

MDS 3.0 OPERATIONAL AND CLINICAL APPROACHES: SAVINGS AND SOLUTIONS FOR YOUR FUTURE

The following questions were received after the MDI Achieve October 5th webcast, *MDS 3.0 Operational and Clinical Approaches: Savings and Solutions for Your Future*, presented by Leah Klusch. To view the archived version of this webcast, go to:

<http://video.webcasts.com/events/pmny001/viewer/index.jsp?eventid=39641>

Q: Is the new rule applied to all PPS residents in the same manner? Do we treat pre Oct 1 residents like we treat post Oct 1 upon admission?

A: All residents under PPS need to follow the new October 1st rules. Residents who were admitted prior to October 1st will have the new rules apply on their next assessment that becomes due after October 1st.

Q: What all do you have to do to modify an assessment to obtain error codes for Sept and Oct billing days?

A: You do not need to change anything within the Original Assessment. You can create your Modification MDS and complete Section X. Submitting a Modification Assessment will automatically generate the Transition RUG scores.

Q: I have a resident admitted 9/14/11 and I have done a I/5D assessment and a 14D assessment. The 14D score (ARD 9/28) is RHA.

A: The first COT would follow your 30 day PPS assessment not your 14 day assessment.

Q: Do existing residents need to be followed for COT starting Oct 1 even if ARD was earlier than Oct 1?

A: No, the first COT would follow the first PPS assessment completed after October 1st. On the MDS form itself, or in the facility software, are the only two official places that the ARD can be set. If the date is not set in one of the two official places, the assessment would be late and you could not use the ARD.

Q: Are e-signatures still accepted for section Z or is a hard copy signature required now?

A: Yes, in section Z, an electronic signature is still permissible when permitted by your state and nursing home policies.

Q: Initially, resident interviews could be done the day before the ARD, the day of the ARD or the day after the ARD. Now the interview must be done the day before the ARD or the ARD date. Please clarify.

A: The interview should be completed the day before or the day of the ARD.

Q: If index maximized to a higher nursing category, is it true that we do not need to perform a COT for changes below the line HE2 with RVB level minutes on COT review therapy drops RH, RM do we do a OMRA?

A: If the resident is receiving Skilled Therapy Services, a COT Review should be performed and reviewed every 7 days since the most recent Scheduled or Unscheduled PPS assessment. Even if the resident is at a Nursing Level, you are still continuing to review the resident to see if the RUG classification would change.

Q: If therapy is unable to start treatment on the day of admission, may grace days be used?

A: Here is CMS's Comment on Using Grace Days:

FY2012 SNF PPS Rule: "Grace days are a longstanding part of the SNF PPS in order to allow clinical flexibility when setting the ARD dates of scheduled PPS assessments. We agree that in practice, there is no difference between regular ARD windows and grace days and we encourage the use of grace days if their use will allow a facility more clinical flexibility or will more accurately capture therapy and other treatments. Thus, we do not intend to penalize any facility that chooses to use the grace days for assessment scheduling or to audit facilities based solely on their regular use of grace days. We may explore the option of incorporating the grace days into the regular ARD window in the future; nevertheless, we will retain them as part of the assessment schedule at the present time consistent with the current policy and the new assessment schedule proposed in the proposed rule."

Q: For a resident admitted on 9/27, had only 2 days of therapy due to illness on 9/28, 9/30...the Admission/5 day with ARD 10/4 will not have a therapy RUG. Will any OMRA need to be completed or just a PPS 14 day?

A: If all rehabilitation therapies are stopped, whether planned or unplanned, for three consecutive days an End of Therapy assessment would need to be completed. So if the last day of Therapy was on 09/30, an EOT would need to be created with an ARD of 10/01 – 10/03.

Q: How are non-Medicare providers going to get RUG levels?

A: You may either use Chapter 6 of the RAI manual or the software as you should calculate a RUG score regardless of payer.

Q: COT ..date fell on w/e. Can the Assessment be opened on the following Monday?

A: No, in theory, CMS says they want the assessment to be entered into the computer on same date as the ARD.

Q: Any regulatory updates on the LOA and in relation to the EOT and COT OMRA observation days?

A: Yes, CMS has added a clarification. See the following:
https://www.cms.gov/SNFPPS/Downloads/Provider_Call_FollowUp082311.pdf

Q: Certs/Recerts- must physicians date the certs or can the facility staff date the cert? I have not read any info where it says the physicians must actually write in the date-just that he/she must be as timely as possible?

A: The physician must sign and date the certification.

Q: If the first MDS score is not a rehab score, and if rehab stopped few days prior to d/c, my understanding is I have to do an EOT MDS. Am I correct?

A: Yes, you would still do an EOT MDS and could combine with a discharge.

Q: How should we document the COT review?

A: CMS does not have any documentation requirements for when a COT OMRA is considered but deemed to be unnecessary. Facilities might wish to make a record of this just so it is clear that an evaluation was completed, but this is not a requirement. Ultimately, if records are requested for medical review, the need for a COT OMRA could be evaluated whether or not such a notation is made, but it certainly could not hurt to add the notation to the record.

Q: If the 30 day ARD (9/28) has a RUG score of RUA and the 60 day is in the start of the middle of October 2011, when does the 7 day window for the COT start.

A: It is best to review Chapter 2 and 6 of the RAI Manual which has explicit examples of what to do in these circumstances.

Q: Do you have to have an order to 'Admit for skilled services, Medicare' at the time of admission?

A: You must have an order to admit to a skilled level of care.

Q: How do you best distinguish diag. of dementia and/or alzheimers and also diag. of depression, for example? We have seen auditors not recognizing both and are seeking recoupment for behavioral therapy. Your thoughts.

A: The physician or therapist must provide you with an accurate diagnosis/ICD-9 code to support their order for treatment. You need to select the correct ICD-9 codes based on the specific diagnosis. For example, there are several codes for different variations of Dementia and Depression individually as well as a combination of Dementia with Depression versus Alzheimer's and they should not be used interchangeably. Appropriate coding of the diagnosis and documentation should then support the need for behavioral therapy.

Q: Shouldn't it be the exception that we are needing to do COT OMRAs? If rehab projects based on a well thought out eval, and treat at that level, it should be the exception that the resident can't tolerate the level of intensity or refuses?

A: Correct. COTs really should be the exception and not the rule! Whenever a COT is determined to be needed, the facility and therapy provider should ask themselves **why**. Why has therapy not be provided as planned? Did staff not get the resident to therapy as scheduled? Was the therapist not available for planned therapy? Are there make-up sessions available? Were physician or other out-of-facility appointments scheduled when therapy was to have been provided? Why should it be for those occasions when the resident was not able to participate in therapy because of illness, change in condition, or something else not avoidable/that couldn't be scheduled another time. If a facility has to complete frequent COTs, WHY is a good place to start the investigation.

Q: If a patient does not participate in therapy for 3 days and they have no other skilled need, a denial letter must be given. The patient still has to receive 2 days notice so they could be in the facility for 5 days without therapy? How are those extra days billed or can they be?

A: For a completely accurate response, more information would be needed. In general, I believe the facility would be responsible for the additional 2 days of non-skilled coverage but to be sure, the facility should contact their FI.

Q: What are your thoughts on making section D mood interview part of the admission process so those scores which would typically be higher earlier in admit when we may be looking to also get the IVF associated with Special Care High levels?

A: Remember that the interviews are to be conducted the day of or day before the ARD of any given assessment. If an interview is conducted the day of admission or next day, it may be too far away from the ARD and thus should not be used for that particular MDS. I'm not so sure that the interview would net higher scores on admit as there's a lot of "fuss and muss" initially

when a resident transfers into a new facility. I personally would conduct the interviews in accordance with CMS directives.

Q: Is there ever an instance when a resident is on isolation for the entire 7 days that concurrent minutes would ever be appropriately coded? My example is an RUL with 40 min concurrent and when questioned there was a response that a therapist was working in the gym on one person and a tech was "setting" up the equipment in the gym for the isolated resident at the same time.

A. In reviewing this question, I pose this: is the resident truly in isolation as per RAI User's Manual/CMS directives?

O0100M, isolation for active infectious disease (does not include standard precautions)
Code only when the resident requires transmission-based precautions and strict isolation alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "strict isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The question to ask is, is the resident truly in isolation as defined above?

Q: If you give a 2 day denial notice, and the patient needs to stay as they didn't progress as well as you thought they would for the last 2 covered days or they have a change in condition that requires them to stay in facility longer, do you give another 2 day notice letter when you once again determine they have met their goals and no longer meet criteria to be in the facility. We are a Short Stay Transitional care unit.

A. Here is the link for Chapter 30 of the Medicare Claims Processing Manual:
<https://www.cms.gov/manuals/downloads/clm104c30.pdf> I think that you would give another notice but best to check the manual and/or check with your FI to be absolutely certain.