Antipsychotic Medication Quality Measures

Two new Antipsychotic Medication Quality Measures (QMs) are now posted on the NH Compare website. The new measures include an incidence measure that assesses the percentage of short-stay residents that are given an antipsychotic medication after admission to the nursing home, and a prevalence measure that assesses the percentage of long-stay residents that are receiving an antipsychotic medication. Data is only posted on NH Compare if there are at least 30 long-stay residents and 20 short-stay residents included in the denominator for those measures, respectively.

For both the long-stay and short-stay QMs, residents with Huntington’s Disease (I5250 = 1/checked), Tourette’s Syndrome (I5350 = 1/checked) and Schizophrenia (I600 = 1/checked) are excluded. A long-stay resident is included in the numerator if the latest assessment (no more than 120 days old) has either N0400A Antipsychotic = 1/checked if the assessment has an Assessment Reference Date (ARD) on or before 3/31/2012 or N0410A = 1-7 if the assessment has an ARD on or after 4/1/2012. The denominator includes all long-stay residents with a selected target assessment except those with exclusions.

For the short-stay QM, the numerator includes short-stay residents with one or more assessments between the initial assessment (first assessment following the admission entry record) and the target assessment that indicate an antipsychotic medication was received using the same criteria as those for long-stay. The denominator includes all short-stay residents with one or more assessments between the initial assessment and the target assessment. Additional exclusions include any patient without an initial assessment and any resident with Huntington’s Disease, Tourette’s Syndrome, or Schizophrenia.

Utilization Guidelines Teleconference

Date: October 18, 2012
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Utilization Guidelines
Handouts: Power Point slides will be available about October 15 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: 21777804

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
On July 12, 2012, a training teleconference was provided on the CAAs: A Closer Look. The following question was received.

Q. What are acceptable diagnoses to justify the use of antipsychotic medications?

A. Appropriate medications must be carefully selected and monitored based on each resident’s specific issues. There should be evidence of psychotic or related conditions before these medications are prescribed. However, the definition of “psychotic or related conditions” varies depending on the application.

In the black box warning that appears on many of these medications, the wordage references dementia-related psychosis: “Elderly patients with dementia-related psychosis treated with atypical or conventional antipsychotics are at increased risk for death. Antipsychotics aren’t approved for the treatment of dementia-related psychosis.”

New CMS Initiative: Improve Behavioral Health and Reduce the Use of Antipsychotic Medications in Nursing Home Residents

On March 29, CMS launched a new initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. As part of the initiative, CMS is developing a national action plan that will use a multidimensional approach including public reporting, raising public awareness, regulatory oversight, technical assistance/training and research. The action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors.

In addition, Medicare announced an initiative to reduce the use of antipsychotic drugs among dementia residents by 15 percent by the end of the year. Federal officials said such drugs are dangerous for elderly residents with dementia—nearly doubling the risk of death—and are overused as a way to control difficult behaviors of nursing home residents. In fact, two out of every five nursing home residents with dementia are given antipsychotics even though they have no diagnosed psychosis.

CMS is supplying every nursing facility with a DVD titled Hand in Hand that is to be used for staff training in ways to deal with residents with behavioral issues.

Antipsychotic Medications QMs (cont’d)

(Continued from page 1)

These measures will not initially be included in the Five-Star Quality Rating System. The long-stay measure will be used to track the progress of the CMS National Partnership to Improve Dementia Care in Nursing homes. Data from the last three quarters of Calendar Year 2011.
October 1, 2012 MDS and PPS Changes

New Section S Item

In March 2012, CMS issued new guidance regarding the handling of records needing inactivation and submission of multiple discharge assessments for the same discharge date. No longer could a nursing facility inactivate a Discharge Return Anticipated assessment and resubmit the same data designated as a Discharge Return Not Anticipated. Submitting a second discharge assessment for the same date but as a Discharge Return Not Anticipated was also not allowed. Both these procedures had been used for many years in Pennsylvania to remove permanently discharged residents from the CMI Report.

Beginning October 1, 2012, S8010H1 Picture Date Reporting will be added to Section S. If the resident was discharged return anticipated (A0310F = 11) during the month before the Picture Date and the facility has knowledge that the resident will not be returning, modify the Discharge Return Anticipated by checking S8010H1 and submitting the assessment. This directs the database to use this assessment as a Discharge Return Not Anticipated for Picture Date reporting requirements and the resident will not be included on the CMI Report.

This new Section S form and instructions may be found at www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/d_006812.pdf and on the CMS MDS Welcome Page Bulletins section. The final form will appear in the revised Resident Data Reporting Manual to be released before October 1. For the August 1, 2012 Picture Date, use the new Discharge after Discharge Change form available with instructions on the same web sites.

PPS Regulation for FY 2013

A notice updating the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year 2013 beginning October 1, 2012 was published in the Federal Register on August 2, 2012. (www.gpo.gov/fdsys/pkg/FR-2012-08-02/pdf/2012-18719.pdf) The notice does not contain any proposals for new policies applicable to the SNF PPS. The rates are increased by 1.8% (Market Basket Increase 2.5% minus Multifactor Productivity 0.7%) resulting in an overall anticipated increase of 670 million dollars to be paid to SNFs. Increases vary depending on the area of the country and the impact of the wage index update for each facility.

Therapy Cap Extension Process

There has been an extension of the Therapy Caps Exception Process which is detailed at www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/therapyservices/. At the current time, the outpatient therapy cap is $1,880 for OT and $1,880 for PT and ST combined. Providers may submit claims using the KX modifier when an exception for more services is appropriate. However, the Middle Class Tax Relief and Job Creation Act of 2012 made several changes to this process beginning October 1:

- Therapy caps now apply to services provided by outpatient hospitals.
- A second threshold amount of $3,700 (one for each therapy cap amount) now applies.
- A manual medical review process is required for claims over these new thresholds.
- The National Provider Identifier (NPI) of the physician or nonphysician practitioner certifying the therapy plan of care must be reported on all claims for therapy services.

Further details can be found on a Therapy Cap Fact Sheet at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/TherapyCapFactSheet.pdf. Phases 1 and 2 have been posted at https://data.cms.gov/dataset/Therapy-Provider-Phase-Information/ucun-6i4t; use your facility NPI number.
Nursing Home Action Plan

CMS’ 2012 Nursing Home Action Plan has been released at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html. This plan guides CMS’ efforts to continue to improve nursing home safety and quality. The aims are to improve the individual experience of care, improve the health of populations, and reduce the per capita costs of care for populations.

There are five actionable strategies:

- Enhance Consumer Engagement: Provide the consumer with information to make informed decisions. CMS is using NH Compare, 5-Star Quality Rating System and the Special Focus Facilities initiative to meet this goal.
- Strengthen Survey Processes, Standards and Enforcement: Improve the effectiveness of standard and complaint surveys as well as strengthening oversight and enforcement standards.
- Promote Quality Improvement: The new Quality Assurance and Performance Improvement (QAPI) process will be implemented soon. There is continued emphasis on reducing the use of physical restraints and the occurrence of pressure ulcers. Advancing Excellence in America’s Nursing Homes program and support of the national “culture change” movement are parts of this effort.
- Create Strategic Approaches through Partnerships: This includes the Partnership for Patients which is working for a 40% reduction in preventable Hospital Acquired Conditions and a 20% reduction in 30-day readmissions; expanded efforts by the Quality Improvement Organizations and State Survey Agencies to ensure quality care; the National Nursing Home Collaborative focusing on preventable healthcare acquired conditions; and continuing the Advancing Excellence in America’s Nursing Homes Campaign.
- Advancing Quality through Innovation and Demonstrations: These efforts include the Nursing Home Value-Based Purchasing Demonstration and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

CMS is committed to using many and diverse efforts to further improve the quality of care in nursing facilities.

Combining a SCSA and a Scheduled PPS Assessment

Close reading of the new RAI Manual reveals an important interpretation about combining a Significant Change in Status or a Significant Correction of a Prior Assessment with a Scheduled PPS assessment.

"OBRA SCSA, OBRA SCPA, and Swing Bed CCA assessments begin modifying the payment rate on the ARD based on the Medicare RUG (Z0100A). The exception is when the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment. In that case, the Medicare RUG (Z0100A) calculated from the unscheduled assessment takes effect on the first day of the standard payment period for the scheduled assessment" (p. 6-9).

Further clarification may be found in the Medicare Claims Manual at 30.2: “Special Billing Requirements Where a Single OMRA, SCSA, or SCPA ARD is Set Within the Window of a Medicare-Required Assessment /...The HIPPS rate code generated from the OMRA, SCSA, or SCPA that “replaces” the Medicare-required assessment must be billed beginning with the ARD found on the replacement assessment only if the ARD was not set on a grace day. Where the ARD for the replacement assessment is set on a grace day, the HIPPS rate code generated from the replacement assessment must be billed beginning on the day the payment rate would have changed for the Medicare-required assessment that was replaced.”

For example, if you set the ARD on Day 5 for a PPS Return/Readmission assessment (A0310B = 6) combined with a Significant Change assessment (A0310A = 4), the RUG will take effect for billing beginning on Day 5. Since you have no RUG for days 1-4, the default rate would have to be billed. It does not matter that the assessment was identified as a Return/Readmission assessment which would usually begin on Day 1. In this situation, there is no billable RUG until Day 5.

The solution to the problem is to be sure to set the ARD in this type of situation for a grace day (Days 6-8). Many facilities regularly use grace days in order to calculate a higher Rehabilitation category. You may then bill this RUG from Day 1.

MC Part A and Consolidated Billing

For a resident in a SNF in a Medicare Part A stay, the facility is responsible for billing almost all services provided to the resident with few exceptions. Problems may occur when the resident sees a provider outside the facility who is unaware or confused about the resident’s status. CMS has posted several notices that a SNF might use to explain the resident’s status to this provider at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html. Their use is not required but they may be a useful resource for the facility.