INTEGRATING THE RAI PROCESS INTO YOUR DAY TO DAY PROCESS, CMS MDS STAFFING COMPLIANCE SURVEY, & CLINICAL REIMBURSEMENT DOLLARS

By: Tamra Hassler, RN, LHRM, CDP, © copyright
Today’s Program Objectives

Upon completion of this program, participants will be able to:

Discuss the role of the resident assessment instrument (RAI) tool and all of its components:

a. minimum data set (MDS)
b. care area triggers (CATs)
c. care area assessments (CAAs)
d. CAA Summary Sheet
Define three roles that the RAI plays in the SNF clinical operational process.

Describe person centered individualized care plans.

Detail the Florida results of the first 16 CMS MDS & Staffing Focus Survey outcomes.

Discuss Medicare Part A & B Compliance Strategies for success.
Let’s Get Started!
The RAI Purpose

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life.
Discuss the RAI Components

There are three components:

1. **MDS**

2. **CAA Process** (& three components of the CAA Process)
   a. CATs
   b. CAAs
   c. CAA Summary Sheet

3. **Utilization Guidelines**
Minimum Data Set

The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.
The MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.
CAA Process

The care area assessment (CAA) process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident.

This process is designed to assist the assessor to systematically interpret the information recorded on the MDS.
CATs

Care Area Triggers (CATs) are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
CAAs

Care Area Assessment (CAA) is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning.
The CAA Summary provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning. It can be used as an informal ‘index’ to the RAI.
The Utilization Guidelines provide instructions or directions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.

This is available from:
Three Roles of the RAI

There are three main roles of the RAI:

1. Medicare and Medicaid Payment Systems (documentation discussion in part II)
2. Monitoring of Care
3. Consumer Access to Nursing Home Information.
Payment Role

Medicare and Medicaid Payment Systems. The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident’s functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups).
The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.
More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at:

http://www.cms.gov/Manuals/IOM/list.asp for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.
Monitoring of Care

MDS assessment data are also used to monitor the quality of care in the nation’s nursing homes.

MDS-based quality measures (QMs) were developed by researchers to assist in four areas.
Quality Measure four Keys

- State Survey and Certification staff in identifying potential care problems in a nursing home;
- Nursing home providers with quality improvement activities/efforts;
- Nursing home consumers in understanding the quality of care provided by a nursing home; and
- CMS with long-term quality monitoring and program planning.
Consumer Access

Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country.

The Nursing Home Compare tool (www.medicare.gov/nursinghomecompare/) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.
To create a person centered and individualized care plan, the evaluator gains the benefit of using the RAI as it provides a structured, standardized approach for applying a problem identification process in nursing homes.

A key point is that the RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.
Individualized Care Plans

To create individualized care plans the CAAs are an essential element by collecting data, determining if proceeding or not to a plan of care and if yes WHY.
Individualized Care Planning

Individualized plans of care establish a course of action with input from the resident (resident’s family and/or guardian or other legally authorized representative), resident’s physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the “how” of resident care.
Included in Care Plans

1. What kind of services needed
2. What type of health care professional should give the services
3. How often and for how long are services anticipated
4. What kind of equipment or supplies are needed (like a wheelchair or feeding tube) any special diet or fluid consistency
5. Goals on how your care plan will help
Integrating RAI

Integrating the RAI into the SNF day-to-day clinical operations is key to meeting the mission of this process. One step is using the definitions found in chapter 3 the item-by-item section by all SNF staff members not just the interdisciplinary team (IDT) which promotes improved communication by your staff members.
How Evaluation Helps

Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident’s status, goals, or improvement or decline.
Solution Oriented

If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident’s quality of care and quality of life.

The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process.
RAI Implementation Successes

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- Residents respond to individualized care
- Staff communication has increased
- Resident and Family involvement increases
- Increased clarity in documentation
CMS MDS & Staffing

Part II
Part II

Let's Get Started

CMS MDS & Staffing Focus Surveys

Results of Florida SNFs ending September 30, 2015 (please see handout)

Medicare Compliance considerations Part A & B
Dear Administrator

This letter is to inform the facility that they will be included in a MDS focused survey which per the Survey & Certification Memo 15-06 NH October 2015 is a nationwide initiative. The letter references that two to four surveyors will plan to be on site for two days (not in advance).

It is not with advance notice.
Using the Facility Copy of the Entrance Conference, providers will note that there are four categories each with associated time frames to provide specified data to the surveyors completing your compliance review.
Entrance Conference

The **Time Frames** are:

- Immediately Upon Entrance
- Within One Hour of Entrance
- Within 24 Hours of Entrance
- Upon Request or as needed
Immediately Upon Entrance

There are **six pieces** for this section:

1. Worksheet #1 Resident Census Sheet (alphabetical with room numbers)

2. Computer access

3. Facility Floor Plans
Immediately Upon Entrance

4. Transfer Records for the last 90 days

5. Identification of Wound Care Nurse (or nurse who coordinates wound care)

6. Identification for who is responsible for staffing
Within One Hour of Entrance

There are four pieces for this section:

7. Key personnel list with location and ext.
8. Computer access
9. All facility policies and procedures related to resident assessment instrument (RAI), including the minimum data set (MDS)
10. All facility policies and procedures related to staffing and scheduling
Within 24 Hours of Entrance

There is one piece for this section:

11. Completed CMS form 671 (Medicare Medicaid application)
Pilot Test

In the initial pilot testing, there were five states that participated.

The testing ended August 2014 and included a total of 25 SNFs.
Pilot Test Activities

These facilities were surveyed for:

- MDS coding accuracy,
- accurate MDS-based reimbursement levels, and
- RAI focused care planning that matches resident needs and promotes person-centered care.
Pilot Test Results

The results were not complimentary, of the 25 facilities surveyed, 24 received deficiencies for errors related to MDS coding.

CMS cited several prominent areas.
Pilot Test Results

CMS Cited Areas:

- Errors in MDS coding (esp. in certain sections)
- Inaccurate staging and documentation of pressure ulcers
- Lack of knowledge regarding classification of antipsychotic medication
- Poor coding regarding the use of restraints
To Have Upon Request

12. Make staff members and other policies and procedures available to surveyors upon request.
FY September 30, 2015 Results

Please see your handout FHCA has provided with a graph of the facilities that received the CMS MDS & Staffing focused survey in our state. You will note a few keys that we shall review and further findings:

- Sixteen facilities completed
- Fifteen facilities were sited
- Thirteen facilities were sited for a minimum of F 356 Staffing
- Twelve facilities were sited for F 278 Assessment
Staffing Compliance
Federal nurse daily staffing information posting requirement includes:

- Facility Name
- Current Date
- Total number and actual hours worked by the following categories:
  - registered nurses
  - licensed practical nurses
  - certified nurse aides

and
Federal requirements continued:

- Resident census
- Post at the beginning of each shift
- Post must be:
  - clear and readable format
  - in a prominent location easily accessible to residents and visitors

and
Nursing Staffing Information

Federal requirements continued:

Provide public access, (upon oral or written request), make nursing staffing data available to the public for review at a cost not to exceed the community standard.

Facility data retention requirements, maintain posted daily nurse staffing data for a minimum of **18 months**, or as required by State law, whichever is greater.
Medicare Part A & B

To Inspect what we Expect it is recommended to review requirements
Take it from the Top

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill.
Consolidated Billing

Based on this, no longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board (1st 20 days), or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted or not in use. Certain medical services are still covered though room and board is not.
The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.
Skilled care is health care given when ‘skilled’ nursing and or therapy is prescribed as determined as medically necessary to treat, manage, observe, and evaluate care.

Some examples of SNF care include wound care, intravenous injections, therapy (e.g., physical, occupation, and speech), etc.
Skilled Care Includes

Skilled nursing and therapy staff includes:

- Registered nurses
- Licensed practical nurses
- Certified nursing assistants (certain aspects)
- Physical, occupational, and Speech therapists
- Respiratory therapists
Non Skilled

Care that can be given by non-professional staff is not considered skilled care.

Custodial care is typically provided in the long-term care portion of your SNFs.

Question - does your skilled care resident documentation read like custodial?
Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Medicare
Custodial Care

Medicare doesn’t cover custodial care if it’s the only kind of care needed.

Custodial care is care that helps with usual daily activities like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, such as managing oxygen, caring for an ostomy, bladder catheter, etc..
Medicare Part A Pays When

Medicare will cover SNF care when all of the following is true:

1. Has Medicare Part A* (Hospital Insurance) and have days left in your benefit period (see next page) available to use.
2. Has a qualifying hospital stay. This means an inpatient hospital stay of 3 consecutive days or more, starting with the day the hospital admits inpatient. The patient enters the SNF within a short period of time (30 days or less) of leaving the hospital.
After the resident leaves the SNF, if resident re-enters the same or another SNF within 30 days, the resident may not need another qualifying 3-day hospital stay to get additional SNF benefits. This is also true if skilled care stops while in the SNF and then re-started getting skilled care again within 30 days.
3. Physician has ordered the inpatient services for SNF care, which requires the skills of professional personnel like registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, or audiologists, and are furnished by, or under the supervision of, these skilled personnel.
4. Required skilled care is delivered on a daily basis and the services must be ones that can only be provided in a SNF on an inpatient basis. Section 2: Medicare SNF Coverage.
Medicare Part A Continued

6. The skilled services must be reasonable and necessary for the diagnosis or treatment of the condition (see page I-3 in Chapter 3 of the MDS manual for definition of Active Diagnosis and your ICD-10 manual for proper coding and sequencing).

7. Skilled services are provided in a Medicare-certified SNF.
5. Skilled services are needed for:

- An ongoing condition that was also treated during the qualifying 3-day inpatient hospital stay (even if it wasn’t the reason admitted to the hospital.)
A new condition that started while getting SNF care for the ongoing condition. For example, if in a SNF because of a broken hip and then the resident has a stroke, Medicare may cover therapy services for the stroke, even if you no longer need therapy for your hip.
Medicare Part B Considerations

The purpose of Medicare Part B helps cover physician services and outpatient care rehabilitative services (such as ST, PT, and OT) based on medical necessity.

Services should not duplicative (such as rehab performing services that nurses staff are qualified and appropriate to complete).
When rehabilitative services are being considered for Part B services, it is essential that in addition to the stated resident medical necessity being:

- identified and
- documented
Medicare Part B documentation is recommended to be further divided between pre and post initiation of Part B services. This includes:

- Prior to rehabilitation services initiation, and
- During rehabilitation services
Prior to the start of the Part B rehabilitative services, we recommend that the facility documents the reason that the services that are being determined medically necessary by the resident of those that are not services that the facility restorative and or rehabilitative program can provide...

Usually this means that the services would be out of the scope and practice of nursing such as transfer training, swallowing, gait re-stabilization, etc.
DURING CARE

This relates to the standard documentation completed by rehabilitative staff during Part B rehabilitative care and services.
Prior to the start of the Part B rehabilitative services we recommend that the facility documents the reason that the services that are being determined medically necessary by the resident of those that are not services that the facility restorative and or rehabilitative program can provide…

Usually this means that the services would be out of the scope and practice of nursing such as transfer training, swallowing, gait re-stabilization, etc.
Method for Success

We feel one method to accomplish this without adding new meetings that would include documentation in the chart (prior to services) would be during the facility morning review and any resident being considered for Part B services to affirm that:

- there was a restorative nursing program that was attempted and failed, noting what the failure was, and or
- that a restorative nursing program could not be attempted as the resident need was out of the scope and practice of nursing.

Then the routine rehabilitation documentation.
To learn more about this topic, to plan your CMS MDS & Staffing survey pre-survey (mock), or to discuss other clinical risk Medicare concerns, please contact: Robin A. Bleier by phone or web 727.786.3032 or email robin@rbhealthpartners.com or visit our web at www.rbhealthpartners.com