Nursing Facility Forum Call

Case Mix Team / Office of MaineCare Services

November 3, 2016

MaineCare Services
An Office of the
Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Welcome to the 4th Quarter Nursing Facility Forum call

Agenda

- Welcome
- HIPAA Reminders
- Review of MDS 3.0 Questions and Answers
- Snippet Training: Section GG, revisited
- Announcements
- Questions

HIPAA Reminder:

When sending email, please do not include **any** identifying information. This table developed by the Federal Department of Health and Human Services gives definitions of 18 examples of 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	

"Somehow your medical records got faxed to a complete stranger. He has no idea what's wrong with you either."

If you need to send a portion of an MDS record:

- Fax is preferred over email
- If you must email, paste the document into an word document and **apply a password**. Do NOT send the password in the same email as the attached MDS document, **OR**

- Black out all identifying information, such as name, social security number, DOB, etc. It is acceptable to refer to a resident as #1, #2, according to a list of residents left during a case mix review.

- If you mail information, please label as confidential and identify the person to whom it is being sent.

For more information:

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

HIPAA
Health Insurance Portability and Accountability Act

Questions, Questions, Questions …

and Answers

Section M

We have a resident who was admitted with intact skin. Within 15 days the resident's heel opened up as a Stage II pressure ulcer, which the wife states is the site of a healed pressure ulcer that he had at home. Is this considered the same pressure ulcer? Do we code this as present on admission or not present on admission?

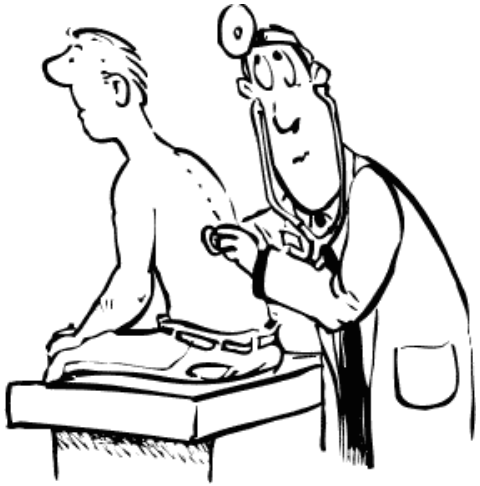
It was not identified at the time of the admission physical assessment so it must be coded as NOT present on admission. The wound would be coded as a pressure ulcer if pressure was the primary cause of the wound. Clinical documentation would contain information reported by the resident's wife that the site was a previously healed pressure ulcer and the care plan would also identify a new pressure ulcer at the site of a previously healed site.

Section O

Regarding respiratory therapy… if there is an order from the MD for nebulizer treatments does there also need to be a diagnosis that reflects the need for the nebulizer treatments?

I understand there needs to be a current order for the treatment as well as documentation of administration, frequency, the number of minutes spent providing care and/or assessment to the resident.

If respiratory therapy is coded, the case mix nurse is looking for a physician's order for the treatment/assessment in question, evidence of care planning, and evidence of delivery of care that meets the qualifications of the MDS (i.e. at least 15 minutes per day x 7 days of the look back period).



- In Section O0400D1. You would code the *total number of minutes* in the last 7 days. (RAI Manual, O-30)
- In Section O0400D2, you would code the *total number of days* the respiratory therapy was administered for at least 15 minutes in the last 7 days (this is the item that triggers possible inclusion in a Special Care RUG group

Section O

Who is considered to be a “qualified therapist.” I had been told that if it is an MD/RN/LPN administering it then that would be considered okay as long as they have been trained in the breathing procedure... is this correct?

Respiratory Therapy Services that are provided by a **qualified professional** (respiratory therapists, respiratory nurse). Respiratory therapy services are for the **assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function**. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or **trained respiratory nurse**. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

Section K

If a resident receives IV hydration, goes to the hospital for a day or two, then returns to the facility. Would the IV hydration prior to the recent hospitalization be able to be captured in Section K upon return (coded while a resident)?

For example, IV hydration given 10/1, resident goes to hospital 10/2, 10/3, OBRA MDS with an ARD of 10/6.

K0510A. Parenteral/ IV feeding

In column 1, while **not** a resident and within the past 7 days *and* in column 2, performed while a resident in your facility and within the past 7 days.

RAI Manual, page K-11 and K-12

K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

Section G

We have always coded residents who eat in their rooms by themselves and don't need any help setting up their tray or cueing of any kind as *independent*. We are now being told that we should be coding at least 1/1 (supervision) on everyone because they are being supervised by staff that are on the floor. Is this correct?

Supervision of the dining room is not the same as supervision of an individual resident.

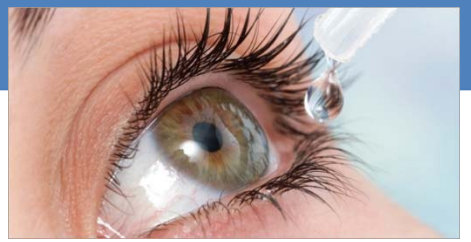
When a resident is coded as requiring supervision for eating, it is because the resident requires oversight, encouragement or cueing, usually due to a risk for choking, a need for cueing to eat due to dementia, or cueing to following an eating program set up by therapy.

Coding on the MDS is about the resident, not the staff and not the dining room. You must have documentation to support coding on your MDS.

Section G

If a resident needs a lot of cueing for eating but staff do not touch the resident, it should be coded as limited assist. Is this correct?

If a resident requires a lot of cueing, it is still supervision. Limited assistance means staff provide guided maneuvering of limbs or other non-weight-bearing assistance.



Section N

Do antibiotic eye drops count as an antibiotic?

Antibiotic eye drops can be coded as antibiotics.

Section N, page N-6 (under Coding Tips)

- Include any of these medications given to the resident *by any route* (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.

Section O

We have a resident who has cancer and is taking Femora which is classified an antineoplastic. Am I able to code this under **O0100A, Chemotherapy**? The resident takes the medication daily. It says in the description that I can " code any type of chemotherapy agent administered an an antineoplastic given by any route in this item.. " So I think that I can code it here... Is this correct.?

RAI Manual, Section O, page O-2:

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment.

Section A

I have a long-term care resident who went out to the hospital on Friday and returning today skilled. Would I do a "Admission/5-day assessment" or just a "5-day assessment"?

Section A

If the resident's most recent assessment was discharge return anticipated, the facility would complete Entry tracking and a 5-day. No admission assessment is needed. Facility might consider a significant change combined with the 5-day as it sounds like the resident's condition may have changed.

Section A

We have a skilled Medicare-A patient who is leaving the facility for ONE overnight due to her husband's death. She will be attending his funeral out of state. Should I be doing a D/C assessment/EOT? The social worker at my facility thinks that there is a leniency in this case and we just have to do a D/C return anticipated. Can I have some clarification?

Section A

The EOT would need to be completed if the resident misses three or more days of therapy. Per the manual, a discharge assessment does not have to be completed for a LOA, but the leave days may alter the Medicare assessment schedule dates for scheduled assessments, but not for unscheduled assessments such as COT.

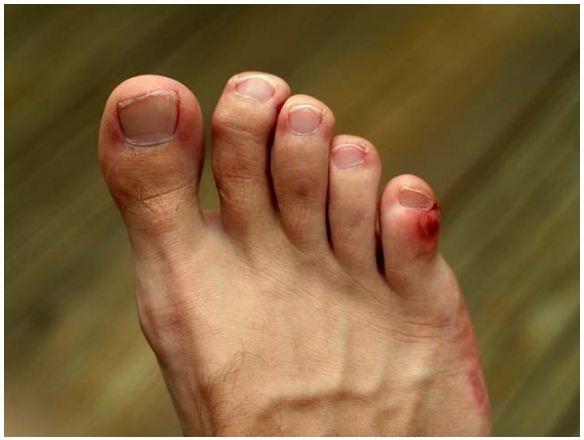
RAI Manual, Chapter 2, page 2-48 EOT

RAI Manual, Chapter 2, page 2-12 LOA

RAI Manual, Chapter 2, page 2-76 LOA from SNF

Section M

I have a resident who has nursing documentation that describes abrasions on the toe, the documentation also stating areas are scabbed. Can this be codes as open lesion on foot? I am unclear if the scab indicated the area is not opened



Section M

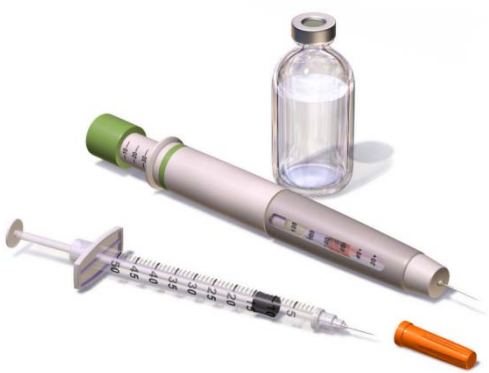
A dry scab cannot be coded as an open lesion.

What is the cause of the abrasions on the toe? Is it related to pressure or circulation? If yes, it would be coded according to the cause of the wound. A skin tear can be coded at M1040G. If the abrasion is not a wound as described in M1040 or a pressure ulcer it cannot be coded in Section M, but would still be captured on the care plan. The MDS is a *Minimum* data set, not a comprehensive assessment.

RAI Manual, page M-33: **Planning for Care**
RAI Manual, page M-34: **M1040D Open Lesion Other than Ulcers, Rashes, Cuts**

Section N

Question N0350B asks if there have been any changes in insulin doses. If a resident was started on insulin during the look back, is this considered a change and would this count this as a change in insulin or does it not qualify because it was only initiated.



A *new* order for insulin would count as a new order for **O0700**, but would not count as new order for N0350B … *with one exception*

Coding Tips and Special Populations (RAI Manual, page N-3)

For sliding scale orders:

— If the *sliding scale* order is new, discontinued, or is the first *sliding scale* order for the resident, these days **can** be counted and coded.

Section A

Should I complete a Day 5 assessment separate from Admission assessment and not submit the Day 5 assessment or is it ok to complete it as one assessment and submit to CMS?

Section A

For a Medicare advantage or Medicare managed care payer source, your facility is required to complete and submit ***OBRA*** scheduled assessments.

Do not submit any PPS assessments to CMS via the ASAP system as CMS as no authority to collect that information.

You can complete the OBRA, submit it and then modify the assessment to include the PPS to submit to the payer as requested or you can complete separate assessments.

Section M

A resident had a 3-suture repair of the bilateral eyelids for involutional entropion.

In this procedure *no incisions are made*, the surgeon places 3 sutures, from the inside of the eyelid to the outside & then pull them tight to prevent the lower lid from turning inwards

Section M

Definition of surgical wound, page M-33:

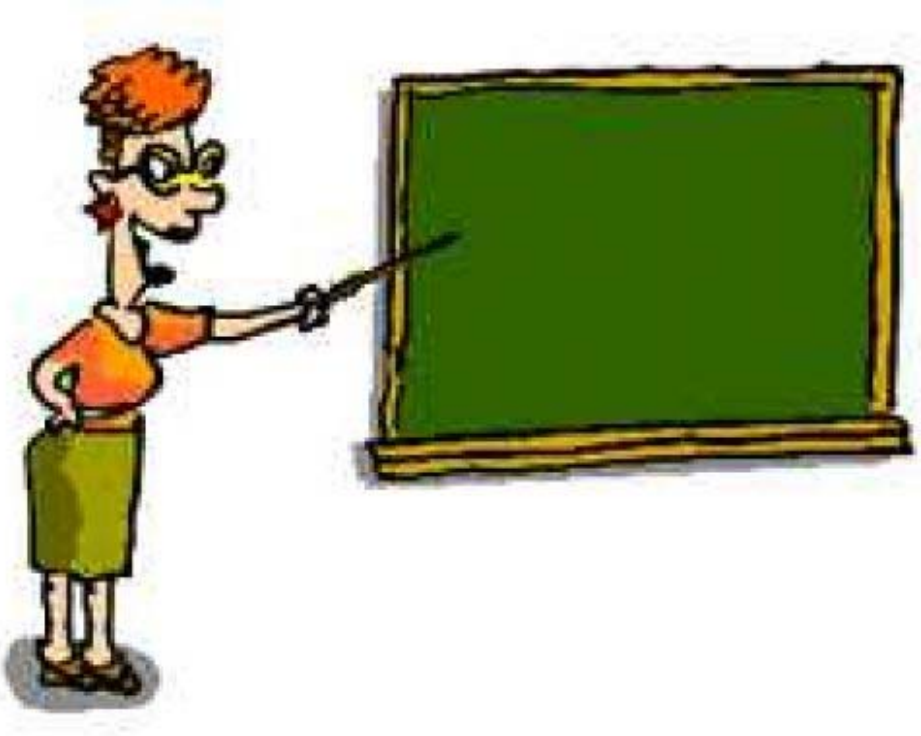
SURGICAL WOUNDS

Any healing and non-healing, open or closed *surgical incisions*, *skin grafts* or *drainage sites*.

- Three sutures holding up an eyelid does not qualify as a surgical wound; there was no incision.

Questions???

Snippet Training



SMS website

Changes and Implications

https://sms.muskie.usm.maine.edu/

It's not just for residential care facilities!

WHY do you want to go the SMS website?????

- Find out if there are Section S errors before Ron calls you
- Get your State validation report that shows the final RUG group

Can you *share* user names?

- NO

How many users are allowed per facility??

- Two

Who can you *call* to you your very own user name?

- Catherine Gunn
- 780-5576

Who do you need *call* when a user leaves your facility?

- Catherine Gunn
- 780-5576

What can you do if you find a pattern of incorrect RUG groups between your MDS and the final validation?

- Call your vendor
- Make sure you are checking your validation reports regularly!

Nursing Facility Forum Call 11/3/16

Announcements

Any evidence of back dating, which may be falsifying MDS records, will be referred to program integrity for review.

AANAC / RAC training is good training, and it is not a substitute for attending State training.

OMS is not required by policy to give advance notice of a case mix review. There may be unannounced visits coming. Facilities, according to policy, are required to give access to all records used to code the MDS.

The first line of information is the RAI manual for the MDS 3.0. If you have a situation that you are unsure of how to code, call your case mix nurse or the MDS help desk for more guidance.

The web site to obtain copies of the *training calendar*, the training power point and handouts, etc. is:
http://www.maine.gov/dhhs/oms/provider/case_mix_manuals.html

Don't forget the training portal:
http://www.maine.gov/dhhs/dlrs/mds/training/index.shtml

Upcoming MDS 3.0 training:

November 8, 2016 - Lewiston

December 15, 2016 - Houlton

January 26, 2017 - Biddeford

Call or email to register:
MDS3.0.DHHS@maine.gov

Next Forum call: February 2, 2017

Contact Information:

- MDS Help Desk: 624-4019, or
  1-844-288-1612 (toll free)
  MDS3.0.DHHS@maine.gov
- Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
- Darlene Scott-Rairdon RN: 215-4797
  Darlene.Scott@maine.gov
- Maxima Corriveau RN: 215-3589
  Maxima.Corriveau@maine.gov
- Sue Pinette RN: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Questions?

Thanks for spending time with the case mix team!

Join us again in February for the next call.

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

Nursing Facility Forum Call 11/3/16