



An Informational Bulletin Brought To You By Polaris Group

CMS Releases Updated Special Facility Focus List

On March 23, 2009, CMS released the most updated Special Facility Focus List (SFF). CMS also provided the background information on CMS "Special Focus Facility" initiative, which is meant to assist the consumer with options in choosing a long term care facility, what each facility is doing to improve quality of care. For additional information, please visit our website at www.polaris-group.com/news_releases.asp

SPECIAL FOCUS FACILITY SCORING METHODOLOGY

The scoring methodology for the Special Focus Facility (SFF) comprises two scores: the deficiency score and the revisit score. Results from the most recent surveys are weighted more heavily than results from earlier surveys. The SFF selection methodology may be understood as a five-step process:

- (1) **Health Deficiencies:** Health Deficiencies are scored and weighted,
- (2) **Revisits:** If the facility required more than one revisit to demonstrate substantial compliance, additional points are added to the SFF score,
- (3) **Weighting by Year:** Results are totaled and weights are assigned to each period, with more recent results weighted more heavily,
- (4) **List per State:** The facilities are grouped within each State and the 15 facilities with the highest SFF scores (i.e. most serious and persistent health care deficiency histories) are presented to the State for consideration as SFF facilities,
- (5) **State Recommendation and Selection:** Each State reviews the candidate list, brings its State-specific knowledge and information to bear (e.g. results of State licensure surveys), and recommends a final selection to CMS.

1. Health Care Deficiencies Health care deficiencies identified during the most recent three standard

survey cycles and during the last three years of complaint surveys represent the most significant factor in the identification of which facilities merit close attention in the SFF initiative. The more deficiencies, and the more serious or widespread those deficiencies, the higher the SFF deficiency score. A high SFF deficiency score indicates more serious quality of care problems compared to other facilities in the State. The deficiency score includes deficiencies that are identified during (a) the last three standard (comprehensive) surveys, and (b) complaint surveys that occurred in each of the last three years and in which a deficiency was identified. Each identified deficiency is evaluated according to two dimensions: (a) The scope of the deficiency (such as whether the deficiency was isolated to one person or was widespread throughout the nursing home), and (b) The severity of the deficiency (such as whether an individual suffered injury, harm, impairment, or death). The Social Security Act and CMS regulations also identify certain deficiencies that are described as representing "substandard quality of care." If a deficiency is among those in the substandard quality of care category, higher points are assigned. This methodology may be more easily perceived in the form of CMS' well-known "scope and severity grid," shown as Table 1 on page 2.

The shaded cells in Table 1 denote deficiency scope/severity levels that constitute substandard quality of care if the requirement that is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15, quality of life; 42 CFR 483.25, quality of care.

Figures in parentheses in those shaded cells indicate points for deficiencies that are for substandard quality of care. For example, an "F-level) deficiency that is not considered part of substandard



quality of care would be assigned 6 points, while an “F-level” deficiency that is within the substandard quality of care category would be assigned 10 points.

**Table 1 Survey Deficiency Score:
SFF Weights for Different Type of Deficiencies**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J-50 points (75 points)	K-100 points (125 points)	L-150 points (175 points)
Actual harm that is not immediate jeopardy	G-10 points	H-20 points (25 points)	I-30 points (35 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D-2 points	E-4 points	F-6 points (10 points)
No actual harm with potential for minimal harm	A-0 point	B-0 points	C-0 points

Complaint deficiency points are summed by provider for each annual period to produce three complaint survey scores. Standard deficiency points are summed by provider and by survey cycle to produce three standard survey scores.

2. Revisits Necessary to Confirm Restored Compliance

When a serious deficiency has been identified, CMS requires that a revisit be conducted to verify that the facility has been restored to substantial compliance with CMS quality of care and safety requirements. Usually the surveyors find that problems have been corrected and the surveys are able to verify substantial compliance in only one revisit. However, in some nursing homes the revisit survey finds that the facility remains out of compliance, and a second, third, or rarely a fourth revisit is necessary before the facility is able to demonstrate substantial compliance with federal nursing home requirements.

Facilities that require more than one revisit before being able to demonstrate substantial compliance have generally failed to make systemic changes in quality of care and quality of life and/or failed to monitor and re-evaluate care, treatment and services

via the quality assessment and assurance process. Such facilities are more likely to exhibit a yo-yo pattern of non-compliance. The number of revisits that are conducted represents an indicator of more serious problems in achieving or sustaining compliance. We therefore assign additional SFF points to a facility for each additional revisit after the first revisit. As shown in Table 2 below, 50 points are assigned for the second revisit needed to demonstrate substantial compliance on the health certification portion of each standard survey, 75 for the third revisit, and 100 for a fourth revisit. Note that revisit points are added only for standard surveys, not for complaint surveys.

For the remainder of the above article, please visit our website at: www.polaris-group.com/news_releases.asp

UPCOMING CMS OPEN DOOR FORUMS FOR APRIL 2009

The next **Home Health, Hospice & DME ODF** is scheduled for Wednesday, April 1, 2009 from 2pm-3pm ET. To participate by phone, dial: 1-800-837-1935 & Reference Conference ID: 88151741.

Special Open Door Forum: **Nursing Home Value Based Purchasing** Demonstration on Monday, April 6, 2009 from 2-4pmET. The primary audience for this call is Medicare certified nursing homes from the States that have been selected to host the demonstration: Arizona, Mississippi, New York and Wisconsin. To participate dial Dial: 1-800-837-1935 with Conference ID: 87622411.

The next **Skilled Nursing Facilities/Long Term Care** Open Door Forum is scheduled for Thursday, April 16, 2009. To participate by phone, dial: 1-800-837-1935 Conference ID: 89325891.

For more information, please contact your Polaris Group representative.



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POLARIS PULSE

Ambulance Open Door Forum Overview:

The Ambulance Open Door Forum handles issues related to the payment, billing, coverage and delivery of services in the ambulance industry. The Ambulance Fee Schedule rules, rural and other ambulance payment enhancements, requirements for ambulance service certification and payment determinations, are just some of the many types of issues addressed within the forum. In addition, discussions differentiating the rules related to provider-based and independent ambulance services are facilitated. Timely announcements and clarifications regarding important rulemaking, agency program initiatives, and other related areas are also included in the forums.

The next **Ambulance Open Door Forum** is Wednesday, April 15, 2009 from 2-3pm ET. To participate by phone dial 1-800-837-1935 Conference ID 88161255.

Q & A

“Where No Question Goes Unanswered!”

Q: If a resident has a stage II on one ankle and a stage III on the other ankle, what DX codes should I use on the MDS?

A: Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages.

When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.



TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following **CEU approved** teleconference trainings

Live Teleconference Trainings

<u>Topic</u>	<u>Date</u>
New Survey Investigative Protocol F-309	4/3
Master Section G Coding	4/9
Medicare Doc & Skilling Criteria	4/9
Case Mgmt for PPS & Accurate Reimbursement	4/16
Quality Indicator Survey-Good, Bad and Ugly	4/16
MDS & Therapy	4/21
Medicare Part A Basics	4/23
QM/QI Coding Review	4/23
Denial Letters & Generic Notices	4/30
Understanding Your 5 Stars	4/30

*Please join us in our Teleconferences .
For further information regarding these seminars, please contact the Seminar Department at: 800-275-6252 ext. 233 or register at: www.polaris-group.com*



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Contributors:

Joanie Bowes-Stephens, RNS, RAC-CT
Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA
Marty Pachciarz, RN, RAC-CT

Editor:

Chuck Cave

Production Manager:

Cindy Hernandez