

MDS Alert

Industry News to Use: ICD-10 Delayed Again -- But Don't Stop Preparing

Also: Attempt rates for MDS resident interviews are soaring.

The entire healthcare community has been abuzz this month about the Protecting Access to Medicare Act of 2014. In a move designed to avert the 24-percent pay cut physician practices were due to face on April 1, Congress introduced this bill.

The resulting temporary fix included another change buried in the text that has a major impact on your facility's diagnosis coding. Mentioned about one-third of the way into the 121-page bill is a short paragraph that states, "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets."

This means that since the bill has been signed into law, ICD-10 will be delayed for at least another year beyond the scheduled Oct. 1, 2014 implementation date.

Remember: This is the second time ICD-10 implementation has been delayed. The original compliance date of Oct. 1, 2013 was officially pushed back a year on Sept. 5, 2012 by the **Centers for Medicare & Medicaid Services** (CMS). According to CMS, this additional one-year delay of ICD-10 will likely cost the industry an additional \$1 to \$6.6 billion on top of the costs already incurred from the previous one-year delay.

While many feel this new law and resulting ICD-10 implementation delay is not good for physician practices or facilities, there may be a small silver lining. "I think it is a bad thing because it affects our momentum to crossing the finish line," explains **Laureen Jandroep, CPC, CPC-I, CMSCS, CHCI**, senior instructor at CodingCertification.org in Oceanville, N.J. "However, we can use the extra time to prepare even more thoroughly so we can make the best of it. For those that have made the investment getting ready it is frustrating to see their investment loose traction."

Despite the delay in implementation, experts warn that healthcare providers must continue their efforts to prepare for ICD-10 use. "Part of the reason we're in this situation is not enough people have prepared and petitioned for more time," Jandroep says. "It is not fair to those that did prepare and are ready or were going to be by the 10/1/2014 date. The changes are in the implementation date, not that it is not coming at all, so prepare on!"

Link: To read the complete text of the Protecting Access to Medicare Act of 2014, visit <http://docs.house.gov/billsthisweek/20140324/BILLS-113hrSGR-sus.pdf>.

In other news ...

Good Job: Most Residents Are Participating In Interviews

You're doing some great work in ensuring that your residents' voices are heard when it comes to MDS 3.0 assessments. So says a March 13 study published in the Journal of the American Medical Directors Association (JAMDA).

More than 83 percent of long-stay nursing home residents attempted all three self-report clinical items in the MDS, the study found. The study compiled data from MDS annual assessments for 757,044 residents in 15,030 nursing homes during 2011 through 2012. Researchers tested the attempt rate of resident interviews for three clinical domains: cognition, mood, and pain.

The attempt rate for the pain self-assessment was 92 percent, while the rates for mood and cognition were 88 percent and 89 percent, respectively. The researchers discovered that residents in smaller, chain-affiliated nursing homes with fewer Medicare residents and fewer assessments per administrative nurse/registered nurse were more likely to attempt

the resident interview items.

Additionally, the study revealed that certain resident characteristics seem to reduce the likelihood of participating in interviews – specifically, having a diagnosis of dementia or cognitive impairment, exhibiting signs of delirium, and having a documented prognosis of six months or less to live.

To access the study entitled, "Finding Gertrude: The Resident's Voice in Minimum Data Set 3.0," go to [www.jamda.com/article/S1525-8610\(14\)00087-5/abstract](http://www.jamda.com/article/S1525-8610(14)00087-5/abstract).

Get Rid Of Market Basket Update For SNFs, MedPAC Says

You may face a heavily-revised prospective payment system (PPS), if the **Medicare Payment Advisory Commission** (MedPAC) gets its way.

In its March 2014 report to Congress on Medicare payment policy, MedPAC recommended that Congress eliminate the market basket update and revise the PPS for skilled nursing facilities (SNFs), stating that prepayment rebasing should begin one year after implementing the PPS revisions.

MedPAC suggested an initial reduction of 4 percent in Medicare payments to SNFs, with subsequent reductions "over an appropriate transition until Medicare's payments are better aligned with providers' costs." Also, MedPAC wants Congress to reduce payments to SNFs with "relatively high" risk-adjusted rates of rehospitalization during Medicare-covered stays.

The Commission's report also shared findings on the three indicators of SNF quality that MedPAC tracks: risk-adjusted rates of community discharge; readmission to a hospital for potentially avoidable conditions during a beneficiary's SNF stay; and readmission to a hospital within 30 days after discharge from the SNF. Between 2011 and 2012, MedPAC found only a small improvement in these three measures.

Additionally, MedPAC based its recommendation to revise the PPS for SNFs on the following findings:

- High and sustained Medicare margins;
- Widely varying costs unrelated to case mix and wages;
- Cost growth well above the change in input prices in most years over the past decade, reflecting little fiscal pressure from the Medicare program;
- Many SNFs' (nearly 900) ability to have consistently relatively low costs and relatively high quality of care;
- The industry's continued ability to maintain high margins despite changing policies; and
- In many cases, Medicare Advantage payments to SNFs are considerably lower than the program's fee-for-service (FFS) payments, suggesting that some facilities are willing to accept rates much lower than FFS payments to treat beneficiaries.

But MedPAC's recommendations regarding SNFs are the same as those the Commission first suggested in 2012. Overall, MedPAC wants these three revisions to the SNF PPS:

1. Base payments for therapy services on patient characteristics, not services provided;
2. Remove payments for non-therapy ancillary services (such as drugs) from the nursing component, and instead make these payments through a separate component established specifically to adjust for differences in patients' needs for these services; and
3. Add an outlier policy to the PPS.

Links: MedPAC's report to Congress is available at http://medpac.gov/documents/Mar14_EntireReport.pdf. You can link directly to Chapter 8 of the report, which focuses on SNFs, by going to http://medpac.gov/chapters/Mar14_Ch08.pdf.