MDS Alert

CMS Updates: Stay Alert to How Changes May Impact Your Facility

CMS is carrying on with some regular updates and introducing others specifically to deal with COVID-19.

The Centers for Medicare & Medicaid Services (CMS) has announced that it will now be enforcing already established requirements surrounding the reporting of infection diseases in nursing facilities, according to a recent memorandum, QSO-20-26-NH, sent to state survey agency directors. Until now, nursing facilities could voluntarily report but were not required to do so.

"Current requirements at 42 CFR 483.30 and CDC guidance specify that nursing homes notify State or Local health department about residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with new-onset respiratory symptoms within 72 hours of each other. At present, these data are not collected by CMS, CDC, or the Federal Emergency Management Agency (FEMA)," says **David R. Wright,** director of the quality, safety, and oversight group at **CMS** in Baltimore.

A separate regulation will require nursing homes to alert residents and resident representatives to cases of COVID-19 within the facility.

"At a minimum, once these requirements are in place, nursing homes must inform residents and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours," Wright says.

Facilities must provide these updates weekly or whenever a (or another) case of COVID-19 is identified and confirmed or when three or more residents or staff are exhibiting a new onset of respiratory symptoms within 72 hours.

"Scientific data derived from solid surveillance is a key element of recommendations to protect Americans, particularly our most vulnerable, from the devastating impact of COVID-19," says **Robert Redfield, MD,** director of the **Centers for Disease Control and Prevention** (CDC) in a recent CMS release. "This coordinated effort with CMS will allow CDC to provide even more detailed information to state and local health departments about how COVID-19 is affecting nursing home residents in order to develop additional recommendations to keep them safe."

Note that some states are enforcing different reporting requirements. New York, for example, has been requiring nursing homes to report COVID-19 deaths, along with the amount of personal protective equipment (PPE) facilities have on hand.

Make These Changes Now

Take these steps from law firm **Hall Render** to streamline your communication with resident representatives, as well as local, state, and federal health authorities, if you haven't already:

- Establish or update policies and procedures for reporting infectious disease to health authorities, residents, and resident representatives.
- Design templates that staff can use to communicate updates to residents and their representatives without compromising resident privacy.
- Make sure facility policies and procedures are updated so public health authorities can "perform on-site infectious disease surveillance, testing of health care personnel and residents, or other related activities." Don't forget to keep staff in the loop on all updates.

Peruse Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) released and published the proposed rule for 2021: "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021" in April.

One big takeaway is an increase in payments to skilled nursing facilities (SNFs).

"CMS projects aggregate payments to SNFs will increase by $784 million, or 2.3 percent, for FY 2021 compared to FY 2020. This estimated increase is attributable to a 2.7 percent market basket increase factor with a 0.4 percentage point reduction for multifactor productivity adjustment," CMS says in a news release concerning the proposed rule.

See These ICD-10-Related Changes

The proposed rule shows CMS' efforts to fix some inadequacies. Some ICD-10 and clinical category mapping updates should better reflect the level of care some diagnoses require, especially for some cancers.

Specifically, CMS proposes updating the surgical clinical categories so that clinical mapping of some ICD-10 codes associated with some diagnoses more accurately reflect what the ICD-10 code or corresponding diagnosis entail, in terms of care, including some major procedures.

"The clinical classification may change based on whether the patient had a major procedure during the prior inpatient stay that impacts the plan of care as captured in items J2100 through J5000 on the MDS. In the current ICD-10 to clinical category mapping being used in FY 2020, ICD-10 codes associated with certain cancers that could require a major procedure ... do not include the option of a major procedure in the prior inpatient stay that may impact the plan of care," the proposed rule says.

"We propose to add the surgical clinical category options of 'May be Eligible for the Non-Orthopedic Surgery Category' or 'May be Eligible for One of the Two Orthopedic Surgery Categories' to the clinical category mapping of the following diagnoses when a major procedure, as described previously, is identified on the MDS," the proposed rule adds.

CMS proposes cleaning up some other ICD-10 coding and clinical category mapping confusion, like sorting out some discrepancies in the orthopedic categories and their respective surgical options or lack thereof. CMS is also updating some surgery aftercare codes, which are Z48 codes in the ICD-10 coding system, so that they more accurately reflect the care required after a major procedure, instead of the current mapping to "Return to Provider" or "Medical Management" categories.

For the current complete updates to the clinical category mapping, check out the revised FY 2020 Patient Driven Payment Model ICD-10 Mappings, which is available as a ZIP folder here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.

Beware These Wage Index Updates

In the proposed rule, CMS says it is adopting some Office of Management and Budget (OMB) "delineations" that determine the urban or rural status of particular providers.

This could mean big changes for many facilities, a reality that CMS hopes to mitigate through a year transition period, according to the proposed rule.

"We believe that adopting the revised OMB delineations would result in SNF PPS wage index values being more representative of the actual costs of labor in a given area. However, we also recognize that some SNFs (42 percent) would experience decreases in their area wage index values as a result of this proposal, though just over 2 percent of providers would experience a significant decrease (that is, greater than 5 percent) in their area wage index value. We also realize that many SNFs (54 percent) would have higher area wage index values after adopting the revised OMB delineations," CMS says.

The proposed transition would involve "a 5-percent cap on any decrease in an SNF's wage index from the SNF's wage

index from the prior fiscal year. This transition would allow the effects of adopting the revised OMB delineations to be phased in over 2 years, where the estimated reduction in an SNF's wage index would be capped at 5 percent in FY 2021 (that is, no cap would be applied to any reductions in the wage index for the second year (FY 2022)),” CMS says.

The proposed rule is available at www.federalregister.gov/documents/2020/04/15/2020-07875/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities and public comments are accepted until 5 p.m. June 9, 2020.