New Medicare Numbers

Use of the SSN as part of the Medicare number has increased the possibility of the fraudulent use of SSNs such as identity theft and illegal use of Medicare benefits. A law was passed that requires CMS to remove SSNs from all Medicare cards by April 2019 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareCard-FactSheet-TextOnly-909365.pdf). The new cards are being mailed out beginning in April 2018; Pennsylvanians will be receiving their new cards between April 2018 and June 2018.

The new number should be used as soon as the resident receives his/her card. These new numbers are known as the Medicare Beneficiary Identifiers (MBI). They consist of 11 numbers and upper-case letters which fits into A0600B. The numbers are randomly generated; there is no meaning to the numbers/letters/pattern. People who are new to Medicare after April 1 will only have the MBI.

The edit for this number is complex: The first (of 11) characters must be numeric excluding 0. The second, fifth, eighth and ninth characters must be alphabetic excluding S, L, O, I, B and Z. The fourth, seventh, tenth and eleventh characters must be numeric. The third and sixth characters must be alphabetic (excluding S, L, O, I, B and Z) or numeric. Type carefully when you enter these new numbers; hopefully your software will retain them and you will not have to do it again. You will get Warnings that the resident’s information has been changed.

A Map to Basic Resources Teleconference

Date: July 12, 2018
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: A Map to Basic Resources
Handouts: Power Point slides will be available about July 11 on the DOH Message Board at https://sais.health.pa.gov/commonpoc/Login/Login.aspx
Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 7857266

Additional questions: qa-mds@pa.gov
On April 12, 2018, a training teleconference was provided on Helpful MDS Hints.

Slide #33 Replacement. Through recent discussion with CMS MDS staff about K0510B Feeding tube, clarification regarding coding this MDS item has become known, and we are sharing this information for future reference. A replacement slide is being posted on the DOH Message Board (https://sais.health.pa.gov/commonpoc/Login/Login.aspx).

The MDS Items in K0510 Nutritional Approaches are intended to capture nutritional approaches to meet a resident's nutritional needs. If the tube is only flushed for maintenance with no nutrition provided, K0510B should not be checked. The presence of the feeding tube alone (which is not being used for nutritional purposes) does not meet criteria for coding K0510B Feeding tube.

The following questions were received:

Q. May a copy of the orders and starting care plan be given to the resident/representative in place of baseline summary?

A. In the Interpretive Guidance for F655 Baseline Care Plans, it states that the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident. This includes, but is not limited to, initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASRR recommendation, if applicable.

Q. In Section M, where would you record cryosurgery for actinic keratosis?

A. Cryosurgery to destroy a skin lesion does not meet the definition of a surgical wound (an "open or closed surgical incisions, skin grafts or drainage sites" RAI Manual page M-35). However, an open lesion (that is not an ulcer, rash, cut or ulcer or on the foot) could be coded in M1040D. A dressing applied to an open lesion (not on the feet and not band-aids) could be coded in M1200G.

Q. How can I find the Department of Health Bulletin Board? Sometimes the link doesn’t work.

A. The internet can be challenging. Usually https://sais.health.pa.gov/commonpoc/Login/Login.aspx will link to the Message Board. Otherwise, I started at www.google.com and searched for the PA Department of Health. The first response was the main site for DOH at www.health.pa.gov. When that screen opened, I selected Nursing Homes and the POC/Online Licensing which led me to the site listed above.

Q. What date should be entered in Z0400 Signature date if data entry cannot be completed on the date the information was gathered?

A. In the RAI Manual on page Z-7, it states: “If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.”

A written summary of this baseline care plan must be provided to the resident/representative and there must be evidence in the clinical record that the summary was given to them.

Q. Should dressings on IV lines, etc. be recorded at M1200G Application of nonsurgical dressings?

A. This question was answered by the national RAI Panel that is sponsored by and collaborates with CMS: “No. IV and Port dressings cannot be included in M1200G as they are not being used to treat a skin condition as specified by the MDS 3.0 Manual.” (RAI Manual v. 1.15 page M-42)

Section M as a whole relates to Skin Conditions. The intent statement on page M-1 is: “The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury.” All of the items in Section M leading up to M1200 are recording ulcer, wounds and skin problems, and this is the context for the skin and ulcer treatments in item M1200. The MDS is a Minimum Data Set, a core set of screening, clinical, and functional status elements. Not every piece of care is captured on the MDS.

Q. When a resident is sent to the hospital for emergency care, must a written notice be provided to the resident/representative?

A. The State Operations Manual includes the following guidance reiterating the requirements for section §483.15(e)(3) (continued on page 4)
Proposed PPS Rule


The overall economic impact of this proposed rule would be an estimated increase of $850 million in aggregate payments to SNFs during FY 2019 due to a 2.4% Market Basket increase. However, the overall payment impact of the SNF Value Based Purchasing Program is an estimated reduction of $211 million in aggregate payments to SNFs during FY 2019.

Transition to PBJ Staffing Measures

Beginning in 2015, facility staffing information has been submitted each quarter through the Payroll Based Journal (PBJ) program. This represents the number of hours staff are paid to work each day of that quarter. It is also auditable back to payroll and other verifiable sources. CMS is now transitioning to use PBJ hours on the Nursing Home Compare tool on Medicare.gov and the Five Star Quality Rating System. (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf)

- Starting in April 2018, CMS will use PBJ data to determine each facility’s staffing measure on Nursing Home Compare, and to calculate the staffing rating used in the Nursing Home Five Star Quality Rating System.
- Staffing data audits are being performed. Guidance is being provided to facilities to improve their accuracy. Nursing homes whose audit identifies significant inaccuracies between the hours reported and the hours verified, or facilities who fail to submit any data by the required deadline will be presumed to have low levels of staff. This will result in a one-star rating in the staffing domain which will drop their overall (composite) star rating by one star for a quarter.
- RN staffing is very important, and there is a requirement to have an RN onsite 8 hours a day, 7 days a week. Nursing homes reporting 7 or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain. This action will be implemented in July 2018.
- CMS is continuing its efforts to help nursing homes submit accurate data.
- As of June 1, 2018, CMS will no longer collect facility staffing data through the CMS-671 form.

Infection Prevention Training

The revised Requirements of Participation effective November 28, 2016 added several requirements for nursing facilities dealing with infection control and prevention. These requirements were phased in over a 3-year period. The broader infection control program was effective November 28, 2016. In November 28, 2017, facilities were required to develop an antibiotic stewardship program to combat the growing concern of multi-drug resistant organisms. Phase 3 is effective November 28, 2019, and includes additional components including specialized training.

CMS and the Centers for Disease Control are collaborating on the development of a training course in infection prevention and control for long-term nursing home staff. (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-18-15-NH.pdf) The course will be free of charge and available on-line and on-demand in Spring 2019. Completion of this course will provide specialized training in infection prevention and control. The training is expected to take approximately 16 to 20 hours and a certificate of completion will be provided after successful completion of an online exam.
Additional Questions (cont’d)

(continued from page 2)

Notice before transfer, applicable to emergency transfers: Emergency Transfers—When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable, according to 42 CFR §483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.

Q. When is Community HealthChoices definitely taking affect? Where would I find the map of the areas and start dates?

A. The Community HealthChoices website contains a wealth of information about this new system and its implementation: http://www.healthchoices.pa.gov/info/about/community/. On this site, there is a section on the left titled Helpful Resources with General Information as a subcategory. Click on Timeline for Implementation; a map appears and the detailed timeline for implementation is presented.

Q. A resident had a surgical procedure on her leg 4-5 years ago. This area has been receiving a treatment consistently. It has been healed a few times for a short while occasionally but the resident will always scratch it back open. Do we still consider it as a surgical wound because that is what it was originally?

A. The RAI Manual defines surgical wounds as “Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.” (page M-35) As long as the wound met the definition of a surgical wound (surgical incision, skin graft or drainage site), even a non-healing surgical wound would be coded in M1040E.

Therapy Caps

On February 9, 2018, the Bipartisan Budget Act of 2018 was signed into law. (https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf).

This new law includes several provisions related to Medicare payment especially the therapy caps. In Section 50202 - Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy - The new law states that for services after December 31, 2017:

- Medicare claims are no longer subject to the therapy caps (currently $2,010 - one for occupational therapy services and another for physical therapy and speech-language pathology combined);
- Claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps, must include the KX modifier indicating that such services are medically necessary as justified by appropriate medical record documentation; and
- Claims for therapy services above certain threshold levels (lowered to $3,000) of incurred expenses will be subject to targeted medical review.

New Medicare Cards (cont’d)

(Continued from page 1)

Either number may be submitted at A0600B Medicare Number. Fatal Error -3878 Incorrect Medicare Number or Medicare Beneficiary Identifier (MBI) details the requirements for both numbers. It will only cause rejection of the assessment if neither the Medicare nor MBI formats are followed. See Chapter 5, page 5-162 of the Provider Users’ Guide https://qtsq.cms.gov/mdstrain.html.