# The MDS Mentor

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VOLUME 6, ISSUE I

TEXAS Department of Aging and Disability Services

MARCH 2013

INSIDE THIS ISSUE:



The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Disease Control (CDC)

Centers for Medicare & Medicaid Services (CMS)

CMS Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Interdisciplinary Team (IDT)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Resource Utilization Group (RUG)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

## Coding Diagnoses in Section I—A Two Step Process

The first paragraph on page I-1 of the RAIM3 indicates "One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status." Accurate completion of diagnoses in Section I is vital because, as noted on page I-2 of the RAIM3, identifying active diseases and infections drives the current plan of care.

Prior to coding diagnoses, staff need to know there are two look-back periods for Section I. These are defined on page I-3 of the RAIM3 as follows:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which is a 30-day look-back period).

To comply with Step 1, the medical record must contain physician-documented diagnoses (or nurse practitioner, physician assistant, or clinical nurse specialist diagnoses, as allowed under Texas licensure laws) within the **last 60 days**. Page I -3 of the RAIM3 outlines that possible sources in the medical record may include "progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered." Included in "other resources" are consolidated physician orders that contain diagnoses and are signed by the physician in the 60-day look-back period. As staff are only looking for physician diagnoses written in the look-back period, there is no reason to look for original or previous copies of orders written more than 60 days prior to the ARD. Also, it is essential that diagnoses communicated by the IDT team and those "obtained from family ... and close contacts must be documented in the medical record by the physician to ensure validity and follow-up." (page I-3, RAIM3)

To comply with Step 2, facility staff must determine whether diagnoses are active. Active diagnoses, as defined on page I-3 of the RAIM3, "are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses."

Physician consolidated orders or other tools that only list and/or confirm existing diagnoses, even if signed in the 7-day look-back period, do not make the listed diagnoses active. However, new orders written in the 7-day look-back period as the result of the onset of a new disease/ diagnosis would qualify as active. As page I-8 of the RAIM3 confirms, "Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is

## Diagnoses Coding in Section I—A Two Step Process

*(Continued from previous page)*

**not** sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis."

Let's use aphasia as another example of determining when a diagnosis is active or inactive. For MDS 3.0, Texas stayed with RUG III V5.2 for Medicaid payment, so coding aphasia and tube feeding on the MDS results in a special care RUG. If upon review of the clinical record of a person with aphasia, there are no medications or treatments; no mood or behavior problems; no speech therapy; no nursing monitoring for aphasia; no risk of death; and no functional decline documented in the 7 -day look-back period, aphasia must not be coded on the MDS. Aphasia is not an active diagnosis and cannot be coded for the special care RUG.

Diseases are coded based on the primary diagnosis and the definition of the category. For example, Quadriparesis or Functional Quadriplegia is not Quadriplegia and I5100 would **not** be checked. In addition, Parkinsonism is not Parkinson's disease and I5300 would **not** be checked. As in the cases above or whenever "a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnoses." (page I-4, RAIM3) Remember: Texas Health & Safety Code §81.103 prevents coding of HIV/AIDS or any related diagnoses in I8000 on the MDS.

"Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, I0200, Anemia, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell)." (page I-4, RAIM3) If a resident had hemolytic anemia diagnosed in the last 60 days and it was active in the last 7 days, it would be coded in item I0200.

## UTI Coding in Item I2300

Unlike all the other diagnoses in Section I that have a 7-day look-back period, item I2300 Urinary Tract Infection (UTI) has a look-back period of 30 days to determine if there is active disease. Also, from page I-8 of the RAIM3, staff may only code UTI if **all** four conditions listed below are met:

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff … diagnosis of a UTI in last 30 days;

2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria);

3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained); **and**

4. Current medication or treatment for a UTI in the last 30 days.

Finally, page I-9 of the RAIM3 notes the CDC does not recommend routine antimicrobial treatment to attempt eradication for colonization of MRSA or any other antimicrobial resistant organism.

"If I were two faced, would I be wearing this one?" — *Abraham Lincoln*

"I'd rather fail with honor than succeed by fraud." — *Sophocles*

**DEFINITION BOX**

Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS)

Pyuria—urine containing pus


CDC recommendations for ordering antimicrobial treatment for drug resistant organisms are:

**Active Infection**—YES

**Colonization**—NO

http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html

# The Final Three of the Top 10 Medicare Questions

The first seven of the top ten Medicare questions were answered in the September 2012 and December 2012 issues of this publication. The final three questions will be answered in this issue.

8. Question: What is the effect of an early Change of Therapy (COT) on payment?

Answer: If a PPS assessment is performed before the days listed in the defined window of the Medicare schedule, the RAIM3, page 2-72, notes the "provider will be paid at the default rate for the number of days the assessment was out of compliance." On page 2-73 of the RAIM3 is an example for an early COT OMRA: "In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. On November 8, which is Day 7 of the COT observation period, it is determined that a COT is required. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13."

**NOTE:** If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the date the error was identified.

9. Question: What is the effect of a late COT on payment, if the ARD is set **prior** to the end of the payment period for the assessment **and/or** no intervening assessment has occurred?

Answer: "**The SNF will bill the default rate for the number of days that the assessment is out of compliance.** This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.**" (pages 2-73 to 2-74, RAIM3) For example, if a COT OMRA was completed with an ARD of Day 37, while Day 7 of the COT observation period was Day 35, the COT OMRA would be considered two days late. In this case, the facility would bill the default rate for two days, then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment. When a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar. The next COT evaluation would be day 44.

10. Question: What is the effect of a late COT on payment if the ARD of a late COT is set <u>after</u> the end of the period during which the late COT would have controlled payment **or** where an intervening assessment has occurred?

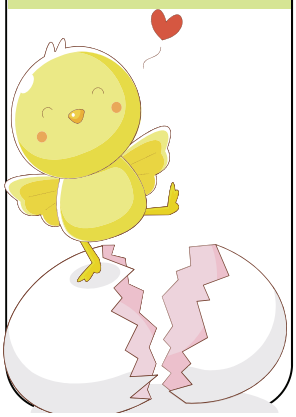
Answer: "**The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment**." (page 2-74, RAIM3) Also, when a late assessment is only used to obtain the default RUG (e.g., not used for payment), it does not reset the COT calendar (RAIM3, page 2-74).

**DEFINITION INTERPRETATION BOX**

**DAYS OUT OF COMPLIANCE:** Count the number of days following the last day of the ARD window (including grace days) up to and including the ARD of the late assessment.

**INTERVENING ASSESSMENT:** Refers to an assessment with an ARD that falls between the last day of the ARD window of the missed assessment (including grace days) and the actual ARD of the assessment which is now late.

(Please read the CMS definitions on page 2-73, RAIM3 )



## MDS News in Review

- December 4, 2012 - An "MDS 3.0 Quality Measures User's Manual V6.0 Errata" document to correct identified issues was posted on the CMS MDS 3.0 Quality Measure page.
- January 28, 2013 - The following technical specifications were posted on the CMS MDS 3.0 Technical Information page.

1. A new version (V1.13.0) of the data submission specifications was posted. Documents associated with this version are dated 01/17/2013. The final version is scheduled to become effective October 1, 2013.

2. A new version (V1.11.0) of the MDS item sets was also posted. The final version is scheduled to become effective October 1, 2013 with the new version of the data submission specifications.

**NOTICE:** The CMS web page noted both postings should be considered provisional or draft and are subject to change until the final versions are posted.

## Scope and Accuracy of Information

Unless otherwise specified, information conveyed by the Texas MDS Clinical and Automation Coordinators by phone, e-mail, website and The MDS Mentor is limited to information disseminated by the RAIM3, CMS and Title 40, Texas Administrative Code, Part 1, Chapter 19, Subchapter I. Therefore, guidance provided by the Texas MDS Clinical and Automation Coordinators by phone, e-mail, website and The MDS Mentor is based on the most current information available at the time and in specific response to the submitted questions. MDS guidance and responses to questions are time-limited and may be superseded by publication of more recent MDS-related information by CMS or the state of Texas.

It is the responsibility of nursing and swing bed facility staff to educate themselves and ensure that they meet all other state and federal requirements, including state practice acts (e.g., the Texas Nursing Practice Act), Medicare requirements, Medicaid requirements, etc. and to keep abreast of changes as they occur.

## A0410 Coding—By The Numbers

Many providers have requested DADS staff provide an easy to use, 1-2-3 guide to coding A0410. CMS coding instructions for item A0410 are on page A-9 of the RAIM3. In Texas, code A0410 as a:

**1**—for Medicare Prospective Payment System (PPS) assessments and Other Medicare Required Assessments (OMRA) for a resident on a unit that is **not** Medicare or Medicaid certified.

**2**—for OBRA assessments, entry/discharge tracking record or discharge assessment for a resident on a unit that is **not** Medicare or Medicaid certified.

**3**—for all assessments completed for a resident who is in a Medicare or Medicaid certified bed, regardless of whether or not CMS requires submission to the federal database.

Remember, A0410 must be coded based solely on the bed certification status.

**Follow-up Questions—Item O0100M and Influenza, posted 2/22/13:**
**Q:** A recent MDS web alert indicated that O0100M could not be coded for contact isolation for influenza, but what if the precautions were droplet or airborne?
**A:** Precautions instituted for influenza may **not** be coded in item O0100M on the MDS.
**Q:** If the IDT notes and the physician orders it is medically necessary to isolate a person for influenza in the 14-day look-back period, then can O0100M be coded?
**A:** If isolation is required and ordered, staff must isolate. The RAIM3 notes isolation for wounds, UTIs or encapsulated pneumonia must **not** be coded on the MDS (page O-4). CMS staff clarified that influenza is another example that may **not** be coded.

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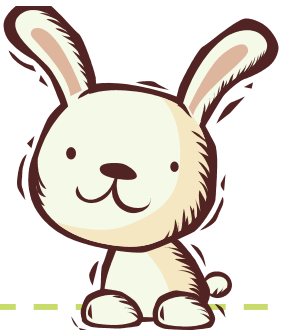

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## Useful Web Links

**DADS MDS Web Site**: Texas MDS site for MDS policy, procedures, and clinical and technical information (including The MDS Mentor). http://www.dads.state.tx.us/providers/MDS/

**Sign up for MDS Resource E-mail updates**: Go to http://www.dads.state.tx.us/, click on the "E-mail updates" tab and follow the directions. The "DADS Texas Minimum Data Set (MDS) Resources" emails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff.

**Centers for Medicare & Medicaid Services (CMS) MDS 3.0 website** : MDS 3.0 RAI Manual, Item Sets (forms), related MDS 3.0 materials and left-side table links to MDS technical information and MDS 2.0.
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

**Centers for Medicare & Medicaid Services (CMS) FY 2012 RUG-IV Education & Training**: Clarification and follow-up documents related to Medicare MDS.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEdu12.html

**QIES TECHNICAL SUPPORT OFFICE (QTSO)**: MDS 3.0/2.0, jRAVEN/RAVEN and CMSNet (Verizon) information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.
https://www.qtso.com/

**Quality Reporting System (QRS)**: DADS information site on Texas nursing homes.
http://facilityquality.dads.state.tx.us/qrs/public/qrs.do

**Nursing Home Compare**: CMS site that compares nursing homes in a given area.
http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp

**5 Star Technical Manual:** Explains data used to create the 5 Star Report.
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

This guidance is being provided on the published date of The MDS Mentor (March 19, 2013). The reader should be aware that guidance regarding topics in The MDS Mentor may be time-limited, and may be superseded by guidance published by CMS or DADS at a later date. It is each provider's responsibility to stay current with the latest CMS and DADS guidance.