In order for a resident’s skilled nursing facility (SNF) stay to be covered by Medicare Part A, many requirements must be met. In Chapter 8 of the Medicare Benefit Policy Manual at 10 – Requirements, it states “Post-hospital extended care services furnished to inpatients of a SNF or a swing bed hospital are covered under the hospital insurance program. The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay….”

Thanks to many diverse instructions about coding hospital stays, it may be difficult to identify if a potential resident has met this standard.

Under the stress and confusion of illness and hospitalization, the patient/resident may have no idea of his/her status until they are trying to arrange post-acute care. In an effort to clarify these situations, CMS has released the Medicare Outpatient Observation Notice (MOON), CMS-10611 (https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=bni). The MOON was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or critical access hospital (CAH).

Beginning February 21, 2017, the MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or Critical Access Hospital must provide the MOON no later than 36 hours after observation services as an outpatient begin. It is intended to inform beneficiaries that they are outpatients receiving observation services and not inpatients, and the reasons for such status.

If your facility is considering admitting a resident and is unclear as to the status of their hospital stay, inquire if the hospital has issued and the resident has received a MOON. The resident or their representative must sign and date the MOON.
New Assessment Requirements Q & As

On January 12, 2017, a training teleconference was provided on New Assessment Requirements. The following questions were received.

Q. Our facility records are almost completely electronic. How can a resident sign the care plan?

A. There may be instances where paper documents need to be incorporated into the resident’s electronic health record. The facility should have a policy in place specifying how that would be achieved. The facility would follow that existing policy to add documentation of the resident’s and/or representative’s signature for the care plan.

Q. Must all residents have a PASRR performed before admission?

A. All individuals being admitted to a Medicare/Medicaid certified nursing facility regardless of payor source must have the PASRR process completed prior to admission.

Q. What are the dates of the three phases of implementation of the Reform of Requirements for Long-Term Care Facilities regulation?


Q. Are orders delegated by the physician as allowed in §483.30 still considered ‘physician orders’ in Section O0700? For example, a therapist writes their own order for PT for therapeutic exercise 6x/week for 3 three weeks on 01/12/2017. The ARD of the MDS is 01/13/2017. Can we count that as a day with a Physician Order on 01/12/2017?

A. No. The facility must follow what is in the RAI Manual to code the MDS which states physician orders “Include[ ] orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.” (RAI Manual page O-43)

Q. In reference to today's teleconference, on page 13, Coordination Incorporation, #2. Referring all Level II residents and all residents with newly evident or possible serious mental disorder, ID or ORC for Level II resident review upon significant change. Does this address the resident who is already a Level II resident and has a Program Office Letter who would need another Level II Evaluation due to a significant change in status. Is this correct? If so could you please specify what the significant change could be and at what point would a second Level II Evaluation be completed.

A. With the Final Rule, they are talking about the Significant Change MDS Assessments. If there is a Significant Change MDS Assessment that affects PASRR, then the NF needs to follow the MA 408 process and send notification to OLTL Field Operations that a PASRR Level II Evaluation needs to be completed. If an individual already has had a PASRR Level II done and has a Program Office Letter, you would only need to do another PASRR Level II Evaluation if something would change with what that Program Office Letter currently says. For example, if the individual no longer is in need of Specialized Services, or the individual could now benefit from Specialized Services, a second PASRR Level II Evaluation could be done to make that determination.

Pressure Ulcer QM Revised


For this revised calculation, the denominator is the number of complete resident Medicare Part A stays which is defined by a 5-day PPS assessment and a discharge assessment, which may be a stand-alone Part A PPS discharge, or a Part A PPS discharge combined with an OBRA discharge, except those who meet the exclusion criteria. Resident stay is excluded if data on new or worsened Stage 2, 3, and 4 pressure ulcers are missing at discharge; if the resident died during the SNF stay; or if there is no data available to derive risk adjustment (covariates).

The numerator is the number of complete resident Medicare Part A stays for which the discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers (M0300B-D) compared to admission.

(Continued on page 4)
Further Litigation on Maintenance Standard

In 2011, Glenda Jimmo and others filed suit against the Secretary of Health and Human Services alleging that the Secretary imposed a covert rule of thumb which improperly imposed an “improvement standard” on services provided to a resident/patient. Medicare coverage was being denied because a patient was unlikely to improve even when the patient needed skilled care to maintain his or her condition or prevent or slow further deterioration.

In the settlement on January 24, 2013, the parties agreed to a “maintenance coverage standard” which provides that skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary required skilled care for the services to be safely and effectively provided.

Part of the settlement required the Secretary to engage in a nationwide educational campaign to communicate the maintenance coverage standards. On March 1, 2016, another suit was filed alleging that the Secretary did not adequately disavow the improvement standard and that the educational campaign was so confusing and inadequate that little had changed because of the settlement.

The final ruling dated February 1, 2017 (https://casertext.com/case/jimmo-v-burwell-1) requires the following actions from the Secretary by September 4, 2017:
1. CMS will publish a new web page dedicated to the Jimmo settlement agreement;
2. CMS will post Frequently Asked Questions;
3. CMS will develop and implement training for Medicare contractors and MA plans making coverage decisions;
4. CMS will conduct a new national call to explain the correct maintenance coverage policy; and
5. CMS will publish the following corrective statement adopting a maintenance coverage standard and disavowing an improvement standard:

“Skilled nursing services would be covered [by Medicare] where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.”

The corrective statement also adds “The Jimmo Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve.”

Cyber Security Memorandum

Most businesses activities, including nursing facilities, are very dependent on their computer systems for day-to-day operations. Interference with these systems, such as a cyber-attack, can result in many serious consequences. On January 13, 2017, CMS released a Survey and Certification Memorandum dealing with Recommendations to Providers Regarding Cyber Security (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-17.pdf).

The primary areas of concern are the disruption to patient care that occurs when a cyber-attack is successful. This could include incomplete discharge instructions, missing patient information or orders, potential compromise of Public Health Information (PHI), personal identifiable information (PII) and possible HIPAA violations. The facility might need to close or temporarily suspend operations.

The memorandum suggests that nursing services may be particularly affected due to lack of knowledge of alternate methods not involving the computer system. Some best practices suggested include:
- Retraining of staff to include use of non-electronic methods, such as written discharge instructions, care planning, and medical records.
- Have staff familiarize themselves with the knowledge of the paper medication administration record (MAR) process.
- Be able to transmit laboratory and radiology orders on paper-based requisition forms that can be hand delivered.
- Pre-program phone/fax numbers into the fax machine.
- Establish communication plans which include alternative methods.

CMS is recommending that facility leadership review current policies and procedures to ensure adequate plans are in place in the event of an attack.
Community HealthChoices Postponement

Community HealthChoices (CHC) is a new initiative from the Department of Human Services that will make it possible for older Pennsylvanians and Pennsylvanians living with disabilities to remain in their communities while they are receiving services. Pennsylvania is working with consumers, advocates, and providers to create a sustainable, person-driven, long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Under CHC, managed care organizations (MCOs) coordinate physical health care and long-term services and supports (LTSS) for older people, people with physical disabilities, and people who are eligible for both Medicare and Medicaid. (http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_237795.pdf).

The program was originally scheduled to begin in the Southwest region of the state on July 1, 2017. However, Pennsylvania is postponing the implementation of CHC due to delays associated with the resolution of several bid protests (http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_253205.pdf).

• Phase 1 will now begin in January 2018 in the Southwest region of the state.
• Phase 2 will now begin in July 2018 in the Southeast region of the state.
• The January 2019 start date for the rest of the state remains unchanged.

Calculation of MA Rates

Recently several questions have been received about the use of the Total Facility Case Mix Index (TF CMI) in the calculation of the Medical Assistance (MA) rates paid to nursing facilities. A brief explanation is found on page 7-1 of the Resident Data Reporting Manual:

“Annually, peer group medians and prices are calculated and used in the July, October, January, and April quarterly rates. These prices are calculated for each of three (3) categories: Resident Care, Other Resident Care and Administrative. Separately, a Capital rate is also calculated. In the early stages of calculating the annual prices, the Resident Care Costs reported by the nursing facility are divided by the Total Facility CMI from the February CMI Report closest to the age of the cost reporting period that is used to calculate the price. This is called Case-Mix Neutralizing; it establishes a Resident Care Cost per case-mix point that allows comparison with other NFs in the facility’s peer group.

Once these prices are assigned to each facility and a limitation calculation is performed (see §1187.107), the Resident Care per diem is multiplied each quarter by the nursing facility’s MA CMI from the applicable Picture Date”.

If more detail about this calculation is desired, refer to the regulations that detail MA rate setting at http://www.pacode.com/secure/data/055/chapter1187/subchapGtoc.html and/or the DHS web site under Rates at http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm#.VkDTFGco6os.

Appendix PP Revision

On Tuesday, October 4, 2016, the final rule on Medicare and Medicaid Programs; Reform of Requirements for Long Term Care Facilities was published. CMS has now released a Revision to the State Operations Manual (SOM) Appendix PP to incorporate the revised Requirements of Participation published in that rule in the Guidance to Surveyors for Long Term Care Facilities (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R167SOMA.pdf). This revision is effective February 10, 2017.

Pressure Ulcer QM Revised (cont’d)

(Continued from page 2)

Covariates are identified from the PPS 5-day assessment and include requiring limited or more assistance in bed mobility self-performance; bowel incontinence at least occasionally; diabetes or peripheral vascular disease; and Low Body Mass.

The measure will be calculated quarterly using a rolling 12 months of data.