



An Informational Bulletin Brought To You By Polaris Group

CMS Releases Revised State Operations Manual, Appendix PP

The Centers for Medicare and Medicaid Services (CMS) released a new Survey & Certification memo on June 30, 2017, detailing revisions to the State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag revisions, and related issues. The revisions will be effective on November 28, 2017.

Key items in the CMS memo;

Revised Interpretive Guidance:

In September 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Requirements for Participation under the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities rule. As a result of these changes, CMS released revised Interpretive Guidance effective November 28, 2017. CMS notes, many standards have remained unchanged since the early 1990's. For these areas, CMS reviewed the existing Interpretive Guidelines and updated where necessary to ensure that the standards and examples were clear. CMS also added a section in some areas to the Interpretive Guidance titled "Key Elements of Noncompliance." This is intended to guide surveyors and nursing facilities about the key behaviors and practices identified in the regulation. The Interpretive Guidance includes clarifications to existing requirements, guidance for new Phase 2 requirements, and references to the revised survey process and protocols.

Revised F Tags:

The revisions of the regulations caused many of the prior regulatory citations to be re-designated. CMS is revising the nursing facility F-tags to correspond with the new regulatory sections. With the re-structuring of the regulation, some tags were combined, and some tags were split into multiple subparts. These new F-tags will be used after November 28, 2017.

Survey Process:

Implementation of Phase 2 is scheduled to occur simultaneously with a new, computer-based Long Term Care survey system. CMS is incorporating the new regulatory requirements while combining the Traditional and Quality Indicator Survey processes. Within the Interpretive Guidance, there is information about the survey process. CMS will be providing additional information in the coming months.

Enforcement and Nursing Home Compare Considerations:

Enforcement – CMS will provide a one-year restriction of enforcement remedies for specific Phase 2 requirements. Specifically, CMS will not utilize civil money penalties, denial of payment, and/or termination. Should a facility be found to be out of compliance with these new requirements beginning in November of 2017, CMS would use this year-long period to educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional directed in-service training. Enforcement for other existing standards (including Phase 1 requirements) would follow the standard process. Please note this one-year period is not a change in the required implementation date for Phase 2 provisions.

Nursing Home Compare- Currently, the Nursing Home Five Star Quality Rating System calculates a rating based on each facility's survey performance as compared to others' in the same State. Most facilities will be surveyed for compliance with Phase 2 requirements using the revised survey process within a year of the November 28, 2017 effective date. However, due to the differing standards being phased in over the year, CMS will be holding constant for one year the Nursing Home Compare health inspection rating for any surveys conducted after November 28, 2017.

Training Resources:

CMS is providing several training resources on their website: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html> and on an MLN Connect call on July 25, 2017.

In addition to the memo and updated guidance in Appendices P and PP in the State Operations Manual, CMS released the F-Tag Crosswalk.

For a copy of the CMS F-tag crosswalk; http://polaris-group.com/news_releases.asp

For a copy of the CMS Survey & Certification Memo and Revisions to the SOM Appendix PP: http://polaris-group.com/news_releases.asp





CMS Releases Proposed CY 2018 Medicare Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) issued the CY2018 Medicare Physician Fee Schedule (PFS) Proposed Rule, which would take effect on or after January 1, 2018. The proposed rule updates Medicare Part B payment policies, payment rates and quality provisions for services under the Medicare PFS. This is the same fee schedule used to pay for Part B therapy services in nursing facilities.

CMS estimates that the CY 2018 conversion factor will be 35.9903, reflecting a 0.5 percent update factor, a -0.19 percent adjustment related to mis-valued codes, and a -0.03 percent adjustment for Relative Value Unit (RVU) budget neutrality.

Summary of key items include:

- Proposed changes to therapy codes based on the Potentially Mis-valued Code Initiative
- Proposed adoption Current Procedural Terminology (CPT) codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes.
- Request for Information (RFI) to receive feedback on solutions to better achieve transparency, flexibility, program simplification, and innovation. CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish these goals
- Adds several codes to the list of telehealth services, including HCPCS G0506 (Care Planning for Chronic Care Management).
- Modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. These proposed modifications are designed to reduce burden and streamline program operations.
- Request for comment on data collection and reporting periods for the Clinical Laboratory Fee Schedule;

To read the complete proposed CY 2018 Physician Fee Schedule; http://polaris-group.com/news_releases.asp

CMS Issues Revisions of Civil Money Penalty Policies and CMP Analytic Tool

The Centers for Medicare and Medicaid Services (CMS) issued a Survey and Certification Memo on July 7, 2017, "Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool." The CMS memo provides a summary of revisions to the CMP Analytic Tool, including how CMPs are applied in instances of past noncompliance, the use of Per Instance versus Per Day CMPs, the timing of the revisit

survey to certify compliance, and CMS Central Office (CO) review of high CMPs.

The new CMP guidance goes into effect July 17, 2017.

Revised CMP Policies and Analytic Tool:

The revised CMP Analytic Tool instructs CMS Regional Offices (ROs) how to use Per Day and Per Instance CMPs depending on the timing of the noncompliance in relation to the survey, whether residents were harmed or abused, whether the facility has a good compliance history, and whether the noncompliance was an isolated event or persistent deficient practices were identified.

- *Past Noncompliance:* ROs will impose a per-instance CMP for past noncompliance – something occurred before the current survey, but has been fully addressed and the facility is back in compliance with that area.

- *Per Instance CMP is the Default for Noncompliance that Existed before the Survey:* CMS ROs will generally impose a Per Instance CMP retroactively for non-compliance that still exists at the time of the survey, but began earlier. However, a Per Day will be used to address noncompliance that occurred where: (1) a resident suffers actual serious harm at the immediate jeopardy level; (2) a resident was abused; (3) or the facility had persistent deficient practices violating federal regulations.

- *Per Day CMP is the Default for Noncompliance Existing during the Survey and Beyond:* In contrast, Per Day CMPs will be the default CMPs for noncompliance identified during the survey and beyond, because there is an urgent need to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. Exceptions allowing Per Instance CMPs will be made for facilities with good compliance histories and where a single isolated incident causes harm to a resident, unless abuse has been cited.

To read the complete CMS Survey and Certification Memo: http://polaris-group.com/news_releases.asp

SNF Quality Reporting Program: Non-Compliance Letters

The IMPACT Act of 2014 mandated the establishment of the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). As finalized in the Fiscal Year (FY) 2016 SNF PPS final rule, beginning with FY 2018 and each subsequent FY, the Secretary will reduce the market basket update (also known as the Annual Payment Update) by 2 percentage points for any SNF that does not comply with the quality data submission requirements with respect to that FY. The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16. This means that FY 2018



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compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016.

CMS provided notifications to facilities that were determined to be non-compliant with Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) requirements for Quarter 4 of CY 2016, which will affect their FY 2018 annual payment update (APU). Notifications of non-compliance were placed into facilities' Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 14, 2017 and also mailed directly to providers. Providers that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 13, 2017. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

CMS to Conduct Pilot Audit Process for PBJ

The Centers for Medicare & Medicaid Services (CMS) has announced in a letter addressed to skilled nursing facility administration that their Pay-roll Based Journal (PBJ) staffing audit team will begin conducting both off-site and on-site audits of PBJ data submitted to CMS. This is a pilot to test audit processes and will not result in any sanctions or negative actions against a facility due to the findings of these audits. All on-site test audits are being announced beforehand, prior to auditors' arrival, so that the facility is aware that the auditors will be coming.

The PBJ audit may include, but is not limited to;

- Information from payroll
- Timekeeping systems
- Invoices for contracted staff
- Interviews with staff responsible for PBJ data entry

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

Question:

We had a resident on hospice for 6-7 months and now is going off hospice. Do I need to do a significant change in status when the resident is going off hospice?

Answer:

Yes. A significant change in status is required when the resident elects hospice, dis-enrolls from hospice or changes hospice agencies.

2017 WEBINAR TRAININGS

Polaris Group is pleased to offer the following CEU approved live Webinars

	<u>Date</u>
<u>Comprehensive Billing Training Series</u>	
Part 8: Diagnosis Coding	8/4
Part 9: FISS Navigation	8/7
Part 10: Business Office Practices	8/8
Part 11: Medicare Risk Management	8/9
Part 12: Managed Care	8/17
Part 13: Medicare Secondary Payer	8/29
<u>New Survey Process Training Series</u>	
New Survey Process—November 2017 <i>*New Topic</i>	8/24
Focus on Phase 2 & New Interpretive Guidelines	8/25
<u>IMPACT Act QMs Training</u>	
De-Mystify IMPACT Future QMs	8/21
<u>Medicare Rules Training</u>	
Medicare Rules & Nursing Documentation: Got Skill?	8/23

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250 or register online at: www.polaris-group.com



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Current 2017 Dates & Locations:**

Advanced Billing for SNFs
August 22-24 Las Vegas, NV
November 14-16 Tampa, FL

SNF Billing - Basics & More
September 19-21 Orlando, FL

Surviving MAC/RAC/ZPIC Audits
November 8-9 Orlando, FL

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