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December 21, 2010

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3140-P
PO Box 8010
Baltimore, Maryland 21244-8010

Re: File Code CMS-3140-P

Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Hospice Services (75 *Federal Register* 65282)

Dear Dr. Berwick:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed regulation to revise requirements that an institution would have to meet in order to qualify to participate as a skilled nursing facility (SNF) in the Medicare program or as a nursing facility (NF) in the Medicaid program, as published in the October 22, 2010 *Federal Register*. Our comments focus on those areas of particular interest to our members.

AHIMA is a not-for-profit professional association representing more than 60,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the Health and Human Services Department related to the use of secondary data for a variety of purposes including quality monitoring, reimbursement, public health, patient safety, biosurveillance, and research.

Our detailed comments and rationale on the proposed regulation for the revised requirements are provided below.

§ 483.75 Administration

§ 483.75(r)(2)(ii)(J)

The proposed regulation discusses reporting alleged abuse to the hospice administrator and the Nursing Home Administrator; however it appears to end at this point in the process. The procedure outlined within the proposed regulation briefly describes a resolution of care delivery

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concerns and liability for the facility if there is a disagreement in services provided and devices used as summarized; however we are unclear on what the nursing facility's liability is if the situation is not corrected and documented within the patient's record. We believe there must be documentation within the patient's record to make clear the resolution plan to ensure those actions are being followed. For example, a nursing facility may recognize that a specialty pressure reduction bed/mattress is warranted for a patient's skin condition. In the event that a resident's skin breaks down, there is now an in-house acquired pressure sore. This example illustrates the need to document the treatment plan which includes how the issue will be resolved.

Recommendation – To reduce uncertainty in the care plan of the patient, in cases where abuse situations arise, we encourage CMS to require a resolution process be documented in the patient's care plan. This enables those who are accountable for the care of the patient to be aware of their roles and responsibilities as well as increasing patient safety and improving quality of care.

§ 483.75(r)(3)

AHIMA is not clear when the facility can go to the patient and family to discuss a concern regarding discrepancies in the recommended care that is being provided. Nursing homes are still bound by the State Operations Manual (SOM) that they must "maintain and attain the highest level of care." We believe the attending physician and not the hospice medical director should maintain oversight of care of the resident and ensure that the care providers are in compliance with the documented plan in the patient's medical record.

Recommendation – The facility should document within the patient's medical record the family's engagement, consent, acknowledgement, and agreement of the patient's care plan and any changes or patient/family requests for a change in the care plan. This will assist the family and the caregivers in identifying when there is a deviation from the plan of care.

General Comments

The proposed regulations appear to separate the patient's care plan into a distinct hospice component and a LTC component and we are unsure which facility will have the "final say" in cases where there are discrepancies to resolve. There should be a unified plan of care which would outline those services to be provided by the hospice and by the nursing home.

Recommendation – Within a documented unified plan of care for the patient it should reflect who has final authority in the decision-making process when there are discrepancies to resolve in treating the patient.

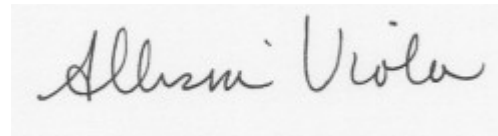
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We believe there should only be one responsible physician who will approve (or disapprove) all documented orders for patient care and that doctor must be credentialed in the nursing facility. We support the hospice physician managing the patient; however in order to do so he/she must be responsible for the entire program of patient care, not just the hospice part, and he/she must be credentialed in the facility.

Recommendation – It is critical to identify and document who has the authority to issue orders and what they can perform, what their responsibilities are and for what types of services that would identify their scope of practice. This would address the compliance perspective of who has the authority to conduct these care plan activities.

If AHIMA can provide any further information or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or AHIMA's director, practice leadership, Michelle Dougherty, at (312) 233-1914 or michelle.dougherty@ahima.org. If we can be of further assistance to you in your efforts, we would welcome the opportunity to provide support.

Sincerely,

A handwritten signature in cursive script that reads "Allison Viola". The signature is written in dark ink on a light-colored background.

Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Michelle L. Dougherty, MA, RHIA, CHP, Director, Practice Leadership
Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations