Codify
BY AAPC

MDS Alert

MDS & Billing News

Do you know how to access the new quality indicator/measure reports? The reports are now available on the CASPER system. "The user ID and password for CASPER are the same as the one the facility uses to sign onto the state MDS system," says **Judy Wilhide, RN, BA, RAC-C**, Virginia RAI manager.

Once you're on the CASPER system, click on reports and you'll see eight different items you can click on, Wilhide says. "One of them says MDS QI/QM package which includes all of the reports that surveyors will have to prepare their offsite resident sample selection," she adds. The package doesn't include the quality measure/indicator monthly trend report, which is a graph or visual representation that compares the facility to state and national averages on each QI/QM. The facility can select the timeframe for comparison, e.g., whatever months the facility chooses.

Facilities received a reprieve from MDS changes proposed by the FY 2006 PPS final rule. The **Centers for Medicare & Medicaid Services** decided against implementing changes to the MDS coding requirements that would have limited SNFs' ability to capture a resident's highest acuity and service use in a number of instances.

In its proposed rule, CMS invited public comments on possible changes to the MDS coding requirements. These included:

1. decreasing the length of the "look-back" period (to restrict coding of certain high intensity services to those actually received in the SNF);
2. decreasing or eliminating the grace periods associated with PPS MDS assessments (specifically with reference to the 5-day PPS MDS assessment);
3. eliminating the projection of anticipated therapy services during the 5-day PPS assessment.

The final rules notes the "overwhelming majority" of commenters opposed eliminating grace days when completing the MDS and doing away with estimating therapy services during the first 15 days of a SNF admission.

However, the agency notes that a few commenters supported doing away with the method of estimating therapy services, mentioning findings by the General Accounting Office and the Data Assessment and Verification project (DAVE) that demonstrated a mismatch between the estimated and actual amount of therapy provided. In addition, a few commenters suggested limiting the use of grace days to the 5-day and 14-day assessments.

CMS says it believes the proposed MDS changes should be addressed "as part of a comprehensive examination of both the MDS 3.0 design initiative and the case-mix classification system."

The final rule expands the RUG system from 44 to 53 groups, which includes nine new groups specifically geared to beneficiaries who need both extensive medical services and rehab. The changes will go into effect on Jan. 1.

Don't get overly presumptuous about the presumption of skilled PPS coverage. The administrative presumption of coverage currently applies only to the 5-day Medicare assessment when a resident is correctly assigned to one of the top 26 RUGS, according to a clarification by CMS' **Bill Ullman** during the Aug. 1 SNF Open Door Forum. "The presumption lasts from the day of admission through the assessment reference date which can be no later than day eight of the stay," he said. Coverage can continue as long as the clinical evidence justifies it.

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Watch out for this change: Come Jan. 1 when the nine new RUG groups go into effect, the presumption of coverage will apply to the 5-day assessment when a resident is correctly assigned to one of the top 35 RUGs, Ullman said.

4. **Mark your calendars for the upcoming Sept. 8 satellite broadcast and webcast on immunizations in nursing homes.** The session will focus on coding Section W (flu and pneumonia immunizations) and include general information on the immunizations provided by immunologists from the **Centers for Disease Control & Prevention.** Register for the webcast and download handouts at http://cms.internetstreaming.com.

5. **Make sure you use the revised definition of hospice for coding Section P1a.** The June 15 RAI Manual revision posted by CMS on May 23 inadvertently left out the following text on page 3-184, section P1a. CMS has corrected this omission in chapter three of the manual, which now reads:

   Hospice Care - The resident is identified as being in a hospice program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

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