

Center for Medicare & Medicaid Services
Skilled Nursing Facilities (SNF)/Long Term Care (LTC)
Open Door Forum
Moderator: Jill Darling
October 11th, 2018
2:00 p.m. ET

Operator: Good afternoon my name is (Chantelle) and I will be your conference facilitator today. At this time I would like to welcome everyone to Center for Medicare & Medicaid Services, Standard Nursing Facilities Long Term Care Open Door Forum.

All lines have been place on mute to prevent any background noise. After the speaker remarks there will be a question and answer session. If you'd to ask a question during this time, simply press star then number one on your telephone keypad. If you would like to withdraw you question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Great. Thank you (Chantelle). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication. And thanks for joining us today for the SNF/Long Term Care Open Door Forum.

Just a reminder to speakers, if your on the phone please mute your line. Before we dive into today's agenda, one brief announcement from me, this open door forum is now intended for the press. And the remarks are not considered on the record. If you are a member of the press you may listed in, but please refrained from asking question during the Q&A portion of the call.

If you have any inquiries, please contact CMS at Press@cms.hhs.gov. And I will hand the call up to John Kane for our first topic, fiscal year 2019 SNF PPS Correction Notice.

John Kane: Thanks very much Jill. And good day everyone. In the August 8th Federal register, we had publish the FY 2019 SNF PPS final rule, which contain the updated SNF PPS rates and policies for fiscal year 2019, which began on October 1, 2018.

However, a number of technical errors were identified in that document, to address these issues. In the October 3rd federal register, we published CMS-1696-CN, a correction notice for the fiscal year 2019 SNF PPS final rule.

This correction addressed the following issues in the rule preamble. Number one, in table six and seven of the final rule we made errors and copying values into the total rate column of the table used in the final rule preamble. So the numbers in this column did not accurately reflect the total case mix adjusted federal per diem rates.

Number two, in table 27, we made a typographical error in the MDS item number reference or column two associated with one of the conditions and extensive services used for the NTA classification.

Number three, in table 45, we missed ordered the ownership labels and the impact table as government profit, non-profit, instead of profit, non-profit, and then government.

Finally, on page 39287, we inadvertently typed "urban rural West South Central region," when we intended to state "rural West South Central region."

In addition to these errors in the word preamble, the correction notice also address an error in the wage index table associated with the final rule, which are published on the SNF PPS website. As discussed in the FY 2019 SNF PPS final rule, in developing the wage index to be applied to SNFs under the SNF PPS, we use the updated, pre-reclassified, pre-rural floor hospital inpatient PPS or IPPS wage data, exclusive of the occupational mix adjustment.

For FY 2019, the updated, unadjusted, pre-reclassified, pre-rural floor IPPS wage data used under the SNF PPS are for cost reporting periods beginning on

or after October 1, 2014 and before October 1, 2015 or FY 2015 cost report data.

In calculating the wage index under the FY 2019 IPPS final rule, we made inadvertent errors related to the calculation of the wage index. These errors are identified, discussed and corrected in the correction notice related to the IPPS final rule, also published on October 3rd in the federal register.

The two errors discussed in that correction notice, which relate to the SNF PPS wage index were the following.

Number one, errors in the wage data collected from the Medicare cost reports of one hospital. And two, the mistaken inclusion of a Critical Access Hospital or CAH in the wage data.

Finally, we made inadvertent errors and copying values into the wage index column in table A posted on the CMS website. The website has updated to reflect all of these changes to the SNF wage index. As discussed in the FY 2019 SNF PPS correction notice, these changes are effective as if they were included in the FY 2019 SNF PPS final rule, meaning that they are effective as of October 1, 2018.

All related CMS products, such as our Pricer have been updated to reflect these latest values. We appreciate the comments and questions from the public which brought a number of these issues to our attention.

One other note that I wanted to make before returning to the regular agenda is that I wanted to address some questions we had received recently in relation to the implementation of the Patient-Driven Payment Model or PDPM.

We understand and appreciate the need for additional education and training materials related to PDPM and we have dedicated significant resources to developing and disseminating these materials as quickly as possible.

Additionally, we are planning to launch in the very near future a website dedicated to PDPM implementation and training, which will house a great a

number of resources for stakeholders and educators to aid and preparing to the implementation of PDPM.

Finally, we are working diligently as it possible to develop and review reversion to the MDS manual, data specification and other important aspects that vendors and other stakeholders will be looking for in order to develop products and training materials for PDPM implementation.

We appreciate your patience as we complete this large body of work. And will continue to endeavor to have all of these materials made available to the public as soon as possible.

Thank you and I'll turn the call back over to Jill.

Jill Darling: Great, thank you John. Next we have Michele Laughman who has announcement on the release of updated Hand in Hand training series for nursing home.

Michele Laughman: Hi, everyone. Thank you. Recently we announced the release of an updated Hand in Hand training series for nursing homes. This updated training opportunity is available on CMS's Integrated Surveyor Training Website and maybe accessed using the links that are located on today's agenda.

Hand in Hand is now available in two formats as a self-paced online training as well as a downloadable instructor led course. This training focuses on caring for residents with dementia and on preventing abuse.

Several years ago CMS supported by a team of training developers and subject matter experts created this training to address the need for nurse aides in-service training on these important topics. Federal law requires that nurse aides complete in-service training on dementia management and resident abuse prevention.

Additionally, facilities must now provide dementia management and resident abuse prevention training to all facility staff, contractors and volunteers. In turn, this training is recommended for all nursing home staff.

If you have issues with registration or other technical concerns, please contact the ISTW help desk at cmstraininghelp@hendall.com. And that's H-E-N-D-A-L-L dot com. Thank you.

Jill Darling: Thank you Michele. Next we have Casey Freeman, who has some SNF QRP updates.

Casey Freeman: Thanks Jill. Good afternoon everyone. On behalf of the SNF QRP team, I wanted to take this opportunity to encourage providers to please sign up for quarterly outreach. This outreach is provided to any SNF that has not met the 80 percent APU threshold requirement.

The e-mail is sent out prior to the quarterly data submission deadlines. So in order to receive this important information please e-mail your facility's name, your CMS certification number and please just request to receive the outreach. The e-mail address is [QRPhelp@cormac](mailto:QRPhelp@cormac.com), which is C-O-R-M-A-C dash corp, C-O-R-P dot com.

This information is also available at the SNF QRP website on the spotlight announcement. And with that, I would like to turn over back to Jill.

Jill Darling: All right, thanks Casey. And last we have PBJ update from (Lorelei Kahn).

(Lorelei Kahn): Hi, everyone. I'm trying – hang on one second. I'm sorry, just as a reminder stuffing data from July first to September 30th must be submitted no later than 45 days from the end of quarter. The final submission deadline for this quarter is November 14th 2018.

We strongly encourage providers to submit data throughout the quarter and not wait until the last week before the deadline. Only data successfully submitted by the deadline is considered timely and used on the Nursing Home Compare website and in the five star ratings calculation.

Once a facility uploads their data file, they need to check their final validation report, which can be accessed in the Certification and Survey Provider Enhanced Reporting (CASPER) folder to verify that the data was successfully submitted. It may take up to 24 hours to receive the validation report. So providers must allow for time to correct any errors and resubmit if necessary.

Please note that the final validation report only confirms that the data was submitted successfully. It does not confirm that the data submitted is accurate or complete.

CMS will continue to provide technical assistance to nursing homes to improve their staffing and data submissions. Facilities should review their monthly provider preview in their CASPER folder for feedback on their most recent submission. We also encourage nursing homes to run CASPER reports 1700D, which is the Employee Report, 1702D, which is the Individual Daily Staffing Report, and/or 1702S, which is the Staffing Summary Report prior to their submission before the quarterly deadline to review their data, and ensure accuracy and completeness.

PBJ policy questions can be sent to NHStaffing@cms.hhs.gov and PBJ technical questions can be sent NursingHomePBJTechIssues@cms.hhs.gov.

Thank you and I'll turn it back over to Jill.

Jill Darling: All right, great thank (Lorelei Kahn). And thank you to all of our speakers today. (Chantelle), please open the line for Q&A.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions.

If you require any further follow up, you may press star one again to rejoin the queue. Your first question comes from the line of (Linda Mathiesen) with Medical Facility. Your line is open.

(Linda Mathiesen), your line is open.

(Linda Mathiesen): Hi, I have QRP question. For those payment to have a five MDS with a reference date of 10/01 forward, but who started Medicare prior to 10/01, on the MDS, it's ask again – ask question about the drug regiment review. And since the drug regiment review was not required when the patient came in prior to 10/01. We're having to dash that question.

So, I'm wondering if when they use that data for the QRP program, will people who were admitted prior to 10/01 be included or not included. In other words are those dashes going to come (against us)?

Casey Freeman: (Linda) thanks for that question. This is Casey. You are correct. We do expect to receive dashes for patients that were admitted into facilities prior to 10/01. And that will not be held against or count negatively toward the APU compliance. Thank you for that question.

(Linda Mathiesen): Thank you.

Operator: Your next question comes from Emily Jones with Fellowship Village. Your line is open.

Emily Jones: Hi, I was just wondering if you can send out those e-mail addresses for PBJ or if they could be repeated.

(Lorelei Kahn): They are actually on the agenda that was sent out (if you have that).

Emily Jones: OK, great. Thank you.

(Lorelei Kahn): great.

Operator: Your next question comes from (Dana Wolfie) with (Cronos). Your line is open.

(Dana Wolfie): Actually, I didn't have a chance to remove my question. I have the same question regarding the PBJ update with the website or the e-mail address and the reports.

(Lorelei Kahn): Yes. Those e-mail addresses are in the agenda that was sent out. And if you want to know the name of the specific reports, if you could just shoot an e-mail to the NHStaffing@cms.hhs.gov and I will be happy to send you the names of the reports.

(Dana Wolfie): OK, thank you.

Operator: Your next question comes from Jane Belt with AANAC. Your line is open.

Jane Belt: Yes. Hi, this is Jane Belt with AANAC: Do you know when the revised MD or the technical user's manual for the QMs will be released?

Casey Freeman: Hi, this is Casey. Jane, that's a great question. I don't have the specific date. But we will release the spotlight announcement when that is available. And additionally will use the Listserv to communicate that.

Jane Belt: All right, thank you.

Operator: Your next question comes from Kathleen Usher with Genesis Rehab. Your line is open.

Kathleen Usher: Hi, we had question about the new section GG mobility item 12 steps, the ability to go up and down 12 steps with or without a rail. Most of our rehab departments have portable stairs with only three or four steps.

Our question is, does the patient have to be assess with a full slide of 12 steps or can we have them negotiate a portable steps three or four times in order to assess the 12 steps? Or should we mark that as not attempted due to environment?

Casey Freeman: Hi, this is Casey. Yes, I think that the best way for us. I want to – before I gave you an answer, make sure it's standardized across all settings. So, if you could actually e-mail that question to SNFQualityQuestions@cms.hhs.gov. I can have our function team return a specific answer that would be applicable to all setting, including SNF (and/or).

Kathleen Usher: OK, you said that was SNFQualityQuestions@hhs?

Casey Freeman: Yes. Oh, at CMS ...

Kathleen Usher: OK, thank you.

Casey Freeman: ... dot hhs.gov. Thank you so much. I appreciate it.

Kathleen Usher: OK.

Operator: Your next question comes from (Julie Schlecht) with Sanford Sylvan Court.
Your line is open.

(Julie Schlecht): Yes, I was wondering if there's a possibility of getting like CEU credit for doing this self-paced online training for the Hand in Hand.

Michele Laughman: At this time, we're not offering CEU credit for Hand in Hand.

Operator: Your next question from (Kimberly Komero) with (Blue Moon) healthcare.
Your line is open.

(Kimberly Komero): Hi, in that same area Hand in Hand training. There was an e-mail address that I think ended with hendall.com. Could that e-mail address be repeated please?

Michele Laughman: Sure. Its cmstraininghelp all one word at hendall.com and it's H-E-N-D-A-L-L.

(Kimberly Romero): Thank you.

Michele Laughman: Thank you.

Operator: Again, if you would like to ask a question, press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your question to one question and one follow up to allow other participants time to question. If you require any further follow, you may press star one again to rejoin the queue.

Your next question comes from (Nancy Hart) with (St. Mary Julie). Your line is open.

(Nancy Hart): Hello, how are you? Hi.

John Kane: Hello.

Female: Yes, hello.

(Nancy Hart): Hi. I'm wondering regarding Hand in Hand. Now we mandate Hand in Hand for all of the CNAs in our building. Is CMS making this mandatory for all other employees in the building or is it a suggestion?

Michele Laughman: In our training requirements, we do describe all staff as direct, indirect auxiliary function, contractors and volunteers. I don't have the specific tag with me to be able to specify that on this call. But it's not mandatory that Hand in Hand in itself it's not mandatory, it's a voluntary training that we provide for this purpose.

So I want to just specify and clarify that that it's definitely not mandatory for anyone to use it. But we provided a free resource for this purpose. Does that help?

(Nancy Hart): Thank you.

Michele Laughman: Thank you.

Operator: Your next question from (Susan Mikula) with TheraCare. Your line is open.

(Susan Mikula): Hi. I just wanted to jump in on the question regard GG and the 12 steps and since it's being e-mailed in and you're going to verify that. That when the answer is obtained that that shared with all providers, somehow through. I don't know memo or a notation on a subsequent open door forum agenda, because I think a lot of folks have that question about, going up and down for stairs three times, does that equal 12?

So, I just wanted to jump in on that because I know a lot of folk have that question.

Casey Freeman: Thanks so much. You're right. We definitely have got a lot of question regarding GG and in an effort to sort of (shore up) and standardize all definition. We are going to be creating some updated webinars as well.

And we will deliver that information via our listeners. So thank you so much. We know this information.

(Susan Mikula): OK, thanks.

Operator: Your next question comes from Jasmine Holden with Royal Springs Health. Your line is open.

Jasmine Holden: Hi. I'm actually on the CMS website. I wanted to know the new SNF rate which before you said – like you said PPS now it's PDPM effective October 1st 2018 is not posted. And neither is the new Medicare co-insurance for SNF effective date 21 is not on there either.

John Kane: Hi. So, as far as the web four rates that are effective for this fiscal year. Those can be found in the SNF PPS correction notice that was – that was published in the federal register on October 3rd. So, in table six and seven of the correction notice, you can find those.

Jasmine Holden: Table six and seven. Thank you.

Operator: Your next question comes from Emily Jones with Fellowship Village. Your line is open.

Emily Jones: Hi, one more question regarding Hand in Hand. You mentioned that volunteers are required to go through it as well. And I'm wondering if this is more like hands on volunteers with resident because we literally have volunteers that just come to (MO) one time a week. But never interact with the residence, so just some clarification on volunteers.

Michele Laughman: I can just comment on what our guidance states and it lists all facility staff, contractors and volunteers. We don't specify what the role of that volunteer would be.

Emily Jones: All right. Thank you.

Michele Laughman: Thank you.

Operator: Your next question comes from Kelly Roberts with Creative Solution in Healthcare. Your line is open.

Kelly Roberts: Thank you. Do you mind repeating the fiscal year 2019 SNF PPS Correction Notice on the agenda?

John Kane: In which part of it?

Kelly Roberts: I actually came in a little bit late on the call. So I wanted – I missed the whole announcement regarding the SNF PPS correction notice.

Jane Kane: So basically I just walk through the – and this is all captured within the correction notice itself, which again was publish in the October 3rd federal register. So, basically I just walk through the fact that there were a series of technical errors that were discovered in the SNF PPS final rule for fiscal year 2019. I think (chief) among those that – I think (chief) among those is probably the – that the rate that were listed in table six and seven in the final rule, the total rate in the total column were inaccurate.

The total rates that were actually in the (first one) table for the labor portion were actually correct. But just the total rates within table six and seven were inaccurate. And so, we had corrected that. There were a few other typographical and small – I think small technical errors that were in the final rule.

And then finally, there were some issues with the calculation of the wage index that we've also since corrected on the SNF PPS website.

Kelly Roberts: Thank you so much.

Jane Kane: No problem.

Operator: Your next question comes from (Joan Jones) with (BKG). Your line is open.

(Joan Jones): This is question for John. I appreciate the work that's going to go into the CMS to do – to get all of us prepared for PDPM. My question is, on the group or tools that already posted within all of the information on PDPM. Can we relatively anticipate that the HIPPS codes that are identified there will probably be the ones that will be use for billing and also that they will be generated from the MDS?

Jane Kane: Yes. I think HIPPS codes should be – should still remain a reflection of their in the current group are. And certainly the fact that they've be derived from the MDS is still going to hold. The one thing I do want to notes and this will become much; more clearer as we release some of the material, is that the group was – the group that's currently on the website was developed based on the MDS either had existed. And so that people could used the items that were currently in existence and their data – current as of – current as of the time that we release it to be able to perform their own analysis and to just think around with it and see what occurs depending on different changes.

Now, there are a couple of those items. Like I think there was one item in section GG that is since been retired. And so that is something that has been – that's going to be updated as well as items that we have been – that we had talked about adding some of the – to the swing that MDS and things like that.

So there are going to be some changes to that group (or logic) to make it more up to date with what the MDS is going to look like as of October 1 of next year. So I still want to note that, it will still derive from the MDS. And that's – it certainly – the HIPPS code should still be reflection of what there are in the current group. But the group are itself is going to be slightly different.

(Joan Jones): Thanks John.

John Kane: No problem.

Operator: Your next question comes from (Melbeth Borne) with HealthEC. Your line is open.

(Melbeth Borne): Good afternoon. My question is regarding audits. I wanted to know, do CMS in auditors into the skilled nursing facility to audit records to be certain that medical necessity at the time when service was applied appropriately?

John Kane: This is John. I can take that. So, I think the short answer is yes. But that – we do have other such as the recovery – our coordinators or (Rex) there are various other contractors that we have it various levels, but federal on state level that would go in and audit records for things like medical necessity – the accuracy of those records for medical documentation to support the skilled service needs and things like that.

So yes, it is possible that we would have orders going in to audit record in terms accuracy and making sure that they reflect appropriate care.

(Melbeth Borne): OK. The reason why I ask that question because I know traditionally the sub-acute level of care was design for seven to maybe 10 days stay. But I've notice over the course of my years in the business. I've been seeing it particularly lately 60 and 100 days of sub-acute, which I don't believe 60 or 100 days would met a medical necessity criteria.

So that's the reason why was asking about auditor. On the back end, do they really look at these things when their bill for that amount of days?

John Kane: Absolutely. And if there's area in which you suspect would there maybe areas concern. There are resources available to be able to help support you in reporting that or to investigate that. So if you need to ascertain those resources, please feel free to e-mail us and we can direct you to the appropriate resource.

(Melbeth Borne): OK. And you have an e-mail address?

John Kane: You can e-mail me directly and I can put you in touch with some of the appropriate resources. So my e-mail is John, J-O-H-N dot Kane, K-A-N-E at cms.hhs.gov.

(Melbeth Borne): CMS.h – h, what?

John Kane: It was at CMS.hhs.gov.

(Melbeth Borne): Oh, hhs.gov. OK, and then my last question is, what is the length of stay that you see most across the continuum of health care that is appropriate?

John Kane: I can say for within the skilled nursing sector and as far as part A covered stays. We have about – about 35ish percentage stays last approximately 15 days – 14, 15 days, about 50 percent of stays and by day 20. And so – so the medium like to say – is around 20 days. So you're about 50 percent of stays might be longer than that. So that – the length of stay in terms of overall distribution certainly trails off relatively quickly ones you get past day 20.

So, you do – we do see stays for people who do need to say for 30, 40, 50 days even up to 100 days which is the total allowable amount within a given benefit period, so but at least half of stays and to a four day 20.

(Melbeth Borne): OK, then. The reason why I'm asking in my role of care coordination, I'm responsible for reduction of healthcare cost. With respect to utilization we have to monitor and track those types of activities to be sure that every hour, every day is based on medical necessity.

And usually on 21st day, the patient will incur a (cold insurance). And I just think that a lot of times when the discharge plan is social workers who's working with these patients that they keep those types of things in mind, because let say if you who are in there for 20 days and really there was no different on the 27th day from what the 20th was, that's really seven days out of pocket expensive.

The patient shouldn't have to incur. If we really look at that medical necessity at the time of service, so does a patient (plato), they (plato) that it means that there's no more rehabilitation from that sampling. So that's why I'm concern.

John Kane: Right absolutely. I mean – and the fact that someone is not showing improvement, that is not necessary reason that they would no longer skilled that something that we have – a number of discussion go on our website. But certainly (meeting) criteria is very important and but again, we do have auditors that do go into facilities and look at the medical records to ensure that the providers are meeting those kind of needs for the resident. And that care is remained to the skilled.

But again, if there are concerns that you have or if there's – areas that – that you want to have more clarity on or that you want further investigation. There are resources available that we can direct you too. So, I you e-mail me we can – I can provide you with those references.

(Melbeth Borne): OK, just one last thing. I don't know if this relates to you guys. But when a patient is in the sub-acute rehabilitation, it is reasonable and customary for the primary care doctor to obtain a progress on a patient, OK.

And I find that some of these facilities say that they don't have to release that type of progress to a primary care physician. And I'm wondering, is that a CMS rule or is that a facility rule? Because the logic doesn't really make sense to me and that a skilled nursing facility particularly the sub-acute rehab side is a specialty much like a cardiologist, endocrinologist, dialysis patient, which is nephrology.

So, they all have to communicate with the primary care in regard to the plan of care and the progress of the patient, why would rehabilitation center have to do the same things. I don't understand why they wouldn't have to.

John Kane: Right. Care coordination is particularly challenging aspect of any form of care along this continuum. And so, I know it sometime difficult to get coordination among all the various physician that a particularly beneficiary

might be working with, would they specialist to primary care, so that, that is always really something of a challenge.

(Melbeth Borne): So my question is that a CMS rule, not to release the progress to the primary care? Or is the individual facility who is making this? Because they keep telling me it's a violation of HIPAA. I don't see where that's a violation of HIPAA, with respect to care coordination.

John Kane: Right. I'm afraid that's beyond my (skip). I'm not sure if anyone else on the call might be able to address that.

(Melbeth Borne): Well, I definitely think it needs to be address so it might be something you might want to jot down to date back to your superiors. But that's very important because misinterpretation of HIPAA is a gapping care, from my perspective.

And as I've just stated before, sub-acute rehab is a specialty, much like all the others that I've just mentioned.

And they have to provide a plan of care and progress to the primary care. And as far as I'm concern from a logical perspective, rehabilitation, you have to do the same thing. It has nothing to do with violation to HIPAA. This care coordination at it's best.

John Kan: Absolutely, I (completely agree).

Jill Darling: All right. Thank you.

(Melbeth Borne): Yes, let's put that down somewhere with somebody to address please.

Jill Darling: OK. Will take next question please. Thank you.

Operator: Your next question comes from Christina Munday with Life Care Center. Your line is open.

Christina Munday: Hello. I had a question about a warning that showing on the final validation report. We are getting a warning for two percent reduction is a

possibility for not reporting goals on every item in section GG. Although – our manual says we only have to report one goal. So I was just curious, if you could provide clarification on why we might be getting these warnings on our final validation report for this.

Casey Freeman: Hi, Christina. That's a great question. Yes. We are – including warning edit and they are link to every – every GG goal that would satisfy the GG goal requirement for the process measure. So, and those warning at it really serve to be a safety net and to be a double check. It certainly does not – please don't receive this warning edit as information that is stating that you have – are not in compliance with the required data submission.

Again, those GG items, all of those goals are link are warning edit. And they are triggered if no GG goal has been entered. We do have some manuals that are on the qtso website that speak directly to the warning edit and what triggers them.

And if you could e-mail – if I could get your information then I could e-mail you those resources.

Christina Munday: OK, that would be wonderful. Yes. It's – my first and last name. So, Christina_Munday M-U-N-D-A-Y at lcca.com.

Casey Freeman: Perfect. And if you need any follow up information. My name is Casey Freeman and my e-mail address is Casey, C-A-S-E-Y dot Freeman, F-R-E-E-M-A-N at cms.hhs.gov. And I will get a e-mail to you today. Thank you so much.

Christina Munday: Thank you.

Operator: Again, if you would to ask a question, press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit you question to one question and one follow up, to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue.

Your next question from (Kimberly Komero) with (Blue Moon) healthcare.

(Kimberly Komero): Hi. Back to the concept of volunteers under the Hand in Hand or the dementia and abuse training requirement. A lot of facilities have like one time entertainers or groups of school children that come in during holiday times. They're interacting with your residence.

What is the expectation for the training requirement in regards to those groups or individuals that may be one visit only?

Michele Laughman: I'm just, thank you for the question. I'm not an expert on the training requirement. So I don't want to speak to that any further than what I've already said. But if you could send that question, I can give you our behavioral health e-mail box, that's where questions about Hand in Hand that aren't technical come to.

So, that e-mail is DNH as in the Division of Nursing Home underscore behavioralhealth, that's all one word at cms.hhs.gov. And I'll make sure that question gets to the right person.

(Kimberly Komero): Thank you so much.

Michele Laughman: Thank you.

Operator: Your next question comes from Mary Ann Leonard with Health Information. Your line is open.

Mary Ann Leonard: Hi, this is Mary Ann Leonard with Health Information Professionals. I'm a medical record practitioner. And this is in response to the question that woman raise regarding release of information in HIPAA in continuity of care.

HIPAA specifically says that you can release information for continuity of care. I would suspect that this is a facility policy base on misinterpretation. I would also recommend that you go to the website for the office of civil rights and look up the information there under their privacy.

And then also to the National Association, the American Health Information Management Association, and see if you can locate some information in there so you can take it back to them and say no, this is – this is not appropriate. This is for continuity of care. And so there are for the information should be release. That's all I have to say.

Operator: Your next question comes from (Melanie Frankford) with (Holly Patterson). Your line is open.

(Melanie Frankford), your line is open.

(Melanie Frankford): I'm sorry. Hello. I have a question regard section GG. And I was wondering if you could please clarify or provide a good resource, which would describe which section GG functional measures are directly linked to the process measure and how it is calculated.

Casey Freeman: (Melanie), yes, we can. If you could e-mail me or if you want to give me your e-mail address, we can provide you direct link to the QM manual and the chapter that address this section GG and the process measure.

(Melanie Frankford): Oh, OK. Yes, I can e-mail you.

Casey Freeman: Sure. OK. Do you – my e-mail is caseyfreeman, so it's C-A-S-E-Y ...

(Melanie Frankford): Yes.

Casey Freeman: ... dot freeman, F-R-E-E-M-A-N at cms.hhs.gov. And will provide you with those specifically.

(Melanie Frankford): Very good. Thank you very much.

Casey Freeman: Thanks.

Operator: Your next question comes from (Melbeth Borne) with HealthEC. Your line is open.

(Melbeth Borne): Hi. I was just on listening to the young one when who responded to me about the skilled nursing facility and my concern about continuity of care and understanding of HIPAA. She says three different organizations. But she was speaking rapidly. She can – that person responding, give me that information again.

(Christine Teague): Hi, this is (Christine Teague) with CMS. So if you look in the state operations manual under federal tag 622 transfer and discharge. It explains what is required when a resident is transferred out of the facility. And the documentation that is required to be provided to the physician or health practitioner that will be assuming the care of the resident once they leave the facility.

The federal requirements do not require that there are updates periodically to a physician that is not the physician of record in the nursing facility. But it is required at the time of discharge to go for continuity care, to the next provider that is going to be taking care of the person once they leave the facility. When each resident is in the facility ...

(Melbeth Borne): Right.

(Christine Teague): They have an attending physician of record that is their primary care physician during their stay in that nursing facility.

(Melbeth Borne): OK. So you're talking about the rehab doctors. So the primary care outside of the rehab, you're saying that they don't have to communicate with this person.

(Christine Teague): That is the discretion of the attending physician at the rehab center, whether or not they want to contact the community physician during the resident stay it is not required. However, there are requirements surrounding discharge and that's federal tag 622 in the state operations manual.

(Melbeth Borne): Right. I'm familiar with that. I was more concern about when the patient is in there when you want to get a clinical update like when I was on the payer side doing utilization review. I could contact them and they would have to do it

because in order to get paid they have to give me, update progress that to whether or not the patient still met the medical necessity.

But I guess from this standpoint of as care coordinator working for accountable care organization. It sounds like they feel like they don't have to really communicated or give that type of information that they normally would give to the payer. So I'm just saying this is ...

(Christine Teague): Right. The physician on record, and the physician who is the attending physician for the resident while in the nursing facility is the physician that provides the certification information that the resident is meeting the skilled needs and is to receive those had need in the facility and certifies whether or not those services should continued. They don't actually go to outside sources unless it's required by a different payer.

(Melbeth Borne): OK. And the reason – OK, it's not required by Medicare you're saying?

(Christine Teague): Correct.

(Melbeth Borne): It's not required by Medicare is what you're saying. OK. And I what I'm saying is, they want to discuss that further because again, the rehabilitation doctor is a fresh list just like cardiologist, endocrinologist. And those physicians nephrologists, rheumatologist all of them, they always have to send a plan of care during of course the treatment that they're treating the patient. And I don't see where the rehabilitation center is any different. I just don't see would that be any different, someone who have to – other than, if not require but – requirements for Medicare.

But I just don't see different. I think they should have to do that, because I'm finding – I'm finding the fact that they'd say that they don't have to do it. I'm finding 60 to 100 days stays. And base on what is reported to me, it doesn't sound like medical necessity. It doesn't sound like a skilled need, a social issue, Medicare don't pay for homelessness.

Medicare don't pay for patient – family being held up in court regarding guardianship, that's not a reason to prolong a stay in a skilled nursing facility,

that's why I'm saying that you have to be more transparency here. I just don't feel comfortable with that.

(Christine Teague): Right. So the attending physician is considered the primary care physician and is responsible for all care that resident receives from all specialist and it's consider the physician of record. However, if you have other concerns, I would encourage you to use the resources that John Kane provided earlier in the call.

(Melbeth Borne): OK. Yes, I know him. I'll do that.

(Christine Teague): OK.

(Melbeth Borne): Thank you (kindly).

Operator: Your next question comes from Mary Ann Leonard with Health Information. Your line is open.

Mary Ann Leonard: Hi, I'm the individual that talk to her earlier. If you go AHIM as in Moses A.org, there is information there. And if you go to HHS.gov as in victor backslash ocr, then that's the office of civil right and they would have information there as well.

Operator: Your next question comes from Carol Maher with Hansen Hunter & Company. Your line is open.

Carol Maher: Hello. I was wondering if we have any timeframe for the updated diagnosis mapping for PDPM.

John Kane: I don't think we have a timeline yet. The existing mapping is still something that I would say people should be using as reference. Although, there are changes and I can't remember exactly when they occur in the year. But they're basically regular changes that are made to ICD-10 codes throughout the year.

And so, certainly there's a possibility that a mapping will be updated to that point. But at this point, the mapping for the diagnosis codes can certainly be used net from for the time being.

Carol Maher: I mainly concern about adding details to the injuries as mapping where there could be the potential of having the procedures to it to get the major joint replacement, if a major joint replacement was related to a hip fracture for example. And the mapping – present mapping only maps the A, seventh character went typically on the long-term care where the subsequent encounter and it would be those (GE).

John Kane: All right, I can – I can take that back to our team – out typical team that does the update for that and see when – basically I can look at to see when that something that we can get it – that we can get up on the website. But I think that, rather than releasing sort of iterative update. I think we want to try and kind of pull a number of different updates together and release them all at the same time.

So, I don't have the exact timeframe on that. But we'll try to get all of these things pull together as soon as possible.

Carol Maher: Great. Thank you very much.

Operator: There are no further questions at this time. I would now turn the call back over to the presenters.

Jill Darling: All right. Well, thank you everyone for joining today's SNF Long Term Care Open Door Forum. As always, we have the SNF LTC ODF e-mail on the agenda. It's always there. So please feel free to send in any question or comments to that inbox.

So thank you everyone. Have a great day.

Operator: Thank you for participating in today's Center of Medicare & Medicaid Services Standard Nursing Facility Long Term Care Open Door Forum Conference Call.

This call will be available for replay beginning at October 11th 2018 at 5:00 p.m. eastern until October 15th 2018 at 11:59 p.m. eastern.

The conference I.D. number for the replay is 33973426. The number to dial for the replay is 855-859-2056. This concludes today's conference call. You may now disconnect.

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