The MDS Mentor

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The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Medicare and Medicaid Services (CMS)

CMS Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Leave of Absence (LOA)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Resource Utilization Group (RUG)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

Section M: Skin Conditions

For clinical accuracy, as well as clinical reimbursement, it is important staff read, understand and follow the coding instructions for Section M in the RAIM3.

The first two items coded in Section M are M0100: Determination of Pressure Ulcer Risk and M0150: Risk of Pressure Ulcers. The RAIM3, pages M-1 to M-3, contains clear and detailed instructions for accurately coding M0100 and M0150.

Next, when using the instructions from the RAIM3, page M-5, to code M0210: Unhealed Pressure Ulcer(s), one selection is "**Code 1, yes:** if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period." When M0210 is "**1**" staff proceed to M0300: Current Number of Unhealed Pressure Ulcers at Each Stage.

For M0300, ensure staff are correctly documenting the type and stage of the pressure ulcer (or the reason the ulcer is unstageable). They must be up-to-date on the current determination and staging criteria according to Section M of the RAIM3. For example, from page M-5, "If an ulcer arises from a combination of factors which are primarily caused by pressure, 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."

Also, confirm staff are aware CMS **adapted** the National Pressure Ulcer Advisory Panel (NPUAP) staging guidelines, but they did not entirely adopt them.

Important differences exist when coding a pressure ulcer that presents as a blister. Staff need to determine if the blister is either a Stage 2 or as an unstageable pressure ulcer due to a suspected deep tissue injury (sDTI). The NPUAP guidelines indicate an intact or open/ruptured serum-filled blister is a Stage 2, while a blood-filled blister is a sDTI. However, CMS guidelines from page M-9 of the RAIM3 indicate an intact or open/ ruptured blister is coded as a Stage 2 unless the following applies:

- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury rather than a Stage 2 Pressure Ulcer.
- Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

Therefore, staff may only code a pressure ulcer that presents as a blister as a sDTI when the adjacent tissue exhibits signs of tissue damage and other causes for the tissue damage have been rejected.

For staff to determine when ulcers should be coded as unstageable due to slough and/or eschar, page M-16 of the RAIM3 clarifies, "Pressure ulcers that are

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Section M: Skin Conditions

"My whole life, I've wanted to feel comfortable in my skin. It's the most liberating thing in the world." - Drew Barrymore

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covered with slough and/or eschar should be coded as unstageable because the true depth (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the depth of the tissue layers involved, can the stage of the wound be determined." Note the instructions do not indicate that ALL the slough and/or eschar must be gone in order to stage the pressure ulcer. From page M-16 of the RAIM3, "Once the pressure ulcer is debrided of slough and/or eschar such that the tissues involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur."

Finally, when coding that pressure ulcers are unstageable due to a non-removable dressing/device, staff first have to be aware there was a pressure ulcer present prior to placement of the non-removable dressing or device. In addition, on page M-14, CMS provides examples of non-removable dressings/devices that "include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast."

M0300: Determining "Present on Admission"

The RAIM3, page M-6, instructs staff, "For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or re-entry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement. "

Continuing on page M-6, it is helpful to note "on admission" is defined by CMS as "as close to the time of admission as possible." To determine "present on admission" accurately, CMS outlines the following five steps:

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or re-entry. If the pressure ulcer was present on admission/entry or re-entry and subsequently worsened to a higher stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage should NOT be considered as "present on admission."
3. If the pressure ulcer was unstageable on admission/entry or re-entry, but becomes stageable later, it should be considered as "present on admission" at the stage at which it first becomes stageable. If it subsequently worsens to a higher stage, that higher stage should NOT be considered "present on admission."
4. 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 facility prior to the hospitalization.
5. If a current pressure ulcer worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and should be coded as "present on admission."

Following these five steps will assist facility staff in making proper determinations regarding when pressure ulcers are "present on admission" and when they are not. As a result, staff will be confident that pressure ulcers are only coded as "present on admission" when the guidelines from page M-6 are met.

Section M0700: Most Severe Tissue Type for any Pressure Ulcer

"What is the difference between a taxidermist and a tax collector? The taxidermist takes only your skin." - Mark Twain

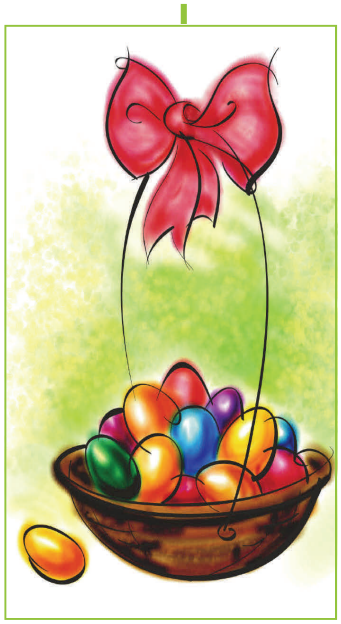
There are two important reasons to evaluate the wound base or bed of each pressure ulcer. One is so the facility interdisciplinary team can determine the best treatment options. Another is so M0700: Most Severe Tissue Type for any Pressure Ulcer can be coded appropriately.

To encode M0700 correctly, facility staff evaluate the wound base of each existing pressure ulcer during the 7-day look-back period. Next, staff code the most severe type of tissue present in the pressure ulcer wound bed. "If the wound bed is covered with a mix of different types of tissue," page M-22 of the RAIM3 continues, "code for the most severe type. For example, if a mixture of necrotic tissue (eschar) and slough is present, code for necrotic tissue (eschar)." Helpful definitions for each type of tissue are contained directly on the MDS Item Sets as well as on page M-22 of the RAIM3. Also on page M-22, "Stage 2 pressure ulcers should not be coded as having granulation, slough or necrotic tissue as by definition they do not have this extent of tissue damage."

Effective April 1, 2012, a new coding option was added to M0700. Page M-23 of the April 2012 RAIM3 instructs staff "**Code 9, None of the above,**" in the following situations:

- Stage 1 pressure ulcer
- Stage 2 pressure ulcer with intact blister (Note: All other Stage 2 pressure ulcers should be coded as "**1**".)
- Unstageable pressure ulcers related to non-removable dressing/device
- Unstageable pressure ulcers related to suspected deep tissue injury.

M0800: Worsening in Pressure Ulcer Status



The purpose of item M0800 is to document the number of new pressure ulcers and whether any pressure ulcers have worsened to a higher (deeper) stage since the last assessment." (RAIM3, page M-24)

Following the instructions in the RAIM3, and comparing the pressure ulcer (PU) status on the current MDS assessment to the PU status noted on last MDS assessment, facility staff code the number of new Stage 2's or PUs that worsened to a Stage 2 in Item M0800A, the number of new Stage 3's or PUs that worsened to a Stage 3 in item M0800B and the number of new Stage 4's or PUs that worsened to a Stage 4 in item M0800C.

The April 2012 RAIM3 instructions on page M-24 and M-25 provide coding tips for when PUs are counted as worsening in pressure ulcer status and when they are not:

- If a pressure ulcer is acquired during a hospital admission, it is coded as present on admission/entry or reentry and not included in a count of worsening pressure ulcers.
- If a pressure ulcer worsens to a more severe stage during a hospital admission, it should also be coded as present on admission/entry or reentry and not included in counts of worsening pressure ulcers.

Coding unstageable pressure ulcers:

- If an ulcer was unstageable on admission/entry or reentry, do not consider it to be worse on the first assessment. However, if it worsens after that assessment, it should be included.
- If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.
- If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable. If the pressure ulcer's stage has worsened, code it as such in this item.

PPS and COT MDS Timing Related to Discharge

This is a clarification of an existing policy. If the ARD of a PPS assessment used for payment is set on or prior to day 7 of a COT observation period, then the COT OMRA is not required and the COT observation period is reset. However, if the COT OMRA is not done in this situation and the resident is discharged before a scheduled PPS assessment takes effect, then the COT becomes a missed assessment. CMS rules allow staff to set the ARD for a COT. As long as staff have set the ARD following CMS guidelines for the COT, staff may complete and submit the COT if a scheduled assessment does not take effect due to discharge. The last day that a late COT ARD can be set for is the day of discharge.

Example 1:

Last day of COT observation is day 28 and the RUG changed. ARD of the 30-day assessment is set for day 28. SNF staff chooses to code only the 30-day, not the COT. Resident is discharged on day 29, thus the 30-day will not take effect.

The COT OMRA that was not done becomes a missed assessment - no Medicare reimbursement (provider liability) starting day 1 of that COT observation period (day 22).

Example 2:

Last day of COT observation is day 28 and the RUG changed. ARD for the EOT OMRA is day 28. SNF staff may choose not to complete the COT OMRA.

If the ARD for the EOT OMRA were set for day 29, regardless of when therapy ended, then a COT OMRA would be required with an ARD of day 28.

"I find that the harder I work, the more luck I seem to have." - *Thomas Jefferson*

"I think we consider too much the good luck of the early bird, and not enough the bad luck of the early worm." - *Franklin Delano Roosevelt*

"The day you decide to do it is your lucky day." - *Japanese Proverb*

Inactivation and ARD Clarifications

According to CMS, the following two policies have been in effect since the start of MDS 3.0.

If an assessment is inactivated for any reason, any replacement assessment must be a brand new assessment with current ARD and completion dates. If the inactivation results in SNF PPS assessments being late, either the late assessment or missed assessment policy applies. More information about this topic can be found on the DADS MDS website, under Communications, in the MDS Notification titled "Minimum Data Set (MDS) 3.0 Inactivation Procedure Clarification – Revised."

The Assessment Reference Date (ARD) of an unscheduled PPS assessment may be set for any day within the allowable ARD window no more than two days after the window has passed (last day of ARD window plus 1 or 2 days). Example: If the last day of therapy is day 10, the facility can wait no later than day 15 to schedule an End of Therapy assessment with an ARD of day 11, 12, or 13.

Corrections

MDS records with a target date (entry date, ARD, discharge date) before April 1, 2012, use the V1.07 data set (without A0050). MDS records with a target date on or after April 1, 2012, use the V1.08 data set (with A0050). CMS did not shorten any completion or submission timeframes with V1.08.

Timing of PPS MDS in an ARD Window

This is a clarification of an existing policy. If the ARD of an unscheduled PPS assessment falls within the ARD window of a scheduled PPS assessment, and the ARD for the scheduled assessment was originally set for a day after that of the unscheduled assessment, then the scheduled assessment must be combined with the unscheduled assessment on the ARD of the unscheduled assessment.

If the above rule is ignored, the scheduled assessment is not used for payment purposes. The unscheduled assessment is used for payment and continues until the next PPS assessment takes effect.

Example 1:

14-day PPS assessment ARD originally set for day 15. Last therapy day is day 11. EOT OMRA completed with ARD of day 14. The 14-day is not rescheduled and combined with the EOT OMRA.

EOT OMRA starts paying on day 12 and continues until the next PPS assessment takes effect.

Example 2:

14-day assessment ARD originally set for day 15. COT OMRA completed with ARD of day 13. The 14-day is not rescheduled and combined with the COT OMRA. COT OMRA starts payment on day 7 (day 1 of COT observation) and continues until the next PPS assessment takes effect (the 30-day).

The 14-day assessment is not used and has no impact on the COT observation period.

If you discover that a scheduled assessment follows an unscheduled assessment within the ARD window of the scheduled assessment, and you want the RUG from the scheduled assessment to affect the billing period, there are two possible courses of action.

Option 1: If you are still inside the ARD window, you can inactivate the unscheduled and scheduled assessments, if either has already been submitted and accepted, and perform a new assessment that combines the unscheduled and scheduled assessments with an ARD set to the current date. The unscheduled assessment will be late but the scheduled assessment will be on time.

Option 2: If you are outside the ARD window, or if you are in the window and do not want the unscheduled assessment to be considered late, you can inactivate the scheduled assessment, if it has been submitted and accepted, and perform a new scheduled assessment with the ARD set to the current date outside the window. The unscheduled assessment will be on time but the scheduled assessment will be late and will follow the Medicare late assessment policy.

Example:

14-day assessment ARD originally set for day 15. Last therapy day is day 11. EOT OMRA ARD set for day 14. If the issue is discovered on day 16, you can either inactivate/delete the two assessments and do a combined 14-day/EOT with an ARD on day 16 OR you can inactivate/delete the 14-day and do a new 14-day with an ARD on day 19.

If the issue is discovered on day 20, you can inactivate/delete the 14-day and do a new 14-day with an ARD on day 20.

MDS News in Review

- April 1, 2012 - MDS 3.0 RAI Manual V1.08 is effective. MDS records with a target date (entry date, ARD, discharge date) before April 1, 2012, use the V1.07data set. MDS records with a target date on or after April 1, 2012, use the V1.08 data set.
- New downloads on the CMS MDS Training webpage: "MDS 3.0 RAI Manual V1.08", "All Change Tables and Pages", "MDS 3.0 Training Aids-Slides-Instructor Guides" and "MDS 3.0 RAI Manual (v1.08) V3 Errata_March_12_2012."
- New download on the CMS FY 2012 RUG-IV Education & Training webpage: "Clarifications to March 2012 National Provider Conference presentation."
- New downloads on the QTSO webpage: jRAVEN 1.1.4 and Five Star Preview Reports.

April 2012 Changes

Unplanned discharges

Effective April 1, 2012, MDS item A0310G will be added to the item set, requiring Discharge assessments to be designated as planned or unplanned discharges. The definition of "unplanned discharge" is:

- Acute care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation OR
- Resident unexpectedly leaving the facility against medical advice OR
- Resident unexpectedly deciding to go home or to another setting.

Note: A planned discharge is any discharge that does not fit the above definitions.

Carrying forward prior interview responses under limited circumstances

Effective April 1, 2012, when coding a standalone (not combined) unscheduled PPS assessment (COT, EOT, SOT), the interview items may be coded using responses provided by the resident on a previous scheduled or unscheduled assessment if the interview responses were obtained within 14 days.

- There must be 14 or fewer days from the date of the last interview to the date when the next interview would be conducted (do NOT use ARD).
- The date determination is based on the original date entered on item Z0400 for the interview items.
- The same individual needs to sign the subsequent assessment (with the carryover interview responses) along with the date of the original interview.
- If the individual that performed the original interview is not available then the interview cannot be carried forward.
- Only interviews that meet all of the above criteria can be carried forward, even within the same assessment. In other words, an interview in one section might carry forward while an interview in another section of the same assessment might not, based on whether or not the interview in each section meets the rules listed above.

Changes and updates to the RAI Manual

Errata documents will be posted on the CMS website to correct any inaccuracies identified in the MDS 3.0 RAI Manual V1.08 effective April 1, 2012. CMS says the inaccuracies identified in the errata documents will be corrected in the MDS 3.0 RAI Manual V1.09 expected in September 2012. Those revisions will also reflect any SNF PPS or other policy changes and are likely to be effective in October 2012.

Effect of early and late COT ARDs on COT observation

Effective April 1, 2012, for both an early and late completed COT ARD, the next COT observation starts the day after the ARD of the early or late assessment. Default is billed for the number of days the ARD is early or late.

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Useful Web Links

DADS MDS Web Site: Texas MDS site for MDS policy, procedures, and clinical and technical information (including The MDS Mentor). http://www.dads.state.tx.us/providers/MDS/

Sign up for MDS Resource E-mail updates: Go to http://www.dads.state.tx.us/, click on the "E-mail updates" tab and follow the directions. The "DADS Texas Minimum Data Set (MDS) Resources" emails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff.

Centers for Medicare & Medicaid Services (CMS) MDS 3.0 website : MDS 3.0 Highlights, RAI Manual, Item Sets (forms), related MDS 3.0 materials, and a link to MDS 2.0.
http://www.cms.gov/NursingHomeQualityInits/01_Overview.asp

Centers for Medicare & Medicaid Services (CMS) FY 2012 RUG-IV Education & Training: Clarification and follow-up documents related to Medicare MDS.
https://www.cms.gov/SNFPPS/03_RUGIVEdu12.asp

QIES TECHNICAL SUPPORT OFFICE (QTSO): MDS 3.0/2.0, jRAVEN/RAVEN and CMSNet (Verizon) information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.
https://www.qtso.com/

Quality Reporting System (QRS): DADS information site on Texas nursing homes.
http://facilityquality.dads.state.tx.us/

Nursing Home Compare: CMS site that compares nursing homes in a given area.
http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp

5 Star Technical Manual: Explains data used to create the 5 Star Report.
http://www.cms.gov/CertificationandComplianc/13_FSQRS.asp

This guidance is being provided on the published date of The MDS Mentor. The reader should be aware that guidance regarding topics in The MDS Mentor may be time-limited, and may be superseded by guidance published by CMS or DADS at a later date. It is each provider's responsibility to stay current with the latest CMS and DADS guidance.