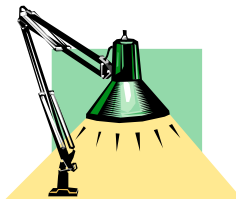


RAI Spotlight



RAI Manual Updates



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On February 11, 2009, CMS released updates to the RAI Manual with a revision date of December 2008 (www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS20Update200812.pdf). Every facility needs to download this material, review it thoroughly, and add the changed pages to facility copies of the manual. Three topics are of particular significance:

- On page 2-37 dealing with MC PPS, two paragraphs were deleted and the following wordage inserted: "If the beneficiary dies or is discharged before the eighth day of covered SNF care following the initial admission from the qualifying three-day hospital stay, a SNF must prepare an RAI as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no RAI is completed under these specific circumstances, the SNF may submit a

claim using the HIPPS default rate code. A stay of less than eight days that does not meet these requirements requires the completion of an MDS to receive payment; the SNF cannot bill the default code." This seems to say that if the SNF does not complete an MDS for the first short-stay ending in a D/08, they may bill the default rate. If the resident returns for a second short-stay, again ending in a D/08, the facility must complete an assessment to receive any payment for these days of care; they may not bill the default rate. Correlating changes were made on pages 2-27, 2-29 and 2-39.

- On page 3-136 discussing Urinary Tract Infections, a sentence was added: "...Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. *The attending physician should*
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Questions about the RAI?

Please submit them to
qa-mds@state.pa.us

Section H Continence Teleconference

Date: April 9, 2009
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Section H Continence
Handouts: Power Point slides will be available about April 1 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: 85920718

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

Additional questions: qa-mds@state.pa.us

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Section J2/3 Pain Q & A

On January 8, 2009, a training teleconference was provided on Section J2/3 Pain. The following questions were received

- Q. Our resident seems to be having pain, but both the physician and the family do not want to administer sufficient medication to relieve the pain. What can we do to help our resident?
- A. *You must be the resident's advocate in this situation. The first step might be a meeting with the physician and family to discuss the situation and identify their concerns. Hopefully, you can correct any misconceptions that may be influencing them. There may be alternative treatments that would be effective and acceptable. The DON and social worker should be included. If this approach does not work, present the situation to the medical director. Another resource would be the ombudsman if all "in-house" approaches are unsuccessful. Relief of pain is essential to a good quality of life; the NF is responsible to see that the resident can function at the highest practicable level.*
- Q. We are a short term rehab facility dealing predominantly with residents who have orthopedic surgical procedures such as joint replacements. The medical director does not want to order routine pain medication because, as they heal, the resident will need less medication. As a result, our numbers for Pain at J2/3 are high and the QM number is affecting our 5 Star rating. What can we do?

- A. *Continue assessing your residents accurately on the MDS. Explain the special issues of your particular resident population to anyone who questions the QM, e.g., prospective residents/families, surveyors, etc. If possible, try to have a discussion with your medical director: if the residents were medicated regularly, they would be more comfortable and could better participate in their rehabilitation program. The medications could be tapered as healing occurs.*
- Q. When will the final Guidance to Surveyors for F309 Quality of Care - Pain be effective?
- A. *This guidance was released in a Survey and Certification letter on January 23, 2009 at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter09-22.pdf. It is effective on March 31, 2009 and includes an expanded definition of Addiction that you should use rather than the shorter definition that was provided on slide 15 of the handouts. In this guidance, Addiction is defined as "A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by an overwhelming craving for medication, or behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving." In addition, "A resident whose pain is not being adequately treated may exhibit drug seeking behavior and may be thought to be addicted until their pain is adequately treated and the drug seeking behavior stops. This is generally not considered a true addiction."*

Medicare Part A Hospice Services in NFs

CMS has issued new interpretive guidance for hospices who provide care in SNFs (www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter09-19.pdf).

What are they responsible for? The hospice is responsible for professional management of the resident's hospice services in coordination with the NF Interdisciplinary Team (IDT). The services that the hospice would supply to a patient in his home should continue to be provided by the hospice in the NF. This includes:

- Ongoing assessment, care planning, monitoring, coordination and provision of care by the Hospice Interdisciplinary Group (IDG).
- Assessment, coordination and provision of any needed general inpatient or continuous care.
- Consultation about the patient's care with facility staff.
- Coordination by the hospice RN for the implementation of the plan of care for the patient.
- Provision of hospice aide services if these services are determined necessary by the IDG to supplement NA services provided by the facility.
- Provision, in a timely manner, of all supplies, medications, and DME needed for the palliation and management of the terminal illness and related conditions.
- Financial management responsibility for all medical supplies, appliances, medications and biologicals related to the terminal illness and related conditions.
- Determination of the appropriate level of [hospice] care to be given to the patient (routine homecare, inpatient, or continuous care).
- Arranging any necessary transfers from the facility in consultation with the facility staff.



RAI Manual Updates



(Continued from page 1)

determine the level of 'significant laboratory findings' and whether or not a culture should be obtained...."

The facility does not have to decide whether laboratory findings are significant; this is the responsibility of the physician.

- Clarification was placed on several pages (3-185, 3-186, 3-215, 3-216) that an initial therapy evaluation is required after an admission or readmission before therapy may be provided and reported in P1b or projected in T1b-d. Initial evaluation minutes may not be included on the MDS (3-187).

Some other topics were clarified:

- Page 2-29: Slight wording change under Significant Change in Status assessment removing "is completed." The Special Comment section now reads "Could establish a new RUG Classification and remains effective until the next assessment [is completed] as long as the resident continues to require a SNF level of care."
- Page 2-31: An OMRA must be completed "...after the discontinuation of *all* therapy."
- Page 3-177 O1 Medications: The following instruction was added: "In the event that information on IV medication additive(s) is not available, do not count as a medication in Section O1 and code P1ac with a dash." Corresponding wording was added on page 3-182 under P1ac.

Ambulance Transport and Consolidated Billing



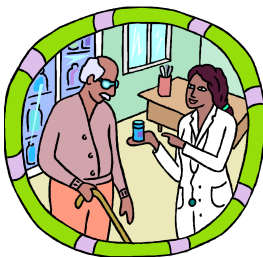
On January 29, 2009, a revision to the MLN Matters article "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services – SE0433" (www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf) was released. Under consolidated building, the SNF is responsible for all services provided to a resident in a Medicare Part A stay except for specifically excluded services. Discussion had arisen as to whether medically required ambulance transportation to a physician's office was the responsibility of the SNF. A clarifying Note was added to this article:

"Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c) which de-

scribe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference *only* the Part B ambulance benefit's general medical necessity requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated, and *not* any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transportation by ambulance, that ambulance roundtrip would be the responsibility of the SNF."

LTC CAPs

A Long Term Care Capitated Assistance Program is an MA managed care program for frail elderly recipients who have been determined to need "nursing facility level of care" but wish to remain in their home and community as long as possible. The provider is paid a negotiated rate by MA to provide a comprehensive all-inclusive package of services centered around an adult day health center where recipients receive most services. In PA, these providers all carry the word LIFE in their name: Living Independence for the Elderly. There is an excellent website detailing this program and identifying the providers at www.dpw.state.pa.us/servicesprograms/medicalassistance/suppservwaivers/003671635.htm.



If the recipient requires NF care, the LTC CAP provider is responsible for paying all bills for the duration of the resident's stay. These residents are considered to be MA for MA Case Mix for their total stay in the NF (see RDRM p. 3-2, sixth bullet). A copy of the PA/FS 162 may be obtained from the LTC CAP for facility records.

In contrast, if the resident has been cared for by an MA HMO in the community, the HMO is only required to pay for the first 30 days of the resident's NF stay. She is considered MA for MA Case Mix only for these first 30 days. On Day 31, she becomes MA Pending, and therefore not MA for MA Case Mix, until the PA/FS 162 is received from the CAO.

Five-Star Quality Rating System



On December 18, 2008, CMS updated the NH Compare web site (www.medicare.gov/NHCompare/Home.asp) to include the Five-Star Quality Rating System. This has generated discussion in the provider community and in the media. You may be wondering why your facility was only awarded two stars. What's so great about XYZ Nursing Home that they received five stars? Others may be concerned about admitting a relative to a less than five star nursing home.

The system is complex, and the following is meant only as an introduction so that you can develop a basic knowledge and be able to respond to questions. Based on a variety of data, the nursing facility is assigned one to five stars each for Health Inspections, Quality Measures, and Staffing. These results are then combined to generate an Overall rating of one to five stars. How does this work?

Health Inspections

In this section, points are assigned based on the number, scope and severity of the deficiencies found in the three most recent annual inspections and all complaint investigations over the last three years. Additional points are given if any of the deficiencies involved substandard quality of care. The most recent survey is given a heavier weight (1/2); the prior year is weighted 1/3, and the survey from two years ago is weighted 1/6. If your facility had a problematic survey two years ago, it receives less weight than the most recent survey which reflects the current status of the facility. Points are also assigned for each revisit necessary beyond the first to assure that the deficiencies were corrected.

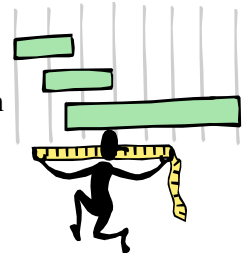


For this category, a lower point score results in a better rating. After the calculation is completed for all nursing facilities in the state, the NFs are ranked by their point totals. The top 10% (low scorers) are awarded five stars; the bottom 20% (high scorers) receive one star; the middle 70% is divided approximately equally (23.33% in each category) and assigned two, three, or four stars. The data is updated monthly with new surveys, so rankings may shift from month to month.

Quality Measures

Ten of the Quality Measures are used in this calculation. Only those considered to be the most reliable and valid, as well as being to some extent under the facility's control, were selected. For the long stay residents, these include the measures dealing with increased need for ADL assistance, decrease in mobility, high risk residents with pressure ulcers, long-term bladder catheters, physical restraints, urinary tract infections and pain. For short stay residents, the measures dealing with pressure ulcers, pain and delirium are used.

For this category, a higher point score results in a better rating with possible scores ranging from 0 – 136. QM data from three quarters is used. Each QM is scored separately. The facility percentage for each individual QM is calculated and for eight of the measures, arrayed with the results calculated for all facilities in the nation. Points are then assigned depending on placement in the array, e.g., 12 points if placed in < 20th percentile; 9 points if placed in 20th to < 40th percentile, etc.



Just to keep life confusing, the QMs dealing with increased need for ADL assistance and decrease in mobility are weighted more heavily (1.667) and are compared to all nursing facilities in the state rather than the nation. Points are then assigned depending on placement in the array, e.g., 20 points if placed in < 20th percentile; 15 points if placed in 20th to < 40th percentile, etc.

The points for all 10 QMs for the facility are then added together and arrayed with other state NFs. The top 10% in the state with scores of 98 or above receive five stars (2/3/09). The bottom 20% with 48 points or less receive one star (2/3/09). Two, three and four stars are awarded evenly among the remaining facilities.

(Continued on page 5)

Five-Star Quality Rating System



(Continued from page 4)

Staffing

Staffing measures are derived from the OSCAR database which contains staffing data self reported by the NF once a year. Two calculations are made: total nursing hours per resident day and RN nursing hours per resident day. This is then case mix-adjusted based on the facility's distribution of MDS assessments by RUG-III group based on the number of RN, LPN and nurse aide minutes associated with each group in the CMS Staff Time Measurement study. For each staffing measure, a star rating is assigned based on where the facility ranks compared to the adjusted staffing hours for all freestanding facilities in the nation AND where the NF ranks compared to optimal staffing levels identified in the 2001 CMS Staffing Study. The "cut points" between star categories will be held constant for two years.



To be awarded five stars, the NF must meet or exceed the CMS Staffing Study threshold for both RN (≥ 0.55) and Total nursing (≥ 4.08) hours per resident day. The two ratings are then reconciled to identify a single star rating for Staffing, e.g. 1 star for Total Nursing hours and 3 stars for RN hours would result in a 2 star ranking for Staffing.

Overall

A NF has now been assigned three different star rankings; how is the final overall result – 1 to 5 stars – calculated? Start with the number of stars assigned for Health Inspections:

- Add one star for 4 or 5 star Staffing
- Add one star for 5 star QMs
- Subtract one star for 1 star Staffing
- Subtract one star for 1 star QMs
- If Health Inspections is only one star, the rating can only be increased by one star based on Staffing or QMs.
- If this is a Special Focus Facility, the maximum Overall quality rating is 3 stars.



There are several references that will provide more detailed information:

The Five-Star Nursing Home Rating System: www.cms.hhs.gov/SurveyCertificationGenInfo/Downloads/ImprovingNHCompare.pdf

The Five-Star Nursing Home Rating System – Questions and Answers: www.cms.hhs.gov/SurveyCertificationGenInfo/Downloads/SCLetter09-18.pdf

Five-Star Quality Rating System: Technical Users' Guide: www.cms.hhs.gov/CertificationandCompliance/Downloads/userguide.pdf

