RUG-IV Classification Changes

On August 6, 2013, the Final Rule for the Medicare Prospective Payment System for SNFs was published in the Federal Register, including the new rates for FY 2014. The rule included a change to the RUG-IV classification system.

To classify into the Medium Rehabilitation category, the resident must receive five distinct calendar days of therapy within a 7-day time period. This reflects the SNF Level of Care requirement that skilled services must be needed and received on a daily basis. Payment rates for these RUGs are based on staff time over the requisite number of distinct therapy days.

However, on the MDS, the facility simply reports the number of days each of the skilled therapies was provided. For example, the resident might receive physical therapy on Monday and Wednesday (reported as two days on the MDS); occupational therapy on Monday and Wednesday (two days on the MDS) and speech therapy on Friday (one day on the MDS). In the current classification system, the days would be added together for a total of five and the resident would qualify for placement in the Medium Rehabilitation category even though she had only received therapy on three days.

To permit facilities to report the number of distinct calendar days on which a resident receives therapy and to permit implementation of the Rehabilitation RUG classification criteria as intended, CMS is adding item O0420 Distinct Calendar Days of Therapy effective October 1, 2013. The facility will report the number of separate days on which therapy was provided. This response will be used in identifying RUG Rehabilitation categories.

Questions about the RAI?
Please submit them to qa-mds@pa.gov

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Section Teleconference

Date: October 17, 2013
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Latest MDS 3.0 Changes
Handouts: Power Point slides will be available about October 14 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: 35771949
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 M Skin Conditions Q & As

On July 18, 2013, a training teleconference was provided on Section M Skin Conditions. The following questions were received.

Q. Must a tool such as the Braden Skin assessment be performed in the 7-day observation period?

A. Yes. Instructions on the MDS state that the “Look back period for all items is 7 days unless another time frame is indicated.” Page 1-8 of the RAI Manual states “It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment…”

Q. If a wound is not showing signs of healing in 14 days, should a Significant Change in Status assessment (SCSA) be done?

A. A SCSA is required when the decline or improvement in the resident’s status will not resolve itself without interventions, impacts more than one area of the resident’s health status, and requires interdisciplinary review/revision of the care plan. Review of the interventions being used for wound treatment is certainly warranted, but unless there are other issues discovered, a SCSA would not be required.

Q. How do you classify blisters that do not appear over bony prominences?

A. All skin lesions require investigation to identify their cause. Pressure ulcers most commonly appear over bony prominences but there may be other sources of pressure, e.g., incontinence brief that causes pressure in the groin area. Consultation with the physician may be necessary to identify any underlying disease processes, e.g., allergies, bullous pemphigus, etc. Classification would depend on the identification of the cause of the blisters.

Q. In M0210 Unhealed Pressure Ulcers, how should an ulcer be coded that is present in the look-back period but heals by the ARD?

A. For M0210 Unhealed Pressure Ulcer(s), you are directed to code 1 Yes if the resident had any pressure ulcer (Stage 1, 2, 3, 4 or unstageable) in the 7-day look-back period. The ulcer was present in the look-back period and should be coded. If the pressure ulcer was coded on the previous assessment, its healing should also be coded at M0900 Healed Pressure Ulcers.

However, the last bullet on the bottom of page M-5 states that “If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0.” Coding for this ulcer will depend on its reported history.

Q. If two pressure ulcers at different stages merge, would it be considered “worsening” at M0800?

A. An ulcer is staged by determining its deepest anatomical stage. Worsening is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1 – 4. CMS’ new guidance on page M-26 is a caution against considering a merged ulcer “worsened” only because its area is larger.

If a Stage 2 and a Stage 3 ulcer merged, the classification of this united ulcer would be based on the depth of the Stage 3 portion of the wound. Both ulcers were present previously – they are not new in this observation period. The overall highest numerical stage has not increased. In this unusual situation, the merged ulcer should not be considered as “worsened” at M0800.

Q. Would a Stage 1 be recorded as healed in M0900?

A. M0900A asks if there were pressure ulcers present on the prior assessment; if the Stage 1 had been present, this would be coded 1 Yes. However, M0900B, C and D deal only with Stages 2, 3 and 4 so all entries would be 0 unless the resident had other ulcers.

Q. How should cellulitis with ulcerations be coded in M1040?

A. All skin lesions require investigation to identify their cause; once that is identified, coding decisions can be made. This might be coded at M1030 Number of Venous and Arterial Ulcers. M1040D Open lesion(s) other than ulcers, rashes, cuts might be appropriate. If there is a quantity of exudate, M01040H Moisture Associated Skin Damage might describe the condition. Accurate assessment will identify the proper coding.

Q. A Stage 4 pressure ulcer was present at admission, healed for a year and now has opened as a stage 2 ulcer. What stage should it be coded at? The resident has never been out of the facility.

A. Since the wound had been healed for a year, this should be coded as a new Stage 2 pressure ulcer with the care plan reflecting the history of the area. It would not be considered Present on Admission – the Stage 2 ulcer developed in the facility.

If the “healed” period had been shorter – e.g., since the previous assessment – the pressure ulcer would be considered a reopened Stage 4 as discussed on page M-30.

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Hospice Services in LTC Facilities

On June 27, 2013, CMS published the Final Rule dealing with provision of Hospice Services in LTC Facilities (www.gpo.gov/fdsys/pkg/FR-2013-06-27/pdf/2013-15313.pdf). It is effective August 26, 2013. This is considered to be a requirement that an institution must meet in order to qualify as a skilled nursing facility (SNF) in the Medicare program, or as a nursing facility (NF) in the Medicaid program. Hospice Conditions of Participation when caring for residents in nursing facilities were defined in the Final Rule issued June 5, 2008.

LTC facilities that choose to arrange for the provision of hospice care through an agreement with one or more Medicare-certified hospice providers must have in place a written agreement with the hospice that specifies the roles and responsibilities for each entity. The hospice agency will receive the Medicare routine home care rate, which is a fixed amount per day for the services provided by the hospice regardless of the volume or intensity of those services. The resident remains responsible for payment of the LTC facility’s room and board charges which may be covered by Medicaid.

LTC facilities and hospices are required to provide many of the same services to residents who have elected to receive the hospice benefit. If hospice care is furnished in an LTC facility through an agreement with a hospice, the LTC facility must meet the following requirements:

* Ensure that the hospice services meet professional standards;
* Have a signed written agreement before hospice care is provided to any resident which includes:
  * the services the hospice will provide,
  * the hospice’s responsibilities for determining the appropriate hospice plan of care,
  * the services the LTC facility will continue to provide,
  * a communication process including how communication will be documented,
  * a provision that the LTC facility will notify the hospice about a significant change, clinical complications, a need to transfer the resident from the facility for any condition and the resident’s death,
  * a provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care,
  * an agreement that it is the LTC facility’s responsibility to furnish 24-hour room and board care, and
  * a delineation of the hospice’s responsibilities, e.g., medical direction, nursing, counseling, social work, durable medical equipment and drugs, etc.

Each LTC facility arranging for the provision of hospice care must designate a member of the facility’s IDT who will be responsible to coordinate care provided by the LTC facility staff and hospice staff. This person must have a clinical background and be able to assess the resident or have access to someone who can perform the assessment.

The LTC facility must ensure that each resident’s written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident’s highest practicable well-being. A Significant Change in Status assessment is still required when hospice care is initiated or revoked. Hopefully the publication of this Final Rule will clarify the responsibilities of the hospice and the LTC facility.

RUG-IV Classification Changes (cont’d)

(Continued from page 1)

Another factor that facilities must consider is the regulations in the Medicare Benefit Policy Manual. It states that staggering the timing of various therapy modalities in an arbitrary fashion throughout the week to meet the requirement for “daily skilled need” does not satisfy the SNF coverage requirement for skilled care (CMS, 2006, chapter 8, section 30.6). This requirement is only met when there is a valid medical reason why both therapy services cannot be furnished on the same day.

Section M Skin Conditions Q & As (cont’d)

(Continued from page 2)

Q. If a Stage 3 ulcer is debrided and now classifies as a Stage 4, would it be considered worsened at M0800?

A. If the ulcer had previously been numerically staged and debridement identified a deeper stage wound, it would be considered worsened; it has increased in numerical stage. This is discussed on page M-26 of the RAI Manual relating to ulcers that have an unstageable phase.

Q. Is a skin lesion removed with Cryotherapy/Cryosurgery considered a surgical wound?

A. No. The definition of surgical wound on page M-13 specifies incisions, skin grafts or drainage sites.

Q. When coding sections M1200A, B Pressure reducing device for bed and/or chair, does the facility need to have documentation every shift that the device was used in order to code on the MDS?

A. There must be documentation that the mattress is pressure reducing and/or relieving. For other devices, e.g., wheelchair pads, there must be documentation that the device was used at least once in the observation period.
Upcoming Item Subset Code Changes

CMS is making several changes to the various ISCs effective October 1, 2013. The addition of O0420 Distinct Calendar Days is discussed in the article on RUG-IV Changes.

- Items are being added to various ISCs. For instance, H0200A Toileting trial is being added to the NQ and NP ISCs.

- K0700 Percent Intake by Artificial Route has been removed. It is replaced by K0710A Proportion of Calories and K0710B Average Fluid Intake which require coding indicating the amounts received for three different time periods: While NOT a resident, While a resident, and During Entire 7 Days. The response for During Entire 7 Days will be used in both the RUG-III and RUG-IV classification systems.

- At the current time, Individual minutes, Concurrent minutes and Group minutes must be reported for speech therapy, occupational therapy and physical therapy. Under each of these sections, item 3A has been added requiring the recording of the total number of minutes each therapy was administered to the resident in co-treatment sessions in the last 7 days.

- CMS continues to refine Section Q Participation in Assessment and Goal Setting. In several items, one of the coding options was “No family or significant other available” leading to confusion as to the exact interpretation of the phrase. In the October revision, the wording is changed in Q0100B to Resident has no family or significant other and at Q0100C to Resident has no guardian or legally authorized representative.

Utilization Guidelines Updates

Appendix PP of the State Operations Manual serves two purposes: it provides guidance to surveyors as to observations and judgments that should be made during their surveys; and, as part of the RAI known as the Utilization Guidelines, it provides information to facilities on providing quality care to their residents.

When CMS wishes to update this section, a Survey and Certification Letter is issued containing the reasons for the update and the new material. Four letters of interest have been issued recently:

1. Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for F309 – Quality of Care and F329 – Unnecessary Drugs. (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-13-35.html?DLPage=2&DLSort=1&DLSortDir=descending). This contains additional information in CMS’ continuing effort to improve care of residents with dementia and decrease the use of antipsychotic drugs. Key principles presented include Person-Centered Care, Quality and Quantity of Staff, Thorough Evaluation of New or Worsening Behaviors, Individualized Approaches to Care, Critical Thinking Related to Antipsychotic Drug Use, Interviews with Prescribers and Engagement of Resident and/or Representative in Decision-Making.

2. Reminder: Access and Visitation Rights in Long Term Care (LTC) Facilities (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-13-42.html?DLPage=1&DLSort=2&DLSortDir=descending). LTC facilities must ensure that all individuals seeking to visit a resident be given full and equal visitation privileges, consistent with resident preference and within reasonable restrictions that safeguard residents. Residents must be notified of their rights to have visitors on a 24-hour basis, who could include, but are not limited to, spouses (including same-sex spouses), domestic partners (including same-sex domestic partners), other family members, or friends.


4. On March 19, 2013, CMS published the Final Rule in the Federal Register dealing with Notice of Facility Closure. It is effective April 18, 2013 requiring that a 60-day notice of closure must be given by the nursing home administrator.