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MDS Alert

Your essential guide to mastering MDS as a tool for payment, risk management & quality of care.

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Contents

MISSION STATEMENT

To help busy nursing and other professionals master the complexities of the Minimum Data Set as a payment, quality-of-care and quality-of-life, risk management and compliance tool. To bring readers clear, practical strategies and tools from the nation's experts on nursing assessment and coding. *MDS Alert* is an independent publication and does not accept advertising. Our only allegiance is to you, our reader.

MDS 3.0

Make Sure You're Correctly Dealing With SCSA Matters For Hospice Care

Pay attention to timing issues to anticipate when you don't need to do an SCSA.

There are a whole host of guidelines in the RAI Manual for completing a Significant Change in Status Assessment (SCSA), and that means it's pretty easy to make a mistake. Understanding when you must (versus when you don't need to) complete an SCSA for hospice care-related changes is even trickier at times. Here's what you need to know to sort this all out.

Did You Miss This Important MDS Update?

In the last RAI Manual update (October 2015), the **Centers for Medicare & Medicaid Services** (CMS) updated its instructions regarding the SCSA for hospice (item O0100K — *Hospice care*). The new instructions state that in addition to completing an SCSA when a resident revokes or initiates hospice care, you must also complete an SCSA if a resident changes hospice providers.

Problem: But some people missed the rule change and don't know that that they need to complete an SCSA when the resident switches hospice providers, says **Michelle Synakowksi, LNHA, RN, C-NE, RAC-MT**, Director of **ProCare** and a consultant at **Leading Age New York**.

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Surveys

Your Survey Exit Conferences Just Got A Little More Vague

How surveyors will handle Immediate Jeopardy citations differently than others.

If you've been accustomed to the survey team giving you valuable insights during the Exit Conference on which tags they might cite, get ready for surveyors to start dodging your questions about their specific findings.

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CMS found that when residents changed hospice providers, care coordination would sometimes fall through the cracks, Synakowski explains. So requiring you to complete an SCSA when residents switch hospice agencies gives you an opportunity to review the care plan. This requirement also prompts you to coordinate with the hospice provider so you know what services the hospice is providing and what service your facility is providing for the resident.

Make Sure You're Following These Rules

Prior to the October 2015 update, "the rule was you had to do an SCSA if initiated on hospice or discontinued hospice," Synakowski states. This hasn't changed.

You must complete an SCSA when a resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider), according to **Scott Heichel, RN, RAC-CT, DNS-CT**, Director of Clinical Reimbursement at **LeaderStat** (www.leaderstat.com). "The assessment reference date (ARD) must be within 14 days from the effective date of the hospice election." And you must perform an SCSA regardless of whether you recently conducted an assessment on the resident.

Also, an SCSA is required "when a resident is receiving hospice services and then decides to discontinue or revoke those services," Heichel notes. In this case, the ARD must be within 14 days from one of the following:

1. The effective date of the hospice election revocation;
2. The expiration date of the certification of terminal illness; or
3. The date of the physician's or medical director's order stating the resident is no longer terminally ill.

Keep an Eye on the ARD

But there are a few situations that you need to keep in mind. Regarding exceptions to the rule of completing an SCSA when revoking or initiating hospice care, "it's really a timing issue," Synakowski notes.

"Often the Admission assessment is the most confusing time for MDS nurses related to a resident's hospice status and determining the need for an SCSA," says **Judi Kulus, MSN, MAT, RN, NHA, RAC-MT, DNS-CT, QCP**, VP of Curriculum Development at the **American Association of Nurse Assessment Coordination** (AANAC). "The resident might come into the facility with hospice orders and may decide to go off hospice, or the opposite might occur."

Case in point: You don't need to complete an SCSA if the resident is admitted to your facility already on the

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hospice benefit or elects hospice on or prior to the ARD of the Admission MDS, Heichel instructs. You should check item O0100K on the Admission assessment, but "since the hospice election was already captured on the Admission MDS, completing an SCSA is not required."

Another scenario is when the hospice election occurs after the Admission assessment ARD but prior to its completion, according to Heichel. In this case, "facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required."

Example: A few days after a resident is admitted on regular rehab PPS coverage, the family says that they want hospice care, Synakowski illustrates. Because the hospice initiation occurs prior to the ARD, you'll capture the hospice in the Admission assessment.

Don't Be Afraid to Move the ARD

For revoking hospice care, you nearly always have to complete an SCSA, according to Synakowski. The only exception is when the Admission assessment captures the hospice status, meaning the resident revoked hospice before the ARD and you were able to reflect that on the Admission MDS. In this case, you don't need to do an SCSA.

Also, when the resident revokes hospice care after the Admission assessment ARD but prior to your completing the Admission assessment, CMS allows you to choose to adjust the ARD to the date of hospice revocation, so that you only need to submit the Admission assessment and not also the SCSA.

(Continued on next page)

A0310. Type of Assessment

Enter Code ☐☐

A. **Federal OBRA Reason for Assessment**
- 01. **Admission** assessment (required by day 14)
- 02. **Quarterly** review assessment
- 03. **Annual** assessment
- 04. **Significant change in status** assessment
- 05. **Significant correction** to **prior comprehensive** assessment
- 06. **Significant correction** to **prior quarterly** assessment
- 99. **None of the above**

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
G. BiPAP/CPAP	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
L. Respite care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

Rule of thumb: You should ask yourself whether you can move the Admission assessment ARD and set it to capture the election, revocation, or change in hospice, Kulus advises. "If yes, then only the Admission assessment is required and no SCSA needs to be scheduled after the Admission assessment."

"Be prepared to move the Admission ARD if necessary. If the resident's status changes during the early days of admission, then the last status on the ARD must be the focus of the CAAs and care planning process," Kulus says. "The only way to avoid completing an SCSA shortly after an Admission assessment is to move the ARD to capture the change in hospice status. If the hospice status changes after the ARD, then an SCSA must be scheduled."

Don't Treat Palliative Care Like Hospice

Mistake: Another common point of confusion is for palliative or "terminal" care versus hospice, Synakowski points out. If someone is terminal or elects palliative care but doesn't elect hospice, this doesn't mean you need to do an SCSA.

Instead, you would develop the care plan with goals for palliative care and all care plan approaches anticipating a decline. But you don't automatically need to complete an SCSA.

Still, you need to determine whether the resident with a terminal condition has a change in that condition that is "an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual," Heichel notes. "If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required."

Important: Also, make sure that the MDS completion date (item Z0500B) is no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the resident's situation has met the criteria for an SCSA, Heichel stresses. "This date may be earlier than or the same as the Care Area Assessment (CAA) completion date, but not later than."

Best bet: If you run into situations involving hospice and are unsure of whether you need to complete an SCSA, always refer to the RAI Manual. You can find SCSA-related information in Chapter 2, section 2.5, Assessment Types and Definitions (starting on page 2-7), and section 2.6, Required OBRA Assessments for the MDS (starting on page 2-14). ❑

(Continued from cover)

This is thanks to a new Advance Guidance Survey & Certification (S&C) letter to surveyors on the procedures for conducting Exit Conferences, which the **Centers for Medicare & Medicaid Services** (CMS) released on March 11. The S&C: 16-11-ALL memo is entitled, "Exit Conferences — Sharing Specific Regulatory References or Tags."

CMS released the memo in response to questions it received regarding how much specific information surveyors may divulge during the Exit Conference to providers and suppliers. CMS also revised the State Operations Manual (SOM), Chapters 2 and 5, and Appendix P.

Consider the Exit Conference 'Informal'

First, CMS reinforced the notion that Exit Conferences are "informal" and conducted during the onsite federal survey as "both a courtesy to the provider and a way to expedite the provider's planning ahead of the formal receipt of the survey findings in the Form CMS-2567, Statement of Deficiencies." The basic function of the Exit Conference is to provide an opportunity to exchange information and informally communicate preliminary survey team findings.

Need to know: The Exit Conference occurs at the conclusion of the survey and is not a requirement. Also, CMS stresses in the memo that any survey findings you discuss with surveyors during the Exit Conference are "preliminary in nature and are subject to change pursuant to the State and CMS supervisory review processes."

"The biggest change is that the facility has far less information regarding the findings (scope and severity) of the survey upon exit," says **Kris Mastrangelo**, President and CEO of **Harmony Healthcare International**.

"Historically, information and feedback obtained during a survey Exit Conference not only guided the facility in their plan of correction but acted as a platform for 'teachable moments,'" Mastrangelo notes. "These nuggets of information contributed to ongoing operational and clinical continuous improvement."

Don't Expect Specific Tag Citations

The most significant clarification in the S&C memo "is that surveyors may not provide Scope and Severity of a deficiency unless it is an Immediate Jeopardy, because supervisory review may change the preliminary Scope

and Severity," agrees **Linda Elizaitis, RN, RAC-CT, BS**, President of **CMS Compliance Group Inc.** "Instead of providing the Scope and Severity, surveyors should use general terms to describe the scope and provide the number of residents affected."

Surveyors may provide you with information regarding specific tags cited, but they must note that the findings are preliminary and may change pursuant to State and CMS review processes, according to Elizaitis. "If the tags are still under discussion, the surveyors will not share this information at the Exit."

If you don't ask for the regulatory basis or specific tag code, CMS allows the survey team to use its own judgment in determining whether to share this information with you — essentially based on whether the survey team thinks the additional information would provide more insight for your facility. Further, if the survey team is still deciding on the specific tags to cite, the team "must not speculate" at the Exit Conference as to the tag coding that they'll apply.

Examples: CMS illustrated a few scenarios, such as if the survey team is still deliberating whether the finding was a care planning deficiency or a staff training deficiency. Or, the survey team may want to consult with other State personnel like a pharmacist before assigning a specific tag number to the deficiency finding.

"In these cases, the survey team should describe the general area of non-compliance without identifying a specific tag code," CMS instructed. "This is a judgment to be made by the survey team onsite, so in preparation for the Exit Conference the team should deliberate as to the degree of detail that will be appropriate."

You'll Get More Detail on Immediate Jeopardy Deficiencies

Caveat: You may get more detailed feedback from surveyors on deficiencies when they fall under the Immediate Jeopardy classification, however. For Immediate Jeopardy citations, the survey team should offer up the Scope and Severity during the Exit Conference.

For other findings, survey teams may describe to you the general seriousness or urgency that a deficiency may pose to residents' well-being. And if you ask the surveyors about whether the noncompliance is isolated, a pattern, or widespread, the surveyors should answer you with the facts.

What's more: CMS also reinforced in the memo that states must follow the federal process. CMS informed States that their laws do not override the federal survey process, and their State process may not deviate from the procedures provided by CMS, Elizaitis explains.

"States are not permitted to have blanket policies that differ from the policy described in this section," the memo said. "For example, States may not require surveyors to always provide certain information during the Exit Conference."

CMS also included a clarification that State surveyors cannot leave draft CMS-2567 forms onsite during the Exit Conference, because they won't be final until they have had a post-survey quality review, Elizaitis notes.

Less Information May Make Compliance Harder

Some industry leaders expect these changes to affect providers negatively, because providers will likely lose out on valuable feedback from surveyors. As Mastrangelo posits, "Why take away a potential discussion that enlightens the facility team on how to do better?"

Bottom line: "The facility will navigate the actual process in a different manner … what the manner is will soon be seen," Mastrangelo states. "Whether it is more caution or less diligence, either response is a product of a lack of feedback from the governmental expert eyes."

"Regardless of the nature and intent of the survey process, providers use this forum to better the quality of care rendered to its residents," Mastrangelo continues. "It is quite possible that the more stringent forum may negatively impact overall results."

Silver lining: But other industry stakeholders are taking a more optimistic approach. "The range of information that has been shared during Exit Conferences has varied widely between States as well as Regional Offices within a State," Elizaitis points out. "This CMS S&C letter should, hopefully, decrease the inconsistencies in information being shared during Exit Conferences."

Look ahead: Consider using an organized methodology "to self-identify what the possible tags might be, based on the information that is being elicited by the survey team," suggests **Marilyn Mines, RN, BC, RAC-CT**, *MDS Alert* Consulting Editor and Senior Manager at **Marcum LLP**. Keep an eye out for future issues of *MDS Alert* for tips on preparing for the annual survey and conducting mock surveys.

Link: To read the S&C: 16-11-ALL memo, go to www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-11.pdf. ❑

Toolkit

Prevent Findings At Your Facility Of The Top 15 Most-Cited Health Deficiencies

Watch out: Comprehensive care plan F-tag ranks fifth on the list.

Recently released nursing home data provides you with valuable insights on what F-tags surveyors are most often citing. Pay attention to the most common health deficiency citations so your facility won't become part of these statistics.

On March 25, the **Centers for Medicare & Medicaid Services** (CMS) released the Nursing Home Data Compendium 2015 Edition, which compiled data from 2005 through 2014. Among a plethora of other nursing home data, the Compendium lists the top 15 cited health deficiencies.

"The list is full of 'gotcha' tags that can be highly cited," according to a March 28 blog posting by the **CMS Compliance Group Inc.** Here are the top 15 deficiency citations for 2005 through 2014:

#	F-Tag	Title	Deficiency Description	Average Ranking (2005 – 2014)
1	F-371	Food Procurement, Store/ Prepare/Serve – Sanitary	*Store, cook, and serve food in a safe and clean way.*	1.8
2	F-323	Free of Accident Hazards/ Supervision/Devices	*Ensure that a nursing home area is free from accident hazards and provide adequate supervision to prevent avoidable accidents.*	2.4
3	F-309	Provide Care/Services for Highest Well Being	*Provide necessary care and services to maintain or improve the highest well-being of each resident.*	3.6
4	F-441	Infection Control, Prevent Spread, Linens	*Have a program that investigates, controls, and keeps infections from spreading.*	4.6
5	F-279	Develop Comprehensive Care Plans	*Develop a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.*	5.8
6	F-281	Services Provided Meet Professional Standards	*Ensure services provided by the nursing facility meet professional standards of quality.*	6.1
7	F-329	Drug Regimen is Free of Unnecessary Drugs	*Ensure that each resident's 1) entire drug/ medication regimen is free from unnecessary drugs; and 2) is managed and monitored to achieve highest level of well-being.*	8.3
8	F-253	Housekeeping and Maintenance Services	*Provide housekeeping and maintenance services.*	8.8
9	F-241	Dignity and Respect of Individuality	*Provide care for residents in a way that maintains or improves their dignity and respect in full recognition of their individuality.*	10.0
10	F-514	Resident Records – Complete/Accurate/ Accessible	*Keep accurate, complete, and organized clinical records on each resident that meet professional standards.*	10.0

#	F-Tag	Title	Deficiency Description	Average Ranking (2005 – 2014)
11	F-314	Treatment/Services to Prevent/Heal Pressure Ulcers	*Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.*	11.1
12	F-315	No Catheter, Prevent UTI, Restore Bladder	*Ensure that each resident who enters the nursing home without a catheter is not given a catheter, unless medical necessary, and that incontinent patients receive proper services to prevent urinary tract infections and restore normal bladder functions.*	11.7
13	F-282	Services By Qualified Persons/Per Care Plan	*Provide care by qualified persons according to each resident's written plan of care.*	13.1
14	F-431	Drug Records, Label/Store Drugs & Biologicals	*Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.*	13.9
15	F-324	Supervision	*Ensure each resident is being watched and has assistance devices when needed, to prevent accidents.* Citation not used 2009 – 2014.	12.7

Source: www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html ❑

Compliance

Beware: New DOJ Task Forces Are Cracking Down On Your Compliance

Why one industry stakeholder calls initiative a 'smokescreen' for cost-cutting.

The top federal government watchdog agency is taking aim at nursing homes' quality of care. Find out how the feds are planning to ratchet-up their investigative and enforcement efforts in the long-term care (LTC) arena.

Coordination Should Bring More Enforcement Actions

Heads up: On March 30, the **U.S Department of Justice** (DOJ) announced that it will launch 10 regional Elder Justice Task Forces to coordinate and bolster efforts to hunt down nursing homes that provide "grossly substandard care" to their residents. The creation of these task forces falls under the DOJ's Elder Justice Initiative, which will provide litigation support and training to the Elder Justice Task Forces.

The DOJ "has a long history of holding nursing homes and [LTC] providers accountable when they fail to provide their Medicare and Medicaid residents with even the most basic nursing services to which they were entitled," said Principal Deputy Assistant Attorney General **Benjamin Mizer**, head of the DOJ's Civil Division, in the March 30 announcement. "By bringing everyone to the table, we will be able to more effectively and quickly pursue nursing homes that are jeopardizing the health and well-being of their residents."

Also in the recent announcement, Acting Associate Attorney General **Stuart Delery** specified that the new task forces will target "nursing home owners or operators

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who put their own economic gain before the needs of their residents."

What this means: "The task forces combine federal, state and local prosecutors, law enforcement and other agencies to root out and prosecute such providers for Medicare and Medicaid fraud," explained attorneys **William Mateja** and **Jason Hoggan** of **Polsinelli PC** in an April 8 report. These new task forces will effectively decrease the DOJ's "historic reliance on whistleblower allegations for such claims."

If you fall short of Medicare's quality-of-care standards, you could face potential liability under the False Claims Act (FCA) and even prison time, Mateja and Hoggan stated. "These task forces will increase the Department's scrutiny on nursing home operations and could lead to more FCA cases and prosecutions for the Department nationwide."

Is Care Quality Really the Issue at Hand?

But major industry stakeholders like the **American Health Care Association** (AHCA) aren't happy about the DOJ's creation of the Elder Justice Task Forces, to say the least. In a March 30 statement, AHCA President and CEO **Mark Parkinson** blasted the DOJ's suggestion that nursing home quality of care is plummeting.

"We support any effort to improve overall care and weed out bad actors, but today's announcement mistakenly conveys that quality is on the decline," Parkinson argued. "It is a smokescreen aimed at finding cost-cutting measures that would threaten life-improving post-acute and [LTC] services for millions of seniors."

Parkinson also pointed to recently released data from the **Centers for Medicare & Medicaid Services** (CMS) showing that deficiencies are declining, which indicates that quality is improving (see www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html). "Creating task forces under the guise of fraud and abuse is actually pointing a finger at a flawed Medicare payment system," he noted.

Find Out If Your Jurisdiction Made the List

These special task forces will be comprised of representatives from the U.S. Attorney's Offices, state Medicaid Fraud Control Units, state and local prosecutors' offices, the **U.S. Department of Health and Human Services** (HHS), state Adult Protective Service agencies, LTC Ombudsman programs, and law enforcement.

They will participate in the Elder Justice Task Forces through "joint investigations, sharing information, and regular meetings," according to a March 30 statement by **Keesha Mitchell**, President of the **National Association of Medicaid Fraud Control Units** and the Director of the **Ohio Medicaid Fraud Control Unit**.

The DOJ will launch the 10 regional Elder Task Forces in the following districts:

- Western District of Washington;
- Northern District of California;
- Northern District of Georgia;
- District of Kansas;
- Western District of Kentucky;
- Northern District of Iowa;
- District of Maryland;
- Southern District of Ohio;
- Eastern District of Pennsylvania; and
- Middle District of Tennessee.

All providers should be concerned, and the DOJ didn't choose these 10 districts at random, according to an April 17 analysis by attorneys **Thomas Zeno**, **Robert Nauman** and **James Hafner** of **Squire Patton Boggs LLP**. Several of the chosen districts — "including the Southern District of Ohio and Eastern District of Pennsylvania — have previously been involved in DOJ-led efforts to pursue elder care providers who seek to defraud their patients and federal programs."

Watch Out for Tougher Consequences

What's more: Also, beware that sanctions won't be limited to criminal penalties and civil fines — in previous elder abuse cases, the **HHS Office of Inspector General** (OIG) "required onerous, multi-year Corporate Integrity Agreements and mandatory, independent quality monitors," the attorneys wrote. "Given the success of DOJ-led task forces such as the Health Care Fraud Prevention and Enforcement (HEAT) Task Force,

providers of healthcare services to the elderly should be especially mindful of the importance of strict compliance with federal and state law."

Trend: And there's no doubt that the DOJ's investigations in recent years have upped the ante when it comes to fines, government oversight, and even prison sentences. A case in 2014 resulted in the LTC provider and its subsidiary paying the government $38 million to settle allegations of insufficient nurse staffing, inadequate catheter care, and failure to follow appropriate preventive protocols, according to Mateja and Hoggan.

Another case that same year a nursing home owner received a 20-year prison sentence in part for "deplorable" facility conditions, including leaky roofs and fly infestations, according to Mateja and Hoggan. And given the DOJ's "increased focus on nursing homes and [LTC] facilities, providers and owners should take the opportunity to review their practices and procedures and ensure compliance."

Resource: For more information on the new Elder Justice Task Forces and the DOJ's Elder Justice Initiative, go to www.justice.gov/elderjustice. ❑

What Do You Think?

Question 1: *We admitted the resident to the nursing home on Jan. 17 and discharged to home on Jan. 21. Therapy staff evaluated the resident on Jan. 18 and treated him on Jan. 19 and Jan. 20, but staff did not provide any therapy on the day of discharge (Jan. 21). Does this qualify for a Short Stay since we provided no therapy on Jan. 21?*

Answer 1: If you didn't provide therapy because you discontinued all therapy services, then a Short Stay would not apply, according to the **Kansas Department for Aging and Disability Services** (KDADS).

Exception: "If the resident was still on therapy caseload and therapy expected treatment to continue but treatment was not given on the day of discharge for an unexpected reason, such as unexpected discharge, then a Short Stay is appropriate," KDADS explained. In this case, you would "put dashes in the rehab end dates."

Question 2: *The resident was admitted with an unstageable pressure ulcer on his right hip. Three weeks later, staff debrided and reclassified it as a Stage 4 pressure ulcer. We listed the pressure ulcer as unstageable on the initial MDS assessment. On the current assessment, should we code the pressure ulcer as worsened?*

Answer 2: No, you would not consider this pressure ulcer as new or worsened, according to a recent training presentation for **Mountain-Pacific Quality Health** by **Jen Pettis, BS, RN, WCC** with **Abt Associates**. You'll

(Continued on next page)

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number ☐	**A. Stage 2**
Enter Number ☐	**B. Stage 3**
Enter Number ☐	**C. Stage 4**

	Pulmonary
☐	**I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
☐	**I6300. Respiratory Failure**

code the pressure ulcer in item M0300D — *Stage 4 Pressure Ulcers*.

But you will not code this pressure ulcer in item M0800 — *Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/ Entry or Reentry*.

Because this is the first time you've been able to stage the pressure ulcer, and the resident entered the facility with an unstageable existing pressure ulcer, the ulcer wouldn't be considered new or worsening, Pettis explained. In other words, if a pressure ulcer is unstageable on admission and then becomes stageable, it's not considered new or worsened unless it subsequently increases in stage.

Question 3: *If a resident has a diagnosis of COPD but the physician says it's stable (no meds or treatment given during the lookback period), would this be considered an active diagnosis?*

Answer 3: To code a diagnosis as active in Section I — *Active Diagnoses in the Last 7 Days*, "you need that diagnosis from the physician in the last 60 days," KDADS said. But in the seven-day lookback period, you also need "documented symptoms, abnormal lab or x-ray results, treatment or meds for the condition, or increased nursing monitoring."

"If you don't have some of these you cannot code it" for item I6200 — *Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease*, KDADS instructed. For more information, refer to the RAI Manual, pages I-7 and I-8.

Question 4: *One of our residents was in the facility for only a short time. While with us, she required a variety of help for toileting: supervision twice, limited assistance twice, and extensive assistance twice. What should I code for self-performance for toilet use?*

Answer 4: For Column 1 (Self-Performance) in item G0110I1 — *Toilet use*, you should code this situation as 2 — *Limited assistance*, according to Pettis. Here, you would apply the third part of the "Rule of 3," because the resident didn't have any particular level of assistance happen at least three times.

The third Rule of 3 states that if you have a combination of full staff performance, weight-bearing assistance and/or non-weight-bearing assistance, you should code limited assistance.

Tip: To reach this answer, you may want to use the ADL Self-Performance Algorithm on page G-8 of the RAI Manual for some help, Pettis suggested. When you have coding scenarios where the ADL happens three or more times, you probably don't need much help if you're following the Rule of 3. But the algorithm can help you figure out the correct coding for these types of less clear-cut coding scenarios.

Question 5: *I'm a new MDS Coordinator at a nursing home, and I've noticed lots of different reports in CASPER. Which reports do I need to look at and which ones can I ignore, if any?*

Answer 5: If you look under the Reports category in CASPER, you'll see the subcategory "MDS 3.0 NH Provider," which lists certain reports that you should periodically order and review, according to the **Oklahoma State Department of Health** (ODH) Quality Improvement & Evaluation Service. Reviewing the reports will help you to improve your accuracy for your quality measure (QM) reports.

These reports include:

- **MDS 3.0 Activity Report** (lists all assessments submitted during a given timeframe that you can define);
- **Missing OBRA Report** (lists all OBRA assessments that had no activity for more than 138 days);
- **MDS 3.0 Roster Report** (lists all residents in your facility that are appearing as active residents); and
- **Error Summary by facility** (lists the percentage of errors by type and percentage of assessments received with each error message). ❑

We Want to Hear From You

Tell us what you think about *MDS Alert*.

• What do you like?
• What topics would you like to see us cover?
• What can we improve on?

We'd love to hear from you.

Please email **Sarah Terry** at **sarahterrync@yahoo.com**.

Thank you in advance for your input!

Industry News to Use

Pay Attention To 3 New PBJ Policy Manual Updates

Plus: What to do if you get a SNF QRP noncompliance notification.

Before even the start of mandatory reporting of electronic staffing data in the Payroll-Based Journal (PBJ) system, which begins on July 1, there are already changes to the Policy Manual that you need to know about.

On March 16, the **Centers for Medicare & Medicaid Services** (CMS) released the updated PBJ Policy Manual V2 to reflect changes to the submission guidelines, which are redlined in the text. And on March 18, CMS issued a Survey & Certification (S&C) memo reminding long-term care (LTC) facilities that the voluntary submission period will end on June 30, and the mandatory submission period will begin the next day. The memo also restates instructions on how to register and where to find instructions for submitting data to the PBJ system.

Don't panic: The changes to the PBJ Manual are not extensive, according to Washington, D.C.-based **Leading Age**. The changes mainly involve clarifications on:

1. How PBJ requirements don't apply to swing-beds;

2. How to submit for staff who split their primary duties; and

3. Who you should report under Administration Services.

The first clarification notes that only LTC facilities that are subject to meeting the Requirements for Participation in 42 CFR Part 483, Subpart B are subject to the PBJ reporting requirements. This requirement doesn't apply to swing-beds.

The second change clarifies that in certain cases, facilities can change the designated job title and report, for example, four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). You may need to do this if you have staff that completely shift their primary roles in a given day — such as if a nurse spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse.

Finally, CMS updated the "Description of Services" for Administrative Services (Labor Category Code 1), Administrator (Job Title Code 1) to read: "Administrative staff responsible for facility management as required under 483.75(d) such as the administrator and the assistant administrator."

CMS also renamed the Labor Category Code 2 labor description as "Physician Services."

Links: You can access the updated PBJ Policy Manual in the "Downloads" section at the bottom of the webpage at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html. Also, the S&C: 16-13-NH memo is available at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-13.pdf.

In Other News …

SNFs: How To Submit A Reconsideration Request For QRP Noncompliance

If you don't comply with the new Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) requirements, you could suffer a 2-percentage-point reduction in your annual payment update (APU). But you do have a potential remedy to save your facility from a pay cut.

On March 24, the **Centers for Medicare & Medicaid Services** (CMS) announced the SNF QRP Reconsideration and Appeals Procedures for the fiscal year (FY) 2018 Payment Determination. CMS finalized the FY 2016 SNF QRP requirements in the Prospective Payment System (PPS) Final Rule (42 FR Part 483).

Background: To comply with the SNF QRP requirements, you must collect MDS data on the following quality measures (from Oct. 1, 2016 through Dec. 31, 2016) and submit that data by May 15, 2017:

- Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF #0678);
- Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay (NQF #0674); and

(Continued on next page)

» Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631).

If CMS finds you in noncompliance with the SNF QRP requirements, you'll receive a notification letter along with instructions for requesting a reconsideration of the compliance decision. You can file for reconsideration if you believe the noncompliance finding is wrong or if you have evidence of extraordinary circumstances that prevented timely submission of data.

What to do: You must submit the request for reconsideration to CMS within a 30-day deadline, and the only way you can submit the request is via email — to the SNF Exception and Extension mailbox at SNFQRPReconsiderations@cms.hhs.gov.

You must make the subject of the email "SNF QRP Exception or Extension Request," and your email must include the following information:

» SNF CMS Certification Number (CCN);
» SNF name;
» CEO or CEO-designated personnel contact information including name, telephone number, email address, and mailing address (the address must be a physical address, not a post office box);
» SNF's reason for requesting an exception or extension;
» Evidence of the impact of extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
» A date when you believe you'll be able to again submit SNF QRP data and a justification for the proposed date.

If you're requesting reconsideration, you should submit other documentation including:

» Proof of submission;
» Email communications;
» Data submission reports from the Quality Improvement Evaluation System (QIES);
» Data submission reports from the National Healthcare Safety Network (NHSN);
» Proof of approved exception or extension for the reporting timeframe; and
» Copy of the CCN activation letter.

Mistake: Don't include protected health information (PHI) or other HIPAA violations in the documentation that you're submitting to CMS for review. For future updates, visit the "SNF Quality Reporting Reconsideration and Exception & Extension" webpage at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-QR-Reconsideration-and-ExceptionExtension.html. ❑