MDS Alert

Industry News to Use: What The SGR Repeal Means For Your Facility

Plus: Prevent these citations when facing an MDS-focused survey.

On April 14, the U.S. Senate approved a bill to repeal the flawed sustainable growth rate (SGR), following an earlier approval by the U.S. House of Representatives. Although the SGR repeal will move Medicare toward a payment system based on quality, Congress failed to also approve the Medicare outpatient therapy cap repeal amendment.

Good news: The SGR repeal effectively saves the healthcare industry from a 21.2-percent reduction to the Medicare Part B fee schedule, which was set to become effective on April 1, according to an April 8 blog posting by **Cyndi Ouellette** for Topsfield, Mass.-based **Harmony Healthcare International Inc.** Instead of the rate reduction, providers will see a 0-percent adjustment for claims dating April 1 through June 30.

"Among the most significant features of the bill are the ways it sets the stage for a transition to value-based healthcare services, and away from the fee-for-service model," according to an April 15 analysis by the **American Physical Therapy Association** (APTA).

Bad news: Another component to the bill was the therapy cap repeal amendment, which the Senate shot down in a 58-to-42 vote, APTA said. "Instead of a full repeal, the therapy cap exceptions process will extend until Dec. 31, 2017."

Ending the SGR system is good news, but "we are of course disappointed that the therapy cap repeal effort was not successful," APTA executive vice president of public affairs **Justin Moore, PT, DPT** said in a recent statement. "But thanks to the hard work of APTA members and supporters, we were able to seize an historic moment and move this issue closer to the goal line than at any time in the 18-year history of the cap."

Technically, the therapy exception process had stopped as of March 31, which would indicate a hard $1,940 therapy cap with no chance for exception, Ouellette explained. But Congress passed the recent "doc fix" bill, which not only repealed the SGR, but also extended the therapy cap exception process.

In Other News ...

Consider 4 Tips To Survive An MDS-Focused Survey

Are you prepared for MDS-focused surveys? If not, here are some quick tips to make the survey a little less painful.

On March 20, the **American Health Care Association** (AHCA) released a tip sheet with advice on how to prepare for an MDS-focused survey, based on the tags cited during the survey pilot in 2014. To create the tip sheet, AHCA formed a Workgroup comprised of its Clinical Practice and Survey/Regulatory Committee members.

According to the AHCA Workgroup, you should heed the following tips:

1. Implement a system to ensure timely completion and submission of MDS assessments, consistent with regular required assessment schedules (e.g., admission, quarterly, annually) and those required due to a significant change of condition (either improvement or decline).

2. Know the scope of practice for an LPN/LVN in your state, and ensure appropriate supervision is provided and reflected in the documentation.

3. Collect information from multiple sources to provide an accurate MDS assessment. Implement a system to ensure documentation about a resident is accurate and consistent in all places.

4. Ensure you use the Care Area Assessment (CAA) process effectively to provide a link between the MDS and care planning.

Also, examples of F-Tags that surveyors cited during the MDS-focused survey pilot included:

- F157 – failure to provide transfer/discharge notification;
- F273 – not assessing timely;
- F274 – not updating when significant change in condition;
- F275 – not conducting annual assessment timely;
- F276 – not conducting quarterly assessment timely;
- F278 – accurate coding for skin conditions and for antipsychotic medications, accurately reflect resident's status;
- F280 – failure to include resident in care planning;
- F281 – (professional standards) scope of practice and functions of LPN/LVN;
- F282 – qualified individuals;
- F287 – encoding/transmitting data timely;
- F315 – timely evaluation for removal of catheter;
- F323 – failure to provide equipment to assist with fall prevention; and
- F520 – failing to monitor accuracy of MDS assessments, failing to identify issues with respect to meeting requirements for timely completing, failing to develop and implement a plan of action to correct identified non-compliance.

Link: AHCA's tip sheet also includes a copy of an Entrance Conference document from the survey agency and given to a nursing facility that was part of the test group in the 2014 MDS-focused survey pilot. To view the entire document, go to www.ahcancal.org/facility_operations/survey_reg/Documents/MDS-Focused Entrance Document.pdf.

LTC Facilities: Go Ahead With Efficient Medication Dispensing Methods

Pay attention to important changes to Medicare Advantage (MA), as well as Medicare Part C and Part D. The **Centers for Medicare & Medicaid Services** (CMS) released the final program changes in early April.

CMS clarified and tightened language in the provision to further support the use of efficient medication dispensing in long-term care facilities, according a Feb. 13 analysis by **Jill Sumner,** Vice President of Health Policy & Integrated Services Advocacy at Washington, D.C.-based **Leading Age.** CMS prohibited payment arrangements that penalize more efficient medication dispensing techniques by prorated dispensing fees.

The provision also adds a requirement that any differences in payment methodology result in incentives to adopt more efficient dispensing methodologies, Sumner added. "Additionally, efficient medication dispensing techniques should be enhanced or, at the least, not hindered by the payment arrangements between Part D plans and long-term care pharmacies." This provision is effective Jan. 1, 2016.

The final program changes also crack down on MA plans' use of extensions on organizational determinations and reconsiderations.

MA plans have very specific timeframes that they must adhere to when a provider or enrollee requests an organizational determination, such as an authorization or approval, or a reconsideration like an appeal of a coverage denial, Sumner said. Typically, the plan has 72 hours to respond to expedited requests but may extend the review timeframe in limited circumstances.

Problem: Based on the results from MA plan audits, CMS found that some MA organizations are routinely and inappropriately exercising the 14-day extension, Sumner noted. So CMS revised the provision by tightening the language regarding when an extension is acceptable "first and foremost, an extension must be in the best interest of the enrollee."

CMS also clarified that extensions are for extraordinary and non-routine circumstances, and that the MA organization cannot invoke extensions for the plan's convenience. As a result of these changes, you may see improvements in timeliness of organizational determinations and reconsiderations from MA plans, Sumner concluded.

Resources: For more information on MA requirements regarding organizational determinations, visit www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf. To see CMS' finalized 2015 payment and policy updates for MA and Part D, go to cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-04-06-2.html.