MDS coding changes effective October 1, 2013

With the release this week of CMS’s fall updates to the RAI User’s Manual, we have regulatory guidance to help us navigate the mandated October 1, 2013, changes. Noteworthy changes include new OBRA and PPS assessment items that have been added to the MDS forms, as well as added clarification on some key coding items. The MDS sections that are most impacted with this update are section K, “Swallowing/Nutritional Status,” and section O, “Special Treatments, Procedures, and Programs.” Additionally, clarification was provided to coders on two “hot-button” issues—capturing activities of daily living (section G) and setting the ARD for Discharge assessments. Following is a summary of the changes outlined in the RAI User’s Manual (v1.11).

Clarification for Coding Activities of Daily Living

The highlight of the update to item G0110, Activities of Daily Living (ADL) Assistance, is clarification on how and when to use the ADL Self-Performance Algorithm. In this update, CMS makes it clear that the coding rules are to be followed in sequence and that once the resident’s self-performance matches the rule, then we are to code that level. According to step one of the Instructions for the Rule of 3: “When an activity occurs three or more times at any one level, code that level” (CMS, 2013a, chap. 3, p. G-6). If step one applies, we are to stop there and not use the algorithm. For example, if a resident is Supervision three times, Limited Assist two times, and Extensive Assist two times, the coding would be Supervision because it happened three times; step one applies, so we stop there.

One helpful addition to the instructions is step three in the Rule of 3, which says, “When an activity occurs three or more times at any one level, apply the following: a. Convert episodes of full staff performance to weight bearing assistance when applying the

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Resident care plans that meet OIG expectations

Risk management is a necessary element in an effective corporate compliance program. Comprehensive resident care plans that are designed and utilized from a risk-management perspective have a significant impact on the provision of quality care. Office of Inspector General (OIG) auditors and inspectors have repeatedly found that a significant percentage of care plans fail to reflect the residents’ actual needs. These OIG staff members continue to discover care plans that are insufficient in addressing residents’ areas of risk. Medicare and Medicaid regulations require the development for each resident of a comprehensive care plan that addresses medical, nursing, mental, and psychosocial needs. The care plan is expected to contain reasonable objectives and timetables for accomplishing desired outcomes. All disciplines involved in a resident’s care should participate in the development of the care plan. Care planning meetings held merely to satisfy the requirement for an interdisciplinary meeting, or care plans developed without participation of the full clinical team, will result in care plans that do not focus on the resident or meet the scope necessary to guide the resident’s care. Care plans that are inadequately prepared make it less likely that care will be coordinated among all appropriate disciplines. Nursing facility leaders reduce these risks when they design systems that ensure that a comprehensive, interdisciplinary approach is used in care planning.

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third Rule of 3” (p. G-6). Coders now have definitive instructions that full staff performance can be considered weight-bearing assist. However, a caution about this is that you must have gotten to step three before the conversion occurs. The update includes additional examples that help to illustrate the coding instructions.

Recently, some industry confusion arose regarding how and when to set the ARD for a Discharge assessment. The update to the manual includes a welcome clarification. This alleviates the difficulty of opening and setting the ARD on the day of discharge when a resident unexpectedly leaves the facility. Note that if the Discharge assessment is combined with a PPS payment assessment, the ARD must be set according to the rules of that required payment assessment (i.e., the 5-day assessment must be opened and the ARD set before the resident discharges).

For a Discharge assessment, the ARD (Item A2300) is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days). (CMS, 2013a, chap. 2, p. 2-36)

Setting the ARD for Discharge Assessments

Recently, some industry confusion arose regarding how and when to set the ARD for a Discharge assessment. The update to the manual includes a welcome clarification. It says:

For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The

New Coding Item Added to Section K

Effective October 1, 2013, a new MDS item, K0710, Percent Intake by Artificial Route, will be added to this section (CMS, 2013b, NC Comp, p. 24). Here is how the new coding item appears on the MDS 3.0 item sets (figure 1).

The new questions in K0710 split the answer options into three items: (1) While NOT a Resident, (2) While a Resident, and (3) During the Entire 7 Days. Effective on October 1, the RUG grouper will filter Special Care High and Special Care Low if the resident receives 51% or more of total calories or at least 26% of their total calories through tube feeding and 501 cc/day or more of fluid intake via the tube (K0710A3, K0710B3) for all seven days in the look back period (CMS, 2013a, p. 6-38, 6-40).

FIGURE 1: New MDS item K0710, Percent Intake by Artificial Route.

New Coding Items Added to Section O

According to the item subset Zip files, v1.11.2, the following questions will be added to the MDS:

- O0400(A) Speech-language pathology and audiology services (3A) Co-treatment minutes (figure 2)
- O0400(B) Occupational therapy (3A) Co-treatment minutes (figure 3)
- O0400(C) Physical therapy (3A) Co-treatment minutes (figure 4)
- O0420, Distinct Calendar Days of Therapy

RUG-IV Impact of Section O Item Set Changes

According to information gleaned from the SNF PPS Final Rule,

In order to qualify for the Medium Rehabilitation (Medium Rehab) RUG category, a resident must receive

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at least 150 minutes of therapy per week (a seven-day time period) and 5 days of any combination of the three rehabilitation disciplines (physical therapy, occupational therapy, or speech-language pathology). The policy has always been that the term “days” in this context denotes distinct calendar days of therapy. Similarly, for the Low, High, Very High, and Ultra High Rehabilitation RUG categories, the policy has always been that distinct calendar days of therapy are required to classify into these RUG categories (for example, for the Low Rehabilitation category, 3 distinct calendar days of therapy are required).

... However, there has not been a way until now to record on the MDS 3.0 the number of distinct calendar days of therapy provided across all rehabilitation disciplines in order to ensure accurate calculation of these days in the RUG grouper software. (Medicare Program, 2013, pp. 87–88)

The RUG-IV files indicate that with the addition of O0420, the previous filter in the RUG grouper using the sum of O0410(A4), O0400(B4), and O0400(C4) (number of days of therapy) will no longer be used. For RUGs in FY 2014, the grouper will select the number of

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Calendar days (O0420) instead. CMS (2013d) states:

For Medium Rehabilitation, the requirement of 5 or more therapy days across the three disciplines (sum of O0410A4, O0400B4, and O0400C4) is being replaced by 5 or more distinct calendar days of therapy (O0420). For Low Rehabilitation, the requirement of 3 or more therapy days across the three disciplines (sum of O0410A4, O0400B4, and O0400C4) is being replaced by 3 or more distinct calendar days of therapy (O0420).

When considering how this change impacts the way therapy is scheduled and delivered in the SNF, it is important to be aware of new regulatory language added to the Medicare Benefit Policy Manual (MBPM). Effective April 1, 2013, CMS included instructions about daily skilled service. It states that in order for skilled service to be considered provided on a “daily basis” (which for therapy services means five days a week), facility staff can’t simply stagger therapy over five days in the look-back period. The MBPM states, “The basic issue here is not whether the services are needed, but when they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the ‘daily basis’ requirement for SNF coverage would not be met” (CMS, n.d., p. 33). Therapy charting should include not only the modality being provided but the reason for the planned treatment schedule. Take note of these instructions in light of the potential for government fiscal integrity audits.

Managing the Transition to the New Coding Items

In anticipation of the transition from FY 2013 to FY 2014 as of October 1, 2013, a caller on the September SNF open-door forum asked CMS how to navigate the transition of the new MDS item O0420. CMS posted a transition memo to guide facility staff during the implementation process.

A caller on the September SNF open-door forum asked CMS how to navigate the transition of the new MDS item O0420. CMS posted a transition memo to guide facility staff during the implementation process. The document specifies that any MDS assessment with an assessment reference date of October 1, 2013, or later must be coded using the new coding items as outlined in the SNF PPS Final Rule and the MDS 3.0 Technical Information documents.

FIGURE 4: New coding item O0400(C) Physical therapy 3A Co-treatment minutes

FIGURE 5: New coding item O0420, Distinct Calendar Days of Therapy

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As for selecting the appropriate RUG-IV for Medicare billing, the transition clarification memo provides the following instructions.

1. For all assessments with an ARD before 10/1/2013, an FY2014 transition RUG will not be produced. Providers should bill all days of service associated with that assessment using the FY 2013 RUG provided by that assessment in Item Z0100A or Z0150A, even if some of those days of service are on or after 10/1/2013.

2. For all assessments with an ARD from 10/1/2013 through 10/13/2013, an FY2013 transition RUG will be produced where the total days of therapy (items O0400A4, O0400B4, O0400C4) will be used for RUG classification. This should produce a FY2013 RUG exactly equivalent to that for an assessment with an ARD date before 10/1/2013. This FY2013 transition RUG should be used to bill any days of service before 10/1/2013 which are associated with that assessment.

3. For all assessments with an ARD date after 10/13/2013, an FY 2013 transition RUG will no longer be produced.

(CMS, 2013e)

Additional Changes to the MDS Item Sets

In addition to the above-detailed changes, there are a number of existing coding questions being added to certain MDS item sets. For example, H0200(A), which concerns urinary toileting programs, is being added to the Quarterly assessment, PPS assessment, and OMRAs, to name a few. For a complete listing of additions, deletions, and title changes, see the item set change table, available for download from the MDS 3.0 Technical Information page (CMS, 2013b).

Navigating the Transition Effectively

The RAI User’s Manual is posted on the AANAC website in the RAI Manual tab. It includes all the updated manual pages as well as the change tables. The complete list of changes is highlighted in yellow and is available for all coders to review. Take time to read through the CMS provided change table so that you are familiar with all the inclusions and exclusions.

While software vendors are aware of the new technical specifications and have been working diligently for the past few months to get their software systems ready for October 1, 2013, don’t assume that everything in your system is correct. Pay close attention to the assessment reference dates selected for the MDS you are completing and be sure that the new coding items are included on any item sets with an ARD on or after October 1.

Review the validation reports to select the correct billing RUG. This is critical, since a RUG established on or after October 1 with the new item sets may have payment days in September, and a RUG set in September with the old item sets may have payment days that carry into October. By utilizing the transition RUG instructions listed above, you can bill the correct RUG for payment days surrounding the October 1, 2013, effective date and beyond.

RESOURCES


Resident care plans, continued from page 1

The OIG recommends the following basic steps to assist facility leaders in meeting the comprehensive resident care planning requirement:

- Appropriately schedule meetings to accommodate the full interdisciplinary team.
- Complete all clinical assessments before the meeting convenes.
- Establish open lines of communication between direct care workers and interdisciplinary team members.
- Involve the resident and the resident’s family members or legal guardian.
- Document the length and content of each meeting and who was in attendance.

Nursing facility leaders play a critical role in coordinating the participation of the attending physician in the development of care plans. To address this area of risk, policies and procedures can be developed that facilitate physician involvement. Improve communication about care planning through advance notice of meetings, and ask the physician how best he or she can participate... with the focus on ensuring the interests of the resident and compliance with regulation.

In the case of residents with mental disabilities, completion of the Preadmission Screening and Resident Review (PASRR) tool is required so that the need for specialized services is identified upon admission. It is also required that there be ongoing support and identification of the need for PASRR review and services throughout the resident’s stay. For residents with mental disabilities who do not require specialized services, the team can ensure that all required “services of lesser intensity” are included in the care plan.

An effective compliance program should also focus on discharge and transfer of residents. Many of the reasons for transfer or discharge require interdisciplinary team input related to the medical and psychosocial needs of the resident, and team members can provide recommendations.

The following examples have been cited under F279, Comprehensive Care Plan:

Resident #7 had multiple falls without injury. A therapy screen recommended Dycem under the mattress, and the care plan documented non-skid strips beside the bed. Neither was in place when the resident was observed by the surveyor. The resident used oxygen at two liters per minute, but oxygen was not addressed on the care plan. Resident #8 had 18 falls without injury. The fall care plan had no new interventions documented for.

Resident #9 had a number of falls on three different days. There was no medication review. Resident #10 experienced six falls without injury. There were no new care plan interventions after any of the falls. She was instructed to use her call light, and that was all that was done for her. Resident #12’s care plan directed staff to encourage the resident for rehabilitation. The care plan was not revised to reflect the resident’s discharge from therapy services.

Resident #22 was sexually inappropriate with other residents and made inappropriate remarks and gestures toward staff. A policy stated that all allegations would be responded to through an investigation process and that the facility staff would assist in resolving behavior issues by assessing, care-planning, and monitoring residents with behaviors that may lead to conflict. A policy titled “Resident-to-Resident Abuse” stated the facility staff were to develop a plan of care that included interventions to prevent recurrence. There was no plan to address the resident’s sexual behavior toward other residents until two days after an incident with another resident. The plan, once developed, did not say which consistent staff approaches were to be used, and there was no increase in supervision.

F279, Comprehensive Care Plan, states:

(A facility must...) use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care... that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

(SOM, Appendix PP)

Corporate compliance applies to every aspect of resident care. By developing individualized resident care plans and implementing them as tools that guide all aspects of care, the health care team will be working effectively to provide quality care that residents deserve and that meets the expectations of the OIG.

If a pressure ulcer has 1% slough can it still be a stage 2?
This is a question I’ve had for a while, but I think relevant to the clarification/update of stage 2 pressure ulcer definition.
If there is just 1% or 5% slough in an ulcer that I would otherwise consider to be a stage 2, does the presence of such a small amount of slough mean that it needs to be coded as stage 3 ulcers?
That is correct—if the wound has the extent of damage that any amount of slough is present, it cannot be coded as a Stage 2, regardless of the depth. If the wound bed is viewable it can be staged at a Stage 3 or higher. If the wound bed is not visible due to the slough, it would be coded as unstageable. (See RAI Manual pages M-10; M-17; M-23 and M-24.)

Jennifer LaBay, RN, RAC-MT
(jlabay@hcltdri.com)

If we complete too many COTs, are we at risk for an audit?
I have a client that is concerned about having too many COTs and how that may flag for audit. I do not have stats on what percentage of their assessments are COTs, but I think I recall that the national average is around 11%. This is one of the target areas on the PEPPER report which is looking for risk of inappropriate billing. If facilities fall in the top 20th percentile for this target item, they may be at increased risk for review. In addition, the PEPPER training says “SNFs that use the change of therapy assessment rarely or never may be targeted by MACs or RACs for review to establish whether those therapy assessments are being completed as required.” It’s not just the high levels of COTs may be required by a unique resident population and low levels of COTs may be appropriate. Documentation is always the key to a successful audit.

80% or more on COTs but also the 20% or less that are considered outliers. That does not mean that facility staff is doing anything wrong. High levels of COTs may be required by a unique resident population and low levels of COTs may be appropriate. Documentation is always the key to a successful audit.

Carol Maher, RN-BC, RAC-MT
(cmaher0121@earthlink.net)

Do we have to chart actual minutes to code Respiratory therapy?
I have question on coding respiratory therapy. Don’t we have to have documentation on the actual 15 minutes per day provided to code this?
In O0400, it asks for total minutes and the number of days (administered for at least 15 minutes) in the 7-day look-back period. The RUG will filter if you capture 7 days of treatment. The MDS manual doesn’t dictate the how you need to chart this. However, if you were audited, how will you show/prove that the treatment occurred for at least 15 minutes each day if you don’t capture actual minutes in your charting?

Judi Kulas, NHA, RN, MAT, RAC-MT, CNE
(jkulas@aanac.org)

Can I code a UTI when the UA is negative?
Have a resident whose physician ordered UA with C/S due to dark amber urine upon discontinuation of F/C. UA results showing no bacteria, WBC 2, negative nitrite, clear urine, small leukocyte esterase, but the C/S result showed >100,000 col/ml enterococcus faecalis. Physician started resident on ATB therapy for UTI. I do not feel this UTI should be coded due to negative UA despite positive C/S. Any input is greatly appreciated. Thanks in advance.

Sounds to me like you should code it. You have a symptom (foul smelling urine), a diagnosis, significant lab findings (C & S), and treatment. The RAI says, “The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained” (p. I-8). In this case, the physician determined that the positive C & S was significant.

Lisa Hohlbein, RN, RAC-MT, RAC-CT
(lhohlbein@leaderstat.com)
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All the articles in this LTC Leader can also be found on the AANAC.org website.

LTC NURSING WORK STUDY

Judi Kulas, NHA, RN, MAT, RAC-MT, C-NE

Every other year, AANAC conducts an extensive LTC Nursing Work Study research project. As part of the project, AANAC surveys its membership of long-term care nurses to understand the issues affecting job performance and satisfaction.

Using the data collected in the 2011 LTC Nursing Work Study research, AANAC published a comprehensive job description for the nurse assessment coordinator (NAC) in the position paper "Defining the Role of Nurse Assessment Coordinators: Beyond Paperwork and Reimbursement." In this position paper, AANAC proposed developing a Scope and Standards of Practice for nurse assessment coordinators that could serve as a guide and reference for professional nurses working as NACs and for their professional development. These standards would support highly educated, focused, confident, and proactive NACs.

With the 2013 LTC Nursing Work Study research, AANAC plans to further this effort by benchmarking the following data among AANAC members:

- Average salary ranges by functional role, state, licensure/education, and experience
- Average completion times by MDS assessment type and facility census mix
- Average nursing-staff mix for licensed and non-licensed nurses by shift and facility size

Other objectives for this research project are to understand:

- Which functional roles are typically responsible for each section of the MDS?
- What other responsibilities do NACs have outside of the MDS process?
- What variables can impact the successful management and completion of the MDS process?

Whom will this data help?

- Administrators, DONs, and other nurse leaders will be provided with AANAC member-reported data as a resource for establishing NAC-specific staffing levels using MDS completion times per assessment type and resident case-mix level.
- NACs and other staff involved in the MDS process will be better able to benchmark their coding time against industry averages, understand the typical scope of duties performed by a NAC, and determine average assessment workloads based on census and case-mix.
- AANAC will be armed with qualitative data and evidence to support our efforts in Washington, DC, advocating on behalf of LTC nursing.

How can I help?

Yesterday, you received an invitation to participate in this important research. Please take 10 to 15 minutes to complete the survey. It’s that simple! ●