Section M: Is your assessment system up to par?
Caralyn Davis, Staff Writer

When the Centers for Medicare and Medicaid Services (CMS) updates the RAI User’s Manual for the MDS 3.0, it’s easy to fall into the trap of doing a quick skim of the changes without ever making time for an in-depth review. However, the overall focus of V1.10 of the RAI Manual is guiding providers to conduct: (1) a specific, holistic resident assessment process and (2) root-cause analysis leading to the development of performance improvement plans, suggests Judi Kulus, NHA, RN, MAT, C-NE, RAC-MT, vice president of curriculum development at AANAC. “The principles of QAPI (quality assurance and performance improvement) are going to have a direct correlation to how we analyze and improve our systems to effect positive outcomes.”

The May update to Section M (skin conditions) provides a good example of how and why a more detailed manual read-through can benefit MDS coordinators and the interdisciplinary team (IDT), putting them on the path to “refining their assessment systems and using their critical thinking skills to support resident outcomes in a very powerful way,” says Kulus. “Pressure ulcer staging is a clinical system, and the manual now guides us to take a look at whether that system is functioning whenever pressure ulcers worsen or develop.”

Key changes to consider include the following:

Cartilage counts as bone. The May update provides a significant level of guidance for pressure ulcer assessment throughout Section M, says Kulus. In M0300 (current number of unhealed pressure ulcers at each stage), CMS clarified that cartilage counts as bone for pressure ulcer assessment.

“So pressure ulcers with exposed cartilage are classified as Stage 4,” says Kulus. “It’s important to note that the bridge of the nose, ear, occiput (back of head), and malleolus (ankle) do not have subcutaneous tissue, and these ulcers can be shallow even though they are Stage 4.”

QAPI: Not too early to begin
Judi Kulus, RN, NHA, MAT, RAC-CT, C-NE

According to the Affordable Care Act (ACA), Quality Assurance and Performance Improvement (QAPI) regulation was supposed to have already been implemented. Like other regulations such as corporate compliance, QAPI has been delayed, and the details for regulatory compliance have yet to be released. That’s not to say that QAPI regulations aren’t in the works. In June 2013, the Centers for Medicare & Medicaid Services (CMS) launched tools and resources on the QAPI website for providers to review in preparation for the anticipated regulation. Central to QAPI is the philosophy that quality improvement reaches all levels of the facility organizational structure and that facility staff are to engage in ongoing introspection in order to enhance and improve the facility care delivery system while including the resident’s voice and choice. So, you may be asking, is it too early to implement QAPI principles into your organization? Absolutely not!

The CMS QAPI demonstration projects are set to conclude in August and at that time the final reporting and lessons learned will be processed and evaluated. When the regulations are released, providers will have an opportunity to review them and provide public comments to the details. Once the final regulations are posted, providers will have 12 months to fully comply. However, survey teams are already scrutinizing each facility’s quality assurance committee’s effectiveness in detecting and responding to quality issues in the facility. Providers who embrace and prepare for QAPI will be better positioned to comply with the regulations when they are released and will better support current scrutiny by survey teams.

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Stage 2 ulcers — epithelial tissue only.
In M0700 (most severe tissue type for any pressure ulcer), “CMS clarified that Stage 2 is exclusively epithelial tissue (epidermis is light pink/regenerating),” says Kulus. “Stage 2 pressure ulcers by definition are partial-thickness wounds and don’t have the granulation, slough, or eschar tissue types that full-thickness (Stages 3 and 4) pressure ulcers do.”

Pressure ulcer healing times. “One of the most notable additions to the RAI Manual update was a focus on how the staging of the pressure ulcer informs the expectation of healing times and consequently planning for care,” says Kulus.

For example, in M0300D (Stage 4 pressure ulcers), CMS states: “If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed.”

Similarly, in M0800 (worsening in pressure ulcer status since prior assessment or last admission/entry or reentry), CMS advises: “The interdisciplinary care plan should be re-evaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.”

These changes really emphasize how closely CMS is correlating the RAI Manual with the State Operations Manual, points out Amy Franklin-Andersen, RN, CDON, RAC-MT, RAI director for Metron Integrated Health Systems in Grand Rapids, MI. For example, the change to M0300D “implies the need to explore the potential for a significant change in status assessment with an actual reassessment by the interdisciplinary team,” she says. “That is reiterating F-tag 314. The verbiage is becoming more symbiotic.”

CMS delves further into the resident care aspect via new language in M0900 (planning for care), adds Franklin. “For example, CMS clarified that a healed Stage 4 pressure ulcer still needs to be on the care plan because it represents a further risk. That’s a good clarification, but IDTs now need to be really careful with their anatomical description and documentation when they heal a Stage IV wound. If you are not correct with the exact anatomical location of the healed ulcer, and then a new wound opens up in the same area, you likely will run into trouble with surveyors if you’ve coded it as a new wound vs. a reopened Stage 4.”

“Worsening” pressure ulcers.
In M0300, CMS has taken out the ambiguous language “worsens to a higher stage” and replaced it with “increases in numerical stage.”

“The problem with the original wording was: How do you measure worse?” says Franklin. “People can have very different ideas of what worse is. So CMS clarified that you have to go by an increase in the numerical stage. For example, if this pressure ulcer is a Stage 2 that has progressed to a Stage 3, then there has been an increase in the numerical stage. Reassessment (significant change) might be required, and the pressure ulcer does fit the definition of worsening for coding purposes. An opposite example is if the surface area of the Stage 3 pressure ulcer has increased but the tissues of the wound still remain Stage 3, then this wound has not increased in numerical stage, and you would not code worsening on the MDS.”

With these wording changes, “comparison of numerical stage is essential for determining if the pressure ulcer has worsened,” agrees Kulus. “So if a pressure ulcer becomes unstageable, then whether it has worsened can’t be determined until it’s stageable again. For example, if a Stage 2 pressure ulcer becomes unstageable, it can’t be considered worsening until, for example, there is debridement and the assessor can then determine that the ulcer has increased to a numeric stage of 3 or 4.”

A related clarification involves determining whether pressure ulcers still qualify as present on admission in M0300, says Franklin. “If an unstageable pressure ulcer that is present on admission subsequently becomes stageable, it has not worsened. So it is still coded as present on admission. For example, if an unstageable pressure ulcer present on admission now presents as Stage 3, it still is coded as present on admission. However, once that pressure ulcer is a Stage 3, if it then increases in numerical stage on a subsequent MDS assessment, it is no longer present on admission.”

Finally, CMS clarified that the merging of two pressure ulcers doesn’t automatically mean the ulcers have worsened, says Franklin. “Even though there might be an increase in the overall surface area of the ulcer, as long as the numerical staging has not gotten worse, the ulcers have just merged.”

Small word changes. Changes in conjunctions or “joiner words” can make a big difference in how Section M is coded, notes Franklin. “Throughout Section M, providers need to pay attention to the and’s, but’s, and or’s.” For example, in item M0210 (unhealed pressure ulcers), CMS discusses that the initial numerical staging of pressure ulcers “should be coded in terms of what is assessed (seen or palpated i.e. visible tissue, palpable bone) during the look-back period.”

Previously, the “seen or palpated” wording had been “seen and palpated,” Franklin points out. “That’s a big deal because and means you have to have both, but or means you have to have one or the other. So providers need to review their policies and procedures and assessment tools to ensure that they are consistent with this wording change.”
One of AANAC’s purposes is to work to influence federal legislation on behalf of our members and the residents you serve. We’re working hard to fulfill this purpose regarding a bill in Congress entitled The Improving Access to Medicare Coverage Act of 2013. This bill is trying to address the issue of Medicare coverage for our residents when a hospital “observation stay” is involved.

As you may know, some hospital stays are coded as “observation,” even when the patient is in the hospital for several days. The problem is that an observation stay does not count as a qualifying stay, which would enable access to Medicare benefits when the patient moves to a SNF or other non-hospital setting. This can leave residents and their families with an uncomfortable decision: choosing a less-than-optimal recovery setting or facing large out-of-pocket costs. The congressional bill, if passed, would require an observation stay of at least three days to count as a qualifying stay for Medicare coverage.

In early June, four of AANAC’s board members and two of our staff members journeyed to Washington, DC, to make personal appeals to their senators and representatives in support of this bill. The AANAC delegates were chosen because each has a senator or representative on one of the key congressional committees to which the bill has been assigned. Even though the bill has not yet come up for consideration, these visits were successful; education about the bill and its impact on residents was the primary goal.

Carol Maher was able to meet with the legislative assistant for health policy for her senator, Maria Cantwell, from the Senate Finance Committee. Carol reports, “The staff member had only vague knowledge of the issue but was very attentive to my stories about how this issue actually affects the senator’s constituents. I told her of a situation where a resident had just been admitted from a hospital. That resident and her family were not aware that the hospital stay had been an observational stay and that Medicare could therefore not be the payer. The facility staff and family estimated that, in order to get this resident back to a level where she could manage in independent living again, the SNF stay would end up being between $24,000 and $30,000. I told the staffer that when residents are on Social Security, this is more than their annual income. That hit home.” Stories like this, of real residents, strike a chord with legislators.

Senator John Thune is also on the Senate Finance Committee and was able to meet in person with AANAC board member Joanne Powell. Joanne reports, “His office shared with me their approval and support of the bill, as they understand the beneficiary is being denied benefits. I cannot go without saying that the staff members in his office had varying degrees of knowledge about the bill, but by the time I left they had a strong foundation. I gave them many examples of the necessity of observation days counting towards the three-day prior inpatient stay requirement to qualify for Medicare coverage in the SNF. I also learned that the bill will take some time before it comes to a vote.”

Peter Arbuthnot was excited about the entire experience. He notes, “It is always invigorating to walk the halls of the Senate and House buildings. You can’t help but feel the buzz of hot topics as you move from one office to the next, hearing the voices of lobbyists and staffers. You can’t help but get pulled into whatever is being discussed; you realize that there are hundreds of requests and comments that each office has to filter through every single day. I visited with my representative, who is on the House Energy and Commerce Committee. This committee is currently holding the observation stay bill. I had met with Congressman Harper last year and he remembered me. Harper was not at all familiar with the legislation and asked what the AHA and AMA thought of it. He also asked if the Congressional Budget Office had any numbers he could review. Despite his uncertainty and tip-toeing around any sort of commitment, he did commit to having staff members review the bill and get together with him. He also said that they would get back with me in the coming weeks.”

Has the bill been passed? No. When will it be passed? We don’t know. It takes a long time to get a bill through Congress. The Congressional Budget Office needs to determine the cost of the bill to the federal budget. Then the House (and/or the Senate) needs to find time to debate the bill and, hopefully, pass it. With the other hot-button issues currently before Congress, such as immigration reform, this may not happen soon—it likely will not even happen this year. Will AANAC continue to fight for the bill? Absolutely! We will continue to contact key members of Congress to urge their support. We may ask you, as our members, to help us in this effort. We’ll keep you up to date on our progress.”
Q + A

Can I care plan the PHQ-9 total score or do I have to detail specific mood issues?

I am a SW at a geriatric facility learning the MDS 3.0 manual. My focus is on sections A, C, D, and Q. As a SW who has done many PHQ-9 reports in the past, I generally looked at the overall score first and based on that, made a determination on if a particular question/answer required monitoring or an immediate response taking the overall score into account. Is that the same principle when doing the MDS PHQ-9 or are you required to care plan every trigger regardless of the overall score.

It is highly recommended that the care planning conducted with and for a resident is personalized. There is no specific regulation regarding addressing the PHQ-9 in part or in whole for care planning. That being said, if there is particular items of note in the details of the PHQ-9 that need to be addressed specifically to successfully meet the resident’s needs, then they should be addressed. Use your clinical judgment to specifically, individualize the care plan according to the resident needs and goals.

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The state accepted my RUG do I still get Medicare default?

Good Morning all. I have 2 situations that I really need help with:

1st situation: I did not do a 30-Dday MDS for a lady because I had to do a COT that covered days 29 – 35, then another COT that covered days 36 – 60. We use AHT and they said I should have done the 30-Day anyway. This is giving us a default code for days 31 – 60. When I submitted these assessments to the state it accepted the RUG score. Again, when I submitted this MDS to the state it accepted the rehab score that I sent.

2nd situation: I did a COT on day on day 6 instead of day 7. It is giving us a default code for day 35 only. The rest of the month we have the appropriate RUG score. When I submitted this MDS to the state it accepted the rehab score that I sent.

My question is, how do I fix this to send to Medicare. We feel that since the rehab RUG scores that were sent to the state is different from the default codes that we have to send in to Medicare how is this fixable?

AHT is correct. The scheduled assessments are required. You cannot substitute an unscheduled assessment for a scheduled assessment. If that resident is still on Medicare set the ARD today for your late 30-day assessment. If you do not do this late 30-day, those days will be provider liable, not default! AHT is also correct billing one day of default for the early COT. You were one day out of compliance. The fact that the assessments were accepted when transmitted does not mean that there are no payment implications. Read chapter 2 of the RAI Manual for information about the timing of assessments and how to bill late or missed assessments.

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Can I modify a 14-day to a 14-day/EOT?

I have a guest that had a 14 day assessment completed that should have had an EOT attached. The guest has discharged and the EOT was missed, not scheduled. With the new rules, my understanding is that if this was an entry/typographical error, I could modify it. But this EOT was not scheduled, so I cannot modify it, correct?

You can modify this to change the assessment type because the item set will stay the same.

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Which HIPPS Codes cover these RUG days?

Okay, I have a question, and it might appear a little odd, however I am getting half and half answers so here is the situation that occurred during our triple check, month end meeting:

A patient admitted on 4/1/13 we did a 5-Day assessment on 4/8 and got a RUB. The RUG was going to go down so to avoid the COT we did the 14-day on 4/13 and got a RVB. Patient then d/c home on the 21st. As far as UBs go, or just MCR days in general, what would you say the RUB10 and the RVB20 would be? Would it be RUB10 for 12 days and RVB20 for 8 days or would it be RUB10 for 14 days and RVB20 for 6 days?

We know the rule of the 5-day pays for days 1 – 14 and so on and so forth however there has been conflicting information. I have a call into the state MDS clinical coordinator, but she has not returned my call so I have called everyone I know, business office and MDS. It is not a landslide one way or the other. Thanks in advance!!

Assuming you didn't miss the COT on the 20th, it would be 14 days for the RUB10 and 6 days for the RVB20. If you use a scheduled to replace a COT, it acts just like a plain old scheduled. And, for billing, the state MDS coordinator is not the person to call. The MAC is who to call, but, in that case, AANAC was there for you!

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Here are some implementation tips to assist your team in getting started with QAPI.

- Recognize that the director of nursing does not have to be the one leading QAPI or be on every performance improvement plan (PIP). While RN assessment and oversight is essential to care delivery, one person cannot carry the burden for QAPI. It takes a team approach. Choose the best person to take the lead as QAPI champion. Provide that champion with invested team members, including staff, residents, and family members.

- It may feel like QAPI is complicated, but use the KISS principle—“Keep it simple, Superman.” It’s better to engage in small successful plans than large programs that don’t improve resident outcomes. Build on quality improvement successes slowly and methodically.

- Formalize the QAPI program in your facility. Form a steering committee that establishes policies and procedures as well as a process to document which facility systems are part of the quality improvement focus.

- It’s essential to use root-cause analysis leading to PIPs to improve quality outcomes.

- Use implementation of QAPI principles to enhance culture change values. Recognizing that a major focus of QAPI is resident choice motivates us to create processes to draw out resident preferences and establish care according to resident wishes.

- Make direct observation of resident care part of your quality improvement data collection. When the resident’s needs and goals are central to quality success metrics, facility staff are more likely to generate positive outcomes. Direct resident observation might be through interviewing residents on their progress toward goals or through watching care delivery to ensure maximum compliance and engagement of staff and residents in the process.

- Document, document, document! Success is reward enough, but having a record of PIPs and progress to support your next annual survey will come in handy.

There are many unanswered questions regarding QAPI. For example, how many PIPs will facility staff be required to work on at any given time? Will facility staff be required to include certain issues for QAPI engagement, such as pressure ulcer or antipsychotic reduction planning? Which documentation is private and which needs to be shared with survey teams? What about liability while engaging residents and families regarding care issues for improvement? Regardless of how the regulation answers these and other important questions, AANAC will monitor information about QAPI and keep you informed as it unfolds. Continue to implement quality improvement using root-cause analysis and performance improvement planning and you’ll be in great shape as the deadline to QAPI draws near.

Visit and review the QAPI tools and resources at the following link:
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html

We invite you to visit AANAC.org and share your QAPI implementation successes, challenges, questions, and ideas in the comments section of the online article.

All the articles in this LTC Leader can also be found on the AANAC.org website.