



**Nursing Facility Forum Call  
November 6, 2014**

**Case Mix Team**  
Office of MaineCare Services



Welcome to the Fall web-based forum call!

In the lower right hand corner of the screen, you will see a box called "files." These are documents that can be downloaded, and they will also be sent out via email.

There is a Q + A box where you can type in questions if you would prefer to submit a written question rather than ask a question.



## Agenda:

- Welcome
- HIPAA Reminder
- Review of Questions/Answers for MDS 3.0
- Section S Concerns
- Snippet Training: Part B Therapy
- Announcements
- Questions



**HIPAA  
Reminder:**

When sending email, please do not include **any** identifying information.

(A) Names	
(B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000	
(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older	
(D) Telephone numbers	(L) Vehicle identifiers and serial numbers, including license plate numbers
(E) Fax numbers	(M) Device identifiers and serial numbers
(F) Email addresses	(N) Web Universal Resource Locators (URLs)
(G) Social security numbers	(O) Internet Protocol (IP) addresses
(H) Medical record numbers	(P) Biometric identifiers, including finger and voice prints
(I) Health plan beneficiary numbers	(Q) Full-face photographs and any comparable images
(J) Account numbers	(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and
(K) Certificate/license numbers	

### Protected Health Information (PHI)

Information in any format that identifies the individual, including demographic information collected from an individual that can reasonably be used to identify the individual. Additionally, PHI is information created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual.

### De-identified

Information that has certain identifiers (see “identifiers” below) removed in accordance with 45 CFR 164.514; no longer considered to be Protected Health Information.

(Note: Please be aware that individual participants may be identifiable by combing other items in the data even when none of the following 18 identifiers are present. Thus, a study may still contain personally identifiable data (PID) even after removing or never acquiring the identifiers listed below, and the investigator may still need to provide complete answers for the data security questions (Items 8-10) in the protocol. )

### Identifiers

- Under the HIPAA Privacy Rule “identifiers” include the following:
1. Names
  2. Geographic subdivisions smaller than a state (except the first three digits of a zip code if the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000).
  3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, and date of death and all ages over 89 and all elements of dates (including year) indicative of such age (except that such ages and elements may be aggregated into a single category of age 90 or older)
  4. Telephone numbers
  5. Fax numbers
  6. Electronic mail addresses
  7. Social security numbers
  8. Medical record numbers
  9. Health plan beneficiary numbers
  10. Account numbers
  11. Certificate/license numbers
  12. Vehicle identifiers and serial numbers, including license plate numbers
  13. Device identifiers and serial numbers
  14. Web Universal Resource Locators (URLs)
  15. Internet Protocol (IP) address numbers
  16. Biometric identifiers, including finger and voice prints
  17. Full face photographic images and any comparable images
  18. Any other unique identifying number, characteristic, or code (excluding a random identifier code for the subject that is not related to or derived from any existing identifier)



For more information:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html>



## Review of Questions and Responses for MDS 3.0



While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.



## Section A

If resident is in LTC under days awaiting placement, when is the discharge done?

Continue with OBRA assessment schedule as resident is in a Medicaid certified facility; the payer source/amount is a Maine-specific issue and does not affect MDS schedule. The discharge is completed when the resident is discharged from the facility.



## Section A

A resident was admitted for a 5-day respite under the hospice contract. They will be leaving once their 5 days are up and will be returning home. Is an MDS required?



If the hospice/respice “resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, a Discharge assessment is required.”

The facility must comply with the Medicare or Medicaid participation requirements for hospice residents. This means that “the resident must be assessed using the RAI, have a care plan and be provided with the services required under the care plan”.

RAI manual, Chapter 2, pages 2-2 and 2-3.



## Section A

A resident comes into the facility under Medicare... after 20 days, they are no longer skilled, but stays in the facility under MaineCare. Do the assessments (admission, 5 day, then a 14 day) count as Medicaid for case mix, or do they have to set another assessment/ARD?



## Response:

When a resident stops receiving PPS services, the RUG from the most recent OBRA assessment remains in place until the next OBRA assessment (quarterly, annual, significant change, etc). There is no requirement in Maine for an additional assessment strictly because of change from Medicare to Medicaid.

In this scenario, the admission assessment would set the RUG for payment, until a subsequent OBRA assessment is completed.



## Section M

A LTC resident has an illness, and changes payer to Medicare PPS for 11 days, and is then sent to the hospital for 5 days. When they come back, they no longer qualify for SNF care, so enters as private pay, non-skilled.

At the time of discharge to the hospital (after their 11 days of MCR) they had a stage 2 pressure ulcer, which was coded on the discharge return anticipated assessment. When they returned from the hospital, the ulcer had healed completely.

For next assessment, which is a Quarterly, how do I code M0900? **“Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?”**



Response:

Code M0900 as yes, as the prior assessment (5-day) was coded to indicate that the resident had a stage 2. The MDS is about the resident, not the payer source.

Did this resident qualify for a significant change assessment (based on improvement and no further need for skilled care) upon return from the hospital? If no, then you would do an entry tracking form and then the next scheduled OBRA assessment.



## Section M

How to code ointments and  
lotions in Section M?



- Do not code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here;
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

Supporting documentation required!

- Care plan
- MD order or policy/procedure
- Documentation of delivery



## POP QUIZ!

Section M :

Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

What would you code?

RAI manual, page M-42



Coding: Do **not** check item M1200C.

Rationale: Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident's response to turning and repositioning. There are not any skin or ulcer treatments being provided.



## Section N

Can Plavix or Persantine be coded as an anticoagulant?

Response: No, Plavix and Persantine are classified as “platelet drugs” and not anticoagulants per the Nurses Drug Handbook.



## Section N

Can Lithium be coded as an antipsychotic?

Response: Yes, it is defined as a mood stabilizer in the Nursing Drug Handbook.



**Coding Tip:**

The COT can be completed when a resident is not currently classified into a RUG-IV therapy group, if **both** of the following conditions are met:

- 1) Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and
- 2) No discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT that classified the resident into his/her current non-therapy RUG-IV group **and** the ARD of the COT that reclassified the resident into a RUG-IV therapy group. (RAI, 2-52)



## Section O

When is flu season?

Response: the season varies annually, RAI manual, page O-8:

This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza:

<http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>

<http://www.cdc.gov/flu/weekly/usmap.htm>

An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.

Flu season vs flu vaccination season

Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.

- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza:  
<http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>,  
<http://www.cdc.gov/flu/weekly/usmap.htm>.

- Facilities can also co

ntact their local health department website for local influenza surveillance information.



## Section O

A resident went to day surgery to have conscious sedation with IV meds for a closed reduction of a wrist fracture. The facility had claimed the IV meds. Is this a surgical procedure; there was no incision. It was simply the setting of a bone under IV sedation.



Response: Per the RAI Manual, Page O-2:

Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.



## Section O

When a resident goes to the ER/Hospital and an assessment is due, does the 14-day look back period for orders cover when the resident was still in the facility?

Response: Yes, this was sent to the RAI panel for confirmation as the manual is not clear. Orders can be claimed for the portion of the look back period when they were a resident of the facility.

Exception: orders received prior to re-entry date.

RAI manual, page O-44: Do not count orders prior to the date of admission or re-entry.

RAI manual, page O-45: Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.

**Exception:** If the resident re-enters with orders that differ from when the resident was discharged, those orders cannot be claimed as new orders.

**Exception:** If the resident qualifies for a significant change, the current assessment would not be completed and the facility should set a new ARD to capture the significant change.



### Section Q

A resident with dementia, no POA, no guardian, and no family support. Family has stated she cannot return home as there is no one to care for her. How to code Section Q if she says she wants to go home.

Response: Document an unsafe discharge due to confusion and lack of family support to provide care in the community. Resident would be unable to comprehend information regarding community resources.



## Section S

### **Typo in the manual!**

**S6200:** Number of hospital stays. Record number of **times** resident was admitted to a hospital for an overnight stay in the last 90 days (or since last assessment if less than 90 days).

In the manual sent out at the time of the training, under coding, the instructions directed users to code the number of days a resident was considered to be an inpatient client of a hospital for at least one overnight in the last 90 days or since the last assessment if less than 90 days.

Updated manual was emailed to everyone on this call. The corrected manual has a date of 10/8/14 at the bottom.



### Section S

Resident is sent to the ED on 10/1 and was admitted to the hospital as an inpatient on 10/1. Discharge return anticipated with ARD of 10/1 is completed. Does the first Bed Hold day of 10/1 count on the discharge assessment and the rest of the bed hold days on the next assessment or are all the bed hold days counted on the next assessment and none counted on the current discharge assessment.

In this same scenario does the hospital stay count on the discharge assessment or on the next assessment?



Response: Neither the first bed hold day (10/1/14) nor the hospitalization counts on the discharge assessment. Count both of them on your return assessment.



Bed hold days can count on only one assessment. Be consistent ... code all bed holds and leave days the same way. This will ensure consistently accurate data.



## Section S

As CPAP and BiPAP are non-invasive ventilation systems, is the time and training associated with their care captured within the domain of ventilator/respirator?



**Response:**

In the RAI Manual, Section O, page 3 under O0100F- the directions indicate Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.”

Under O0100G: directions indicated “The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual.

Coding in Section S would not include CPAP and/or BiPAP.

In the RAI Manual, Section O, page 3 under O0100F- the directions indicate “Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.”



## Section S

What are the anticipated supporting documentation requirements for direct care as required for Section S?

Response:

Documentation must support coding of the MDS; this is a requirement of the MDS. The facility chooses the manner in which to document.

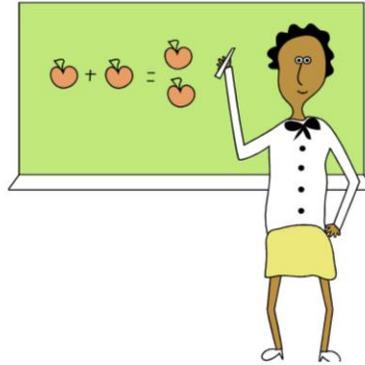
While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

If a case mix nurse needs additional documentation, she asks and the facility may submit whatever documentation they feel is pertinent and part of the medical record.



# Snippet Training

Medicare Part B  
Therapy





### Therapies (PT, OT, and/or ST)

- For Part A, services must be ordered by a physician. **For Part B the plan of care must be certified by a physician following the therapy evaluation;**
- The services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;

RAI Manual, page O-20 and O-21

The therapist's time spent on documentation or on initial evaluation is not included.

Family education when the resident is present is counted and must be documented in the resident's record.

Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS.

The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.



The services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.

Rehab potential, or  
Maintenance program



- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.
- Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.



Code services for **respiratory, psychological, and recreational therapies** (Item O0400D, E, and F) when the following criteria are met:

- the physician orders the therapy;
- the physician's order includes a statement of frequency, duration, and scope of treatment;
- the services must be directly and specifically related to an **active written treatment plan** that is based on an initial evaluation performed by qualified personnel;

the services are required and provided by qualified personnel;

the services must be reasonable and necessary for treatment of the resident's condition.



Questions???





### Announcements and Reminders:

- New Toll Free Help Desk number:  
1-844-288-1612
- Please do NOT send protected health information (PHI) via email unless the email is encrypted.
- Upcoming MDS 3.0 Training:  
11/7/14 Portland  
12/3/14 Houlton
- 2015 dates / locations to be announced
- Next call: February 5, 2015



## Change in obtaining grouper report

Effective January 1, 2105, facilities will no longer be able to download or print reports from the MDS 2.0 website. This site is being shut down by CMS.

Beginning in January facilities will go to the SMS site to get grouper reports. More information will be sent by mail and email in November. Training will be available via webinar in December. Please plan on having someone from your Facility participate in this training.



## Contact Information

**New!**

- MDS Help Desk: 624-4019  
→ **toll free: 1-844-288-1612**  
[MDS3.0.DHHS@maine.gov](mailto:MDS3.0.DHHS@maine.gov)
- Lois Bourque RN: 592-5909  
[Lois.Bourque@maine.gov](mailto:Lois.Bourque@maine.gov)
- Darlene Scott-Rairdon RN: 215-4797  
[Darlene.Scott@maine.gov](mailto:Darlene.Scott@maine.gov)
- Maxima Corriveau RN: 215-3589  
[Maxima.Corriveau@maine.gov](mailto:Maxima.Corriveau@maine.gov)
- Sue Pinette RN: 287-3933  
[Suzanne.Pinette@maine.gov](mailto:Suzanne.Pinette@maine.gov)