
THE QUALITY MEASURES

David Rokes, RN
Chief Executive Officer

A PARTNERSHIP OF CARE & COMPLIANCE
Objectives

Participants will understand:

- The updated Quality Measures
- The impact of the MDS 3.0 items
- How the new QM’s will effect 5 Star Reporting
- How they effect your internal Quality Improvement Program
- Ongoing CMS initiatives related to quality of care
- Value Based Purchasing Initiatives and ACO’S
Purposes

To give information about the quality of care at nursing homes to help you choose a nursing home for yourself or others

To give you information about the care at nursing homes where you or family members already live

To get you to talk to nursing home staff about the quality of care

To give data to the nursing home to help them with their quality improvement efforts
Quality Measures show ways in which nursing homes are different from one another

There are things nursing homes can do to improve their percentages

The measures assess the resident’s physical and clinical conditions and abilities, as well as preferences and life care wishes

In June 2011 the National Quality Forum (NQF) endorsed 16 Nursing Home Quality Measures
Short Stay Measures

- Percent of residents who self-report moderate to severe pain*
- Percent of residents with pressure ulcers that are new or worsened*
- Percent of residents assessed and given, appropriately, the seasonal influenza vaccine
- Percent of residents assessed and given, appropriately, the pneumococcal vaccine
- Percent of residents who newly received an antipsychotic medication

*used for calculation of 5 Star QM rating
Percent of residents experiencing one or more falls with major injury*

Percent of residents who self-report moderate to severe pain*

Percent of high-risk residents with pressure ulcers*

Percent of long stay residents assessed and given, appropriately, the Influenza vaccine

Percent of long stay residents assessed and given, appropriately, the Pneumococcal vaccine

Percent of long-stay residents with a urinary tract infection*
Long Stay Measures (2)

- Percent of low-risk residents who lose control of their bowel or bladder
- Residents who have/had a catheter inserted and left in the bladder*
- Percent of residents who were physically restrained*
- Percent of residents whose need for help with daily activities has increased*
- Percent of residents who lose too much weight
- Percent of residents who have depressive symptoms
- Percent of residents who received an antipsychotic

* used for calculation of 5 Star QM rating
Importance

- Drives internal Quality Review Process
- Provides state/surveyors with survey process guidance
- Public image
  - 5 Star Quality Reporting
- Pay for Performance/Value Based Purchasing
- May affect Accountable Care Organizations (ACO) and Bundled payment initiative participation
Pay for performance

- Demonstration in process in New York (79 homes), Wisconsin (62 homes) and Arizona (41 homes)
- 3 Year project started July 1st, 2009
- Based upon Quality Measures
  - Staffing
  - Appropriate hospitalizations
  - Outcome measures for the MDS
  - Inspection survey deficiencies
  - Satisfaction surveys (pending)--CAHPS
Performance payments

- Intent is to reward homes that provide overall high quality care rather than those that excel in individual areas.
- Nursing homes will be eligible for awards based on both attainment and improvement.
- Homes that have an overall performance score that is 80th percentile or higher will qualify for performance payment.
- Homes in the 90th percentile or higher would receive performance payments that are 1.2 times those in the 80–90th percentile.
- To ensure the qualifying homes contribute to reduced hospitalizations rates:
  - Hospitalization rate does not exceed 20%  OR
  - Home hospitalization rate does not exceed median rate in the State.
Accountable Care Organizations

- Medicare Shared Savings Program
  - Currently 153 organizations participating in shared savings initiatives
- A voluntary program consisting of health care providers coordinating high quality care to Medicare beneficiaries
- 33 Measures to assess quality
- Electronic Health Records are not required but weighted heavier than any other measure for quality-scoring purposes
- Paid for reporting first year, subsequent years paid for reporting and performance
- Health Care delivery is trending in this direction
5 Star Quality Reporting

Publically reported

- Overall Quality
- Health Inspection
  - Derived from Nursing Home Statements of Deficiencies (CMS form 2567)
  - 15 months worth of complaint surveys that resulted in deficiencies
- Quality Measures
  - 9 measures used toward score
- Staffing
  - Looks at RN, LPN/LVN and CNA staffing (based on form 671)
  - In July 2012 Physical Therapy staffing was added but does not affect score; it does not include PT Assistants
5 Star Quality Reporting

- Proposed Changes for 2015
  - Ensure accuracy of staffing data
    - Looking to assess staffing levels on a quarterly basis
    - Phase in use of electronic data
  - Quality Measures
    - Looking to add 3 additional measures
    - Rehospitalizations
    - Discharge back to community
    - Antipsychotic use
NY Nursing Home Quality Initiative (NHQI)

- An annual quality and performance evaluation project to improve the quality of care for residents in Medicaid-certified nursing facilities across New York State.
- The current NHQI is based on the previous calendar year's performance and is worth 100 points.
- Nursing homes are awarded points for quality and performance measures in the components of Quality, Compliance, and Efficiency.
- Specific deficiencies cited during the health inspection survey process are also incorporated into the results.
- The points for all measures are then summed to create an overall score for each facility. Facilities are ranked into quintiles based on their overall scores.
- Quintile one represents the top-performing facilities, while quintile five represents the lowest-performing.
The quintile ranking below is a spreadsheet that contains the following worksheets:

- nursing facilities in each of the five quintiles
- nursing facilities with certain deficiencies cited during the health inspection survey process
- nursing facilities that are excluded from the NHQI for various reasons
NHQI

The 2014 Nursing Home Quality Initiative (NHQI) is comprised of three areas:

- Quality Measures (70 points—from 60 for 2013)
  - 14 quality measures for the 2013
- Compliance with reporting (20 points)
- Potentially Avoidable Hospitalizations (10 points—from 20 for 2013)
Quality Measures for NHQI

Staffing Measures

(1) Annual level of temporary contract/agency staff used
   - Maximum points are awarded if the rate is less than 10%, and zero points if the rate is 10% or greater. Staffing hours associated with specialty beds are included in the denominator of this measure due to the level of data available on the cost report schedule used for contract staff.

(2) CMS five-star quality rating for staffing
   - As of April 1, 2014

NYS–Specific Measure

(3) Percent of employees vaccinated for the flu – annually reported to the Bureau of Immunization*
   - Used from May 01, 2014 data submission, max points for >85%, Zero points if <85%
MDS 3.0 Quality Measures

1. (4) Percent of long stay high risk residents with pressure ulcers
   Risk adjusted by the New York State Department of Health (NYS DOH)

2. (5) Percent of long stay residents assessed and given, appropriately, the pneumococcal vaccine*
   Maximum points are awarded if the rate is 85% or greater, and zero points if the rate is less than 85%

3. (6) Percent of long stay residents assessed and given, appropriately, the seasonal influenza vaccine*
   Maximum points are awarded if the rate is 85% or greater, and zero points if the rate is less than 85%

4. (7) Percent of long stay residents experiencing one or more falls with major injury

5. (8) Percent of long stay residents who have depressive symptoms
Quality Measures

- (9) Percent of long stay low risk residents who lose control of their bowel or bladder
- (10) Percent of long stay residents who lose too much weight
  Risk adjusted by the NYS DOH
- (11) Percent of long stay residents who received an antipsychotic medication.
  ◦ In addition to the exclusions put forth by CMS, NYS excludes the diagnosis of bipolar disorder/manic depression (CMS uses Schizophrenia, Tourette's, and Huntington's)
- (12) Percent of long stay residents who self-report moderate to severe pain
  ◦ Risk adjusted by the NYS DOH
- (13) Percent of long stay residents whose need for help with daily activities has increased
- (14) Percent of long stay residents with a urinary tract infection
Compliance

- The compliance component consists of three areas
- CMS’ five-star quality rating for health inspections
- Timely submission of nursing home certified cost reports
- Timely submission of employee flu immunization data.
CMS Five-Star Quality Rating for Health Inspections

- CMS’ facility ratings for the health inspections domain are based on the number, scope, and severity of the deficiencies identified during the three most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations. All deficiency findings are weighted by scope and severity.
- This measure also takes into account the number of revisits required to ensure that deficiencies identified during the health inspection survey have been corrected.

CMS Five-Star for Health Inspection Scores as of April 1, 2014

- Ten points are awarded for obtaining five stars or the top 10 percent (lowest 10 percent in terms of health inspection deficiency score). Seven points for obtaining four stars,
- four points for obtaining three stars,
- two point for obtaining two stars,
- zero points for one star
Compliance–Cost Report

- Timely submission of complete nursing home certified cost reports
  - Failure to file timely, certified, and complete Nursing Home cost reports for 2013 to the NYS DOH by the deadlines of August 14, 2014 for calendar year filers, and September 30, 2014 for fiscal year filers.
  - 2013 Nursing Home cost reports
  - Five points for timely, certified and complete submission of the 2013 cost report
Compliance– Flu Vaccine

- Timely submission of employee flu immunization data
  - Failure to submit timely data to the NYS DOH Bureau of Immunization on Employee health worker annual flu immunization by the two deadlines of November 15, 2013 and May 1, 2014.
  - Nursing Home Employee Flu Immunization data for 2013/2014
  - Two and a half points for timely submission of immunization data for each deadline. May receive points for hitting one or both.
Potentially Avoidable Hospitalizations

- NYS DOH has developed a potentially preventable hospitalization quality indicator that is based upon the Nursing Home Value Based Purchasing (NHVBP) demonstration.
- MDS 3.0 data are utilized.
- Only long stay nursing home episodes (101 days or more) are used.
- Nursing home episodes are constructed based on assessments from January 1, 2012 through December 31, 2012. Hospitalizations from the nursing home are identified and the hospital discharge record found in SPARCS.
- The hospitalization is identified as potentially avoidable or not, based on diagnoses criteria. Rates are calculated for each nursing home by dividing the total number of potentially avoidable hospitalizations by the total number of long stay episode days in that nursing home (lower rates are better). Rates are risk adjusted.
Potentially Avoidable Hospitalizations

- Potentially Avoidable Hospitalizations
- The number of potentially avoidable hospitalizations per 10,000 long stay episode days
- 10 points are awarded for obtaining the first quintile. 8 points for obtaining the second quintile,
- 6 points for the third quintile,
- 2 points for the fourth quintile,
- zero points for the fifth quintile
Ineligibility for NHQI ranking

- Due to severity of Letter J, K, and L health inspection deficiencies.
  - Data used between July 1 of measurement year (2013) and June 30 of reporting year (2014)
- Type of Facility
  - Non-Medicaid
  - CMS designated Specialty Focus during 2013 or 2014
  - Specialty facilities or units within a nursing home
  - CCRC’s and TCU’s
QUESTIONS

A PARTNERSHIP OF CARE & COMPLIANCE
Challenges and Strategies for Success
Challenges

- Inappropriate coding on the MDS cost many facilities
  - ADL’s
  - Missing Diagnosis that qualify into certain RUG categories
- Lack of Understanding of Skilled Criteria for Nursing Observation and Assessment
- Lack of documentation on behaviors
- Poor communication amongst departments
- Poor ARD management
- Missed MDS’s
  - Greater financial implications instituted April 2012 resulting in increased default and provider liable situations
Challenges

- Do you have the appropriate staff in the appropriate position?
- Managing the MDS process has become very specialized.
- Lack of systems.
- Poor meeting management:
  - Meetings are a necessary “evil”
Challenges

Turn Over in Staff
- What is the cause?
- Are people crossed trained?

Increased Time Constraints

Compliance with MDS completion
- Are all staff doing their parts?
- Timeliness of assessments
- Integrity of coding
- Late transmissions—only 14 days to transmit
Challenges

- Additional Assessment Types
  - Discharge assessments
  - Start and End of Therapy Assessments
  - Change of Therapy OMRA Educational Needs
  - Does your staff fully understand the process
  - Does everyone know their part in the process

- MDS drives the survey process
  - Errors on the MDS can also equate to survey tags
  - The shift to the QIS survey makes process less subjective
MDS Coordinator

- Detail oriented
- Able to multi-task
- Flexible
- Team approach
- Educator
- Organized
- Knowledgeable
- Must take ownership of the process
Management Systems Implementation

- ICC – Introductory Care Conference
- Daily Skilled Review Meeting
- Weekly Skilled Review Meeting
- Month End Close Reconciliation
Interdisciplinary Team to meet with resident and/or responsible party within 72 hours of admission

What does the IDT need to know?
Outline the course of treatment by each member of the team based on their assessment.
Discuss the services to be provided.
Discuss the goals to be achieved prior to discharge.
Discuss any barriers to discharge.
Discuss prior services in the community.
Address any questions or concerns
What are the resident’s goals and expectations
Daily Skilled Review Meeting

- Brief Daily Meeting to Review Medicare and Managed Care Residents with PPS team
  Nursing, Rehab, Business Office, Social Services, etc.
- Effective way to monitor reason for skilling on a daily basis and update any changes in condition and/or treatment
- Process leads to clean month end close and effective Medicare management
- Daily Tracking Log Implementation
Items for review

- Pending Admissions/Discharges
- Medicare Stay Day
- MDS status including 3.0 required assessments (BIMS, PHQ-9, etc.)
- Assessment Reference Date Review
- RUG Score
- Any changes in clinical or therapy treatment
- Scheduled appointments
- Tests, labs, transportation and services to be delivered (Consolidated Billing)
- High Cost Medications
- Any update to ICD-9 Codes/Diagnosis Codes
**Weekly Skilled Review Meeting**

- Commonly referred to UR (Utilization Review) Meeting
- Focused interdisciplinary review of short term skilled residents
- Ensure all compliance criteria are being met
- Physician Certification of Skilled Nursing Facility (SNF) Requirements
- Review Elements of Daily Meeting Review in More Depth i.e. detailed therapy status updates, progression towards discharge and required services
- Also includes Managed Care and Medicare Part B
- Residents in 30 Day Window of Part A benefit cessation
- Residents in the 60 Day Window to Review for Spell of Illness/Benefit Period
- Brief Review of Exhaust of Benefits for No-Pay Billing
Strategies for Success

- Keep your MDS Coordinators and Therapy Directors educated
- Ensure MDS department is keeping the rest of the staff educated
- Sign up for the CMS SNF Open Door Forum
  - Call happens every 6th Thursday
  - Information is provided on these calls that is not provided elsewhere
- Sign up for the CMS SNF List Serve
- Ensure there are back up
  - For changes
  - Time off
  - Times of increased volume
Strategies for Success

Communicate

- Daily meetings with the PPS team
- Listen to what staff are saying
- Focus on assessments completion daily

Redefine the role of the MDS Coordinators

- This has become a specialty
- Is the correct person in the job
- Are they doing duties that could or should be assigned elsewhere

Therapy Department

- Daily monitoring of minutes, refusals, treatment tolerance, upcoming appointments
Strategies for Success

- **Team process**
  - All members need to understand their roles
  - What and when needs to be completed

- **Accountability**
  - All staff need to be held to the same standards
  - Everyone needs to understand the importance of the process

- **Meeting Success**
  - Must be focused and well run

- **Encourage your staff**
  - A little Thanks goes a long way
Ongoing initiatives

- **Value Based Purchasing A.K.A. Pay for Performance**
  - Affordable Care Act directs Value Based Purchasing plan to implemented for SNF’s
  - Report to Congress was due October 1st, 2012
  - Pilot completed for SNF’s in July 2012
- **Payment Adjustment of Hospital Acquired Conditions**
  - Outcomes to be reported to Congress by January 2012
  - Looking to apply to other settings
- **Questioning Recalibration of RUG levels every year based on prior year utilization**
- **Allow SNF’s to be “originating site” for Telehealth**
Thank you

Drokes@postacuteconsulting.com
(888)688-5224 X202
www.postacuteconsulting.com