This document has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Resource Utilization Group – Version 4 (RUG - IV) Conference Call
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Contents

Operator: Welcome to the Skilled Nursing Facility Prospective Payment System Resource Utilization Group Version IV Conference Call. All lines will remain in a listen-only mode until the question and answer session.

Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Thank you for participating in today's call. I will now turn the conference call over to Ms. Leah Nguyen. Ma'am, you may begin.

Welcome

Leah Nguyen: Thank you, Shannon. Hello. I am Leah Nguyen from the Provider Communications Group here are CMS. I would like to welcome you to the Skilled Nursing Facility Prospective Payment System Resource Utilization Group Version IV National Provider Conference Call.

This call is one in a series of calls designed to provide information on key aspects of the RUG-IV SNF PPS case mix system which was put into place on an interim basis on October 1st, 2010.

For this call, CMS subject matter experts will review some significant changes associated with the RUG-IV payment system. At the end of the presentation,

we will open up the phone lines to give you an opportunity to ask questions of our subject matter experts.

Before we get started, there are few items that I need to cover. There is a PowerPoint slide presentation for this call. If you have not already done so, this presentation may be downloaded now from the CMS SNF PPS website located at www.cms.gov/snfpps. At the left side of the web page, click on RUG-IV Training and Education and scroll down the page to the Downloads section.

Also, this call is being recorded and transcribed. We have a lot to cover today, so without further delay, we will get started. At this time, I would like to introduce Jeanette Kranacs, Deputy Director of CCPG's Division of Institutional Post-Acute Care.

I will now turn the call over to Ms. Kranacs who will give some brief remarks as well as introduce today's speakers.

Jeanette Kranacs: Thank you, Leah. Again, my name is Jeanette Kranacs, and I'd like to welcome you to today's teleconference.

With the recent implementation of MDS 3.0 and RUG-IV, we thought it was important to take this opportunity to provide additional training information and also some answers to commonly asked questions. As mentioned, we will have a short question and answer session at the conclusion of our presentation to address some of your specific questions.

And with that, I'd like to go ahead and start on slide two which goes over the agenda. You see, we have about five topic areas that we would like to cover today. I'll go through the resource sites slide that shows you where you can find some valuable information.

And after that, I'll turn it over to Jean Eby from IFMC who will do a presentation on the MDS 3.0 submission and validation. After Jean, Chrissy Stillwell-Deaner will do a few slides on survey and certification issues.

Finally – well, I'm sorry, not finally but after Chrissy, – we'll do a part on SNF payment policy. I'll do a few slides and Ellen Berry will cover the more interesting topics of the OMRA issues. Finally, Tom Dudley will go over MDS 3.0 issues and then we'll have our question and answer period.

So if you'll join me on the presentation, on slide four, we go through several resource sites. The first site is the QIES Technical Support Office site. The second site is the CMS MDS 3.0 Technical Information site. It has information such as the specifications.

The third site is the Survey and Certification Policy Memos to States and Regions. Chrissy will talk about a specific notice that was sent out and you can find it listed on this site.

The fourth site is the Internet-Only Manuals which includes the State Operations Manuals, Claims Processing Manuals, and other such manuals.

The site listed after that is the CMS Forms site and it includes the MDS 3.0 Manual, and Survey and Certification Forms.

The site after that which you'll probably are already familiar with is the SNF PPS website which deals with SNF payment policy and that's the website where you can find today's presentation, previous presentations that we've done, and SNF payment rates.

The last site that's listed on here is the MDS 3.0 Training Materials site.

Now that you know where to find a lot of valuable information outside of this call, I'd like to turn the presentation over to Jean Eby from IFMC to do the MDS 3.0 submission and validation.

Jean Eby: Thank you, Jeanette. This is Jean Eby from IFMC. I have worked with MDS for 12 years, so this is a new and exciting submission. We have a few bumps in the road as you all know, but I wanted to talk about some of the things that might help smooth out some of your information or some of the questions you have.

I also put on in the welcome page – we have updated it to include some direct links. One of them are – is the Helpful Hints document that we put out by memo and by e-mail to all vendors and people with submission user IDs.

That kind of condenses what's in the manual. The manual has a lot of information. It has a lot of information and hopefully, the Helpful Hints will get you started, then you need more information, you can also reference the manual.

We have the CASPER Reporting User's Guide for all the CASPER reports, and the link to CASPER Reporting that is where you will find your validation reports in the shared folders.

The next page, we also have, as we referred to as the QTSO. On the MDS QTSO page, we have put a direct link to the RAI Manual, so it's easy for you to find, and also to the technical page as well as some of the other links that have always been there and again, to the provider manual. We're hoping this makes it easier for you to find stuff and not have to remember so many different links.

Some of the helpful hints that we have found people are having a little trouble with is sometimes, they couldn't see their shared folders and oftentimes, this was because in MDS 2.0 and CASPER, you had to use the shared log-in that the state issued. In this particular case for MDS 3.0, you've all been issued individual user IDs and you must use your individual user ID to access the MDS 3.0 information in CASPER. So if you're having trouble, be sure and check your user ID to make sure that you're using your individual user ID.

The processing of the MDS assessments and records is two-step. One of them is we've taken the file and we say, "The update is" – "upload is completed. We received your file." We send the page that says, "All right, this is your submission ID, your submission date, and your file name." You should print this because if you want to refer to this file or refer to this information, if you have printed what it is, you don't have to say, "Oh, I wonder what my submission ID is," or "I wonder what day I submitted it at." This is also helpful if you need to call the help desk and ask them something.

If you want to know if your submission has been processed, to see if all the edits have gone through and you'll have a Final Validation Report, you should select the submission link on the MDS 3.0 File Submission System menu bar, and this will give you a list of submissions on the page and the default is to give you the submission for the current day. You can change the default to get two or three days back and it will give you a list of, "This is your submission. This is the name of the file. Is it completed processing and how many records did we find?"

One of the things that some of the vendors have been having some issues in trying to submit the files and if the status is completed and the record count is zero, we were not able to produce a generated Final Validation Report for your provider. So you won't have a final validation in your folder because we weren't able to tell who the file belongs to. This is because the file was created such that we were either unable to zip it or there weren't any files in it. It might have been used extra compression. There is a super compression that we do not support and – or they might have sent in something that wasn't even a zip file. Maybe they sent in a text file and it wasn't zipped. So if these things come up, you should check with your vendor.

When the status is completed and the record count is greater than zero, that means we were able to unzip the file and we're able to look at the records inside. Now, this is when you want to go view your shared folder with your validation report in it to ensure that all of the records in your file were processed without error.

If for some reason you look at your Final Validation Report and you don't have all of the records you submitted on there, then there was again something very severe that happened that we could not read the record at all, so we could not tell which submission that – which facility the submission belonged to.

In that case, the submitter of the file needs to run the Submitter Validation Report. This isn't anybody who can get into CASPER. This is the person who actually did this particular submission.

I also put in some fatal errors. I'm not going to go through all of them. I wanted you to be able to look at these. These are the most common fatal errors. We will be discussing some of these in more detail, but these are just ones that come up. This 1004 Invalid XML, if I – if it's not a structured XML file, the system is unable to read it. So this is another vendor issue that you need to discuss with your vendor.

We now are up to most common warnings. We're going to discuss some of the Medicare RUG warnings in more detail.

I would like to talk about number 1055 on slide 16 before I go into the other ones. This is when a state might have only set up one of two calculations for their RUG calculations. If you have your error and it says it's for the second RUG calculation and the state didn't tell you, they said, "Oh, we're just collecting one RUG calculation," this may be ignored in that situation.

If they didn't set up a second one, they said, "yes, we're going to calculate it. We looked for a second one, it isn't there." We're just saying we did not find a second RUG calculation for your state. Now if that's what they did, then it's fine.

1056, these are ones where we calculate the RUG on anything that is not – A310A is 99 and A310B_is 99. And some of these are not PPS records. In this case, you might not have done a RUG calculation because it isn't a PPS record. However, you might find out in two or three weeks that it should have been a PPS record and you need a RUG. So, what we have done is we have calculated the RUGs. We're telling you what the RUG-IV is. If you need it later, you'll be able to go back and look at it. If you don't need it, again, this is just an informational message that you can ignore.

"Post call clarification" A310A should be A0310A. A310B should be A0310B.

I want to talk a little bit about the RUG items. Some of them, I've had a lot of questions about these. The Medicare RUG-IV items are submitted in Z0100 and Z0150. The ASAP system does recalculate all of these and the recalculated values are comparative to submitted values.

If any of submitted items does not equal one of the recalculated values, then the ASAP system will send a warning message 3616. This will tell you what item it is. If it's the Z0100A that doesn't match, the item in error will say Z0100A. It will also display what was the submitted value and what the recalculated value is. So, you can take a look at that and say, "All right, we thought ZO100A should be RUB and the system said it should be RUA. If the submitted value matches the recalculated value for the RUG-IV items, no message is sent. So, if you get no RUG-IV message that means whatever you calculated is correct.

The ASAP system also calculates a Medicare transition RUG-III. This is not submitted, so there is no comparison. It's just – you just get an informational message, 1057, for any assessments with an Assessment Reference Date between October 1st and October 31st. This is so that if you need to bill for Medicare days of service from this assessment prior to 10/1/2010, it does give you the RUG-III value but there is no comparison. This RUG-III that's displayed in 1057 is not your RUG-IV and is not compared to any of the other fields.

Medicaid RUGs, for the states when they require Medicaid RUGs, are submitted in Z0200 and Z0250. We only calculate them if the state had said, "Yes, we'd like you to calculate them." They're only calculated on NC, NQ, and NP item subset codes. They are not calculated for swing bed assessments.

Again, the recalculated values are compared to the submitted value. If they don't match, it's the same 3616 error. Again, it will say, "All right, it's Z200. This is what you've submitted. This is what the system calculated," and give you the two values. If the submitted values do match the recalculated values then no message is sent.

"Post call clarification" Z200 should be Z0200.

The Medicaid RUG items just – we had some people that they were having question of what do I do if the state isn't doing Medicaid RUGs. These are always active and as active items, your vendor must have included them in

your XML file with valid values. The valid values are some in text value which is not all blanks, not all spaces or a caret symbol. We've had things that came in that didn't have anything. They were just totally empty and that's not a valid value, so they were getting rejected.

So, if the state requires the Medicare RUG, then we should have an appropriate text value. If the state does not require a Medicare RUG to be submitted, then your vendor should be submitting a caret for a skip pattern in that particular field.

There were some RUG issues with the ASAP system. They have all been resolved. We reprocessed the submission IDs from 1 through 33,291 on October 21st. New validation reports were created and are located in your shared folders.

Again, if I could not read – if the file could not be read by the ASAP system, you will need to get a Submitter Validation report. But if the submitter – submission status says there's zero records the file – talk to your vendor, the file could not be opened or didn't have any records in it or it's the wrong type of file.

The accepted assessments are available for the state if they are working with you in the MDS viewer and in the work bench and they are – it's also been delivered to the state for their Medicaid calculations on October 22nd. Thank you very much.

Jeanette Kranacs: Thanks a lot, Jean. I think at this time, we're going to turn the presentation over to Chrissy Stillwell-Deaner who will talk about Survey and Certification.

Chrissy Stillwell-Deaner: Thank you. Good afternoon, everyone. I just have a couple of things to mention about the survey and certification impact, if you will, with the implementation of MDS 3.0.

On slide 23, I have a couple of items and then we'll talk about some of the regulatory changes and compliance with submission timeframes.

So, first and foremost was that as a result of the MDS 3.0 coming about, we needed to make changes to the traditional survey process. That information is included in the State Operations Manual Appendix P – as in Paul. That's the long-term care survey process- it's all out there in that. What we did was to actually make changes to that process so that it was on a temporary basis, and I'll explain why in just a moment.

First, I want to mention that the memos that are mentioned on this slide and the next, as well as any of the interpretive guidance where State Operations Manual information can be found on the CMS website as Jeanette had mentioned earlier. Those websites are on that resource list slide at the beginning of this slide set.

With the MDS 3.0 coming about, we've had a different way, if you will, or a different amount of data coming in to be able to calculate Quality Measures and Quality Indicators. Because we need a certain definitive amount of time to be able to calculate those Quality Measures and Quality Indicators, they became unavailable for survey use as of October 1st.

They're-- we will be looking at that data as it comes in to see how these Quality Measures and Quality Indicators will be utilized. That timeframe looks to be somewhere around a year, maybe more and I'm talking about for survey use here.

As a result of that, surveyors did not have a mechanism, beginning October 1st, to be able to select the focus of the sample offsite. So what we have done is to have surveyors, to give them guidance, to go into facilities and utilizing that first set of observations to pick their samples and their focus of the survey.

Many people call this the 1995 Survey Process, I've been told, and we issued those changes on July the 30th through SMT Memo 10-27-NH. We did that because that is a temporary process. As I mentioned before, once Quality measure, Quality Indicator reports are available for survey use again, we will reinstitute the current process. And so therefore, we did not make a change to Appendix P itself other than the S&C memo that as mentioned here that

supersedes the current process for a particular timeframe. And when we get to that timeframe, we'll again issue another S&C memo to say we now will be utilizing Appendix P again.

The other areas that we've had to make changes to were survey forms and the interpretive guidance for surveyors. The interpretive guidance for long-term care surveyors is found in the State Operations Manual Appendix PP and we issued an advance copy an S&C memo which is number 10-33-NH on September 24th. On October 1st, Appendix PP was officially revised to incorporate all of the information that was in this memo as an advance copy.

What we did was to change the references from MDS 2.0 item and coding to MDS 3.0 item and coding references. In addition, we changed the language from the MDS 2.0 Resident Assessment Protocols or RAPs to the MDS 3.0 Care Area Assessments or CAAs.

We also incorporated definitions for pressure ulcers, ABO, and assessment types such as discharge assessments as well as the regulatory changes to the submissions, which I'll talk about on the next slide, such as the timeframes and the reference to the system.

In addition, we provided clarifying language regarding the electronic maintenance of assessments and we have assessments for 15 months. It remains at 15 months of maintenance. What we did instead was to say that even if you're not an entirely electronic medical record facility and you do not have electronic signatures in place, you could still maintain your MDS assessments electronically.

What we had provided is that we expect that facilities that do not have electronic signatures in place will provide hard copy printouts of all of the signature pages for that particular assessment in the medical records. And that the rest of the assessment data that is maintained electronically is maintained so that it's readily acceptable and available when either surveyors come in or anyone that's providing care to the resident and needs to know and that facilities have policies in place for how that is handled.

The next area that we made changes to were the survey forms to go along with the survey process and that is the form 672, 802, and 805. We issued the changes to those which again are crosswalks from MDS 2.0 items and coding and references to Quality Measure, Quality Indicator to the MDS 3.0. What that means is that we will need to go back in for the 802 form when Quality Measures and Quality Indicators are available to indicate what those item references will be.

We issued the survey form changes as an advance copy again on September the 24th through S&C Memo 10-33-NH. Again, it's all out on the CMS website. And the forms themselves on the CMS Forms site were also revised October the 1st.

On your next slide, I wanted to talk a little bit about the MDS submission. As many of you are aware, under MDS 2.0, the regulation at 483.20(f)(3) indicated that submissions needed to be done within – on a monthly basis, I should say. For MDS 3.0, we have gone to a 14-day submission after completion that is, of the assessment. And we did this because we were aligning ourselves with what many of our swing beds were already doing and our data that came into us was that many facilities were already submitting within the 14-day timeframe.

That regulation information was changed in the interpretive guidance and the survey process as well. And as a result – I shouldn't say as a result – but many questions have been coming in for that- about the submissions as well as some of the issues people have had with either their vendor, programs, or the QIES ASAP system.

In response to that, we issued S&C Memo 11-02-NH on October the 29th. And what that memo said was that surveyors were instructed to accept the date stamps that the QIES ASAP system would provide the facilities as evidence of assessment submission.

In addition, if facilities were not submitting their assessments within the Federal timeframe that is that 14 days and a surveyor team decides that that is

an issue that would be cited as a deficiency, it would not be cited at a severity level any higher than a level 1, so at the lowest level of severity.

At this time, I'd like to turn it over to Jeanette who will provide us some information regarding SNF Part A.

SNF Part A Presentation

Jeanette Kranacs: Thanks, a lot, Chrissy. This portion of our presentation is going to deal with SNF payment policy. We've received a lot of questions about which payment system is in effect and what the status is of the ACA provision which required the delay of the RUG-IV system.

Again, section 10325 of the Affordable Care Act mandated that the RUG-IV system be delayed by one year. However, we should take the RUG-III system and implement two of the RUG-IV policies. Those policies are the allocation of concurrent therapy and the look back period. This combination of the RUG-III model with the two RUG-IV payment policies is referred to as the Hybrid RUG-III or HR-III system.

Section 10325 of the Affordable Care Act also mandated that we use MDS 3.0 effective October 1st, 2010. At the time that the passage of ACA happened, we were well into planning for RUG-IV implementation and therefore, we didn't have all Hybrid RUG–III Grouper available in time to implement for the 10/1/10 effective date. Therefore, in interim, the RUG-IV Grouper is being used to determine payments until the HR-III system is implementable. So payments based on RUG-IV began 10/1/10. Once the Hybrid RUG-III system is in place, retroactive adjustments will be made back to October 1st.

Our current focus is on getting the HR-III Grouper ready and the implementation of the HR-III system. Details – specific details about the adjustment process for comparing RUG-IV payments to HR-III payments will be determined at a later date. Once we have specific information available, we'll provide it to you.

Another question that we've gotten a lot has to do with payments, and just a reminder, that aggregate payments from HR-III or from RUG-III, I'm sorry, to

RUG-IV and from RUG-IV to HR-III and then if we move back from HR-III to RUG-IV, they're all done in a budget-neutral manner.

At this time, CMS must continue to work towards the implementation of the Affordable Care Act section 10325 and the implementation of the HR-III system. It is still possible that this provision will be repealed. However, since the only thing that we can go by is the current law that's in place, we have to prepare for the fact that we may need to move to the HR-III system and we're doing everything possible here to implement that as soon as we can.

Even though we have a new payment system, the RUG-IV system, we wanted to let you know that we are continuing to look at SNF payments and mechanisms for providing the most accurate payment possible. As part of that, we have done some research in the non-therapy ancillary usage and cost. NTA services such as lab, diagnostics, and pharmacy are currently reimbursed as part of the nursing component and not separately payable. We've done previous research on this issue through contractors with Abt Associates and Urban Institute, and MedPAC has done their own research.

Possible areas that we would consider- or a possible criteria that we would consider for prospective payments for NTA cost would include things such as the information would need to be available from administrative data, in other words data that's currently required on claims or MDS. This would make the system implementable. Costs would also be based on an add-on NTA index to RUG case mix groups. It would have to have a minimal number of payment groups to limit complexity. Some of the other research that's done – that has been done has included systems that would multiply the complexity of our current – you know, if you think we're moving from RUG-53 to RUG-66 is a little bit complicated, it would multiply the number of groups by four or five times. It also would utilize clinically intuitive and readily understandable payment groups. We're continuing to do that and we will update you as we continue our research.

At this point, I'd like to go ahead and turn the presentation over to Ellen Berry.

Ellen Berry: Thank you, Jeanette. Good afternoon or good morning depending on where you are in the U.S.

One slide 29, we go over the OMRA, the Other Medicare Required Assessment. As you all are well aware, there are two OMRAs at this time. You have the Start of Therapy OMRA and the End of Therapy OMRA. Both these assessment are shortened assessments. They may not replace a scheduled PPS assessment. They may be combined with that assessment though. For both assessments, a new RUG will be established that will need to be used for payment and you are required to follow those rules.

For all assessments that are PPS-related, you must follow the coding instructions in the RAI Manual. We worked with many people, providers, many of you on the call, to clarify our language around specific items related to the OMRAs such as A23C, the end of Medicare date.

So, the Start of Therapy OMRA, this is a new assessment type and it is optional. It is optional if you want to obtain a therapy RUG, which is a Rehabilitation Plus Extensive Services or a Rehabilitation only. You may complete this assessment any time during the stay. However, it is not to be completed to increase or decrease a therapy RUG once the resident is assigned a therapy RUG. It is only to obtain the therapy RUG where the resident is not in a therapy RUG.

The ARD must be set five to seven days after the start of first therapy day. As we've stated before, the first therapy day is the evaluation date. If the evaluation requires two days to be completed, it is the first day that you started the evaluation.

Payment will begin on the first day of therapy, the earliest date. We do index maximize, keep that in mind when you're completing the Start of Therapy OMRA. You must be aware of your CMIs and accordingly determine whether or not you should complete the Start of Therapy OMRA.

CMS strongly recommends that you do not combine this OMRA with the 5-day assessment with the exception being for the short stay assessment. When

you combine the 5-day with the Start of Therapy OMRA, you must be bill the non-therapy HIPPS for the days prior to the earliest start of therapy date. And then you would bill the therapy HIPPS beginning the first day therapy started.

As we've stated before, know your CMIs and you also must know the current status of the resident at the time of the ARD. For example, be aware of the ABL index. That can change throughout the resident's stay.

Slide 31, End of Therapy OMRA. This assessment is not new. It is not optional. We did change when you may choose the ARD. This is to be completed only when the resident remains in the facility and skilled care continues. In order to be paid for days after therapy has stopped being furnished, you need a non-therapy RUG. The ARD should be set one to three days after the last day of therapy provided. Day 1 is the next day therapy is normally provided and available. "Normally provided" we have defined on the slide. We've received many questions on that. The payment changes to the non-therapy HIPPS the day after last day of therapy. There is no penalty if you set the ARD early for the End of Therapy OMRA.

Some questions to ask yourself whether or not the End of Therapy OMRA is required. You must determine if the person still requires skilled care. If the answer is yes, then an End of Therapy OMRA is required. If the answer is no then the Part A stay and Medicare Part A benefit has stopped as of that last day of therapy. Please note that when a few days of therapy are missed, three or more treatments, you must complete at End of Therapy OMRA.

On slide 32, we provide, based on comments received, how do you count the ARD when therapy is not provided on seven days. For this slide, we showed therapy being provided five days during the week.

The next illustration on slide 33 shows you an example when a resident is discharged during that allowed ARD for the End of Therapy OMRA. In order for the provider to receive payment after therapy ends, as I stated earlier, an End of Therapy OMRA must be completed.

In this example, when therapy ended on Thursday, the allowed days would be Friday, Saturday, Sunday, or Monday. The resident is discharged on Monday. Since therapy was not available on Saturday and Sunday, you would actually be able to choose Monday as the ARD and combine that with the discharge assessment. You are not required to combine it with the discharge assessment but combining it would decrease the number of assessment you must complete.

Since there may be instances when a resident doesn't receive therapy due to illness, a medical hold, awaiting equipment, and more than three days will have passed, in order to obtain a therapy RUG, you will need to complete a Start of Therapy OMRA. A new therapy evaluation will be required. A resident may have new deficits or regressed during the time that he or she was not receiving therapy. You must clinically determine if the current plan of care and goals need to be modified based on the current resident's condition.

Whether or not you need physician orders, that will need to be determined case-by-case. Obviously, if the plan of care or the treatment regimen needs to be modified, you may require new orders. If they do not need to be modified, it will be dependent on the state practice act and your facility policy.

Medicare Short Stay, slide 35, is outlined in chapter six of the MDS 3.0 Manual. Therapy minutes are prorated. In chapter six, we provide how we calculate the minutes for therapy. Please refer to that calculation. In addition, your software should do that for you. In order to qualify for the rehab low categories, you do not need to have been providing restorative nursing. You must meet the therapy requirement of minutes in order to bill that category. Again, for the short stay, the Start of Therapy OMRA is required. Follow the manual instructions.

A2400C, the Medicare end date, may or may not be the actual discharge date. With the short stay, we do have an exception for the Start of Therapy OMRA and that exception is you cannot set the ARD five to seven days after the earliest start of therapy. So you will need to set that ARD according to the manual instructions.

Also in chapter six, we provide instructions for how to bill the short stay and which HIPPS code to use from which assessment. If you combine the 5-day with the Start of Therapy OMRA, you would bill ZO100A from the earliest start of therapy date until the last covered pay day. And then you would bill the non-therapy HIPPS from Day 1 up until the day prior to the earliest start of therapy date. The only time you bill the therapy RUG for all days for a Medicare short stay is when therapy started on Day 1.

Briefly on slide 36, the late and early assessments as well as missed assessments are outlined at the end of chapter six. The late and early assessments are based on the ARD and whether or not it is set within the allowed ARD window. Late assessment from a SNF PPS standpoint is not based on the transmission of the assessment. It is solely based on the ARD. Is it within the window or is it not for that assessment? However, you may not bill Medicare until you have a validated RUG.

Some miscellaneous, for claims, when you're using two HIPPS from the same assessment on the UB-O4, you would have the ARD listed twice on two separate lines and you would have the appropriate Medicare HIPPS. The Medicare HIPPS on one line, the non-therapy Medicare HIPPS on the second line, and with the appropriate units for each of those.

RUG assignment does not mean that the person is actually at a skilled level of care and that the criteria are being met. The provider must determine that.

Skilled therapy and unattended modality time, you're recording the skilled time on the MDS. For unattended modalities, when you leave a resident, that person is not within line of sight, they are not receiving individual time, they're not receiving current – concurrent time or group time.

Last but not least, for cleaning up, the presumption of coverage. That remains in effect up until the ARD of the 5-day assessment or Day 8 should the assessment have a late ARD, and it applies to the upper 52 categories.

And I'll hand it over to Tom now.

MDS 3.0 Presentation

Tom Dudley: Thank you, Ellen, and hello everyone. Thank you for joining us on this audio conference today.

I know I'll start off on slide 38 if you're following along with the slides. Some of items I may discuss in the next few moments are some general comments from the first month after implementation of MDS 3.0, discuss comments we've received about the interview frequency, discharge assessments, some of the common coding questions we have received, the status of Quality Measures, and where we're heading next.

Some of the – moving on to slide 39, with our first month of experience, we received a number of anecdotal comments and the comments have been mixed. What I'm going to mention here are by no means and inclusive, but what we have heard is that the nursing homes are eliciting more valuable information from the residents, that the interviews take less time than chart abstraction. Residents seem to appreciate the increased interaction. There is a lot of adjusting going on to the new discharge assessment, and there are a number of comments offering suggestions to decrease or eliminate duplication with the assessments.

Moving on to slide 40. One of the very- the most common comments are regarding the frequency of the interviews. Let me start off by saying at this time, the interview frequency will remain unchanged. The intent of the interviews is to ensure patient needs are not inadvertently overlooked. The status of a resident can change abruptly, thus what may appears to be – appear as a redundant interview is actually a safety valve for each resident under your care.

CMS will re-evaluate the frequency of the interviews and provide updates as deemed appropriate as we move forward. It's only been a month since we've implemented. We're in a listening mode right now and we will re-evaluate. We take all the comments seriously.

Next, moving on to slide 41, a little discussion about the discharge assessments. The discharge assessments are to be completed for all resident

discharges as indicated in the RAI manual. Discharge assessments should be completed to the extent feasible. For example, planned discharges should include a complete assessment. Unplanned discharges, providers should complete the assessment based on the information that is readily available.

A discharge to home or back to the community is a good thing and the planned discharge assessments will provide data to support good or positive outcomes. This is a big plus for the providers and we want to keep viewing it from that perspective. We want to be able to promote the good care that is being provided. And again, CMS will re-evaluate the items included in the discharge assessments and provide updates as deemed appropriate. Many of you have heard my presentations in the past and as I've stated before, the MDS instrument is a living document. It will change. It will not remain static for 15 years as with MDS 2.0.

I'm moving on to slide 42 right now with coding questions. Top of the list here, pressure ulcers present on admission. For each pressure ulcer, determine if the pressure ulcer was present at the time of admission and not acquired while the resident was in the care of the nursing home. This text is verbatim out of the manual.

The second for the coding, review for location and stage at the time of admission or re-entry. If the pressure ulcer was present on admission and subsequently worsened to a higher stage during the resident's stay, the pressure ulcer is coded at the higher stage, and that higher stage should not be considered as present on admission.

If the pressure ulcer was unstageable on admission, but becomes stageable later, it should be considered as present on admission at the stage at which it first becomes stageable. If it is subsequent – there wasn't a break in the sentence there. If it subsequently worsens to a higher stage, that higher stage should not be considered present on admission.

Moving on to slide 43, continuing on with pressure ulcers coding at –for present on admission. If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer should not

be coded as present on admission because it was present at the facility prior to the hospitalization. If a current pressure ulcer worsens to a higher stage during the hospitalization, it is coded at the higher stage upon re-entry and should be coded as present on admission.

Provider should keep in mind when coding, we're not looking at – we do look at the individual assessments, but we also look at the series of assessments. So, the dates are on there and we are looking at trending the data over a period of time, not just from the single assessment. So we're looking at what happens not only – and not only in the nursing home but what happened in the hospital and other care settings.

Moving on to slide 44, medications received on section N0400. This is addressing the medication categories. Medication categories should only be checked if the resident received a medication whose approved use, which means a pharmacological classification, falls into the specified category. Do not code off-label use of medications. For example, oxazepam may be used as a hypnotic, but it is classified as an anti-anxiety medication. It would be coded as an anti-anxiety medication, not a hypnotic.

Another – moving on to slide 45, continuing with the coding questions. Isolation or quarantine for active infectious disease. This is talking about section O and particularly item O100M. For isolation, code only when the resident requires strict isolation or quarantine alone in a separate room because of active infection. For example, symptomatic or have a positive test and are in a contagious stage with a communicable disease, in an attempt to prevent spread of illness. That is the intent of this strict isolation.

Comment [RF1]: CMS, per slide, this is O0100M. Speaker leaves out the zero before the one. Do you wish to insert an errata comment?

"Post call clarification" O100M should be O0100M.

Do not code this item if the resident only has a history of infectious disease, for example, MRSA, C-Diff, with no active symptoms, but facility policy requires cohorting of similar infectious disease conditions. Do not code this item if the isolation primarily consists of body/fluid precautions, because these types of precautions apply to everyone or in common practice on a day-to-day basis. More information related to the types of transmission-based

precautions can be found in the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. This is on the CDC website and the full URL is listed on slide 45 of this presentation.

Moving on to slide 46 referencing Swing Bed Assessments. Swing bed assessments are the same as for everyone else. Yes, this is more than what was required under MDS 2.0. We're moving ahead. The swing bed assessments are as follows: the entry tracking – this cannot be combined –, death in facility tracking when applicable, discharge assessment, return anticipated or return not anticipated, swing bed PPS, Start of Therapy OMRA, and End of Therapy OMRA, and clinical change assessment, I'm sorry, I left out that slide.

Moving on to coding questions discussing the transition from MDS 2.0 to 3.0. Only for the Initial MDS 3.0 Assessment, item A0310E, should be coded as 1 or yes for all existing residents. If such assessments have been coded as 0 or no, then the assessments need to be corrected. Future assessments should be coded based on the resident's status at the time of the assessment.

Please thoroughly review the transition document located on the cms.gov website. The URL is listed on slide 47 of this presentation. This provides special coding guidance for initial MDS 3.0 assessment, emphasis being on the initial MDS 3.0 Assessments.

Now moving on to the Quality Measures. The MDS 2.0 Quality Measures that you are familiar with have been mapped over to MDS 3.0. NQF voting for the Nursing Home Measures ends November 16th. With regards to Nursing Home Compare and the use of the Quality Measures, January of 2011 the last MDS 2.0 Quality Measure data will be updated under Nursing Home Compare. Effective April 2011, the Quality Measure data will be removed from Nursing Home Compare and factored out of the 5-star. We anticipate in the spring of 2012 that Quality Measure data will be reposted on Nursing Home Compare and factored back into the 5-star using MDS 3.0 data.

The Quality Measure Development Plan and the next phase of development will begin in 2011 moving on beyond this mapping the measures over to MDS

3.0. New or enhanced Quality Measures will be submitted to NQF late 2011 or early 2012. This will be cross setting measures. CMS' Quality Measure focus moving forward is to develop measures that are safe, effective, patient-centered, timely, efficient, and equitable care. Topic areas under consideration include hospitalizations and re-hospitalizations, patient satisfaction, reduction in injuries, and advanced directives.

Some of the next steps, we're going to evaluate the data and the comments from the initial implementation of MDS 3.0. We're probably going to collect the information over about three-month period before we start taking any additional action. All comments that are submitted are viewed as being valuable and are being evaluated. Some will require individualized responses and some will be global responses that will result in update of the manual or the instrument itself.

CMS will – is committed to reassess the item set composition and item sets for each assessment based on the comments. We will modify the instrument or provide guidance as deemed appropriate after evaluating the comments and suggestions.

I anticipate that the next manual or item set update will be some time in the spring of 2011 at the earliest. We are in the process right now of re-evaluating how to best disseminate responses to questions and further guidance will – further information will be released as we develop that plan.

And that's all that I have, Leah.

Leah Nguyen: Thank you, Tom. We have now completed the presentation portion of this call. We will move on to the question and answer session. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many as your questions as possible, we ask that you limit your question to just one.

All right, Shannon, you may open the line for questions.

Question and Answer Session

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question and pick up your handset before asking your question to ensure clarity. Please note, your line will remain open during the time you're asking your question so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Joel Van Eaton. Your line is now open.

Joel Van Eaton: Yes. I have a couple of questions if I could please. The first question is on the short stay OMRA. And the question that I have there is part of some confusion that came out on the last conference call on RUG-IV in relationship to the ARD of the Start of Therapy OMRA not being three – more than three days after the start of therapy date.

And in the original conference call that you guys had on this, you indicated that that three days after the start of therapy date was three days after the actual date that therapy started where there was actual minutes provided.

And in the start of therapy date items that are listed in chapter six, item O400A5, B5 and C5, these are the dates that the actual evaluation was completed so there may not have actually been minutes.

And I want to make sure that we're clear on what those three days entail, is it actually three days after the eval date for the short stay or three days after the first day that therapy minutes were actually provided?

Ellen Berry: This is Ellen. It's three days from the start of therapy.

Joel Van Eaton: OK.

Ellen Berry: So if therapy started on the first of October, in order to qualify for the short stay, the stay would have ended – had to have ended by October 4th or earlier.

Joel Van Eaton: Right, right. I just want to make sure that thee three days after the start of therapy date is the – when we talk about the start of therapy date there, are we talking about the same start of therapy date as we're talking about with the regular Start of Therapy OMRA? There seemed to be some confusion on that on the original conference call because the start of therapy day for a Start of Therapy OMRA is the eval date.

Ellen Berry: Right. And it's the eval date on any other assessment also.

Joel Van Eaton: OK. All right. I wanted to make sure about that. And then I had another question just quickly on the wound care that we were talking about or the clarification on the wound care – or on the coding for wounds, pressure ulcers that were included in the number – let me find the slide real quick here – it included in the number of – that were present on admission and on slide – there was a slide that you went over today, that Tom went over –- here we go – this is on slide 43. And the first bullet point there is "If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer should not be coded as present on admission because it was present at the facility prior to the hospitalization."

The question continues to surface and some folks are actually teaching that this means that if a resident came to the facility originally and had a wound or pressure ulcer that was considered present on admission, that if indeed they go out of the hospital and that wound comes back at the same stage, even though it was present on admission the first time that if they go out to the hospital, say, a second time return of the same stage, we now have to code – we can't code this as present on admission. Is that the case?

Tom Dudley: I heard you on this, I'm sympathizing. In both instances where you talked about return one and going out and coming back again, it should not be coded as present on admission.

"Post call clarification" In both instances where you talked about a patient returning with a pressure ulcer and going out to the hospital and coming back in to the nursing home, it should be coded as "present on admission."

Keep in mind, I made the comment that we're looking across different assessments and they have the dates with them. So, we're looking at trend. So, we will be able to track across different assessments and we'll know which ones were truly present on admission to a facility when a resident first enters a facility or transfers infrom a hospital or from wherever or pressure ulcers that actually develop while the resident is in the care of the nursing home.

Joel Van Eaton: OK. So what you're saying is that if a resident comes into the facility with the present on admission ulcer, goes out to the hospital again with that same ulcer, the same stage and comes back that second assessment or that second round of assessments, we would code that as not present on admission?

Tom Dudley: That is correct.

Joel Van Eaton: OK. And so…

Tom Dudley: What you're looking at is an individualized assessment.

Joel Van Eaton: OK. So in the question that if – so what you're saying is if you're looking at the trending and so forth, that were something that were impact, say, Quality Measures or indicators or 5-star or something in the future, that original present on admission would be taken into account?

Tom Dudley: That is correct.

Joel Van Eaton: OK. All right. Thank you very much.

Tom Dudley: Yes.

Operator: Your next question comes from the line of Rashawn Defier. Your line is now open.

Rashawn Defier: Yes. I basically have a question about the infection with isolation coding on the MDS. I'm wondering, because the CDC guidelines do allow us to cohort patients that have like infections. For example, if you have a patient that has

C-Diff and then you have another patient and you put them in the same room that has C-Diff, we're allowed to do that under the CDC guidelines. However, on the MDS, they've added the verbiage that the patient has to be alone. Are we disregarding what the CDC has said or are we saying that we can no longer do that?

Ellen Berry So, you can cohort but if you cohort, you can't code it on their assessments as isolation.

Rashawn Defier: OK. So, just to clarify, even if they're isolated, they're on contact isolation for C-Diff. They both have to be…

Ellen Berry: Well, they're not isolated if there was somebody in the room for purposes of the MDS.

Rashawn Defier: OK. So, they have to be in two separate rooms in order for us to code it on the MDS.

Ellen Berry: Yes.

Rashawn Defier: OK.

Ellen Berry: Thank you.

Operator: Your next question comes from the line of Nadine Eigenmann. Your line is now open.

Nadine Eigenmann: Hi. I'm calling from New York and I have a request. On the submission, when we submit CMS and we've got our Final Validation Report, they are voluminous. They extend for pages. Is it possible to change the font so more can go on less pages. I submitted five assessments. All of them were accepted and my report is 26 messages and it's been about 26 almost pages. Thank you.

Ellen Berry: Thank you, we'll take that into consideration.

Nadine Eigenmann: Thank you.

Operator: Your next question comes from the line of Christy Beard. Your line is now open.

Christy Beard: Thank you. I've got some – I've got a question about a rejection – a specific rejection actually. It's 3804 and it has to do with the RUG Logic Version. We've gotten this a couple of different states that we're operating in and we kind of meet some guidance as to how to get this one fixed because we feel like what we're calculating based on what the specs say and what we're submitting is the right information. So, therefore, we're kind of loss as to how to fix that particular one.

Bob Godbout: This is Bob Godbout with Stepwise. And if you could send us one of the assessments, the ID and the submission ID – the assessment ID? We'll look at that. We've looked at a dozen of these in the last week or so and there are a lot of errors being made concerning index maximizing.

The 3804 requirement is that the index maximized RUG be a rehab or rehab plus extensive RUG, and so if you would index maximize, say, from RMA to HB1 then you'll get a rejection on that. It's only valid if you get a rehab or rehab plus extensive classification. But if that doesn't satisfy you, send in the assessment ID and the submission ID to MDS technical questions and we'll take a look at it.

Christy Beard: Thank you.

Operator: Your next question comes from the line of Jean Corkis. Your line is now open.

Jean Corkis: Thank you very much. I'm actually calling with more of a billing end question. At the Department of Veterans Affairs, we have now five nursing home facilities. I've been diligently checking the CMS website on a- several times a day and I've made calls into our provider assist line.

And at this point, the only rates that I can find are ones that are more of a presumptive based on the percentage calculation of what was elected in. I

have yet to see actual rates that we can bill our facility care under and rather than go through the exhausting process of adjustments and rebilling. We're just kind of in a holding pattern. Can any of you answer that question? And thank you.

Jeanette Kranacs: Are you looking for your specific billing rates?

Jean Corkis: That would be correct. In the state of Florida, there are no rates other than what I can find at a specific nursing journal and again, those rates that I'm finding are considered estimated rates. They're not ones that CMS has released.

Jeanette Kranacs: All right. Are you speaking about Medicare Part A rates?

Jean Corkis: That would be correct, for all of the skilled nursing facility therapy charges.

Jeanette Kranacs: If you go to the resource sites listing, the one that's cms.gov/snfpps…

Jean Corkis: That's where I'm going on a daily basis.

Jeanette Kranacs: On the left-hand side under Regulations, if you click on that, it will take you to all of the latest Federal regulations which include the SNF PPS rates. What you would want to look at is the Federal Register Notice that was issued in July this year. And in that document, in that Federal Register document, you will find the rates for both the RUG-IV system and the Hybrid RUG-III system.

Ellen Berry: And then you need to apply your CBSA requirements.

Jeanette Kranacs: You would adjust that by your specific wage index and that's all explained in that Federal Register.

Jean Corkis: And forgive me but that was updated with what – went into effect – effective 10/1?

Jeanette Kranacs: Yes, yes. Again, that was published sometime around the end of July.

Jean Corkis: Well, I did see the published July date. And do you specifically – and forgive me, I don't know which of you is answering but I'm just going to throw this question out. Do you know specifically that those rates are effective because everything that I'm getting from the CMS providers is indicating that those rates have not been updated to be the new release? And on slide 26, you specifically addressed having the HR-III.

Jeanette Kranacs: Yes. And again, as we said on there, the RUG-IV rates are in effect. They started October 1st. Once we have the HR-III system up and running then the HR-III rates that are also available in that same Federal Register will come into effect and we will start paying off of that system.

Both types of rates are available on that Federal Register and if you have any questions, please call me specifically. This is Jeanette Kranacs and I can be reached at 410-786-9385 and I can sit down on the phone and walk you to the correct page.

Jean Corkis: That would be awesome. Thank you so much, Jeanette.

Jeanette Kranacs: Sure. You're welcome.

Operator: Your next question comes from the line of Sandra McQuinn. Your line is now open.

Sandra McQuinn: Hello. I'm calling from the Pennsylvania Physical Therapy Association. And I have a question about section G of the ABO where there is mention of the patient using the needed assistance device and there is a check for the price and device or prosthesis, but braces are not mentioned in that section. Is there any consideration given to lower extremity bracing for a resident?

Ellen Berry: You know, just a minute, we're catching up to you. We're looking at section G now.

Yes. Right now, you would not code that. If you submit your suggestions to MDS 3.0 comments at cms.hhs.gov?

Sandra McQuinn: Great. I'll go ahead and do that. Thanks.

Tom Dudley: Thank you.

Leah Nguyen: Shannon, it looks like we have time for one final question.

Operator: Your next question comes from the line of Jean Lyle. Your line is now open. Jean Lyle, if your line is on mute, would you please unmute your line. Your next question comes from the line of Jean Lyle. Your line is now open. Jean Lyle, if your line is on mute, will you please unmute your line.

Your next question comes from the line of Emma Albany. Your line is now open.

Emma Albany: Hi. I have a question with regards to the hard copy of signatures. The facilities have implemented electronic record as of October 1st and what's mentioned earlier in this conference as hard copy of signatures must be in the clinical records. Do you mind repeating that, please? I am not sure.

Chrissy Stillwell-Deaner: No. Actually, you do not have to maintain hard copies of the MDS assessments. You can maintain them electronically even if you are not an entirely electronic medical record facility and even if you don't have electronic signatures in place in your facility.

However, what you will need to do is if you do not have electronic signatures in place, you will need to have hard copies of just the signature pages for assessments in the medical record.

In addition, anyone that has a need-to-know basis to provide care to the resident or CMS or surveyors that comes in, will need to have a mechanism in place for them to have that information readily available and accessible to them. Does that clarify?

Emma Albany: Yes, thank you.

Leah Nguyen: OK, Shannon, it looks like we do have time for another question.

Operator: Your next question comes from the line of Roselyn Romblon. Your line is now open.

Roselyn Romblon: Hi. I have a question regarding the transition from atsection A0310, the type of assessments. It's kind of contradicting about – that you mentioned that only for the initial MDS 3.0 assessment item A0310E – for all existing residents but the one that you have printed out on the transition process it says, "Special transition rule applies to the first assessment under MDS 3.0 for each resident." So, MDS 3.0 assessment should have A0310E coded as 1 or a yes? MDS 3.0 assessment whether or not there was a prior MDS 2.0 assessment before 10/01/2010, I don't know if this is contradictory or what's your comment on this?

Tom Dudley: What we're asking you to do for any patient, even if they had an MDS 2.0 assessment prior to October 1, if any – if it's the first MDS 3.0 assessment, item A0310E should be coded as a 1 or a yes. And it's only for the first MDS 3.0 admission and it applies to all patients. Does that help?

Roselyn Romblon: Yes, OK. Thank you.

Tom Dudley: You're welcome.

Leah Nguyen: All right, Shannon. It looks like we can take one final question.

Operator: Your final question comes from the line of Sally Olsenmeyer. Your line is now open.

Sally Olsenmeyer: Yes, ma'am. I'm calling from The Village at Germantown. My question is regarding the assessments. It's not short stay assessment but it refers to the evaluation for the start of therapy being on Day 4 which, as an example, the resident comes in on Friday and they are not evaluated with the first day of treatment until Monday. And the ARD date can then be set on Day 6, 7, or 8, being Day 8, say the 29th of the month. Would that be allowed?

Ellen Berry: You're talking about the 5-day?

Sally Olsenmeyer: Yes.

Ellen Berry: Yes. That's within the allowed window. For the 5-day, the allowed window is Day 1 through Day 8.

Sally Olsenmeyer: So there was no indication and that the initial eval – that initial eval was not…

Ellen Berry: We can barely hear you.

Sally Olsenmeyer: The eval being on day 4 was no consequence because it was not a short stay and it's all within the window.

Ellen Berry: Right. There is no consequence. That is why on Slide 30, CMS strongly recommends that you do not combine the Start of Therapy OMRA with the 5-day except when it's a short stay.

Sally Olsenmeyer: OK. All right. Thank you.

Leah Nguyen: Unfortunately, that is all the time we have for questions today. We have one final comment from Chrissy here at CMS.

Chrissy Stillwell-Deaner: Hi. I just wanted to make sure that everyone is aware that Appendix B of the MDS Manual contains your state point of contact or reference for MDS questions.

In Appendix B of the MDS 3.0 Manual, you will find a list of automation coordinators. There is one – sometimes two- listed per state where questions can be sent regarding submission or a technical issue.

In addition, there is an RAI coordinator listed per state that would be able to assist you with clinical issues. They are your point of contact for your particular state. Thank you.

Leah Nguyen: Thank you, Chrissy. We would like to thank everyone for joining us and for your participation in the question and answer portion of the call.

Written and audio transcripts will be posted to the RUG-IV Training and Education section of the CMS SNF PPS website at www.cms.gov/snfpps in approximately one to two weeks.

I would like to thank our subject matter experts for their participation. Have a great day, everyone.

Operator: This concludes today's conference call. You may now disconnect.

END