



An Informational Bulletin Brought To You By Polaris Group

Healthcare Reform Law and Mandatory Compliance Programs

The Patient Protection and Affordable Care Act (PPACA) grants to the Secretary of the Department of Health & Human Services the authority to require health care providers to adopt compliance programs as a condition to enrollment or revalidation in the Medicare, Medicaid and CHIP programs.

For the last 12 years, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has promoted the voluntary adoption of compliance programs throughout the healthcare industry by the development and promulgation of compliance guidance tailored to specific healthcare industry segments. The Healthcare Reform Law creates a new opportunity for HHS and its Inspector General to promulgate regulations that impose on most healthcare providers and suppliers a form of compliance program intended to be “effective in preventing and detecting criminal, civil, and administrative violations” under the Medicare and Medicaid laws.

Nursing Facility Compliance Program Implementation:

By **December 31, 2011**, the Secretary shall establish and implement a quality assurance and performance improvement (QAPI) program for nursing facilities that will address best practices.

By **March 23, 2012**, the Secretary of HHS, working jointly with OIG, must promulgate regulations for “an effective compliance program” for nursing facility operating organizations.

By **March 23, 2013**, skilled nursing facilities and other nursing facilities must have “in operation” a compliance and ethics program that meets the Law’s criteria.

By **March 23, 2013**, the HHS Secretary shall have completed “an evaluation” of the compliance and ethics programs that nursing facilities will be required to establish.

Sometime after **March 23, 2013**, the Secretary must submit an evaluation report to Congress with recommendations on changes to the regulatory requirements for nursing facility compliance programs.

For nursing facilities, the Healthcare Reform Law specifies certain “required components of a compliance and ethics program” that include:

- ◆ Compliance standards and procedures for employees and other agents “that are reasonably capable of reducing the prospect” of criminal, civil, and administrative law Medicare and Medicaid violations.
- ◆ The assignment of overall compliance program oversight to “high-level personnel” with “sufficient resources and authority” to assure such compliance.
- ◆ The exercise of “due care” not to delegate “substantial discretionary authority” to individuals whom the nursing facility knew or should have known had a “propensity to engage in criminal, civil, or administrative violations.”
- ◆ The effective communication of compliance standards and procedures to all employees and agents, including training programs or published materials.
- ◆ The adoption of reasonable monitoring and auditing systems reasonably designed to detect compliance violations by employees and other agents and a mechanism for employees and agents to report violations without fear of retribution.
- ◆ The consistent enforcement of appropriate disciplinary mechanisms, including for failure to detect an offense.
- ◆ Following detection of an offense, reasonable responses to include steps to prevent further similar offenses, including any modifications to the compliance program.
- ◆ The periodic reassessment of its compliance program to identify modifications necessary to reflect changes within the nursing facility organization and its facilities.

Medical Directors release guidance on transferring patients from acute care to skilled nursing facilities

AMDA has released a new white paper highlighting successful and effective processes for transferring patients from acute care to skilled nursing facilities. The goal of the paper is to “guide policies and procedures that enhance communication and support safe, patient centered care” during transfer between sites of care. The current system of care transitions contains significant deficits, according to the paper.



AMDA recommends that the key elements to ensure a safe care transition process should be focused on the following:

Patient-Centered Care

- ◆ Transfer occurs with the patient's and/or family's input and understanding to the extent possible.
- ◆ Transfers are consistent with goals of care and advance care documents of the patient and/or family.
- ◆ Transfers include appropriate patient and caregiver education.

Communication

- ◆ Information about the patient, including medication and care plans, should be collected through the stay and be available well in advance of any transfer.
- ◆ Those professionals involved in the care of long-term care patients and other frail, at-risk patients should actively work with other relevant professionals and each site of care to create and improve policies and procedures that assure timely and accurate communication.
- ◆ When possible, communication about transfers should be communicated from professional in different sites of care.
- ◆ The sending and receiving professionals should have reliable contact information for each other (e.g., phone, pager, fax).

Safety

- ◆ Safe transfers rely on appropriate assessment of the patient prior to transfer. AMDA provides tools such as the AMDA *Acute Change of Condition in the Long-Term Care Setting* Clinical Practice Guideline to help with such assessment.
- ◆ Safety requires accurate and timely transfer of key information including

- ⇒ patient's functional and cognitive status;
- ⇒ plan of care and advance care directives;
- ⇒ current problem list;
- ⇒ current treatment regimen, including all necessary equipment needed;
- ⇒ allergies;
- ⇒ meal consistencies and preferences; and
- ⇒ recent labs, consultations, and diagnostic testing results.

This goal of this white paper is to guide policies and procedures that enhance communication and support safe, patient-centered care as patients and families transition between sites of care.

For additional information, please visit our website at:
http://www.polaris-group.com/news_releases.asp

CMS Announces Timely Filing Requirements for Medicare Fee-For-Service Claims

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the timely filing requirements to reduce the maximum time period for submission of all Medicare fee-for-service (FFS) claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, the law mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

For additional information, please visit our website at:
http://www.polaris-group.com/news_releases.asp

MDS Corner

What changes can SNF's expect with a RUG-111 Modified grouper vs. a Rug IV grouper for MDS 3.0



CMS stated the following during their "Train the Trainer" held in Baltimore in April:

- ◆ MDS 3.0 will be implemented Oct 1. **Rumors about delayed implementation are false.**
- ◆ With delay in RUG-IV, CMS stated a new grouper for a modified RUG-III must be created to work with MDS 3.0.
- ◆ The grouper is the software program that calculates the RUG category from the MDS 3.0 for billing Medicare Part A. **The grouper may also be referred to as the crosswalk.**
- ◆ This new modified RUG-III grouper will not be ready until at least January 2011.
- ◆ CMS stated they have not solved the problem of how SNFs will bill Medicare starting on Oct 1st.
- ◆ Without a grouper for Oct 1st, CMS may hope the billing crises for SNFs will force a RUG-IV implementation as the quickest solution.
- ◆ When the grouper becomes available, all MDS would need to be "re-run" through the grouper to calculate a RUG for Part A claims.
- ◆ With MDS 3.0 implementation, the most challenging aspects of the RUG-IV system will be implemented Oct 1st regardless of grouper type (RUG-III modified or RUG-IV).



- ◆ These challenges include short stay rules, concurrent therapy allocation, no look back into hospital, and end and start of therapy MDS.
- ◆ CMS stated they will provide RUG-IV (or modified RUG-III) training sometime in summer.

With all the changes and challenges of MDS 3.0 implementation (regardless if grouper is modified RUG-III or RUG-IV), SNFs should continue to educate their staff to RUG-IV and MDS 3.0 rules.

Understanding changes related to short stays, concurrent therapy, look back into hospital, and end and start of therapy MDS is imperative as staff must be prepared to manage their MDS 3.0 for optimal revenue.

Q & A
“Where No Question Goes Unanswered!”

- Q. We have a Part A resident who is skilled for nursing. She has a Stage 4 pressure ulcer with daily dressing changes. The physician has ordered comfort care measures but not Hospice. Can we continue on Part A?
- A. Yes, as long as she continues to receive daily skilled services.

Memorial Day

5.31.10



TELECONFERENCE TRAININGS

Polaris Group is pleased to offer the following **CEU approved** live teleconferences

<u>Topic</u>	<u>Date</u>
RUG-IV-Part 1: Qualifiers & MDS Coding	5/20
RUG-IV-Part 2: Medicare MDS Requirements	5/27
MDS 3.0-Part IV: Care Area Assessments	6/3
MDS 3.0-Part I: Basics and More	6/8
MDS 3.0-Part II: Clinical Nurses Sections	6/9
MDS 3.0-Part III: Interviews & MDS Coding	6/22
MDS 3.0-Part IV: Care Area Assessments	6/23
RUG-IV-Part 1: Qualifiers & MDS Coding	6/24
RUG-IV-Part 2: Medicare MDS Requirements	6/29

Please join us!

For further information, please contact the Seminar Department at: 800-275-6252 ext. 233 or register online at: www.polaris-group.com

Risk Management solutions at your fingertips

- * **Immediate analysis for improving MDS**
- * **Survey outcomes & clinical support applications**
- * **Regulatory research library and manuals**

Apollo RM (risk management web application)

Demo date: May 21st at 1:00 PM EST

Learn more and register for demo online:

www.polaris-group.com

• 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 Philips, RN, AAS
- Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA
- Marty Pachciarz, RN, RAC-CT
- Deborah Moss, RN, MHS, RAC-CT
- Susan Dickson, RN, RAC-CT

Editor:

Chuck Cave, BS, CHC

Production Manager:

Cindy Hernandez