POLARIS PULSE

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New Quality Measures Coming to Nursing Home Compare, Five-Star Rating

New quality measures for skilled nursing facilities will be introduced in April 2016 the Centers for Medicare & Medicaid Services (CMS) officials announced during an Open Door Forum on March 3, 2016.

Data for the six new quality measures will be based on Medicare claims or MDS data.

CMS will begin posting data on the following six new quality measures (QMs) on Nursing Home Compare in April 2016:

1. Percentage of short-stay residents who were successfully discharged to the community (Claims-based)

2. Percentage of short-stay residents who have had an outpatient emergency department visit (Claims-based)

3. Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)

4. Percentage of short-stay residents who made improvements in function (MDS-based)

5. Percentage of long-stay residents whose ability to move independently worsened (MDS-based)

6. Percentage of long-stay residents who received an antianxiety or hypnotic medication (MDS-based)

Five of the six new measures will be phased in to the Five-Star Quality Ratings systems over a nine-month period, beginning this July. The measure on anti-anxiety and hypnotic medication use will be left out of the Five-Star system due to concerns about specificity and appropriate thresholds for star ratings.

The information used for the new measures will use a year of data up to the beginning of July 2015. Providers will receive a preview of their data for the measures in April, 2016.

CMS Releases Skilled Nursing Facility Utilization & Payment Data

The Centers for Medicare & Medicaid Services (CMS) released a public data set that provides information on services provided to Medicare beneficiaries by skilled nursing facilities (SNFs). The Skilled Nursing Facility Utilization and Payment Public Use File (SNF PUF) contains information on utilization, payments, and submitted charges organized by provider, state, and resource utilization group (RUG). The data includes information on 15,055 skilled nursing facilities, over 2.5 million stays, and almost $27 billion in Medicare payments for 2013. The data set does not contain any individually identifiable information about Medicare beneficiaries.

In addition to information on payments and charges, the SNF PUF contains information on two categories of RUGs for patients who receive a significant amount of therapy: Ultra-High (RU) and Very High (RV) Rehabilitation RUGs. Consistent with prior CMS findings, the SNF PUF shows that for these two RUGs, the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify a patient for these categories. Medicare SNF per diem payment amounts for rehabilitation RUGs are primarily based on therapy minutes and payment amounts for these two RUGs can exceed payments for comparable RUGs with fewer therapy minutes by more than 25 percent.

The Skilled Nursing Facility PUF contains five tables:

- Aggregated information by provider
- Aggregated information by provider and RUG
- Aggregated information by RUG
- Aggregated information by RUG and state
- Aggregated information on therapy minutes by provider

This PUF is based on information from CMS's Chronic Conditions Data Warehouse (CCW) data files. The data in the Skilled Nursing Facility PUF covers calendar year 2013 and contains 100% final-action (i.e., all claim adjustments have been resolved) skilled nursing facility institutional claims for the Medicare fee-for-service (FFS) population.

Office for Civil Rights Launches Phase 2 of HIPAA Audit Program

As a part of its continued efforts to assess compliance with the HIPAA Privacy, Security and Breach Notification Rules, the HHS Office for Civil Rights (OCR) has begun its next phase of audits of covered entities and their business associates. Audits are an important compliance tool for OCR that supplements OCR's other enforcement tools, such as complaint investigations and compliance reviews. These tools enable OCR to identify best practices and proactively uncover and address risks and vulnerabilities to protected health information (PHI).

In its 2016 Phase 2 HIPAA Audit Program, OCR will review the policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the Privacy, Security, and Breach Notification Rules. These audits will primarily be desk audits, although some on-site audits will be conducted.

The 2016 audit process begins with verification of an entity's address and contact information. An email is being sent to covered entities and business associates requesting that contact information be provided to OCR in a timely manner. OCR will then transmit a pre-audit questionnaire to gather data about the size, type, and operations of potential auditees; this data will be used with other information to create potential audit subject pools.

If an entity does not respond to OCR's request to verify its contact information or pre-audit questionnaire, OCR will use publically available information about the entity to create its audit subject pool. Therefore, an entity that does not respond to OCR may still be selected for an audit or subject to a compliance review. Communications from OCR will be sent via email and may be incorrectly classified as spam. If your entity's spam filtering and virus protection are automatically enabled, they expect entities to check their junk or spam email folder for emails from OCR.

To learn more about OCR's Phase 2 Audit program, please visit their website at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html

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

Question:

We had a resident that was here on a skilled stay under Medicare Advantage payer. They went out to the hospital overnight they were not admitted, so it was a LOA. The LOA day was the ARD for the 14 day PPS MDS. I didn't change the ARD date and now we have received a denial from the Medicare Advantage plan for that 14 day PPS MDS and all the days associated with that MDS. Can they do that?

Answer:

Yes, because a LOA day can't be used as the ARD date for a scheduled PPS MDS. The Medicare Advantage payer is saying the facility doesn't have a valid ARD date so the 14 day PPS MDS is not valid. The RAI says in Chapter 2, Section 2.13 Factors Impacting the SNF Medicare Assessment Schedule for a Resident that Takes a Leave of Absence from the SNF: If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-12 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments. For scheduled PPS assessments, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment.

Question:

Our new billing software is including the miscellaneous medical supplies from our facility on the UB04 for Medicare Part A claims. For example, incontinent briefs, mouthwash, gloves, etc. On my old system these charges were not set up to go to the UB04. The trainer for the new system said they could. I wanted to check with you before I had them removed because I don't think they should be billed.

Answer:

You are correct, routine medical supplies cannot be charged out on the UB04. Only supplies that are resident specific, like wound care for a skillable wound, ostomy, trach or urological supplies should be included on the UB04.

POLARIS GROUP LTC TRAINING INSTITUTE

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

Training Workshops for LTC
Current 2016 Dates & Locations:

Medicare & PPS Compliance for SNFs
May 17-19 Philadelphia, PA
October 11-13 Las Vegas, NV

SNF Billing Training—Basics & More
July 12-14 Raleigh, NC
September 13-15 San Antonia, TX

Advanced Billing for SNFs
April 12-14 Chicago, IL
August 16-18 Las Vegas, NV
November 15-17 Orlando, FL

Surviving MAC, RAC & ZPIC Audits
April 27-28 Brentwood, TN
October 5-6 Las Vegas, NV