Final PPS Regulation

The final Medicare Prospective Payment System (PPS) regulation effective October 1, 2011, was published in the Federal Register on August 8, 2011 (www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf). There are several changes that will affect your work with MDS 3.0 and the PPS RUG-IV classification system.

Rate Setting Adjustments
In the transition from MDS 2.0 and RUG-III to MDS 3.0 and RUG-IV, CMS adjusted the Nursing CMI portion of the PPS rate in an effort to maintain budget neutrality – to spend approximately the same money under the new system as they did under the old. Unexpectedly, many more residents classified into the top Rehabilitation groups leading to a spike in payments. To correct this situation, CMS has made two major changes:

- CMS had increased all nursing CMIs by 61% October 1, 2010. This increase will remain for all non-therapy RUG groups. For therapy RUG groups, the increase will be recalibrated to 19.84% with the result that rates for Rehabilitation categories will be lower.
- Group therapy has been redefined as requiring participation of four residents. In addition, when therapy minutes are calculated for RUG-IV, only 25% of the group minutes will be included with the result that residents may classify into a lower Rehabilitation RUG or a non-therapy RUG.

PPS Schedule Changes
To avoid capturing the same data on more than one assessment, CMS has reset the ARDs for the scheduled PPS assessments. Schedule dates for the 5-day/Readmission/Return assessments remain the same.
On July 14, 2011, a training teleconference was provided on RAI Manual Revisions. The following questions were received.

Q. Would a supplement given for weight gain be considered a therapeutic diet (K0500D)?

A. No. A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium). A supplement given for weight gain would not meet this definition.

Q. Would a regular diet with fluid restriction be considered a therapeutic diet (K0500D)?

A. Therapeutic diets are not defined by the content of what is provided or when it is served. Whether this would be considered a therapeutic diet depends on the reason for the fluid restriction, e.g., renal failure.

Q. Must there be documentation of 6 months or less to live to code a resident on hospice (O0100K)?

A. Directions say “Code residents identified as being in a hospice program for terminally ill persons . . .” The definition for Hospice services on page J-24 dealing with J1400 Prognosis ends with “Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.” The NF may need to obtain this from the hospice agency.

Q. What is the proper coding in G0300D Balance Moving on and off toilet if a Hoyer lift is used?

A. This is confusing because the two intermediate codes ask for a choice between being able to stabilize without or with human assistance with no reference to mechanical devices. In the revised manual on page G-22, CMS clarified that if a Hoyer lift was used, the proper code was 2 Not steady, only able to stabilize with human assistance.

Q. At O0100M Isolation/Quarantine, it says to code if the resident has pathogens “that have been acquired by physical contact or airborne or droplet transmission.” What about a new severe episode of c. difficile diarrhea?

A. The Centers for Disease Control identifies c. difficile as a significant pathogen requiring scrupulous contact precautions but does not require that the resident be isolated in a room alone. They can be cohorted with other residents with similar conditions. Since the final requirement for coding O0100M is “The resident is in a room alone because of active infection and cannot have a roommate” (RAI Manual page O-4), this resident would not be coded as requiring isolation or quarantine for active infectious disease. www.cdc.gov/HAI/organisms/cdiff/Cdiff.html

Q. There is confusion about completion dates for resident and staff interviews. Please clarify.

A. D0200 Resident Mood Interview (PHQ-9©) and the Pain Assessment Interview beginning at J0300 should be completed on the ARD or the day before (RAI Manual pages D-4 and J-7). The Brief Interview for Mental Status (BIMS) beginning at C0200 must be completed during the look-back period. Signatures in Z0400 should reflect the dates on which these resident interviews were done. Resident interviews completed after the ARD should not be entered on the MDS.

Staff assessments should not be completed until after the ARD to include information from the total look-back period including the ARD. If the resident interviews cannot be completed because of an unplanned discharge, the gateway questions at C0100, D0100 and J0200 should be coded 0 No and the staff assessments completed.

Q. We are not to submit PPS records (5-day, 14-day, etc.) for HMO residents. What about Entry and Discharge records?

A. Entry and Discharge records are completed to meet OBRA requirements. Along with Admissions, Quarterlies, Significant Changes, etc., these records must be completed and submitted for HMO residents.

Q. Is it acceptable to complete an Admission assessment and designate it as a 5-day PPS for an HMO resident?

A. No. A0310B PPS Assessment and A0310C PPS OMRA should not be coded unless the resident is in a MC Part A stay. For an HMO resident, A0310B should be coded 99 Not PPS assessment and A0310C would be coded 0 No.

Q. 00600 Physician Examinations: Is a “virtual” medical examination considered to be a telehealth physician visit to be counted on the MDS?

A. “Virtual” and “telehealth” seem to mean basically the same thing: physician and patient are connected through electronic media rather than being in the same room. The RAI Manual states on page O-36 that 00600 Physician Examinations includes telehealth visits as long as the requirements are met for physician/practitioner type as defined.
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<thead>
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<th>Assessment Type</th>
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<td>90 day</td>
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In the regulation, CMS states that the agency encourages the use of grace days if their use will allow more clinical flexibility or more accuracy in capturing therapy and other treatments.

EOT and EOT-R Assessments
Use of the End of Therapy (EOT) assessment is further clarified in the regulation. All facilities are considered to be 7 day/week therapy providers. If a resident misses three consecutive days of therapy, an EOT assessment must be completed. Additionally, if the therapy resumes within five calendar days and the therapy RUG has not changed, the facility may complete the new EOT-Resumption OMRA indicating the resumption of therapy. A new therapy evaluation and Start of Therapy (SOT) OMRA are not required. Two new items have been added to the MDS to make this possible: O0450A Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this EOT OMRA, and has this regimen now resumed at exactly the same level for each discipline? and O0450B Date on which therapy regimen resumed.

COT Assessment
CMS is very concerned that the system reimburse facilities only for the level of therapy that is actually being provided. To this end, the new Change of Therapy (COT) assessment (A0310C = 4) is being implemented. Beginning with day 1 – the first day after the ARD of the current assessment – the level of therapy provided must be evaluated every 7 days. Therapy provision is evaluated by Reimbursable Therapy Minutes (RTMs) which reflects the number of minutes the therapist spent providing therapy rather than the minutes the resident spent receiving therapy. The RTMs are always used in calculating Rehabilitation therapy provision for RUG-IV classification: 100% of individual minutes; 50% of concurrent minutes; and 25% of group minutes. In addition, group therapy must be no more than 25% of total therapy minutes calculated per discipline. If, on day 7, therapy remains the same, no assessment must be done and a new 7-day observation period begins the next day. If the provision of therapy has changed so that the resident classifies into a different RUG, a COT assessment must be done with an ARD on day 7. This requirement applies even if the assessment has index maximized to a nursing RUG. It does not apply if the RUG change is due to a change in ADLs, not a change in therapy provision. This COT RUG would be billed from the first day of the observation period, and a new 7-day observation period begins the next day.

Therapy Student Supervision
Another change presented in this regulation is that a therapy student working in a SNF would no longer be required to be in the supervising therapist’s line of sight. Each SNF will determine for itself the appropriate manner of supervision of therapy students consistent with State and local laws and practice standards. CMS has released “Student Supervision Guidelines” at www.cms.gov/SNFPPS/02_Spotlight.asp.

RAI Manual Revision
A revised RAI Manual is due to be released in September/October to provide additional guidance for these complex changes. Monitor the CMS MDS 3.0 Training Materials site at www.cms.gov/NursingHomeQualityInitiatives/45_NHQIMDS30TrainingMaterials.asp#TopOfPage for its release.

RAI Manual Revisions Q & As (continued)

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below and whether it qualifies as a telehealth billable visit. Chapter 15 of the Medicare Benefit Policy Manual states that beneficiaries are eligible for telehealth services only if they are presented from an originating site located either in a rural Healthcare Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. Telehealth visits may be counted if they originate from a NF in a rural county.

Q. A resident who left her room was coded as being in Isolation (O0100M). Must this be corrected?

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Transition

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A. Yes, this should be corrected. If this is a resident covered by Medicare Part A, you may need to redo your billing since her RUG classification will probably change.

Q. If the resident does not return within 30 days of a Discharge Return Anticipated (DRA), we must consider them as a new admission if they do return. When must the DRA be changed to a Discharge Return Not Anticipated (DRNA)?

A. There is no federal requirement that a DRNA be completed. If the discharge occurred in the month before the Picture Date, it might be necessary to inactivate the DRA and submit a DRNA to assure an accurate CMI Report. Contact the Myers and Stauffer help desk for assistance.
Therapeutic LOAs and Discharge Assessments

Historically, no Discharge assessment has been required when the resident was on therapeutic leave or a temporary visit home even if several days were involved. In May 2011, the Revised RAI Manual was released and the definition of a Leave of Absence was changed (page 2-12). It now states that “A Leave of Absence (LOA) which does not require completion of either a discharge assessment or an entry tracking record occurs when a resident has a:

- Temporary overnight home visit; or
- Temporary overnight therapeutic leave; or
- Hospital observation stay less than 24 hours and the hospital does not admit the resident.”

During the teleconference, it was stated that if the resident is out of the facility for more than one overnight, a Discharge assessment should be completed with an ARD of the day they left the facility. An Entry tracking form should be completed on their return. This interpretation was the result of a collaboration of RAI professionals but has been questioned. CMS is in the process of reviewing Chapter 2 of the RAI Manual. We will monitor for further clarification from CMS and will communicate this to facilities. Because of this ongoing discussion, facilities are advised to continue previous practices until definitive guidance is available directing otherwise. Clarified text is planned in the RAI Manual Fall 2011 revision.

Submitting PB-22s to DOH

The Division of Nursing Care Facilities Event Reporting System has been enhanced to allow nursing home providers to electronically complete and submit PB-22s, Report Form for Investigation of Alleged Abuse, Neglect, or Misappropriation of Property. The new enhancement provides a more expedient method to collect and submit the many required data elements and documentation and should lead to a reduction in paperwork. The enhancement also provides a message to the Department of Health when any required

PB-22 is not submitted within 5 days. The announcement and form may be found at http://app2.health.state.pa.us/CommonPOC/content/FacilityWeb/FacMsgBoardDetails.asp?msgid=2539&msgindex=5&Selection=NCF&isHospice=0.

The implementation of this enhancement began Tuesday, August 9, 2011.

MDS 3.0 Completion—October 1, 2011

Several changes must be made to your software to implement the changes decreed in the FY 2012 PPS regulation. Be certain that your vendor plans to provide the upgrade by October 1.

There is a new version of MDS 3.0 designated version 1.00.5 that will be required. Some changes are obvious:

- A0310C PPS Other Medicare Required Assessment adds 4 Change of therapy assessment;
- O0450 Resumption of therapy is added allowing you to report that therapy has resumed at exactly the same RUG level and the date. Complete this item only if A0310C = 2 End of Therapy or 3 Both Start and End of Therapy and A0310F Entry/discharge reporting = 99 Not an Entry/discharge record;
- X0600C adds 4 Change of therapy to allow modification or inactivation of these assessments.

- X0900 adds E. End of Therapy—Resumption (EOT-R) date as a Reason for Modification.

Other data base changes are internal but may cause difficulties if you are unaware of them:

- Z0100C Short stay indicator may only be set if the assessment is designated as a Start of Therapy assessment at A0310C and not also as an EOT. If you designate A0310C = 3 Both Start and End of Therapy, this assessment can’t also be a short stay assessment;
- SOT OMRA must classify into R** group or the default RUG classification AAA will be assigned.

New assessment indicators (AIs) are needed for these new therapy assessments to create the HIPPS codes at Z0100. They are available to your vendor on the CMS MDS 3.0 Technical Information site www.cms.gov.

Resident Data Reporting Manual Revised

The latest revision of the Resident Data Reporting Manual dated 08/01/2011 has been posted on the DPW Long Term Care Case Mix Information site at http://www.portal.state.pa.us/portal/server.pt/community/long-term_care_case_mix_information/19342. Changes were made to align the manual with recent changes in MDS 3.0 as well as to correct minor typographical errors. In addition, a section on RUG Item Documentation Guidelines taken from the RAI Manual was added.