Long-Term Care Survey Alert

What Do You Think?

Question: Should a Facility Code Pain Education as a Non-pharmacological Pain Remedy on the MDS 3.0 at J0100C?

Answer: "The RAI manual does not include education as a non-pharmacological remedy for Section J," says **Sherri Robbins, RN,** supervising consultant for BKD LLC in Springfield, Mo. Thus "my answer would be no." Education about pain "may be a part of the skilled nursing care provided to the patient during a Medicare Part A covered stay and would certainly need to be addressed in the care plan."

Marty Pachciarz, RN, RAC-CT, says she "leans toward not coding" education at J0100C, because it's not identified by the RAI manual as a scheduled and implemented intervention. "The result of the education, hopefully, includes treatment options which are nonpharmacological pain management and then that could be coded," adds Pachciarz, director of clinical services for the Polaris Group in Tampa, Fla.

Jennifer Pettis, RN, WCC, RAC-MT, and **Elisa Bovee, MS, OTR/L,** say they don't believe education really meets the definition of non-pharmacological interventions for coding J0100C. "But approaches such as teaching relaxation, guided imagery, breathing techniques, distraction etc., can be coded as such in J0100," says Bovee. (Pettis and Bovee are consultants with Harmony Healthcare International in Topsfield, Mass.)

MDS, Compliance & Research News

Beware: A subscription electronic referral system for post-acute providers didn't fly with the OIG. An OIG advisory opinion targets a scenario where a company charges hospitals and post-acute providers for "an online referral service ... whereby post-acute care providers would pay a fee to electronically receive and respond to referral requests from hospitals for postdischarge care."

In the particular case considered by the OIG, the software company is currently charging hospitals for the software, and plans to start charging the postacute providers. The company says it would fax requests to non-paying providers, even though it would be cheaper to electronically transmit them.

The OIG notes that "Under the Proposed Arrangement, Providers would pay the Requestor in return for the opportunity to use the System to electronically receive and respond to hospital referral requests for post-acute care services," including those covered by the federal health care program. This would "implicate the antikickback statute," warns the OIG, "because the Requestor would be soliciting and accepting, and Providers would be paying, remuneration in return for the Requestor's arranging" to furnish post-acute care paid by a federal health care program.

Also: The proposed arrangement providers "would be required to pay fees they cannot afford for services they require to remain competitive, or risk substantial loss of business," the OIG says. "This pressure could create incentives to, among other things, prolong patient stays, provide separately billable, unnecessary services, or upcode resident Resource Utilization Group assignments -- all of which could result in increased costs to the Federal health care programs."

Implications: The advisory opinion provides "a clear signal to nursing homes and other providers that they be should be wary of consultant/companies who promise quick or easy ways to increase your census," says **Neville Bilimoria,** with the Chicago office of Duane Morris LLP.

Bilimoria notes that the opinion states that the arrangement "fails to satisfy several of the safe harbor's requirements, including the requirement that referral fees be assessed uniformly against all participants and be based only on the cost of operating the referral service" (page 4 of the opinion).

"Long-term care providers should stay away from arrangements that offer, for example, 'tiered' participation, where

there are different levels of access to the service based on the amount of compensation paid," advises attorney **Wayne Miller**, with Compliance Law Group in Los Angeles.

Also: If a facility is going to use such a service, it "may want to demand that the service provide an opinion from qualified legal counsel confirming that the service meets the referral service safe harbor and its operation can be distinguished from the arrangement described in the [OIG] opinion," Miller adds.

Editor's note: Read the opinion at http://oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-06.pdf.

Make sure you're aware of these two new MDS developments. One is the June RAI User's Manual revisions, which are now in effect. Among other changes, the update clarified that to qualify for isolation coded on the MDS, a resident must have an "active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission," states the manual. The resident must require and receive "transmission-based precautions (contact, droplet, and/or airborne)," be alone in a room without a roommate -- and remain there. "This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.)."

The manual goes on to note: "If a facility transports a resident who meets the criteria for strict isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.), which the facility does not or cannot provide, theyshould follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for strict isolation since it is still being maintained while the resident is in the facility."

Also: Read the CMS memo, "Completing the MDS 3.0 Assessment: Potential Impact to Beneficiaries and Nursing Facilities." The document instructs that "for the BIMS, PHQ-9 and Pain interviews, if the resident is discharged unexpectedly and the resident interview has not yet been completed, the staff assessment should be completed if appropriate clinical record information is available. In this case the gateway questions, C0100, D0100 and/or J0200 should be coded No (0) and the staff assessment should be completed."

The document also notes that "future manual updates will provide more detailed guidance and training to appropriately code clinical items to accurately reflect care provided. In the meantime, we stress to all providers that the assessments must be fully completed with all available information at the time of assessment."

You can download the revised RAI User's Manual, change tables, and the memo on dashes at www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.

Check out a new study on cranberry juice and UTI. The study by **Terri Camesano, PhD,** professor of chemical engineering at Worcester Polytech Institute, and colleagues found that cranberry juice cocktail can "inhibit the formation of biofilm by uropathogenic Escherichia coli," according to a study abstract (http://www.ncbi.nlm.nih.gov/pubmed/21480803).

"What's really interesting about cranberry is that it doesn't kill bacteria," Camesano told Eli in an interview. Instead, the juice prevents bacteria from "latching onto the bladder or kidney cells." And the bacteria can't become resistant to the cranberry juice as it does to antibiotics, she adds.

"The effect of cranberry juice in preventing UTI is fairly well accepted at least for UTIs caused by E. coli," says geriatrician **David Dosa, MD,** at Brown University.

"Should we put everyone at risk of UTI on cranberry juice? I don't think there are any guidelines that suggest that," Dosa tells Eli.

Nursing home medical director Charles Crecelius, MD, PhD, says cranberry juice can be used for recurrent UTI, although he usually prescribes cranberry extract for that purpose. "Forcing people to drink cranberry juice when they have an inflamed bladder can be painful," he says. To prevent recurrent UTI, "you can use agents that acidify the urine, such as methanamine," he adds.

Warning: Patients taking warfarin should "avoid cranberry supplements and limit intake of cranberry juice as this can

inhibit warfarin metabolism and increase the risk of bleeding," advises **Albert Barber, PharmD,** in Stow, Ohio.

More: Camesano notes that cranberries have also "shown some activity in preventing aggregation of oral bacterial in the mouth -- so sometimes you see mouthwash with cranberry or cranberry coated dental floss."

Next: "We are starting to look at the effects of cranberry on beneficial health bacteria in your gut to see if cranberry could enhance the population of healthy bacteria," Camesano says.