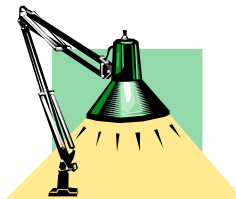
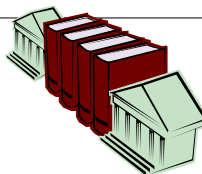


RAI Spotlight



MC PPS Proposed Rule for FY 2015



There are several interesting changes in the recently published MC PPS Proposed Rule for FY 2015 released on May 6, 2014 (www.gpo.gov/fdsys/pkg/FR-2014-05-06/pdf/2014-10319.pdf). Overall, there will be a 2% increase in the amount paid to NFs. There are no changes in the RUG classification or index weights for the various groups. There is increasing regulation proposed about the manner in which states can use Civil Money Penalties. Two other proposed changes are of particular interest.

Rural/Urban classification for Medicare: The wage index adjustment incorporated in the calculation of the MC PPS rates is based on whether the facility's county location is designated as Urban or Rural. The Office of Management and Budget issued a bulletin in 2013 that revised these delineations. The Proposed Rule plans to incorporate this new information into the Core

Based Statistical Areas (CBSAs) used in the rate calculations. There will be a one year phase-in period for all facilities when NFs will be paid 50% of the wage index calculated based on the old CBSAs and 50% of the wage index based on the new CBSAs to mitigate any rate changes (transition wage index).

In Pennsylvania, no counties move from Urban to Rural status. Five counties (Adams, Columbia, Franklin, Monroe and Montour) move from Rural to Urban status. In addition, one Pennsylvania CBSA has been split. All five counties currently included in CBSA 37964 will remain designated as Urban counties but will split into two CBSAs: Delaware and Philadelphia counties remain in CBSA 37964; Montgomery, Bucks and Chester counties would form the new CBSA 33874. This will result in slightly different wage indexes for

(Continued on page 3)

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Questions about the RAI?

Please submit them to
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CASPER Reports Teleconference

Date: July 10, 2014
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: CASPER Reports
Handouts: Power Point slides will be available about July 7 on the DOH Message Board at <http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp>
Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 46448249

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

Additional questions: qa-mds@pa.gov



Section J Health Conditions Q & A



On April 17, 2014, a training teleconference was provided on Section J Health Conditions. No questions were received during the teleconference or through the DOH mailbox (qa-mds@pa.gov).

YouTube Videos on MDS Sections G, I, M and O

CMS recently released updated videos on MDS 3.0 Sections G, I, M and O (www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html). These are not item by item reviews of the sections but rather discussion of the more challenging items, especially those that have been the cause of many questions. This article details some of the highlights of the presentations, but there is much to be gained by viewing the videos.



The video on **Section G Functional Status** is devoted to a review of G0110 1 ADL Self-Performance, clarifying the many issues that have arisen around the Rule of 3 with examples. The first issue clarified is the Extensive Assistance definition (p. G-4 of RAI Manual): Code 3, Extensive Assistance, if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:

- Weight-bearing support provided **three or more times**, **OR**
- Full staff performance of activity **three or more times** during part but not all of the last 7 days.

If weight-bearing occurred three or more times or full staff performance occurred three or more times, there is no need to refer to the Rule of 3 box on the right on page G-7. The proper coding is 3, Extensive Assistance. However, you cannot combine the times of weight-bearing support and full staff performance for this code, e.g., 2 episodes of weight-bearing and 2 episodes of full staff performance could not be used for the three episodes for this code at this point.



The Rule of 3 is reviewed with particular attention to section 3c. For the resident with 2 episodes of weight-bearing and 2 episodes of full staff performance, this section should be used to identify the proper code in those situations where an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level.

Be certain you have the revised page of the ADL Self-Performance Algorithm with the designation October 2013 (R) that adds asterisks between the double-lined boxes to clarify the relationship of the ADL Self-Performance Algorithm with the Instructions for the Rule of 3 on the right. This page can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html; scroll

to the bottom for the file of replacement pages.

The video on **Section I Active Diagnoses** reviewed the requirements to identify a diagnosis as “active.” Clarification was also provided on the coding of Quadriplegia at I5100 which is only to be coded if the quadriplegia is caused by spinal cord injury. A resident who has lost function of their limbs due to Alzheimer’s Disease, Cerebral Palsy, Rheumatoid Arthritis, etc. should only be coded for this causative disease.



The video on **Section M Skin Conditions** discussed factors that would indicate the etiology of the various lesions – pressure ulcers, venous and arterial ulcers, and diabetic foot ulcers. Staging of pressure ulcers was reviewed as well as the various tissue types that might be found in the wound bed.

Several miscellaneous points were covered:

- Worsening: A pressure ulcer is considered to have worsened only if the ulcer is staged at a higher number. There must be a staging number on the prior assessment for comparison.
- Lesions on mucosal surfaces are not staged as pressure ulcers.
- If cartilage is exposed, the wound is classified as Stage 4.



Measurements on Stage 3, Stage 4 or Unstageable due to Eschar/Slough ulcers do not include the extent of undermining or tunneling. Measurements should be made between healthy skin edges.

The video on **Section O Special Treatments, Procedures and Programs** began with a discussion of non-invasive versus invasive ventilation. Non-invasive was identified as ventilation by mask which might be intermittent; this would be coded under O0100G BiPAP/CPAP. Invasive ventilation involves the use of an endotracheal tube or tracheostomy, and would be constant; this would be coded under O0100F Ventilator or Respirator.

Another point stressed was the two time periods – While NOT a Resident and While a Resident within the last 14 days. For Restorative Nursing at O0500, the criteria found on page O-36 of the RAI Manual were reviewed.



OIG Report on Adverse Events in SNFs



In February 2014, the Department of Health and Human Services Office of Inspector General released a report titled “Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries.” (<http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>) An adverse event results in harm to a resident as a result of medical care or in a health care setting. An adverse event may or may not be preventable.

In this report, the happening was considered to be an adverse event only if harm reached the resident:

- Harm occurred that prolonged the SNF stay or led to a transfer to a different SNF or other post-acute facility and/or hospitalization;
- Harm occurred that contributed to or resulted in permanent resident harm;
- Harm occurred that required intervention to sustain the resident’s life;
- Harm occurred that may have contributed to or resulted in resident death.

A sample was selected of Medicare residents who were admitted to the SNF within one day of hospital discharge and stayed for 35 days or less. Hospital and facility records were first reviewed by nurse screeners to identify any potential adverse events. Those records were then reviewed by a physician panel to confirm the event and determine whether it was preventable or not.

In the sample group, approximately one in five beneficiaries (22%) experienced at least one adverse event during their stay. Of these events, 59% were designated as being clearly or likely preventable. Resident suffering and Medicare costs could have been greatly decreased if the events did not

occur.

What were identified as the possible causes of these preventable events?

- Appropriate treatment was provided in a substandard way;
- The resident’s progress was not adequately monitored;
- Necessary treatment was not provided;
- Error was related to medical judgment, skill, or resident management;
- Resident care plan was inadequate;
- Care plan was incomplete or not sufficient in describing resident’s condition;
- The resident’s health status was not adequately assessed.

An adverse event was identified as not preventable if:

- The resident was highly susceptible to event because of health status;
- Event occurred despite proper assessment and procedures followed;
- The resident’s diagnosis was unusual or complex, making care difficult;
- Care provider could not have anticipated event given information available.

Close scrutiny of care provided both in hospitals and nursing facilities will continue. Everyone wants the best possible results for the patient or resident. CMS has stated that it expects the Quality Assurance and Performance Improvement (QAPI) process (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html) mandated by the Affordable Care Act to aid facilities in identifying and decreasing adverse events.

Hand Hygiene Lacking in Health Care Facilities



In the OIG Report on Adverse Events (see above), 17% of the hospitalizations were related to infection events. These events incurred the highest cost per hospitalization. A report titled “Hand Hygiene Lacking in Many U.S. Health Care Facilities” (www.nlm.nih.gov/medlineplus/news/fullstory_144875.html) states that health care-associated infections kill about 100,000 people annually in the United States, and cost about \$33 billion to treat.

However, one in five U.S. health care facilities does not make alcohol-based hand sanitizers available everywhere they are needed. In addition, staff may not receive sufficient training. Are there sanitizers available throughout your facility? Do all staff understand the importance of frequent use? This can be a very significant step in controlling the occurrence of infections in your facility.

MC PPS Proposed Rule for FY 2015 (cont’d)



(Continued from page 1)
the two CBSAs.

COT Changes: There has been discussion about how to restore a resident to a Rehabilitation RUG when they have placed in a Nursing RUG on the latest COT. In the Proposed Rule, if the resident was in a Rehabilitation RUG and

now places in a Nursing RUG (e.g., only 4 distinct days of therapy with no restorative care) and if the therapy program continues, the NF can do a COT to return the resident’s classification to a Rehabilitation RUG. However, if the therapy program ends in the interval and later resumes, the NF must either do a SOT or wait for next scheduled assessment to classify the resident in a Rehabilitation RUG.



New PASRR Forms

OBRA '87 required the implementation of a preadmission screening program, applicable to all persons seeking admission to a Medical Assistance (MA) certified nursing facility, whether that person is applying for or receiving MA benefits. The purpose of the preadmission screening is to determine whether an individual with mental illness (MI), intellectual disability (ID) or other related conditions (ORC) requires nursing facility services and, if the individual does, whether that individual meets target criteria and requires specialized services for their condition. An MA certified nursing facility may not admit any new resident with MI, ID or ORC unless the Department of Public Welfare (Department) has determined and notified the nursing facility via letter that the individual requires nursing facility services and whether that individual meets target criteria and requires specialized services for MI, ID or ORC.

This process involves the use of three forms:

- PA-PASRR-ID (Level 1 - MA 376) which must be completed prior to or no later than the day of admission.
- PA-PASRR-EV (Level II - MA 376.2) which must be completed if the individual meets any of the criteria for a

Level II assessment for MI, ID or ORC on the PA-PASRR-ID (MA 376). The Level II assessment is filled out by either the Area Office of Aging or Division of Nursing Facility Field Operations.

- Target Resident (MI, ID, ORC) Reporting Form (MA 408) is used as a communication tool for nursing facilities to notify the Division of Nursing Facility Field Operations when a resident with MI, ID or ORC is admitted to a nursing facility or has any changes once there regardless of payment source.

The results must be reported on comprehensive MDS 3.0 assessments (NC) at A1500 – A1550.

The Department has issued a revised set of forms that were effective beginning March 1, 2014. The Bulletins announcing the change were issued on February 12, 2014 and may be found at www.dpw.state.pa.us/publications/bulletinsearch/bulletinsearchresults/index.htm. The forms may be ordered or printed at www.dpw.state.pa.us/findaform/ordermedicalassistanceforms/index.htm. If you have questions, contact Ruth Anne Barnard at rbarnard@pa.gov or your Field Operations Representative.

Improving Dementia Care

CMS has released an Interim Report on the CMS National Partnership to Improve Dementia Care in Nursing Homes (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfor/Downloads/Survey-and-Cert-Letter-14-19.pdf). Formation of this public-private Partnership was inspired by an Office of the Inspector General (OIG) report (<https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>) that found that 83% of atypical antipsychotic drug claims were for elderly nursing home residents who had not been diagnosed with a condition for which antipsychotic medications were approved by the Food and Drug Administration. Many of these medications carry Black Box Warnings.

The result of the National Partnership's efforts? Over 18 months, the national prevalence of antipsychotic use in

long-stay NH residents was reduced by 15.1% (the rate decreased from 23.8% to 20.2%). To support the individual facility's efforts to improve dementia care, CMS sent letters to NFs with high rates of antipsychotic use and developed resources such as a new webpage (<https://www.nhqualitycampaign.org>) and the Hand-in-Hand training DVDs. New Quality Measures were posted on NH Compare and enhanced guidance was provided for surveyors in Appendix PP.

In addition, through MLN Connects National Provider Calls, there have been a series of calls dealing with the National Partnership to Improve Dementia Care in Nursing Homes which can be heard at www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html. As you work to improve dementia care in your facility, this report may provide guidance to resources that will help.



New CMS Surveys

CMS is currently developing two distinct focused survey processes to assess dementia care and MDS 3.0 coding practices in nursing homes (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfor/Downloads/Survey-and-Cert-Letter-14-22.pdf). CMS is planning to pilot these survey types beginning in 2014. Two short-term, small-scale, focused reviews of the survey process will be conducted through partnerships with approximately five survey agencies each.

The first survey process will review and document dementia

care practices by nursing homes. CMS will identify the specific facilities to be surveyed and will work with the states to identify dementia care experts to accompany surveyors for the first survey whenever possible.

The second survey will focus on MDS 3.0 coding practices and will evaluate MDS assessments and the associated care planning for nursing facility residents. CMS will identify the specific facilities to be surveyed.

