January 30, 2019

POLARIS PULSE

An Informational Bulletin Brought To You By Polaris Group

PDPM Clinical Category Updates

MDS Item I0020B will drive the PDPM Clinical Category

The fiscal year (FY) 2019 skilled nursing facility prospective payment system (SNF PPS) final rule included now inaccurate information related to how the default primary diagnosis clinical category will be determined for the physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) components of the patient-driven payment model (PDPM) that will be implemented on October 1, 2019.

The final rule cited first-listed MDS item I8000 (additional active diagnoses) as the source of the primary SNF diagnosis code that would drive the default primary clinical category for three PDPM payment components (PT, OT, and SLP).

However, a new item called I0020B will actually be the source of the primary SNF diagnosis code used to determine the default primary clinical category for the PT, OT, and SLP components, said officials with the Centers for Medicare & Medicaid Services (CMS) during the December 11, 2018 SNF PPS: PDPM National Provider Call

The existing item I0020 (indicate the resident's primary medical condition category) will have no direct impact on patient classification under PDPM. However, I0020 will serve as a gateway question to reach the new item I0020B. The assessors will code the resident's primary medical condition as any of the responses 01 – 13, and then will proceed to I0020B. Effective October 1, 2019, CMS will delete response 14 (other medical condition) as a coding option for I0020, as well as deleting I0020A, the space to enter an ICD-10 code for response 14, according to the newly released draft item sets v1.17.0. Therefore, I0020 (I0020A is gone Oct 1) is not relevant in determining the patient's primary clinical category for PT, OT, and SLP. I0020B will ask, "What is the main reason this person is being admitted to the SNF?" To answer this question, assessors will enter the ICD-10 code, including the decimal, of the primary diagnosis of the SNF patient. SNF residents have many complex needs and may suffer from a number of different conditions, but a diagnosis coded in I0020B should represent the primary or main reason that person is being admitted. This primary SNF diagnosis may or may not be the same reason that the patient was admitted to the qualifying hospital stay

Coding in new Section J items can change the patient's primary clinical category.

The resident's clinical category may change depending on the presence of a surgery during the preceding hospital stay. The 30 new items J2100 – J5000, which code past surgical history, will capture any major surgical procedure that occurred during the qualifying hospital stay that would require active care during the current SNF stay. If no qualifying major surgical procedure occurred during the hospital stay, the SNF patient will remain in their default primary clinical category identified via I0020B. However, certain major surgical procedures can divert or upgrade the patient into one of the three surgical primary clinical categories.

J2100 will ask if there was a recent surgery during the preceding inpatient hospital stay that required SNF care. If the answer is 1 (yes), the provider will proceed to J2300 – J5000 and fill out the checkboxes that correlate to the surgery or surgeries received during the immediate prior inpatient hospital stay that require SNF care.

If a patient has had more than one surgery that meets the criteria, assessors can check off as many items in J2300 – J5000 as appropriate.

The ICD-10 Clinical Category Crosswalk, which converts the ICD-10 code captured in I0020B into one of the 10 PDPM primary clinical categories in the column "Default Clinical Category," also has a column, "Resident Had a Major Procedure During the

POLARIS GROUP™ Strategic solutions for health care
POLARIS PULSE

Prior Inpatient Stay That Impacts the SNF Care Plan?" This column shows whether the ICD-10 code in I0020B also has what officials described as a "Surgical correlate" that will be applied if the patient meets the coding criteria for the relevant Section J items.

For PDPM Resources http://polaris-group.com/news_releases.asp

CMS Posts Draft MDS 3.0 Item Sets Version 1.17.0

The Centers for Medicare & Medicaid Services (CMS) updated its MDS 3.0 Technical Information. A new DRAFT version of the 2019 MDS item sets (v1.17.0), which is scheduled to take effect on October 1, 2019, has been posted to the CMS webpage. The files are located in the Downloads section at the bottom of the webpage https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

January 2019 OIG Updates

Follow-up Review on Inpatient Claims Subject to the Post-Acute-Care Transfer Policy

Medicare makes the full Medicare Severity Diagnosis -Related Group (MS-DRG) payment to a hospital that discharges an inpatient beneficiary "to home." Under the post-acute-care transfer policy, however, for certain qualifying MS-DRGs, Medicare pays a hospital that transfers an inpatient beneficiary to post-acute care a per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the inpatient beneficiary had been discharged to home. A prior OIG review identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (42 CFR § 412.4(c)). The OIG found that hospitals transferred patients to certain post-acute-care settings but improperly claimed the higher reimbursement associated with discharges "to home." Specifically, these hospitals used incorrect patient discharge status codes on their claims by indicating that their patients were discharged "to home" rather than transferred to a post-acute-care setting (e.g., home health services, skilled nursing facilities (SNFs), non-Inpatient Prospective Payment System (IPPS) hospitals or hospital units). OIG's review found that CMS common working file (CWF) edits related to transfers to home health care, SNFs, and non-IPPS hospitals were not working properly. As a result, OIG recommended that CMS correct the CWF edits, ensure they are working properly, and recover the identified overpayments in accordance with its policies and procedures. CMS agreed with the recommendations and stated that it will update the CWF edits. This follow-up audit will determine whether CMS corrected the CWF edits and ensured they are working properly.

States' Compliance with New Requirements to Prevent Medicaid Payments to Terminated Providers

To prevent terminated providers from treating Medicaid enrollees or receiving Medicaid payments, the 21st Century Cures Act (Cures Act) requires CMS to provide information to all States on Medicaid providers that have been terminated for cause. This study, mandated by the Cures Act, will examine the extent to which terminated providers included in CMS's terminations database have been terminated from all State Medicaid programs and the amount of Medicaid payments for items/services associated with terminated providers. Additionally, this study will examine the extent to which State contracts with managed care entities include a provision that terminated providers are excluded from all managed care networks

 3030 N. Rocky Point Drive, Suite 240, Tampa, FL 33607 813-886-6500, www.polaris-group.com

POLARIS GROUP™
Strategic solutions for health care

POLARIS PULSE

Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question
Would gangrene be listed under other lesion on the MDS?

Answer:
Yes. The RAI says, "Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.

Question:
We have a resident who had a UTI in the hospital in the past 30 days (with documentation in the hospital records), but was not treated in the facility. Should the UTI in the past 30 days be coded on the MDS in section I.

Answer:
Yes, the RAI says in Chapter 3 page I-12 "If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork after paperwork.

Question:
We have survey in our facility and they are asking if we do a DC return anticipated MDS and the resident does not return, what do we do? We have never done anything besides making sure the DC summary was done when they did not return within 30 days. Is there anything in the RAI that I am missing?

Answer:
Not at the Federal level but it might be at the State level. According to the RAI Chapter 2, page 2-38: "When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements".

2019 WEBINAR TRAININGS

Polaris Group is pleased to offer the following
CEU approved live Webinars

PDPM Introduction Training ***Hot New Topic***
Introduction to Patient Driven Payment Model 2/5

GG Coding Training ***Hot New Topic***
GG Coding for Function Scores and QMs 2/7

Emergency Preparedness Training
Emergency Preparedness Requirements for LT 2/13

Part B Training
Part B Therapy Programs-Therapy Documentation 2/12
Part B Therapy Programs-Coverage & Billing 2/19

CD-10 IMPACT on PDPM Training ***Hot New Topic***
ICD-10-CM IMPACT on PDPM 2/20

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

2019 LTC Dates

POLARIS GROUP LTC TRAINING INSTITUTE

Comprehensive 3-day training workshops to implement a compliant and successful Medicare program

SNF Billing Basics
April 16-18 St. Louis, MO

Medicare & PPS/PDPM & SNFQRP Compliance
February 26-28 Las Vegas, NV

Advanced Billing
March 19-21 Las Vegas, NV
May 21-23 Dallas, TX

POLARIS PULSE is an informational newsletter distributed to **POLARIS GROUP** clients. For further information regarding services or information contained in this publication, please contact **POLARIS GROUP** corporate headquarters at 800-275-6252.

Contributors:
Debora Glatfelter, RN, RAC-CT
Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA
Marty Pachciarz, RN, RAC-CT
Cynthia Wilkins, RN, MSN, LNHA
Wendy Erickson, BSN, RN, RAC-CT, CCA

Editor:
Chuck Cave, BS, CHC

Production Manager:
Mica Meadows