Modification Changes

CMS has released a new set of data specifications that will be effective on May 19, 2013. For the past two years, modification of target dates and reasons for assessment was not allowed. If this was attempted, the record was rejected and Edit -3811 appeared on the Final Validation Report: None of the Reasons for Assessment (A0310A, A0310B, A0310C, A0310D, A0310F) nor the target date (A1600 for an entry tracking record, A2000 for a discharge, or A2300 for an assessment) may be modified. Inactivation was required, setting a new target date and doing a new assessment.

On May 19, 2013, Edit -3811 will be deleted and a new edit, -3839, added. These changes allow modification records (where A0050 = 2) to change a record’s target date and/or reasons for assessment IF the modification does not affect the record’s item subset code (ISC). If the modification would change the ISC, Edit -3839 will appear rejecting the record.

It will be possible to correct the typo in the target date with a modification, e.g., entered 01/01/2013 when it should have been 02/01/2013. It will be possible to change the Admission assessment to an Admission 5-day PPS without redoing the assessment. However, a quarterly (NQ) cannot be turned into an annual (NC) – the ISC cannot be changed.

This will be effective retroactively. Beginning on the implementation date, this edit applies to all records regardless of their target date. If there are problems with an April record and the modification is submitted on or after May 19, the change in target date or reasons for assessment will be accepted.

However, this is not in place yet. Until May 19, use of inactivations to correct target dates or reasons for assessment must be continued. ARDs for the replacement assessment must be set for the date the error was discovered. But relief is coming; watch for further details from CMS!

Section Teleconference

Date: April 18, 2013
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Section N Medications
Handouts: Power Point slides will be available about April 15 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: 11138348
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@pa.gov
Section K Swallowing/Nutritional Status Q & As

On January 17, 2013, a training teleconference was provided on Section K Swallowing/Nutritional Status. The following questions were received.

Q. How do we resolve the differences in the definition of therapeutic diet in F325 and the MDS?

A. F325 and MDS definitions differ for therapeutic diet. F325 states that “Therapeutic diet” refers to a diet ordered by a health care practitioner as part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

By contrast, the RAI Manual definitions for Mechanically altered and Therapeutic diets separate these types:

- **K0510C** Mechanically altered - A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat and thickened liquids.
- **K0510D** Therapeutic diet - A diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease or increase certain substances in the diet (e.g., sodium, potassium).

For MDS 3.0 completion, do not code a mechanically altered diet as therapeutic unless it also meets the definition for K0510D, regardless of the definition found in F325. Be sure when you are talking with surveyors that everyone is clear as to how the phrase “therapeutic diet” is being used.

Q. If a G-tube is not being used for nutrition or hydration but is kept patent with flushes, can it be recorded at K0510B?

A. Yes. Just the presence of the tube is sufficient for coding this item.

Q. Must the weight be taken in the last 7 days to be used in the Weight Loss/Weight Gain calculations at K0300 and K0310?

A. See article on page 3.

Q. How should we identify weights from 30 days ago and 180 days ago?

A. The most practical way seems to be to identify a weight as close as possible to the date 30 days prior to the date of the current weight and 180 days prior to the date of the current weight.

Q. A medication is administered in 100cc of IV fluid. Can this be coded at K0510A?

A. First, you would have to identify whether the fluid is being given to meet nutrition and/or hydration needs. If so, it could be coded.

Q. Resident is sent to the ER with a diagnosis of UTI. IVs are given for medication administration, and to establish vascular access. Can this be coded at K0510A?

A. Read the records of the ER visit very closely. If you can identify that the fluids were given for hydration and not just as a medication administration vehicle, it could be coded.

Q. What must be included in the documentation to code K0300/K0310 Weight Loss/Gain as “on a physician-prescribed regimen”?

A. There must be a physician ordered diet plan, or documentation of expected weight loss due to loss of fluid with physician orders for diuretics. The physician should give some indication of the expected fluid loss so that the resident can be monitored for other possible weight loss issues.

Q. A resident is ordered a regular diet with protein supplements to aid in healing a pressure ulcer. Can this be counted as a therapeutic diet?

A. This may be part of the treatment for a disease or clinical condition manifesting an altered nutritional status with a need to increase protein in the diet. However, the particular deficit must be identified. Nutrition interventions implemented as part of a treatment plan for a clinical condition (such as pressure ulcers) may be therapeutic, but don’t necessarily meet the definition of a therapeutic diet.

Q. Should therapeutic diet (K0510D) be coded for all supplements since they are utilized for calorie or protein malnutrition? If a resident is on a supplement due to poor appetite with no diagnosis, should this be checked as a Therapeutic diet at K0510D?

A. Poor appetite or weight loss may be symptoms, but by definition, therapeutic diets are required to treat a disease or clinical condition. Alone, supplements do not constitute a therapeutic diet; they must be administered as part of a therapeutic diet to manage problematic health conditions. Therapeutic diet would not be coded in any of these...

(Continued on page 3)
Many questions were received this month as to whether a medical diagnosis of functional quadriplegia should be coded at I1500 Quadriplegia.

Quadriplegia is paralysis of all four extremities usually caused by catastrophic damage to the brain or upper spinal cord by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

Functional quadriplegia is defined as the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the brain or spinal cord.

Instructions in the RAI Manual for coding Section I Active Diagnoses state that "If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000 Additional active diagnoses." (P. I-4) On the SNF Open Door Forum on February 14, 2013, CMS stated that functional quadriplegia is not to be coded in item I5100 on the MDS. The underlying medical conditions which cause the inability to move will be captured in the appropriate items in section I, and additional active diagnoses may also be coded in item I8000.

K0510D Therapeutic Diet

The question as to whether the ordering of protein supplements with a regular diet can be designated as a therapeutic diet at K0510D has been the subject of discussion and research with the RAI Coordinator and dieticians at the Department of Health, as well as close reading of the RAI Manual.

The guidance in the RAI manual states that "therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status." In addition, "Supplements are only coded in K0510D Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions."

That being said, to meet the parameters provided above, we believe the actual nutritional alteration must be identified, and that there must be appropriate evidence that the supplement, as an intervention, is part of the corresponding treatment. For example, for a resident with low albumen, the protein supplement would be part of a therapeutic diet; the specific deficiency has been identified. The simple presence of pressure ulcers would not be sufficient evidence to designate the protein supplement as part of a therapeutic diet.

Section K Weights Update

When the RAI Manual v. 1.09 was released on November 7, 2012, wording was changed in Section K Swallowing/Nutritional Status on pages K-4, K-5, K-8 and K-9 so that it stated “This item compares the resident’s weight in the 7-day look back period with his or her weight at two snapshots in time.”

On November 29, 2012, CMS issued change pages and Errata files to correct several issues in the new version of the manual. At this time, the wording for page K-4 under Steps for Assessment for K0300 Weight Loss was returned to the previous form: “This item compares the resident’s weight in the current observation period with his or her weight at two snapshots in time.” Directions for K0200B Weight direct that you are to “Base weight on the most recent measure in the last 30 days.”

The Resident Data Reporting Manual will be changed to reflect the previous wording.

Section K Swallowing/Nutritional Status Q & As (cont’d)

(Continued from page 2) situations. See the additional article on page 3.

Q. Is a clear or full liquid diet a therapeutic diet to be coded at K0510D?

A. Yes. The physician progress note would likely include the rationale for a liquid diet order that would meet the therapeutic diet definition.
PPS Assessment Details

Remembering all the details concerning PPS assessments is a challenge, and the penalties for overlooking one may be severe. The following article highlights some of the more significant details. All page references are to the RAI Manual.

Scheduled PPS Assessments

Setting the ARD for a scheduled PPS assessment can be challenging: not only must you select an appropriate date, you must do it while you are in the designated window.

- If the date is set, it may be moved while you are in the window including grace days;
- If the date was not set while in the window, it cannot be set for any date other than the current date.
- The facility is required to set the ARD on the MDS Item Set or in the facility software within the appropriate timeframe of the assessment being completed (p. 2-8). Having the date on a list or a scheduling calendar is not sufficient.
- MDS completion requirements are the same as OBRA assessments, e.g., resident interviews must be completed on or before the ARD.
- If the resident is not in the facility at midnight, the Scheduled PPS assessment calendar must be adjusted.

Missing assessments can be a costly event for your facility: “If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident is no longer a SNF Part A resident, … the provider may not usually bill for the days when an assessment does not exist in the QIES ASAP … there is not an assessment based RUG the provider may bill…. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Par A when this is discovered, an assessment may not be performed.” (p. 6-54) In this last situation, the facility may be liable for the costs of the stay.

There are instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP:

- The stay is less than 8 days within a spell of illness,
- The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
- The SNF is notified on an untimely basis of a beneficiary’s enrollment in Medicare Part A,
- The SNF is notified on an untimely basis of the revocation of a payment ban,
- The beneficiary requests a demand bill, or
- The SNF is notified on an untimely basis or is unaware of a beneficiary’s disenrollment from a Medicare Advantage plan. (p. 6-54)

 Unscheduled PPS Assessments

Unscheduled PPS assessments have some different timing requirements than the scheduled assessments.

When coding a standalone COT, EOT or SOT, facilities must set the ARD for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. (p. 2-52) If set later, ARD must be set for the current date.

- COT ARD must be on Day 7 of the observation period. ARD may be set as Day 7 on Day 8 or 9.
- EOT ARD must be Day 1, 2 or 3 of the three missed therapy days. ARD may be set as Day 1, 2 or 3 on Day 4 or 5.
- SOT ARD must be set on Day 5, 6 or 7 after the start of therapy. ARD may be set for Day 5, 6 or 7 on Day 8 or 9.
- Facilities may still exercise the use of this flexibility period in cases where the resident discharges from the facility during that period. (p. 2-52)
- For a COT, the interview items may be completed one or two days after Day 7 of the COT observation period. (Clarification from the November 2011 Provider Training Call)
- If the resident is not in the facility at midnight, the Unscheduled PPS windows are not adjusted.

In some cases, the facility has a choice as to whether to complete the unscheduled PPS assessment.

- If a scheduled PPS assessment occurs before Day 7 of the COT observation period, a COT is not required. If the ARD of the scheduled PPS is set for Day 7 of the COT observation period, it is the facility’s choice as to whether to also designate the assessment as a COT. (p. 2-51)
- A COT OMRA may not be used as the first assessment that would classify a resident into a RUG-IV therapy group. This initial classification must be done using one of the regularly scheduled assessments or by completing a Start of Therapy OMRA. (Clarification from the November 2011 Provider Training Call)
- An EOT is not required if the resident is discharged or ends her Medicare Part A stay on Day 1, 2 or 3 of missed therapy. (p. 2-48)
- A SOT is always optional.