Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE ADELMAN ADVANTAGE by Rebecca Adelman

Nursing Homes MUST Verify – OIG's February 2019 Report

This month, the Department of Health and Human Services (DHHS) , Office of the Inspector General (OIG) issued its report " **CMS GUIDANCE TO STATE SURVEY AGENCIES ON VERIFYING CORRECTION OF DEFICIENCIES NEEDS TO BE IMPROVED TO HELP ENSURE THE HEALTH AND SAFETY OF NURSING HOME RESIDENTS**."

Under an agreement with the Centers for Medicare & Medicaid Services (CMS), State survey agencies (SAs) perform surveys to determine whether nursing and skilled nursing facilities (nursing homes) meet specified program requirements, known as Federal participation requirements. During a survey, a SA identifies certain deficiencies, such as a nursing home's failure to provide necessary care and services. *The SA must verify that the nursing home corrected identified deficiencies before certifying whether the nursing home is in substantial compliance with Federal participation requirements.*

Per the OIG report, in its previous reviews of nine SAs across the Nation, the OIG found that seven did not always verify or maintain sufficient evidence that they had verified nursing homes' correction of deficiencies identified during surveys in accordance with Federal requirements. The stated objectives of the OIG are that the reviews are intended to (1) help CMS understand the need for improvements to SAs' practices for verifying nursing homes' correction of identified deficiencies and maintaining documentation supporting verification and (2) offer CMS recommendations to help ensure the health and safety of nursing home residents.

After describing the process of the SA reporting of deficiencies and deficiency ratings (Severity and Scope Levels for Deficiency Ratings), the OIG then describes the process for correcting deficiencies and certifying substantial compliance (the Nursing Home's Plan of Correction). Focusing on the verification process, the OIG report iterates that after a nursing home submits a correction plan, the SA must verify that the nursing home corrected the identified deficiencies to certify that the nursing home is in substantial compliance with Federal participation requirements. A nursing home is in substantial compliance when identified deficiencies have ratings that represent no greater risk than potential for minimal harm to resident health and safety (A, B, or C). Forms 2567 and 2567BB and other related forms are identified by the OIG as the correction mechanism by CMS.

The OIG then describes how it conducted its review as previously reviewing nine SAs to determine whether they verified nursing homes' correction of deficiencies identified during surveys in accordance with Federal requirements. It summarized the results of those reviews for the report. In addition, the OIG assessed CMS's Manual guidance to SAs on verifying nursing homes' correction of deficiencies and its interim guidance to SAs on maintaining documentation to support verification of deficiency correction.

The Findings

Of the nine selected SAs in its previous reviews (Washington, Oregon, Arizona, Missouri, Kansas New York, North Carolina, Florida and Nebraska), two SAs verified nursing homes' correction of deficiencies identified during surveys in accordance with Federal requirements. However, the remaining seven SAs did not always verify nursing homes' correction of deficiencies as required. Specifically, for 326 of the 700 sampled deficiencies, these SAs did not obtain evidence of nursing homes' correction of deficiencies or maintain sufficient evidence that they had verified correction of deficiencies.

For less serious deficiencies, the practice of six of the seven SAs was to accept a nursing home's correction plan as confirmation of substantial compliance with Federal participation requirements without obtaining from the nursing home the evidence of correction of deficiencies. Further, three of the seven SAs had technical issues with maintaining supporting documentation in the Automated Survey Process Environment (ASPEN) system; as a result, they did not have sufficient evidence of correction of deficiencies.

According to the OIG, if SAs certify that nursing homes are in substantial compliance without properly verifying the correction of deficiencies and maintaining sufficient documentation to support the verification of deficiency correction, the health and safety of nursing home residents may be placed at risk.

In addition to summarizing the issues identified during the nine previous reviews, the OIG determined that CMS's guidance to SAs on verifying nursing homes' correction of deficiencies and maintaining documentation to support verification needed to be improved.

Several examples of failure to verify and other statistics are included in the report. Most notably under the heading in the report "The Health and Safety of Nursing Home Residents May Be Placed at Risk if Correction of Deficiencies Is Not Properly Verified", the OIG cites the following examples:

"A State agency did not have sufficient evidence that it had verified a nursing home's correction of a G-rated (more serious)

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deficiency related to quality of care. A surveyor noted: "Based on observation, record review and interview, the facility staff failed to obtain treatment orders and failed to evaluate nutritional requirements for the development of a pressure ulcer for 1 resident."

"A State agency did not obtain evidence of correction for an E-rated (less serious) deficiency related to quality of care. A surveyor noted: "Based on interviews and record reviews, it was determined that for one of five residents reviewed for unnecessary medications, the facility did not ensure that all of the residents were free of significant medication errors."

CMS officials provided information to the OIG essentially stating that CMS has little guidance on how SAs must verify and document verification of nursing homes' correction of less serious deficiencies before the SAs certify nursing homes' substantial compliance with Federal participation requirements. CMS' defense then resulted in the ultimate finding by the OIG that without specifying how a SA should document the information or evidence it used to verify the correction of deficiencies, CMS cannot be assured that a SA verified that a nursing home corrected the deficiencies. The SA may have certified the nursing home's substantial compliance with Federal participation requirements even though the nursing home did not correct the deficiencies.

Thus, recommendations were made. We can expect that these recommendations will be adopted and implemented and the survey process will involve even greater scrutiny and documentation and investigations. Compliance and certification/ recertification will become even more challenging.

Recommendations

OIG makes the following recommendations to CMS:

1. Reconsider its position on permitting SA to certify nursing homes' substantial compliance on the basis of correction plans without obtaining evidence of correction for less serious deficiencies (deficiencies with ratings D, E, and F without substandard quality of care);
2. Revise guidance to SA to provide specific information on how SAs should verify and document their verification of nursing homes' correction of less serious deficiencies before certifying nursing homes' substantial compliance with Federal participation requirements;
3. Revise guidance to SAs to clarify the type of supporting evidence of correction that should be provided by nursing homes with or in addition to correction plans;
4. Strengthen guidance to SAs to clarify who must attest that a correction plan will be implemented by a nursing home;
5. Consider improving its forms related to the survey and certification process, such as the Forms CMS-2567, CMS-2567B, and CMS-1539, so that surveyors can explicitly indicate how a SA verified correction of deficiencies and what evidence was reviewed; and
6. Work with SAs to address technical issues with the ASPEN system for maintaining supporting documentation.

CMS Comments

In written comments on OIGs draft report, CMS concurred with the OIGs recommendations and provided information on actions that it had taken or planned to take to address the recommendations.

Regarding the first recommendation, for less serious deficiencies in which no actual harm was identified, CMS stated that it will review current guidance regarding the requirement to provide evidence of correction of a deficiency and determine whether updates are needed to help verify correction.

Regarding the second recommendation, CMS stated that it will review the current guidance to SAs regarding the verification and documentation of correction of less serious deficiencies and discuss with SAs any areas needing additional clarification in determining the scope of changes needed.

Regarding the third recommendation, CMS stated that it will review guidance to SAs and continue to educate SAs on the types of supporting evidence of correction that should be provided with corrective action plans.

Regarding the fourth recommendation, CMS stated that it will review its existing policies and guidance to ensure that a nursing home official with authority and responsibility for operations of a facility is attesting to the plan of correction and its implementation.

Regarding the fifth recommendation, CMS stated that it will review forms related to the survey and certification process and evaluate whether updates are needed.

Regarding the sixth recommendation, CMS stated that it continually reviews its systems for technical issues and addresses those issues as they arise. CMS also stated that it will continue to provide education and technical support to SAs on its systems.

The Future Impact

The survey and certification process is, at present, extremely burdensome and we can expect that the OIG reports and recommendations and CMS' comments, SAs will increase the levels of investigation, documentation and become increasingly punitive with citations and the verification of compliance. As proactive measures, properly document and retain documentation and prepare detailed plans of correction with support to minimize the opportunity for the SAs to reject a Plan of Correction. Understanding the need for verification and the impact of failing to comply with care standards, these interests can be protected without the continued enhancements of regulations by CMS and its SAs. Without much choice but to cooperate with the SAs and provide the needed information if there are deficiencies cited at your community, do your best to thoroughly document the needed information we know the SAs will need to verify and Plan of Correction.

JOIN US AND REGISTER TODAY! The 7TH annual complimentary long-term care conference I host along with Horne Rota and Kaufman Borgeest & Ryan is now open for registration. Join us on April 3-4, 2019 for The National Long-Term Care Defense Summit (love our new conference name!) in Memphis! Education, networking, blues and BBQ! Please contact me for more information and registration details and the agenda! The invocation, keynote presentation, special luncheon guest and local vendor market place accompany this senior housing summit!

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation. Contact Rebecca at rebecca@adelmanfirm.com and visit www.adelmanfirm.com and www.rebeccaadelman.com.

Getting on the Same Page by Paige Hector, LMSW

FORMS, FORMS…ENOUGH ALREADY!

Part I

Healthcare workers use a lot of forms. I'm a forms geek but it's truly a love-hate relationship. I love reading forms and thinking about the processes behind them – what was the intention, does the form work, how can it go wrong, do staff use it properly, were they trained? And, I hate when staff are expected to use a horrid form that leaves them wondering how (but may not inform leadership) and what to do when a field doesn't fit the situation. They end up "winging-it", resulting in unnecessary risk to the staff member and to the facility.

It has been my experience that form development and maintenance are not high priorities for most leadership staff. Sometimes, it's the leadership (corporate included) that unwittingly inflicts a state of "forms purgatory" on staff. Unfortunately, leadership often jumps to a "forms solution" in the aftermath of a poor survey, erroneously thinking that a new form solves a problem or that it looks good in the plan of correction. When forms are chosen for the wrong reason, the result can be increased confusion, chaos and complexity for many people, typically the folks on the front lines, and ultimately may not result in better care for the residents.

Creating a form seems simple but it requires planning and focused critical thinking skills. A well-developed and intelligent form simplifies staff work and serves a useful function. A poorly-developed form does the opposite and also increases risk for subpar or even poor resident care, a deficiency citation, or a lawsuit.

Think about the forms in your facility, both paper and electronic versions. Be critical. Are the forms useful? Efficient? Are they duplicative and difficult to follow? Are they overly time intensive? Do they serve a purpose? In other words, does the facility actually use the information gathered on the forms, or is their completion simply an exercise in futility, or rationalized as "the way it has always been"? Be brave: ask the people who use the forms (nurses, social workers, nurse aides, activity staff, dietary staff, therapists and medical providers) those same questions. Be sure to give them genuine permission to be honest with their feedback! If you haven't already, start thinking about a process improvement project on forms.

Grab a form used in your facility and examine it through fresh eyes and a strong critical thinking mindset. Read it slowly, *considering each and every field and question*. In the most basic of questions, one can find the most egregious of errors. For example, on an abuse reporting form one field reads "Date Reported/Identified." Those could be two different dates so how would the staff member complete that field? On an elopement risk assessment, the first question is "Does the resident have a court-appointed legal guardian?" and requires a Yes/No answer. I wonder, how does the status of a court-appointed legal guardian impact elopement? I'm reaching here but perhaps there's an assumption that if a resident has one, he or she is not capable of decision-making, therefore increasing the risk of elopement? Since there are other questions that ask about cognitive diagnoses and mental status, that seems like a stretch. At the end of this form, the assessor is then asked to determine (worded as "Conclusion") the level of elopement risk, categorized as Low, Medium or High Risk. With absolutely no guidance except one's subjective determination based on a poorly designed form, one person in the facility is asked to determine elopement risk?! And, at the bottom of this form it states, "If necessary, document approaches in the progress notes and care plan." *If necessary?!*

Do not make the mistake and assume that just because a form is purchased from a reputable company that it warrants a free pass from your examination. Right now, I'm looking at an elopement risk assessment (different from the one referenced above) from a well-known company. The format of this particular form asks the assessor to answer a series of yes/no questions about the resident - questions about impaired decision-making, diagnoses such as dementia and schizophrenia, history of elopement attempts, wandering aimlessly, previous admissions, changes in resident's status or routine – all very good questions!

Then, on the back of the form it invites the assessor to determine whether or not the resident is at risk of elopement. Seems straightforward, until one really thinks about it. Of the multiple yes/no questions, is there a particular combination that would lead one to determine "yes, this resident is an elopement risk"? Or, if all the answers are "no" except for the one about leaving the facility without supervision, is that resident at risk? Would different staff interpret the actual questions and combination of answers in the same way, consistently identifying those individuals who are at risk?

Let's take it a step further. What is the process in your facility by which routine (monthly/quarterly) assessments are completed? Some facilities divvy up the caseload among the different shifts. This practice seems to make sense, except for when it doesn't. For some residents, it would make far more sense for a particular shift to complete some assessments (elopement, smoking, falls, etc.). Continuing with the elopement example, if a resident is nocturnal, it wouldn't be logical to have the day shift complete an elopement risk assessment for that individual. How does your facility make such accommodations and is that type of critical thinking encouraged?

Don't make the mistake of giving your electronic medical record (EMR) a pass, either. It's no secret that EMR's have complicated our lives and added time consuming tasks to already jammed work days. As with many EMR platforms, the facility has the discretion to build personalized forms. For example, one form includes specific questions related to Quality of Life: Does the resident have enough clothing? Does the resident feel compatible with their roommate? Is the resident's room personalized and homelike? Is the resident aware of the spiritual services offered in the facility and how to engage in them?

So, according to whomever created those questions, if a person answers affirmatively, it therefore follows that the

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Broad River Rehab, "*A **knowledgeable** and **compassionate** Partner*"

ICD-10 Rules PDPM

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affair

When it comes to understanding the Patient Driven Payment Model (PDPM), I often say that ICD-10 is king. This article is all about the intersection of ICD-10 and PDPM. We will look specifically at the PT/OT categories now and the other 3 PDPM categories in future offerings.

It is critical that providers get ahold of the importance of, and how the PDPM payment is shaped by, accurate ICD-10-CM coding. Failure to do so will result in inaccurate resident classification into appropriate PDPM payment category as well as potentially inaccurate resident care pathways.

ICD-10-CM coding affects payment in all 5 of the PDPM payment categories in very significant ways. Currently, in the RUG IV 66 version of PPS, providers mainly stay clear of ICD-10-CM codes that will get a bill rejected. Other than a dx of HIV, most providers are content to see ICD-10-CM coding as primarily informational only. As long as the UB-04 is clean, providers are happy.

ICD-10-CM Impact Area	PDPM Payment Category			
	PT/OT	SLP	Nursing	NTA
Default Clinical Category	x	x		
Final Primary Diagnosis Clinical Category	x			
SLP Related Comorbidities		x		
AIDS			x	
Nursing Clinical Services			x	
NTA Related Comorbidities				x

Under the PDPM, concern about a bill passing the MAC's edits related to ICD-10-CM will be shared with, if not superseded by, whether or not the ICD-10-CM codes selected are the exact codes that will determine appropriate payment for the unique characteristics of the resident for whom they are caring.

Generally, under the PDPM, ICD-10-CM codes significantly affect payment in every one of the 5 payment categories. The table below indicates where in each PDPM payment category ICD-10-CM codes impact payment.

Let's take a look at some specific examples of how payment is affected by ICD-10 from each payment category. Let's start with the PT/OT categories. In the PT/OT category ICD-10-CM codes define the default clinical category as well as the final primary diagnosis clinical category. One code among 65,000 codes that could potentially map to this category will make these determinations. Providers will be required to record the code that best defines the primary reason the resident is coming to the SNF at new MDS item I0020B. Once that code is selected there will be a default clinical category determined by the mapping that CMS has defined. Finally, if the primary code is further mapped to a potential surgical procedure providers will be required to select a surgical procedure category from new MDS items J21000 – J5000. Any mistake in this coding process could cost providers thousands.

Here's an example of a coding scenario for the PT/OT categories. Suppose a resident is admitted to your facility with a diagnosis of **S34124D** - Incomplete lesion of L4 level of lumbar spinal cord, subsequent encounter. This diagnosis would map initially to a default clinical category of Acute Neurologic. In addition, the mapping guidelines allow that this code may be eligible for one of the two orthopedic surgery categories.

The provider would then review the documentation that they received from the hospital to determine if a surgical procedure was indeed performed while the resident was in the hospital. If so, they would then look to new MDS items J2100 – J5000 to determine if the surgical procedure performed in the hospital fits into any of the 29 categories listed there under the headings, Major Joint Replacement, Spinal Surgery, Other Orthopedic Surgery, Neurological Surgery, Cardiopulmonary Surgery, Genitourinary Surgery and Other Major Surgery.

Here is how this all shakes out. Notice in the table below, a resident can qualify for any one of the 16 different PT/OT groups, TA – TP. If due to an appropriate surgical procedure being identified at J2410 Spinal surgery - fusion of spinal bones, the diagnosis pathway indicated above would lead to a final primary diagnosis clinical category of Major Joint Replacement or Spinal Surgery. For our example, with a GG function score of 12, the resident would be classified into the TC group for both PT and OT categories. Note the shaded area in the table below.

PT Clinical Categories	Function Score	Group	Index	Urban Rate	Rural Rate
Major Joint Replacement or Spinal Surgery: (Major Joint Replacement or Spinal Surgery)	0-5	TA	1.53	$ 90.77	$ 103.47
	6-9	TB	1.69	$ 100.27	$ 114.29
	10-23	TC	1.88	$ 111.54	$ 127.14
	24	TD	1.92	$ 113.91	$ 129.85
Other Orthopedic: (Non-Surgical Orthopedic/Muscoloskeletal, Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	0-5	TE	1.42	$ 84.25	$ 96.03
	6-9	TF	1.61	$ 95.52	$ 108.88
	10-23	TG	1.67	$ 99.08	$ 112.94
	24	TH	1.16	$ 68.82	$ 78.45
Medical Management: (Medical Management, Acute Infections Cancer, Pulmonary, Cardiovascular and Coagulations)	0-5	TI	1.13	$ 67.04	$ 76.42
	6-9	TJ	1.42	$ 84.25	$ 96.03
	10-23	TK	1.52	$ 90.18	$ 102.80
	24	TL	1.09	$ 64.67	$ 73.72
Non-Orthopedic Surgery And Acute Neurologic: (Non-Orthopedic Surgery, Acute Neurologic)	0-5	TM	1.27	$ 75.35	$ 85.89
	6-9	TN	1.48	$ 87.81	$ 100.09
	10-23	TO	1.55	$ 91.96	$ 104.83
	24	TP	1.08	$ 64.08	$ 73.04

***For purposes of this article only the PT rate table is used. The OT table differs only in the CMI and rates.**

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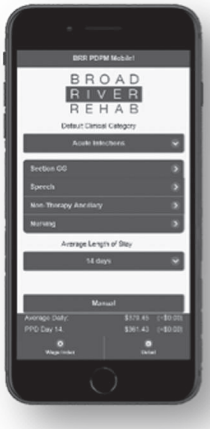
However, even though a surgical procedure was performed, it is possible the documentation received from the hospital did not contain that information or that it was overlooked by the facility assessor. In this case the default clinical category of Acute Neurologic, initially identified as a result of the primary diagnosis, would remain the default clinical category. The diagnosis pathway indicated above would then lead to a final primary diagnosis clinical category of Non-Orthopedic Surgery and Acute Neurologic. The resident would then be classified into the TO group, note the shaded areas in the table above.

You have most likely already noticed that the payment difference between TC and TO is $22.58/day for an urban facility, and $22.31/day for a rural facility. This discrepancy is based solely on appropriate ICD-10-CM coding and supporting documentation. The same situation may also occur simply by selecting an ICD-10-CM code that did not allow mapping to a surgical procedure, even though one may have occurred. ICD-10-CM really is king in the PDPM.

Stay Tuned! Next month we will investigate how ICD-10-CM intersects the SLP category. Broad River Rehab is uniquely situated to help providers understand the PDPM and to make real time accurate PDPM decisions related to their residents as well as potential admissions. Have you seen our **Mobile PDPM Navigator©**? This is a smart phone application that allows providers access to all necessary PDPM information, including ICD-10 mapping, from the palm of your hand. No manuals or bulky documents to carry around from meeting to meeting.



We would love to start a conversation with you about this must have resource and how Broad River Rehab can help your facility navigate PDPM successfully. Visit us at www.broadriverrehab.com or better yet give us a call at (800) 596-723. We would also love to answer any PDPM related questions you might have at https://www.broadriverrehab.com/expert/?

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individual must have "quality of life." Going down that rabbit hole requires a whole different article!

Back to the form. With your critical thinking lens, go beyond the surface question and consider *the process*. The format is a check box. So, if the resident has enough clothing, it seems pretty simple to check the box, which is assumed to mean "yes, the resident has enough clothing." But what if the resident doesn't have enough clothing? The only choice is to leave the box unchecked (blank). On this particular form, there isn't a narrative section where the assessor can write an entry explaining why the resident doesn't have enough clothing and what is being done about it. So, a seemingly innocuous question leaves the facility wide open for criticism, or worse.

It's time to get forms savvy, and take charge of this area of resident care and risk management! Next month I'll address the relationship between forms and facility policy.

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