MDS coding and the QMs: Watch out for these hot spots

Caralyn Davis, Staff Writer

The accuracy of the quality measures (QMs) hinges on accurate MDS coding. However, there are no quick fixes to ensuring that interdisciplinary teams are coding accurately, says Colleen Toebe, RAC-MT, a nurse consultant with White Bear Lake, MN-based Pathway Health. “You have to audit the QMs resident by resident and compare what was documented in the medical record against what was coded on the MDS items that feed into the measures.”

Following the coding rules in the current version of the RAI User’s Manual for the MDS 3.0 is important for every QM item. However, here are some issues that Toebe has identified in recent provider audits:

Diagnoses

To be coded in Section I, diagnoses must be physician-documented in the last 60 days and active during the seven-day look-back period. Active diagnoses “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.”

Active diagnoses “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.”

CAA survivor

Barbara A. Bates, MSN, RAC-CT, C-NE

Does your facility have tools and skills in place to survive regulatory scrutiny related to completing the MDS, Care Area Assessments (CAAs), and comprehensive care plans (CCPs)? Have you reviewed the processes for completing these? Have you asked your interdisciplinary team (IDT) if the process is working and what the issues are? Have your facility managers given the CAA responsibility to the MDS coordinator or the RN charge, with the expectation that the CAA will be completed correctly? If you haven’t asked these questions or reviewed these systems, you may find that your team is not a CAA survivor.

The MDS is not a comprehensive assessment. It is a method of collecting minimum data that identifies potential problems and these problems’ impacts on resident function and quality of life. The CAA process helps to capture the resident’s voice and identify his or her goals, strengths, and needs; this then assists with developing resident-centered care plans. The CAA process pulls the information together to assist the team in organizing the data collection, understanding the resident’s clinical issues, and determining how best to proceed with caring for the resident.

The CAA process helps to capture the resident’s voice and identify his or her goals, strengths, and needs.

IDT members need skills and tools in order to complete the CAA process. The CAAs need to be a team responsibility, not a delegated task that a single person, such as the MDS coordinator or RN charge, completes and returns to the team. Team members need a procedure whereby the CAA is initiated, reviewed, and analyzed, and decisions are made to proceed or not with care planning, all within acceptable time frames. The CAAs need to be developed by team members who work directly with the resident, then reviewed and revised by appropriate disciplines. The team collectively should be reviewing the analysis of findings and determining the need

continued on page 2

continued on page 4
The one exception to these time frames is item J1300 (urinary tract infection), which must have a physician diagnosis within the last 30 days and must be active during the 30-day look-back period, as well as meeting its own more specific coding criteria. (See pages I-8 – I-9 for details.)

A common coding mistake with diagnoses, particularly with J1300, that can impact the QMs is continuing to code diagnoses that are no longer active, says Toebe. “Sometimes facilities mistakenly carry forward resolved diagnoses from a previous assessment. However, sometimes the staff member who does the coding, for example, medical records, may not be aware of current diagnoses or if a specific condition has been resolved. The key to accurate coding in Section I is a clear and concise process.”

Another error to avoid is not having a physician-documented diagnosis, says Toebe. “State law may allow the physician diagnosis to be made by a nurse practitioner, physician assistant, or clinical nurse specialist, but it is not appropriate for someone other than a physician or a physician extender to add a diagnosis to the medical record.”

Life expectancy

J1400 (prognosis) is another QM item that hinges on physician documentation. “Occasionally I will find that the staff deemed comfort care for Alzheimer’s residents as meeting the definition of the end stage of life, so they coded Alzheimer’s residents as having a chronic condition or disease that may result in a life expectancy of less than six months,” says Toebe. “However, there was no physician documentation in the medical record that any of these residents were terminally ill or receiving hospice services—as required to code 1 (yes) in J1400. This coding error would impact not only a facility’s quality measures but also the CMS survey process.

Behavior

Items in Section E play a role in two QMs, but providers sometimes apply definitions other than those provided in the RAI Manual, says Toebe. For example, page E-14 in Chapter 3 of the manual defines rejection of care for item E0800 as “behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.”

However, sometimes staff have coded a resident as rejecting care in E0800 “because the resident kept forgetting to lock his wheelchair brakes before transferring,” she notes. “That doesn’t meet the definition for interference with care: ‘Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.’

However, if facility staff thought the resident wasn’t “forgetting” and was instead trying to disrupt care routines by not locking his wheelchair brakes, they should follow the steps for assessment on pages E-14 – E-15, says Toebe. “They would need to directly ask the resident whether he meant to decline or refuse care, or interview the family or significant other about the resident’s healthcare preferences and goals if he couldn’t or wouldn’t respond.”

Death in Facility tracking records

Discharge assessments (A0310F = 10 or 11) are included in both long-stay and short-stay QM calculations. So it’s important to know when to use a Death in Facility tracking record vs. a discharge assessment in order to avoid inappropriate assessments, says Toebe.

Page 2-9 of the RAI Manual states: “Death in Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA). The facility must complete a Death in Facility tracking record. A Discharge assessment is not required.”

Providers often are confused about what to do when a resident dies in the emergency room, notes Toebe. “For example, a facility resident is transported to the ER at 7 p.m. She then passes away at 8 p.m. without being admitted as a hospital inpatient. In this type of situation, facilities often are completing a discharge-return not anticipated. However, if the nursing home didn’t discharge the resident, that resident was on an LOA when she died, and a Death in Facility record should be completed, not a discharge assessment.”

Falls

J1900C (number of falls with major injury since admission/entry or re-entry or prior assessment) is a QM item, but a surprising number of providers make the mistake of carrying forward falls with major injuries that occurred prior to the time frame established for this item, says Toebe. “Providers should have an audit system in place to review the accuracy of the MDS assessment and review their quality measures routinely.”

Another issue relates to the definition of a major injury. Page J-31 of Chapter 3 of the RAI Manual states that a major injury “includes bone fractures, joint dislocations, closed head injuries with altered consciousness, [and] subdural hematoma.”

However, some providers make arbitrary decisions about what constitutes a major injury, says Toebe. “For example, facilities sometimes code a fall under major injury based on the length of a skin tear. But a skin tear meets the definition for J1900B (injury, except major) not J1900C. The length of the skin tear isn’t a factor in the coding decision.”

[Note: The original text was slightly edited for clarity and conciseness.]
A new resident is admitted to your skilled nursing facility (SNF) and a nursing department staff member calls the physician to request that he come to perform the initial comprehensive visit. The nurse is informed that the nurse practitioner will be making rounds that afternoon and will “take care of everything.” Do attempts at this type of inappropriate delegation happen in your setting? Does your nursing staff understand that this delegation will result in non-compliance for a SNF?

Attending physicians are required to follow regulatory requirements provided in F388 Physician Visits regarding delegation and physician responsibility. Because of the prevalence of inappropriate delegation, state survey agency directors received Survey and Certification Memorandum S&C: 13-15 NH from the Centers for Medicare & Medicaid Services (CMS) in March 2013 addressing physician delegation. The memo provides clarification on physician delegation of certain tasks to non-physician practitioners (NPPs) such as nurse practitioners, physician assistants, and clinical nurse specialists. The memo addresses the following categories:

**Physician-Required and Other Medically Necessary Visits in Skilled Nursing Facilities (SNFs)**

42 CFR 483.40(c)(3) states that all required physician visits must be made by the physician personally and may not be delegated. These visits specifically include “the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders” for a resident newly admitted to the SNF. This visit must occur within the 30-day period after the resident is admitted, and may not be delegated. Although non-physician practitioners may make other medically necessary visits before and after the physician’s initial comprehensive visit, they may not perform the admission visit. After the physician satisfies the regulatory requirement for the initial comprehensive visit, the NPP may perform the alternate visits. When alternate visits and medically necessary visits are performed by NPPs, a physician co-signature is not required except by state-specific regulation.

**Certifications/Recertifications in SNFs**

According to 42 CFR 424.20, certifications and recertifications are required in order to verify that a resident needs daily skilled nursing care or rehabilitation services. Nurse practitioners and clinical nurse specialists who are not employed by the SNF and who work in collaboration with the attending physician may sign the initial certification/recertification when permitted by their state’s scope of practice. The Affordable Care Act of 2010 authorizes physician assistants not employed by the facility to sign initial certification and periodic recertification for a resident’s need for a skilled level of care.

**Physician-Required Tasks in Nursing Facilities (NFs)**

As in a SNF, in a nursing facility (NF) it is required that within 30 days of a resident’s admission the initial comprehensive visit occur, during which the physician completes a thorough visit, develops a plan of care, and writes or verifies admitting orders. Unlike regulatory governance of a SNF, Section 483.40(f), at the option of individual states, allows any NPP who is not employed by the facility and who works in collaboration with the physician to perform tasks that the regulations state must be performed personally by the physician. These NPPs may also perform any other required visit or medically necessary visit in a NF if state law allows. At the option of each state, NPPs who are employees of the NF may perform other medically necessary visits and may write orders during these visits. The physician does not need to co-sign unless the individual state requires that practice. Visits in NFs that are performed by facility-employed NPPs cannot take the place of physician-required visits, and cannot be counted towards meeting the required schedule of physician visits.

**Dually Certified Facilities (SNFs/NFs)**

In a facility where the beds are dually certified under Medicare and Medicaid, the staff must understand how the individual’s stay is being paid for. If a resident is in a Medicare Part A stay, guidelines for SNFs apply. If the resident is in a Medicare stay, guidelines for NFs apply.

*continued on page 4*
Are your physicians delegating correctly?, continued from page 3

The following table, developed by CMS, demonstrates the authority for physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS) in SNFs and NFs:

<table>
<thead>
<tr>
<th></th>
<th>INITIAL COMPREHENSIVE VISIT/ORDERS</th>
<th>OTHER REQUIRED VISITS</th>
<th>OTHER MEDICALLY NECESSARY VISITS &amp; ORDERS</th>
<th>CERTIFICATION/RECERTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNFs</strong></td>
<td>PA, NP, &amp; CNS employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May perform alternate visits</td>
<td>May perform and sign</td>
</tr>
<tr>
<td></td>
<td>PA, NP, &amp; CNS not a facility employee</td>
<td>May not perform/ May not sign</td>
<td>May perform alternate visits</td>
<td>May perform and sign</td>
</tr>
<tr>
<td><strong>NFs</strong></td>
<td>PA, NP, &amp; CNS employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May perform</td>
<td>May perform and sign</td>
</tr>
<tr>
<td></td>
<td>PA, NP, &amp; CNS not a facility employee</td>
<td>May perform/May sign</td>
<td>May perform</td>
<td>May perform and sign</td>
</tr>
</tbody>
</table>


CAA survivor, continued from page 1

to care-plan. The expectation of the entire process is that the IDT members share their knowledge and expertise to address the complex needs of our resident population.

One of the key skills needed by all IDT members is an understanding and recognition of the purpose of the CAA process. The process is expected to be more than just identification of data that supports or negates a particular issue. The data found should be reviewed by the team members to determine how they can utilize it to improve or enhance the resident’s care, with the resident’s goals and desires driving the process. The CAA process can as well assist the team in identifying problems that may be clinically linked, addressing these issues jointly, and streamlining the care plan into a user-friendly document.

A second skill needed by team members is the ability to involve and truly listen to our residents and/or their loved ones. Interviews are required for completion of the MDS, and these interviews often become rote due to their frequency. Many residents know when you enter the room what you will be asking them and answer “blue, sock, bed” before you even ask, in order to save you time. What else do you hear or see besides the questions you ask your residents? Do you hear their humor? Do they look happy or sad? Are they answering correctly but taking more time to process? Is there a change since the last time you did the interview? Are they less interested or less engaging? If so, what do you do with this information? Do you share your observation with the team? The CAA process can aid in identifying strengths, needs, and goals, which can then be utilized to develop resident-centered care plans, but only if the information is communicated to the team members and not kept in a silo. The process, if utilized correctly, may identify new or additional areas that need focus, motivate the resident, and enhance compliance or goal achievement.

Another key area of need is staff knowledge and understanding of the regulations involved in the MDS, CAA, and care plan processes. Are new staff members trained during orientation? Are periodic regulatory updates provided or is review only done during plans of correction? How do new staff achieve the skills required to become team members, and who teaches them their role? Team members responsible for any sections of these processes need to clearly understand what the requirements are, understand their roles and responsibilities, and have periodic evaluations done on their individual performance and the overall effectiveness of the team.

Facility teams strive to care for our residents the best they know how. Teams need to routinely discuss their strengths and identify areas needing improvement. If they are to achieve success, teams must have resources and skills to care for our residents and be prepared for regulatory review. The CAA process is a major link between the MDS and care plan development. If the IDT has the tools and skills it needs, the team will be on its way to being a CAA survivor and will improve the interdisciplinary care process in the facility.

Register for this featured conference session and see the rest of the great educational content we’re offering in Las Vegas at www.AANAC.org/2014Annual
**Q + A**

**MDS Completion Timeframes**

I think I already know the answer, but there has been a discussion here. I believe that the MDS should be completed as close to as possible after the ARD (the date after). But others do not complete the MDS until the date of the care plan, up to 7 days after the ARD. Am I wrong?

Completion timeframes depend on the type of assessment.

Admission MDS must be completed no later than day 14 of the stay, so depending on when your ARD is, you could have several days after the ARD to complete as long as you do not go past day 14.

**Significant change / Correction assessments** you have 14 days from the date you determine there was a significant change or correction to complete the assessment, so again, depending on the ARD; you could have several days after the ARD to complete the MDS.

All other assessments, you have 14 days from the ARD to complete the assessment—so actually you and your colleagues are all correct as long as you don’t deviate from the required timeframes in the RAI manual. Of course your facility or company may want a tighter timeframe so be sure to stay within your facility policies.

Don’t forget of course that in most cases, Resident interview items must be completed on or before the ARD.

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

**Language Translation Requirements**

One of our social workers had worked in a hospital previously. She was questioning our use of a resident’s family members as interpreters when the resident only speaks a foreign language. She stated the hospitals must have someone who is fluent in the specific language certify that a staff member speaks and translates the language properly before using them to translate, and that family members can never be used as translators. Hospitals have to hire someone or a firm specifically to verify that the staff member is fluent in the language. I cannot find any regulation that this applies to long-term care facilities. We have used the language phone services when family did not speak English, or there weren’t any employees to interpret, but we have always used family when they spoke both English and the native language. Does anyone have any information about not using family members or non-certified staff members to translate?

F156 addresses informing residents of their rights both orally and in writing in a language they understand. It states, “For foreign languages commonly encountered in the facility locale, the facility should have written translations ... and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to acknowledgement of receipt.” The “representative” is usually a family member, and in this example provided in the State Operations Manual, is authorized to translate for the resident. It is common practice in nursing homes to have family members who want to be involved in their loved one’s care provide translation services when they are in the facility. Given the CMS emphasis on resident and family choice and maintaining previous life habits, it is hard to imagine telling family members not to translate for the resident. I am unaware of a requirement to have translators certified, whether employees or individuals from the community. In my experience, surveyors wanted to see a current list of employees and others from the community with the languages they spoke, and any other resources we used for translation services. Language lines like the phone line you mentioned are an excellent resource, as well as translation services provided via the Internet.

Betty Frandsen, RN, NHA, MHA, C-NE
(bfrandsen@aanac.org)

**Medicare Part B Therapy**

We have a resident who came in Medicare A. Benefits were exhausted. He continued to stay in our facility as long term care resident and received therapy under Medicare B, one to two times per week. There has been a 60 day break since Medicare A benefits was exhausted? Can there be a 60 day break in spell of illness, since Medicare B was used during that time?

continued on page 6
AANAC Board of Directors

Ruth Minnema, RN, MA, C-NE, RAC-CT
Chair
Peter Arbuthnot, AA, BA, RAC-CT
Chair-Elect
Carol Maher, RN-BC, RAC-CT
Secretary
Susan Duong, RN, BSN, NHA, RAC-CT, C-NE
Treasurer
Gail Harris, RN, BSN, RAC-CT, C-NE
Jo-Anna Hurd, RN, MSN, RAC-CT
Stephanie Kessler, RAC-CT
Linda Krueger, RN, AAS, BA, RAC-CT
Benjamin Ruggles, BSN, RN, RAC-CT, C-NE, CPRA
Carol Smith, RN, BSN, RAC-CT

AANAC is pleased to introduce you to our panels of volunteer reviewers who represent the best and the brightest in our field:

MDS/Medicare Expert Panel

Judy Wilhide Brandt, RN, RAC-CT, C-NE
Chair
Andrea Otis-Higgins, RN, MLNHA, CDPNA, CCLNC, RAC-MT
Vice Chair
Robin L. Hillier, CPA, STNA, LNHA, RAC-MT
Lisa Hohlbein, RN, RAC-MT
Becky LaBarge, RN, RAC-MT
Jennifer LaBay, RN, RAC-MT
Mark E. McDavid, OTR, RAC-CT
Deb Myhre, RN, C-NE, RAC-MT

Director of Nursing Expert Panel

Sandy Biggi, RN, BSN, C-NE-MT, RAC-MT
Mary Pat Carhart, RN, BSN, RAC-CT
Kathy Lashomb, RN, AAS, C-NE, RAC-CT
Lynn Milligan, RN, BSN, C-NE, RAC-CT
Linda Shell, RN, BSN, MA, C-NE
Linda Winston, RN, BS, MSN, C-NE, RAC-CT

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

Q + A, continued from page 5

For Part B to be considered at a “skilled” level of it has be to 5 days per week. So, if the patient was receiving therapy 1-2 times per week then that does not meet a skilled level of care so do not count those days in the 60 day break.

Mark McDavid, OTR, RAC-CT (mmcdavid@rehabmanagement.com)

Physician Visit Requirements

If a nurse practitioner makes the first visit when a resident arrives at a SNF instead of the doctor, it is my understanding that we can receive an F tag for that......is F388 a paper tag or a patient care tag? Is it Medicare fraud if a NP sees the resident first?

F388 Physician Visits is not listed with the regulations that result in citations of substandard quality of care. However, now that you have identified that F388 Physician Visits was not followed, you need to make correction. Through your QAA Committee, audit to see how often this has happened, and if a physician has not yet seen the identified resident(s), a visit should be scheduled as soon as reasonably possible. It may be that the Medical Director could see the resident(s) to get the correction quickly in place. Make sure that your facility’s policy on physician visits complies with F388. The QAA Committee should develop a plan of correction with input from the Medical Director that includes notifying attending physicians in writing of the requirements of F388. Monthly monitoring should occur until it is determined that physician visits are in compliance, with periodic follow-up audits reported at QAA meetings. This is not likely to be considered fraud, as an actual visit was conducted, but it is considered non-compliance. Identifying the problem in-house and making systemic correction indicate a good-faith attempt at compliance. Document the actions taken so that you have the necessary paper trail to demonstrate that you identified this issue and addressed it timely.

Betty Frandsen, RN, NHA, MHA, C-NE (bfrandsen@aanac.org)