CMS Releases Updated Five-Star Rating System

On Feb. 20, 2015 the Centers for Medicare and Medicaid Services (CMS) publicly released a revised Five-Star Quality Rating System that CMS labeled Nursing Home Compare 3.0.

On December 18, 2008 CMS added the Five Star Quality Rating System to the CMS Nursing Home Compare website. As part of CMS’s continued effort to improve the information available to consumers. To assist the public in identifying meaningful distinctions among providers, the Five Star Quality Rating System lists an Overall rating for each facility based on facility performance on three separate measures, each of which has its own Five Star rating:

- **The health inspections rating.** This includes the results from on-site inspections from the most recent three-year period. That is both standard surveys plus the results of complaint investigations and targeted surveys.
- **The quality measures (QM) rating,** which is based on select resident-level QMs.
- **The staffing rating,** which is based on the staffing levels in nursing homes.

**Key changes with Nursing Home Compare 3.0:**

1. **Adding the long-stay and short-stay antipsychotic medication QMs to the Five-Star QM rating calculations.**

   Previously, the antipsychotic medication QMs have been publicly reported on Nursing Home Compare, but they weren’t used in calculating the Five-Star QM rating. Effective with the February release, the addition of the antipsychotic medication QMs means that a total of 11 QMs will be used to calculate the Five-Star QM rating.

   The following eight long-stay QMs will be included in the Five-Star QM rating:

   - Percent of residents experiencing one or more falls with major injury
   - Percent of residents who received an antipsychotic medication*

   The following three short-stay QMs will be included in the Five-Star QM rating:

   - Percent of residents with pressure ulcers (sores) that are new or worsened
   - Percent of residents who self-report moderate to severe pain
   - Percent of residents who newly received an antipsychotic medication*

   *Newly added to the Five-Star Quality Rating System.

   Note: Providers that need to review the MDS 3.0 data that feed into the two antipsychotic medication QMs should access the **MDS 3.0 Quality Measures User’s Manual.**

2. **Resetting the quality measures scale that is used for the QM rating.**

   This change marks the first time that CMS has reset the scales since the Five-Star system was implemented six years ago. CMS had planned to do this rescaling earlier but was delayed by the transition from MDS 2.0 to MDS 3.0. This raises the standard for nursing homes to achieve a high rating on all measures that are publicly reported in the quality measure dimension.

3. **Adjust Staffing Algorithms**

   To more accurately reflect staffing levels, Nursing homes must earn 4-stars on either the individual Registered Nurse (RN) only or the staffing categories to receive 4-stars on the overall staffing rating and can have no less than a 3-star rating on any of those dimensions.

CMS has updated the Five Star Quality Rating System Technical Users’ Guide so that providers can understand “the technical details behind the ratings. For additional information:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html
ICD-10-CM Transition Series Part 2

Special Acknowledgement Testing Weeks

Special Acknowledgement Testing Weeks for 2015 are scheduled for March 2-6, 2015 and June 1-5, 2015. Registration is not required for these virtual events. Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service. These acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Test claims will receive the 277CA or 999 acknowledgement as appropriate to confirm the claim was accepted or rejected. It will not confirm payment or produce a remittance advice. Talk to your MAC or visit your MAC’s website for specific questions on testing.

Questions to be Asking Your Software Vendor in Preparation for ICD-10-CM:

What system upgrades or replacements are needed to accommodate ICD-10-CM?

What costs are involved and will upgrades be covered by existing contracts?

When will upgrades or replacement systems be available for testing and implementation?

What customer support and training will they provide?

How will their products/services accommodate both ICD-9-CM and ICD-10-CM as you work with claims submitted both before and after October 1, 2015?

ICD-10-CM Training

ICD-10-CM will require detailed training for the following personnel:

- DONs
- Medical Records (or other coders)
- MDS Coordinators
- Clinicians (Nurses/Therapists)
- Business Office/Billing Staff
- Administrators/Corporate Staff (Overview)

Consequences of Poor Preparation for ICD-10-CM:

It will be crucial to be prepared for ICD-10-CM before implementation date of October 1, 2015. Consequences of poor preparation include: increased claim rejections and denials, increased delays in processing authorizations and reimbursement claims, compliance issues, and decisions based on inaccurate data. Problems can be mitigated with proper advance preparation.

Polaris Group can provide on-site ICD-10-CM training that includes the coding rules and theory as well as case studies comparing ICD-9-CM codes to ICD-10-CM codes for the same resident scenarios. It also include hands-on practicums to put your new found skills to the test.

CMS Resumes Part B Therapy Manual Medical Review (MMR) Program

The Centers for Medicare and Medicaid Services (CMS) sent a notice to organizations representing providers that they were resuming the Medicare Part B therapy manual medical review (MMR) program immediately. As you may recall, the MMR program was implemented by CMS in October 2012 as part of a previous extension of the therapy caps exceptions process. Under MMR, Medicare recovery audit contractors (RACs) are to review Part B therapy claims over a $3700 threshold per beneficiary per year. Due to problems in the MMR process and delays in issuing new RAC contracts, the therapy MMR program was put on hold at the end of February 2014.

Below is a summary of the key elements of the MMR resumption:

Starting immediately, RACs may resume part B therapy MMR for all MMR eligible claims over the $3700 threshold for claims paid between March 1, 2014 and December 31, 2014.

1. The reviews will be post-pay review only in all states for the 2014 claim reviews.

2. Claims will be reviewed in chronological order so that, for example, claims paid in March 2014 will be reviewed before claims paid in April 2014.

3. There will be 5 waves of reviews conducted to address all 2014 MMR reviews which AHCA estimates will be conducted from February through August 2015. Providers with therapy MMR eligible claims should expect to receive therapy MMR additional development requests (ADRs) approximately every 45 days as follows:

- Phase 1 - One claim review request will be issued in the ADR.
- Phase 2 - Up to 10 percent of the total MMR eligible claims for 3/14-12/14 will be included in the ADR.
- Phase 3 - Up to 25 percent of the remaining MMR eligible claims for 3/14-12/14.
- Phase 4 - Up to 50 percent of the remaining MMR eligible claims for 3/14-12/14.
- Phase 5 - Up to 100 percent of the remaining MMR eligible claims for 3/14-12/14

CMS notes that this current resumption only applies to facility-based providers, including skilled nursing facilities. In addition, CMS has not identified a process yet for how they intend to conduct reviews for 2015 MMR eligible claims.
New PEPPERresources.org Launched

TMF Health Quality Institute announces the launch of their newly-redesigned website. The website has been updated to improve customer access to resources and information on http://PEPPERresources.org.

- PEPPER website address - http://PEPPERresources.org has not changed.
- Information is provided to help you access your PEPPER via the PEPPER Portal or the QualityNet Portal, depending on how your PEPPER is distributed.
- The site now supports the latest browsers, is completely mobile-friendly and has an improved video streaming experience.
- If you have saved bookmarks to your favorite pages, many will automatically be redirected to the new site.
- Many of the recorded webinars will be updated in the coming months to reflect the new website and access to information.

Question:
How do we code the MDS when a patient loses weight then regains it from one quarterly to the next quarterly?

Answer:
The variances are not captured on the MDS. The RAI says, A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

Question:
If someone admits to our facility under a Medicare Part A stay then goes to the hospital the next day and is admitted to the hospital, upon their return should I code A1700 as an admission or a re-entry? I did a discharge return anticipated.

Answer:
If a discharge return anticipated was completed and they returned within 30 days then it would be a re-entry. The RAI update of 2/5/2015 clarified a re-entry: A re-entry refers to the situation when all three of the following occurred prior to this entry: a the resident was previously in this facility nursing home and was discharged return anticipated and returned within 30 days of discharge.

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

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Question:
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Answer:
If a discharge return anticipated was completed and they returned within 30 days then it would be a re-entry. The RAI update of 2/5/2015 clarified a re-entry: A re-entry refers to the situation when all three of the following occurred prior to this entry: a the resident was previously in this facility nursing home and was discharged return anticipated and returned within 30 days of discharge.