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CMS Revises Guidance on Immediate Jeopardy

The Centers for Medicare & Medicaid Services (CMS) released a memorandum on March 5, 2019, "Revisions to Appendix Q, Guidance on Immediate Jeopardy", which includes revisions to the guidance on citing immediate jeopardy in Appendix Q of the State Operations Manual (SOM). These revisions to Appendix Q apply to all provider and supplier types and go into effect immediately. CMS intends for this guidance to increase clarity and consistency in identifying and citing immediate Jeopardy.

CMS Memorandum Summary

- **Core Appendix Q and Subparts** - Appendix Q to the State Operations Manual (SOM), which provides guidance for identifying immediate jeopardy, has been revised. The revision creates a Core Appendix Q that will be used by surveyors of all provider and supplier types in determining when to cite immediate jeopardy. CMS has drafted subparts to Appendix Q that focus on immediate jeopardy concerns occurring in nursing homes and clinical laboratories since those provider types have specific policies related to immediate jeopardy.
- **Key Components of Immediate Jeopardy** – To cite immediate jeopardy, surveyors determine that (1) noncompliance (2) caused or created a likelihood that serious injury, harm, impairment or death to one or more recipients would occur or recur; and (3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment or death to one or more recipients.
- **Immediate Jeopardy Template** – A template has been developed to assist surveyors in documenting the information necessary to establish each of the key components of immediate jeopardy. Survey teams must use the immediate jeopardy template attached to Appendix Q to document evidence of each component of immediate jeopardy and use the template to convey information to the surveyed entity.

Key Changes in the Core Appendix Q:

The Core Appendix Q contains a number of key changes from the previous version of Appendix Q. Those changes include:

- **Likelihood instead of potential** – The previous version of Appendix Q suggested that a potential for serious harm might constitute immediate jeopardy. Core Appendix Q makes it clear that in order to cite immediate jeopardy in situations where recipients have not already suffered serious injury, harm, impairment or death, the nature and/or extent of the identified noncompliance creates a likelihood (reasonable expectation) that such harm will occur if not corrected, not simply the potential for that level of harm to occur.
- **Culpability has been removed** – The previous version of Appendix Q made culpability a required component to cite immediate jeopardy. Because the regulatory definitions of immediate jeopardy do not require a finding of culpability, that requirement has been removed and has been replaced with the key component of noncompliance, since the definitions of immediate jeopardy require noncompliance to be the cause of the serious injury, harm, impairment or death, or the likelihood thereof.
- **Psychosocial harm** – Core Appendix Q includes a section instructing surveyors to consider whether noncompliance has caused or made likely serious mental or psychosocial harm to recipients. In situations where the psychosocial outcome to the recipient may be difficult to determine or incongruent with what would be expected, the guidance instructs surveyors to use the reasonable person concept to make that determination. The reasonable person approach considers how a reasonable person in the recipient's position would be impacted by the noncompliance (i.e. consider if a reasonable person in a similar situation could be expected to experience a serious psychosocial adverse outcome as a result of the same noncompliance).
- **No automatic immediate jeopardy citations** – Core Appendix Q makes it clear that each immediate jeopardy citation must be decided independently and there are no automatic immediate jeopardy citations.

To read the complete CMS memo: http://polaris-group.com/news_releases.asp

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PDPM Update
Interim Payment Assessment Alert

The Interim Payment Assessment (IPA) is one of three SNF PPS assessments under PDPM. The other two SNF PPS assessments, the 5-day PPS assessment and the PPS (NPE) Discharge assessment, are required. Except for the transition to PDPM from RUG-IV, the IPA will be an optional assessment. The optional IPA "will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment," says CMS.

CMS had previously said, the ARD must be within 14 days of change, and the change needed to last 14 days, and needed to be a "first tiered" change in a component of the rate. However, now they have opened the door with their new guidance of "optional" and "to be completed when the provider determines there are clinical changes warranting a new PDPM assessment (IPA)." CMS has also stated that the ARD is set when the team discovers the change. The ARD must be immediately communicated to team members as the BIMs and Mood Interviews must be completed on or before the ARD to calculate the SLP component. The change in Case Mix Group (s) and related rate changes effective on the ARD .

So consider, a resident may be improving with rehab, and their Function Scores are improving. Their Function Scores may improve enough to cause an increase in the PT/OT component of the rate. However, remember the Nursing Component of the rate may go down as Function Scores improve. The Function Score impact on PT/OT is the reverse of the Function Score impact on the Nursing Component.

The Final RAI is expected to be published in May, this may give us more directions, but for now, there are no "rules" limiting completing an IPA for any change that could change a component of the rate Case Mix Group.

Improvements to Nursing Home Compare and Five Star

On March 5, 2019, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum that includes changes to the Five-Star Rating system on Nursing Home Compare that will go into effect in **April 2019.** CMS has also posted a revised Five- Star Technical Users' Guide reflecting these changes.

CMS Memorandum Summary

- **Ending the Freeze on Health Inspection Star Ratings** - In April 2019, the Centers for Medicare & Medicaid Services (CMS) will end the freeze on the health inspection domain of the Five Star Quality Rating System. CMS will resume the traditional method of calculating health inspection scores by using three cycles of inspections. Inspections occurring on or after November 28, 2017, will be included in each facility's star rating.
- **Quality Measure (QM) Domain Improvements** – CMS is introducing separate ratings for short- and long-stay measures to reflect the level of quality provided for these two subpopulations in nursing homes. CMS is also revising the thresholds for ratings, adding a system for regular updates to thresholds every six months, and weighting and scoring individual QMs differently. Additionally, CMS is adding the long-stay hospitalization measure and a measure of long-stay emergency department (ED) transfers to the rating system. Two measures from the Skilled Nursing Facility Quality Reporting Program (QRP) will be adopted to replace duplicative existing measures.
- **Staffing Domain Improvements** – CMS is adjusting the thresholds for staffing ratings. In addition, the threshold for the 'number of days without a registered nurse (RN) onsite' that triggers an automatic downgrade to one star will be reduced from seven to four days.

To read the complete CMS and memo and the revised Five -Star Technical User's Guide http://polaris-group.com/news_releases.asp

March OIG Update

Post-Hospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries

Skilled nursing facilities (SNFs) are specially qualified facilities that provide extended care services, such as skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. During previous OIG reviews, the OIG noted that some nursing facility residents who were receiving Medicaid-covered nursing home care were admitted to a hospital and returned to the same facility to receive Medicare-covered post-hospital SNF care. In some cases, hospital physicians discharged beneficiaries to "home" rather than "SNF," yet nursing facility physicians certified that skilled care was needed. Because Medicare pays substantially more for SNF care than Medicaid for nursing home care, nursing facilities have financial incentives to increase the level of care to "skilled."

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The OIG will determine whether the post-hospital SNF care provided to dually eligible beneficiaries met the level of care requirements. Specifically, they will determine whether (1) the SNF level of care was certified by a physician or a physician extender (2) the condition treated at the SNF was a condition for which the beneficiary received inpatient hospital services or a condition that arose while the beneficiary was receiving care in a SNF for a condition for which the beneficiary received inpatient hospital services; (3) daily skilled care was required; (4) the services delivered were reasonable and necessary for the treatment of a beneficiary's illness or injury; and (5) improper Medicare payments were made on the claims reviewed. The OIG will also determine whether any of the hospital admissions they review were potentially avoidable.

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

Question:
We have a long-term care resident who was receiving Medicare Part B therapy. Therapy discharged her off Medicare Part B. What notices are required to give the resident?

Answer:
You would give the NOMNC for her right to appeal your decision to discharge her off Medicare Part B and if she wanted to continue with any therapy that was not medically necessary, you would give the Medicare Part B ABN (CMS R-131 form). If she agrees with therapies decision to discharge her off Medicare Part B then no ABN is required.

Question:
We had a resident come in on 2/20/19. I set the 5 day PPS MDS on 2/28/19. I have already transmitted the MDS. Can I go in and change the ARD to 2/27/19 because 2/28/19 is day nine not day eight of the stay?

Answer:
No. The ARD cannot be changed once the date is outside the ARD window for the specified MDS. The facility will have to take one day of default since the ARD is one day outside the 5 day PPS ARD window.

Question:
On an EOT, what should I put under A2400A, A2400B and A2400C?

Answer:
Under A2400A you would say yes this is a Medicare Part A stay then under A2400B you would put the date they started Medicare then under A2400C you would dash it for being ongoing.

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July 9-11 Denver, CO
Sept 10-12 Las Vegas, NV
Nov 5-7 Phoenix, AZ

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