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AAPC NEWSLETTERS

MDS ALERT

Your essential guide to mastering MDS as a tool for payment, risk management & quality of care.

In this issue

MISSION STATEMENT

To help busy nursing and other professionals master the complexities of the Minimum Data Set as a payment, quality-of-care and quality-of-life, risk management and compliance tool. To bring readers clear, practical strategies and tools from the nation's experts on nursing assessment and coding. *MDS Alert* is an independent publication and does not accept advertising. Our only allegiance is to you, our reader.

Surveys and Compliance

Prepare for Survey Resumption

Take infection control and COVID-19 reporting responsibilities seriously.

Nursing homes that have been juggling the added cost of infection control, cohorting sick residents, short staffing, and hazard pay aren't getting any more breaks, in regard to surveys and citations.

"Many providers are now significantly overdue for survey due to the focused prioritization of infection control surveys over the past few months," says **Linda Elizaitis, RN, RAC-CT, BS,** president and founder of CMS Compliance Group in Melville, New York. "It is important to look beyond COVID-19 when you are prepping for survey since, while infection control is likely to be a major focus, the [Long Term Care Survey Process] Guide provides a much broader look at a facility's practices, including those that are nonclinical in nature."

Know What These Surveys May Entail

Although nursing facilities were alerted June 1, 2020, that some surveys would resume, the Aug. 17, 2020, Quality Safety Oversight (QSO) Memo authorizes additional survey types. The guidance has been updated to include:

» On-site revisits specified in the State Operations Manual "revisit" policy,
» Complaint investigations that had been triaged as not "immediate jeopardy," and
» Annual recertification surveys that are required within 15 months of the facility's last survey.

CMS will also be focusing on resolving enforcement cases that were paused, CMS says in a press release. Additionally, CMS "will also temporarily expand the desk review policy, when state surveyors ensure that facilities return back into compliance with Federal requirements without an onsite survey, to include all noncompliance reviews except for immediate jeopardy citations that have not been removed," the agency says.

Note that surveyors will only be able to resume inspections if they have the necessary staff and sufficient personal protective equipment (PPE), Elizaitis points out.

Beware CMPs

In a new survey of long-term care facilities, the American Health Care Association and National Center for Assisted Living found 40 percent of nursing homes surveyed said they won't be able to sustain operations another six months, and 55 percent are currently operating at a loss.

Still, there may be more financial stress coming down the pike: The Centers for Medicare & Medicaid Services (CMS) announced it had levied $15 million in civil monetary penalties (CMPs) to more than 3,400 nursing facilities that were found to be noncompliant with infection control measures or did not report data on COVID-19 in their facility.

The survey process was adjusted at the start of the public health emergency in March to limit their inspections to focus mostly on infection control, and CMS reports that surveyors made 180 immediate jeopardy level findings — a threefold increase compared to rates in 2019. Of the $15 million in CMPs levied, nearly $10 million was due to these violations, affecting nursing homes in 22 states. The average penalty was $55,000.

"The Trump Administration is taking aggressive enforcement action against Medicare and Medicaid certified nursing homes that fail to implement proper infection control practices," said **Seema Verma,** CMS administrator. "Now more than ever, nursing homes must be vigilant in adhering

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to federal guidelines related to infection control to prevent the spread of infectious disease, including COVID-19. We will continue to hold nursing homes accountable and work with state and local leaders to protect the vulnerable population residing in America's nursing homes."

CMS says as of Aug. 3, 2020, more than 99 percent of facilities are reporting data about COVID-19 infection rates. However, CMS has already taken action against those facilities that have not reported or have lapsed in their reporting, levying approximately $5.5 million in CMPs and citing more than 3,300 deficiencies in nursing homes' reporting of COVID-19 data.

Bottom line: Don't fall short on infection control measures, and make sure you're reporting your COVID-19 data, especially if your facility is chosen to receive a COVID-19 testing device. See "Continue to Report Data with In-House Testing Device," page 7, for more information on reporting responsibilities if you receive a testing platform. AAPC

CMS Updates

Stay Abreast of These Federal COVID-19-Related Updates

Understand which big-picture announcements may impact your day-to-day work.

The Centers for Medicare & Medicaid Services (CMS) is trying to get back to some semblance of prepandemic normal, despite the spikes of coronavirus cases across the country and within nursing facilities, especially.

This means that facilities are going to need to juggle compliance and administrative responsibilities that had, for a time, been waived — but the official extension of the public health emergency (PHE) does continue to provide a bit of relief.

Take Solace in Extension of PHE

Extension: On July 23, the Department of Health and Human Services (HHS) Secretary Alex Azar renewed the PHE. The change was effective on July 25 and extends the PHE through Oct. 23, 2020 — for an additional 90 days. This is the second extension Azar has issued after originally declaring the COVID-19 pandemic a PHE on Jan. 31.

Review the PHE particulars at www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx.

The extension is a real boon for nursing facilities and the long-term care industry as everyone struggles to combat the virus. "This renewal extends the wide array of waivers and flexibilities that have been issued by HHS in response to COVID-19," says attorney **Madison Pool** with Arnall, Golden, Gregory LLP in online analysis. However, facilities must remember that the federal government can roll back policies at any time, and the Secretary can terminate the PHE at his discretion.

"The declaration will not extend indefinitely, so providers should keep one eye to the future and be aware of how changes implemented to respond to COVID-19 will have to be reverted once the flexibilities terminate," Pool advises.

Keep Tip Sheet Handy

CMS added COVID-19 PHE tip sheets for home health, inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), and skilled nursing facility (SNF) Quality Reporting Programs (QRPs). The tip sheets address the end of temporary exceptions on June 30 and the restarting of data collections on July 1 in the various QRPs.

In addition, CMS includes the following items in each tip sheet:

- A breakdown of the exception and extension policies for extraordinary circumstance under the PHE specific to that QRP
- An overview of data collections' exceptions by quarter
- Current data collection and submission requirements and expectations
- Dates and deadlines for each QRP
- Flexibilities resulting from the PHE
- Guidance on delays in QRPs
- Resources specific to each program

Find the SNF tip at www.cms.gov/files/document/snfqrp-covid19phetipsheet-july2020.pdf.

Prepare for Resumption of Claims Review

Medicare is cranking up its medical review machine for all providers, and more details are coming out about what that means. For example: "Beginning August 17, the MACs are resuming with post-payment reviews of items/services provided before 3/1/2020," HHH Medicare Administrative Contractor (MAC) Palmetto GBA reveals in a recent post to its website. That means no claims from the pandemic period will be included in the restart. "The Targeted Probe and Educate program (intensive education to assess provider compliance through up to three rounds of review) will restart later," says HHH MAC National Government Services in an identical post on its website. "The MACs will continue to offer detailed review decisions and education as appropriate."

Don't Expect COVID-19 Relief in 2021 Final Rule

CMS says that much is beyond the scope of rulemaking.

Although COVID-19 is a major focus of nursing facility staff (and residents) as the pandemic rages on, the recently finalized rule, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021," is mostly "business as usual."

Final Rule Reflects Current Challenges

However, the Centers for Medicare & Medicaid Services (CMS) says this final rule is a bit more bare bones than other years, in acknowledgement of the circumstances surrounding COVID-19.

"In recognition of the significant impact of the COVID-19 public health emergency, and limited capacity of health care providers to review and provide comment on extensive proposals, CMS has limited annual SNF rulemaking required by statute to essential policies including Medicare payment to SNFs," CMS says in a press release about the final rule.

One example: Several commenters on the proposed rule requested "excluding services from consolidated billing that would not otherwise qualify for such exclusion," CMS says. The agency responded in the final rule, saying that, while they recognize the "unique circumstances" surrounding the COVID-19 PHE, "excluding services from SNF consolidated billing that would not otherwise meet the statutory conditions for exclusion would require congressional action."

Some good news: CMS says it will increase aggregate Medicare program payments to SNFs by $750 million, a 2.2 percent increase over FY 2020. However, some facilities may be juggling lower wage index calculations if their urban or rural status changed due to the Office of Management and Budget's revised geographic delineations. However, there's a 5 percent cap on any provider wage index decreases, CMS assures.

However, and somewhat unrelatedly, CMS is making fewer or delaying changes to the minimum data set and Resident Assessment Instrument (RAI) Manual than some other years.

Note These ICD-10-Related Changes to PDPM Clinical Categories

Some changes outlined in the proposed rule that have been finalized include adjustments to some clinical category mapping that will affect how some residents' clinical categories are mapped according to the Patient-Driven Payment Model (PDPM). The adjustments mostly affect MDS item I0020B (*I0020: Indicate the resident's primary medical condition category, ICD Code*) and items J2100 (*Recent Surgery Requiring Active SNF Care*) and J2300-J5000 (*Recent Surgeries Requiring Active SNF Care*). The update means that some residents who had certain major surgical procedures within a particular timeframe may have their clinical category eligible to become surgical, instead, which pays higher reimbursement.

Some ICD-10 codes reflecting certain cancer diagnoses will also map differently, in acknowledgement by CMS that some cancer care is more intensive and should entail more reimbursement. There are two additional clinical category options now, "May Be Eligible for the Non-Orthopedic Surgery Category" or "May Be Eligible for One of the Two Orthopedic Surgery Categories," which these cancer diagnoses will map to, in reflection of the potential effect on the amount of care affected residents require.

Read the full final rule here: www.govinfo.gov/content/pkg/FR-2020-08-05/pdf/2020-16900.pdf.

Heed Title VI Responsibilities

If you're getting financial assistance from the federal government, you may want to revisit the rules and requirements under Title VI of the Civil Rights Act of 1964, cautions a recent HHS Office for Civil Rights (OCR) brief.

On July 20, OCR issued new guidance reminding "recipients of federal financial assistance" that they must comply with "federal civil rights laws and regulations that prohibit discrimination on the basis of race, color, and national origin in HHS-funded programs during COVID-19," an agency release warns.

Recent data suggest there's been an increase in discriminatory practices across the healthcare spectrum during the pandemic. This has prompted the agency to work in tandem with the Centers for Disease Control and Prevention (CDC), the HHS Office of Minority Health, and the National Institutes of Health (NIH) to identify, research, and stop racial and ethnic inequities.

Additionally, OCR offers specific guidelines to aid the healthcare community with Title VI compliance — and ensure equal access to care, treatment, and testing. A couple of the OCR highlights pertinent to nursing facilities include:

- Set up stronger policies to circumvent harassment and discrimination.
- Allot beds, services, and medicine "without regard to race, color, or national origin."

"HHS is committed to helping populations hardest hit by COVID-19, including African-American, Native American, and Hispanic communities," stresses **Roger Severino,** director at OCR. "This guidance reminds providers that unlawful racial discrimination in healthcare will not be tolerated, especially during a pandemic," he adds.

Read the bulletin at www.hhs.gov/sites/default/files/title-vi-bulletin.pdf. AAPC

COVID-19 Mitigation

Protect Employee Privacy While Testing

Enact a protective buffer for residents and staff without violating employee privacy.

As COVID-19 infections continue to swamp the U.S., employers of all ilk are trying to figure out how to conduct business safely — or whether doing so is even possible. The Department of Health and Human Services (HHS) is sending some nursing homes testing devices, but others will still be managing testing or symptom screening on their own. While routine staff testing used to be recommended by the Centers for Medicare & Medicare (CMS), it is now a requirement, according to **David R. Wright,** director of Survey and Certification Group at CMS, in an August QSO memorandum.

Performing tests and screening are short-term goals but may have long-term legal implications, suggests **Karla Grossenbacher, JD,** partner in labor and employment at Seyfarth Shaw LLP, in Washington D.C. Employee health privacy rights are not diminished by the public health emergency, and even though employers need to intrude somewhat on employees' privacy, with body temperature and symptoms screenings, for example, they should be careful to not overstep, she says.

Mesh CDC Guidelines with Common Sense

Practices that want to protect employees who may be at higher risk for more serious complications from COVID-19 without invading their privacy should let employees self-identify whether they have any conditions that put them in the high risk category and then honoring their concerns, Grossenbacher says.

Although the U.S. Equal Employment Opportunity Commission (EEOC) recommends that employers stay abreast of and follow CDC and other public health agency recommendations, the EEOC outlines some crucial language that employers should be aware of when navigating protecting employees without interfering with their privacy or chancing discrimination.

Federal agency, public health, and professional organization guidance have all encouraged employers to prioritize safety as they pursue a return to business, and screening employees has been recommended consistently. The recommendations from the Centers for Disease Control and Prevention (CDC) for healthcare personnel (and others working in medical offices or facilities) have included taking employee temperatures before each shift, as well as running through a symptoms questionnaire. The CDC doesn't specify who exactly should be conducting these screenings, though the agency does mention that the screenings should, ideally, occur before employees enter the office or facility.

Consider Company Policy Carefully

But employers should think carefully about who is tasked with doing this work — and what happens to protect everyone's physical safety, as well as privacy. Even if the employer is legally taking employees' temperatures, the ways in which the employer conducts this screening could create privacy concerns or even be against the law, Grossenbacher says. While most workers seem grateful for all the precautions organizations are taking to protect them, litigation from disgruntled employees is always a possibility, especially if employers overstep. Although a staff member who works at the front desk or provides security outside the office may be the most convenient, logistically, a human resources staff member who has the training to prioritize discretion may be a better choice.

She lists these questions as points to consider: Are employees' temperatures recorded? Who has access to that information? Do staff members wait in a physically distanced line to be screened — but with the possibility of overhearing others' results? What happens if someone comes to work and has a fever? How is the designated screener protected physically?

One option is to encourage employees to screen themselves, which obviously requires more trust for employer and employee both — and among colleagues.

For nursing homes that acquire testing platforms, additional technical training will be necessary so the designated staff know how to operate the devices. Those that receive platforms from HHS will receive a six-week supply of tests, but will then need to obtain tests directly from the manufacturers, the estimated cost of which ($25 per test) will not be reimbursed, law firm Hall Render points out.

Even if you've been operating with rather ad hoc protocols, the increasing rate and widespread nature of the pandemic should bring new focus. Make sure you establish procedures and write them down. Keep staff in the loop and keep communication lines open so they can voice their concerns, fears, or even confide personal challenges they may be navigating outside of work that may be affecting their performance.

Know These Particular Guidelines

For nursing homes that are struggling to maintain enough staff, the EEOC's guidelines for hiring and onboarding are particularly pertinent. The EEOC says that during the public health emergency, and consistent with CDC guidelines, employers may test new hires before their start date, delay anyone who tests positive from starting, and even withdraw a job offer if the potential hire has COVID-19, as they cannot work safely.

However, it is not legal to withdraw a job offer or postpone the start date unilaterally for a potential hire who is older than 65 or who is pregnant, even though these factors may make the person at higher risk for more serious complications from COVID-19, the EEOC says. An employer should instead make accommodations like offering telework, if the role allows such flexibility, or determining whether the individual would prefer to postpone their start date.

Nursing home staffing decisionmakers should also know that antibody tests for COVID-19 are subject to different rules from the EEOC than the tests that detect the presence of SARS-CoV-2, the virus that causes COVID-19 infection.

"An antibody test constitutes a medical examination under the ADA. In light of CDC's Interim Guidelines that antibody test results 'should not be used to make decisions about returning persons to the workplace,' an antibody test at this time does not meet the ADA's 'job related and consistent with business necessity' standard for medical examinations or inquiries for current employees. Therefore, requiring antibody testing before allowing employees to re-enter the workplace is not allowed under the ADA," the EEOC says. AAPC

Reader Questions

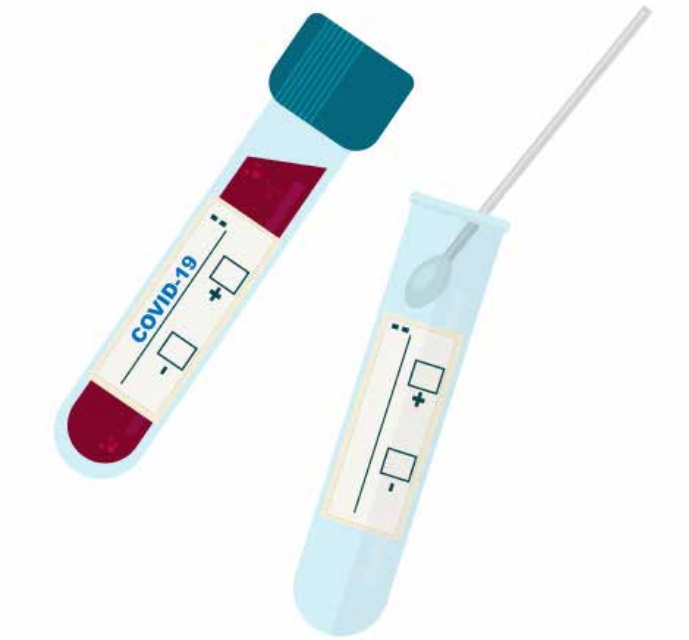
Continue to Report Data with In-House Testing Device

Question:
Our facility has been chosen to receive a device to test for COVID-19 infection. Since we'll be able to do the tests in-house now, are we still required to report the data?
Illinois Subscriber

Answer:
Yes, you must report the test results. "All laboratories must have a CLIA Certificate and report the results of the COVID-19 tests that they conduct to the appropriate federal, state, or local public health agencies. Laboratories must report data for all testing completed, for each individual tested. This data must be reported within 24 hours of test completion, on a daily basis, to the appropriate state or local public health department, based on the individual's residence. Testing sites must report all diagnostic test data in accordance with the HHS Lab Data Reporting Guidance for COVID-19 issued June 4, 2020 and meet these reporting requirements by August 1, including providing your facility name and CLIA number when reporting results," CMS says in a Frequently Asked Questions document for skilled nursing facilities.

However, note that the location of your facility may matter. Washington and New York are both exempt from the Clinical Laboratory Improvement Amendments (CLIA) certification.

"Although Washington State's Medical Test Site program and New York State's Clinical Laboratory Evaluation Program are exempt from CLIA, they do authorize a SNF/NF to have certificates that are equivalent to CLIA certificates, including the CLIA Certificate of Waiver. Nursing homes in Washington State are issued a CLIA Certificate of Waiver



in addition to a Washington State License and those in New York State are issued a Limited Service Laboratory Registration. Nursing homes in these states will also be included in the HHS distribution program," CMS says.

New York facilities can find more information at https://protect2.fireeye.com/url?k=5dee6edc-01ba77a0-5dee5fe3-0cc47adc5fa2-d45645ac8b1d5c6a&u=https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs, and facilities in Washington state, can find more information at www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/LaboratoryQualityAssurance. AAPC

Pay Attention to Resident Status, Not Payer Source

Question:
One of our residents was Medicaid but went to the hospital and came back as a skilled resident on Medicare Part A. Do I have to do a significant change assessment since the resident is on Medicare now?
New Mexico Subscriber

Answer:
Pay attention to the activities of daily living (ADLs) instead of payer source for significant change assessments, except for when a resident goes on hospice. However, you will need to do a 5-day assessment since the resident is beginning Medicare Part A.

To review: "The SCSA is a comprehensive assessment for a resident that must be completed when the [interdisciplinary team] IDT has determined that a resident meets the significant change guidelines for either major improvement or decline," says the Resident Assessment Instrument (RAI) Manual, page 2-22. The RAI Manual does not mention resident payer source; the determination should be made by evaluating the resident's condition.

The hospice exception makes sense, as hospice reflects both a change in status and a different program for payment. "An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place," the RAI Manual says, page 2-23. AAPC

COVID-19 Does Not Equate to Skilled Status

Question:
I am being pressured by some of the folks in our finance office to skill all residents if we get a positive COVID-19 case in our facility. I feel like this can't be correct, but I'm not sure. Are MDS coordinators supposed to skill everyone if they get a single positive case?
Massachusetts Subscriber

Answer:
No, the Centers for Medicare & Medicaid Services (CMS) is explicit in saying that a COVID-19 diagnosis does not entitle an individual resident to beneficiary status. "A COVID-19 diagnosis would not in and of itself automatically serve to qualify a beneficiary for coverage under the Medicare Part A SNF benefit. That's because SNF coverage isn't based on particular diagnoses or medical conditions, but rather on whether the beneficiary meets the statutorily-prescribed SNF level of care definition of needing and receiving skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis," CMS says in a COVID-19 Medicare Fee-For-Service (FFS) FAQ.

Therefore, it would be an even bigger stretch — and expressly not compliant with Medicare rules and regulations — to skill residents across a facility for one positive diagnosis. AAPC