Ellen Berry of CMS has announced that CMS would use RUG-IV beginning October 1, 2010 as a “stop-gap” until a new version of RUG-III is developed. Since Section T Projected Therapies is not included on MDS 3.0, and the regulation does not say that the Medicare Short Stay Assessment (Z0100C) may be used, there are many issues in designing a revised version of RUG-III. The announcement is available at www.cms.gov/SNFPPS/02_Spotlight.asp. As soon as this revision is available, it will be implemented for assessments submitted after that date. All assessments paid using RUG-IV will be recalculated and necessary adjustments made.

NOTE: Implementation of MDS 3.0 is NOT postponed and will occur on October 1, 2010.

CATs and CAAs Teleconference

Date:    July 8, 2010
Time:    1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic:   CATs and CAAs
Handouts: Power Point slides will be available about July 1 on the DOH Message Board at http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp

Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 76638903

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

Additional questions: qa-mds@state.pa.us
MDS 3.0 Section M Q & As

On April 8, 2010, a training teleconference was provided on MDS 3.0 Section M. The teleconference information, as well as the responses to the following questions, was based on the current (11/09) MDS 3.0 RAI Manual and information received at the March 2010 RAI conference. If later guidance is released by CMS that contradicts or augments this material, the more current information from CMS becomes the acceptable standard.

Q. What if a Pressure Ulcer was open during the 7 day observation period but healed by the ARD? Should it be coded as a Pressure Ulcer at the appropriate stage (M0300)? As a Healed Ulcer at M0900? As both?

A. The directions for coding ulcers have changed for MDS 3.0. The manual for MDS 2.0 on page 3-160 directs that you “Record the number of skin ulcers at each stage...in the last 7 days.” MDS 3.0 instructions do not reference the lookback period. For example, p. M-8 for M0300B states "Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2." It doesn’t say specifically, but it seems that "currently present" could be interpreted as meaning on the ARD.

Step 1 for completing M0300A-G (p. M-5) says "For each pressure ulcer, determine the deepest anatomical stage." An ulcer that was healed on the ARD has no "deepest anatomical stage" and is not currently an open ulcer. It would be reported at M0900 Healed Pressure Ulcers.

In addition, the manual says specifically that "Each ulcer should be coded only once" (p. M-5) so it would not be coded at both places. When the final RAI Manual is released in late May/June, the pages covering Section M should be reviewed for any further clarification.

Q. You stated that, according to information received at the RAI conference, a blood-filled blister was to be coded as a Stage 2 pressure ulcer. This is contrary to the NPUAP guidelines which state that such blisters should be coded as Stage 4 or suspected Deep Tissue Injury.

A. CMS has chosen not to adopt this portion of the NPUAP guidelines. A blood-filled blister caused by pressure with little inflammation of the surrounding area should be coded as a Stage 2. If the blister was part of the complex of indicators of a suspected Deep Tissue Injury as stated on p. M-16 (“Purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue. The adjacent or surrounding area may be painful, firm, mushy, boggy, warm or cool.”), it would be coded as a suspected Deep Tissue Injury.

Q. Is a blister in the groin due to pull-ups a Pressure Ulcer?

A. Every lesion must be evaluated individually. Page M-5 states, “If an ulcer arises from a combination of factors of which pressure is the primary cause, then the ulcer should be included in this section as a pressure ulcer. Each ulcer should be coded only once, either as a pressure ulcer or an ulcer due to another cause.”

Q. The RAI Manual states: If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer should not be coded as “present on admission” because it was present at the residential facility prior to the hospitalization. (p. M-6) Shouldn’t it make a difference as to what that pressure ulcer was coded during the NF stay prior to hospitalization—present on admission or not present on admission? If they returned with it at the same stage, should it not be coded as it was?

A. “Present on admission” is a confusing coding decision. The proper response varies with the specific circumstances. If the resident had a Stage 2 pressure ulcer on admission to the facility, it would be coded as Present on admission. If the resident goes to the hospital and the ulcer remains a Stage 2 on return, it now must be coded as Not present on admission as addressed in Chapter 3, p. M-6, number 4 under Step 3. CMS apparently wishes to identify the environment in which the pressure ulcer developed or worsened. This ulcer was present at this stage “while the resident was in the care of the nursing home” and did not change during the period that the hospital cared for the resident. CMS’ historical time frame only covers pre- and post-hospitalization; it does not encompass the whole nursing home stay.

Observation Stays

A trend seems to have developed recently with patients being kept on Observation status for several days in the hospital rather than being admitted as an inpatient. In order to receive Medicare Part A services in a SNF, the resident must first have a “qualifying hospital stay.” A qualifying hospital stay is defined as being admitted as a hospital inpatient for at least three days counting the day of admission but not the day of discharge. Most nursing facilities have learned to check the potential resident’s hospital status very carefully before admission to assure that the proper payer sources are billed.

To the prospective resident, this is very confusing. She has been in the hospital for several days; surely this qualifies her for a Medicare Part A stay! To assist everyone understanding this issue, CMS has released information entitled “Are You a Hospital Inpatient or Outpatient?” at www.medicare.gov/Publications/Pubs/pdf/11435.pdf. This release may be helpful to nursing facilities as they try to explain the situation to a potential resident and family.
Tips for Successful Interviewing

Ask almost any nurse what she would most like to change about her current position, and you will probably receive some version of “I’d like to be able to spend more time with my residents.” MDS 3.0 provides this opportunity with its multiple interview sections. While there are very specific instructions provided for conducting these interviews, you will have time to interact with the residents and truly listen to what they have to say. Detailed information about interviewing can be found in Appendix D of the MDS 3.0 RAI Manual.

The first consideration is whether the interview is to be conducted. Most residents can respond to simple questions, so usually the interviews should be attempted. However, if B0700 Makes Self Understood is coded 3 Rarely/never understood, the alternate staff assessments should be used. The alternate process should also be used if the interview is started but the resident does not respond; gives nonsensical answers (responses that are unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated); or an interpreter is not available.

If you will be attempting the interview, you must set up the environment:

- Introduce yourself.
- Be sure the resident can hear what you are saying: hearing aids? amplifier?
- Provide an interpreter as necessary. This person should translate the questions and responses but add no interpretation to the material.
- Find a quiet, private area where you won’t be interrupted or overheard.
- Sit where you can easily see each other and observe the resident’s expressions.
- Establish rapport and respect. Meet any needs expressed by the resident before continuing with the interview.

Explain the purpose of the questions. Identify the topic; explain that these questions are asked of everyone in order to help develop a care plan.

The first interview section is the Brief Interview for Mental Status or BIMS beginning at C0200. The purpose is to evaluate the resident’s cognitive status. The instructions for this are very specific; you may not assist the resident with their responses as you may with other interviews. The MDS 3.0 RAI Manual on pages C-5 through C-14 provides many examples for coding in different situations.

- Ask the resident: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are **sock, blue, and bed**. Now tell me the three words.” Record the number of words repeated after the first attempt. Do not repeat the words even if the resident requests it.
- After the resident’s first attempt, repeat the words using cues (“sock, something to wear; blue, a color; bed, a piece of furniture”). You may repeat the words now up to two more times.
- Ask the resident: “Please tell me what year it is right now.” Code based on resident’s response. You can ask the resident for clarification, e.g., if she said “10”, ask her for the complete year.
- Ask the resident: “What month are we in right now?” Code based on resident’s response.
- Ask the resident: “What day of the week is today?” Code based on resident’s response.
- Ask the resident: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?” If unable to remember a word, give the cue (something to wear; a color; a piece of furniture) for that word. Code based on resident’s response, and record the Summary Score at C0500.

During the BIMS interview, observe the resident for Inattention, Disorganized thinking, Altered level of consciousness and Psychomotor retardation. These items must be completed at C1300 Signs and Symptoms of Delirium (from the Confusion Assessment Method or CAM©).

For the other three interviews, D0200 Resident Mood Interview (PHQ-9©), F0400/500 Interviews for Daily and Activity Preferences and J0300+ Pain Assessment Interview, you are interested in obtaining as much information about the topic as possible with as much specificity as possible. If the resident has pain, where is it? How often? Has it interfered with her life? You may use several interview techniques to elucidate this information.

- Say and show the response items written in large, clear print on a piece of paper or card that the resident may hold.
- Ask the questions as they appear in the questionnaire. Actively listen to the resident’s responses.
- Break the question apart if the resident has difficulty understanding, requests clarification or seems hesitant.

(Continued on page 4)
MDS 3.0 ADL Decision Flow Sheet

With the new RAI Manual, CMS included a new MDS 3.0 ADL Decision Flow Sheet (p. G-6). This, as well as the MDS 3.0 Section G, included Instructions for the Rule of 3 to aid nurses in identifying the proper code for the ADL Self-Performance sections. After the various Baltimore conferences, CMS has issued a slightly revised version at http://www.cms.gov/NursingHomeQualityInits/Downloads/MDS30ADLFlowchart.pdf

The first two instructions remain the same:
• When an activity occurs three times at any one given level, code that level.
• When an activity occurs three times at multiple levels, code the most dependent. Exceptions are: total dependence (4) – activity must require full assist every time; and activity did not occur (8) – activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).

The clarification occurs under the third section: When an activity occurs at more than one level but not three times at any one level, apply the following:

• Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance – this is total dependence).
• When there are 3 or more episodes of a combination of full staff performance and weight-bearing assistance – code extensive assistance (3). For example, it seems that if there were two episodes of full staff performance, two episodes of extensive assistance and two episodes of limited assistance, the interpretation would be that there were four episodes of weight-bearing assistance, and so the proper code would be a 3.

When there are 3 or more episodes of a combination of full staff performance/weight bearing assistance and non-weight bearing assistance, code limited assistance (2). For example, it seems that if there was one episode of full staff performance, one episode of extensive assistance and one episode of limited assistance, the proper code would be a 2. And finally, if none of the above are met, code supervision (1). The concept of combining self-performance events based on “weight-bearing assistance” is a changing approach. When the final MDS 3.0 RAI Manual is available, everyone will need to read it carefully for further clarification.

Tips for Successful Interviewing (cont’d)

(Continued from page 3)

• “Unfolding” refers to the use of a general question about the symptom followed by a series of more specific symptoms. For example, read the item to the resident, then say “Do you have this at all?” If yes, then, “Do you have it every day?” If no, then, “Did you have it at least half the days in the past 2 weeks?”
• “Disentangling” refers to separating items with several parts into manageable pieces. The resident can respond to each part separately. For example, an item asks about “Poor appetite or overeating.” Disentangle this item by asking “Poor appetite?” Pause for a response and then ask, “Or overeating?”
• “Probing” is encouraging the resident to tell you if the symptom bothered them, even if it was only some of the time. Probe by asking neutral or nondirective questions such as “What do you mean?” “Tell me more about that.” “Give me an example.”
• Summarize long answers, and repeat the original question. For example, “You’re telling me the food isn’t what you eat at home and you can’t add salt. How often would you say that you were bothered by poor appetite or overeating during the last 2 weeks?”
• Clarify using “echoing” which simply restates part of the resident’s response.

Other ideas that may lead to successful interview completion:
• Repeat the response options as needed.
• Move on to another question if the resident is unable to answer. Guidance is provided in the manual as to scoring for incomplete interviews.
• Break up the interview if the resident becomes tired or needs to leave for therapy, etc. However, it is particularly important to complete the BIMS in one sitting.
• Do not try to talk a resident out of an answer.
• Record the resident’s response, not what you believe they should have said.
• If the resident becomes sorrowful or agitated, sympathetically respond to the resident’s feelings. End the interview if so desired by the resident.

Resident preferences may be influenced by many factors in a resident’s physical, psychological and environmental state, and it can be challenging to truly discern the resident’s wishes.