POLARIS PULSE

An Informational Bulletin Brought To You By Polaris Group

Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in healthcare consulting, puts Polaris Group in limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.

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THERAPY CAP EXCEPTION PROCESS UPDATE

The Senate late Wednesday passed the Medicare bill that would extend the therapy caps exceptions process for Part B therapy caps by 18 months. The process expired on June 30, 2008. The bill also would freeze physician payments for 2008 and provide a 1.1% increase for physicians in 2009. A 10.6% freeze on physician payments was set to take effect July 1, but was temporarily suspended. The legislation also would delay for 18 months an unpopular competitive bidding program for durable medical equipment.

The vote clears the bill to be sent to the president. Although the president's advisors have indicated that he would veto the bill, the Senate vote provided a veto-proof margin. The measure previously cleared the House by a veto-proof margin. Polaris Group will continue to monitor legislative action.

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REVISED GUIDANCE TO SURVEYORS F 325 & F 371

Revised Surveyor Guidance for surveying Nutrition (F325) and Sanitary Conditions (F371) requirements in long-term care facilities will become effective on September 1, 2008. The revised Guidance deletes Tags F 326 (Therapeutic Diets) and F 370 (Approved Food Source incorporates their guidance into F 325 and F371 respectively.

Following the pattern established with prior guidance revisions, the Nutrition and Sanitary Conditions guidance include:

- Expanded Interpretive Guidelines that clarify areas such as assessment, care planning, and interventions related to nutrition and sanitary conditions for nursing home residents.
- New Investigative Protocol that explains objectives and procedures surveyors will need for their investigations.
- Deficiency categorization that provides guidance for the determination of the correct level of severity for citations at Tags F 325 and/or Tag F 371.

Nutrition – F 325

Intent

The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional status and that the facility:

1. Provides nutritional care and services to each resident, consistent with the resident's comprehensive assessment
2. Recognizes, evaluates, and addresses the needs of every resident, including but not limited to , the resident at risk or already experiencing impaired nutrition
3. Provide a therapeutic diet that takes into account the resident's clinical condition and preferences, when there is a nutritional indication.

Investigative Protocol

The protocol will be used for each sampled resident:

- To determine if residents maintained acceptable parameters of nutritional status, relative to his/her comprehensive assessment
- For a resident who did not maintain acceptable parameters of nutritional status, to determine if the facility assess and intervened (e.g., therapeutic diet) to enable the resident to maintain acceptable parameters of nutritional status, unless the resident's clinical condition demonstrated that this was not possible
- For a resident who is at nutritional risk, to determine if the facility has identified and addressed risk factors for, and causes of, impaired nutritional status, or demonstrated why they could not or should not do so.

Deficiency Categorization

The guidelines include the following examples of Severity determinations:

Level 4 – Immediate Jeopardy

- Substantial and ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic soft, pureed) provided by the facility against the resident's expressed preferences
- Development of life-threatening symptoms), or the development of continuation of severely impaired nutritional status due to repeated failure to assist a resident who required assistance with meas.

Level 3 – Actual Harm that is Not Immediate Jeopardy

- Loss of weight from declining food and fluid intake due to the facility's failure to assess and address the resident's use of medications that affect appetite and food intake;
- Decline in function related to poor food/fluid intake due to the facility's failure to accommodate documented resident food dislikes and provide appropriate substitutes

Level 2 – No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy

- Failure to obtain accurate weight's) and to verify weight's) as needed
- Poor intake due to the facility's intermittent failure to provide required assistance with eating, however, the resident met identified weight goals
- Failure to provide additional nourishment when ordered for a resident, however, the resident did not experience significant weight loss

Level 1 – No Actual Harm with Potential for Minimal Harm

- The failure of the facility to provide appropriate care and services to maintain acceptable parameters of nutritional status and minimize negative outcomes places residents at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

Sanitary Conditions – F 371

Intent

The intent of this requirement is to ensure that the facility:

1. Obtains food for resident consumption from sources approved or considered satisfactory by Federal, State or local authorities; and
2. Follows proper sanitation and food handling practices to prevent the outbreak of food borne illness. Safe food handling for the prevention of food borne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes.

Investigative Protocol

The protocol will be used:

1. To determine if the facility obtained food safe for consumption from approved sources;
2. To determine if the facility stores, prepares, distributes, and serves food in a sanitary manner to prevent food borne illness;
3. To determine if the facility has systems (e.g., policies, procedures, training, and monitoring) in place to prevent the spread of food borne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food safety; and
4. To determine if the facility utilizes safe food handling from the time the food is received from the vendor and throughout the food handling processes in the facility.

Deficiency Categorization

The guidelines include the following examples of Severity determinations:

Level 4 – Immediate Jeopardy

- A roast (raw meat) thawing on a plate in the refrigerator had bloody juices overflowing and dripping onto uncovered salad greens on the shelf below. The contaminated salad greens were not discarded and were used to make salad for the noon meal.
- The facility had a recent outbreak of Norovirus after the facility allowed a food worker who was experiencing vomiting and diarrhea to continue preparing food. Observations and interviews indicate that other food service staff with gastrointestinal illnesses are also permitted to prepare food.

Level 3 – Actual Harm that is Not Immediate Jeopardy

- Outbreak of nausea and vomiting occurs in the facility related to the inadequate sanitizing of dishes and utensils.
- Episode of food poisoning occurs because facility had an event in which tuna, chicken, and potato salads served in bulk.

Level 2 – No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy

- During the initial tour of the kitchen, two food service workers were observed on the loading dock. One was smoking and the other employee was emptying trash. Upon returning to the kitchen, they proceeded to prepare food without washing their hands.
- Upon inquiry by the surveyor, the food service workers tested the sanitizer of the dish machine, the chemical rinse of the pot-and-pan sink, and a stationary bucket used for wiping cloths. The facility used chlorine as the sanitizer. The sanitizer tested less than 50 ppm in all three locations. Staff interviewed stated they were

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unaware of the amount of sanitizer to use and the manufacturer's recommendations to maintain the appropriate ppm of available sanitizer.

Polaris Group will present Live Teleconference training detailing the Revised Surveyor Guidance in August 2008. To register for this training visit our on line store at www.polaris-group.com.

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SKILLED NURSING FACILITY BILLING WHEN QUALIFYING STAY OR TRANSFER CRITERIA ARE NOT MET

Effective July 1, 2008 Skilled Nursing Facility (SNF) providers are required to submit claims to Medicare for beneficiaries that receive a skilled level of care. This includes beneficiaries that do not meet the qualifying stay or transfer criteria for a Medicare Part A covered stay. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to update the beneficiary's spell of illness in the Common Working File. SNFs must follow the billing instructions for benefits exhaust claims as provided in the Medicare Claims Processing Manual, Chapter 6, SNF Part A Billing, Section 40.8. This includes the submission of covered claims in order to allow the Medicare systems to deny the claims for the appropriate reason. *Source: CMS Transmittal 1450.*

Q & A
"Where No Question Goes Unanswered!"

Q. Is therapy permitted to project days and minutes through day 15 on Section T when the resident returned to the hospital on the Assessment Reference Date of the Medicare 5-Day MDS?

A. Coding guidelines located in CMS's Resident Assessment Instrument (RAI) Version 2.0 User's Manual instructs the coder to "Calculate the expected number of days through day 15, even if the resident is discharged prior to day 15." The same instructions repeat regarding estimation of number of minutes. The manual provides one exception to this guidance. "When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7."

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

Live Teleconference Trainings

Topic	Date
RAPS and Care Plans	7/15
Medicare Part A Basics	7/16
Skilled Medicare Nursing Documentation	7/17
PPS and Case Management of MDS	7/22
QI/QM Report Review	7/23
New Nutrition & Sanitation Surveyor Guidance	7/23
F-Tag Review	7/24
Documentation Basics for RUG 34	7/24
Survey Process and Preparation	7/29
Writing a POC	7/30
MDS for Administrators	7/31
Pressure Ulcer	8/5
Super Supervisor	8/6
QA Program	8/7
Bowel and Bladder	8/12
Texas RUGS Part 1	8/12
Feedback on Performance	8/13
QIS Survey	8/14
Fall Management	8/19
Texas RUGS Part II	8/19
Anatomy of a Chart	8/20
Survey Prep	8/21
Revised Nutrition & Sanitary Surveyor Guidance	8/21

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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