MDS Alert

MDS Management: Home In On These 3 Problem Areas of the MDS 3.0

Clarity of Section O instructions for coding isolation is on the list.

Facilities and residents are expressing concerns about what they view as a few MDS 3.0 trouble spots, including how to code isolation, a qualifier for Extensive Services and Rehab plus Extensive Services.

Problem: "Coding isolation in terms of whether the person comes out of the room is a gray area in that I don't think the RAI User's Manual instructions make that clear to providers," says **Sandra Fitzler, RN, BSN,** senior director of clinical services for the American Health Care Association.

"Until CMS comes out with further clarification, the big issue we are hearing" is that for residents to qualify for isolation coded on the MDS, they can't come out of their rooms, says **Ron Orth, RN, NHA, CPC, RAC-CT,** president of Reimbursement Solutions in Milwaukee, Wis.

Orth thus believes that a facility's documentation needs to "strongly support that the resident did not leave the room, if that's what CMS comes out and says," he relays. Orth notes that he's heard CMS is going to clarify the issue. Nursing facility staff should also document why the resident is on isolation, he adds.

CMS hasn't issued any changes to the manual instructions for coding isolation at O0100M (see page 27 of this issue).

Joan Brundick, BSN, RN, state RAI coordinator for Missouri reports, however, that she received the following information from CMS when she requested clarification on coding isolation/quarantine in item O0100M.

The isolation/quarantine item O0100M can only be coded when the following criteria are met:

1. Resident has active contagious disease

2. Resident has precautions assigned over and above standard precautions

3. Resident is under strict isolation/quarantine -- cannot come out of the room

4. Resident is alone in a room (does not have to be a private room)

Reverse isolation does not meet the above criteria.

In the STRIVE (Staff Time and Resource Intensity Verification) study, researchers found that individuals who met the above criteria required more support from staff to care for them, reports **Teresa Mota, RN, CALA, RAC-CT,** senior program coordinator for QIO Quality Partners of Rhode Island. "And CMS wanted to be able to reimburse the facility for the additional cost for these residents."

A major cost related to isolation involves the fact that "regardless of whether the facility has a private room or a semi-private one, a patient must be in a room by himself," says **Patricia Newberry,** executive director of clinical reimbursement for United Clinical Services-UHS-Pruitt, in Atlanta, Ga. "So facilities with semi-private rooms have two beds tied up when they put a patient in isolation."

Facility Takes the High Road on Isolation Pending CMS Clarification

United Clinical Services-UHS-Pruitt is interpreting the RAI User's Manual as "patients having to be on strict isolation 'in an attempt to prevent the spread of illness,'" which is what the manual says, explains Newberry. And based on the

organization's interpretation, patients who require that level of isolation can't come out of their room and must receive therapy there. Thus, the MDS shouldn't include any concurrent or group therapy until the person is off isolation, she adds.

What gets "tricky," however, is the 14-day lookback period for isolation coupled with a seven-day lookback for therapy, says Newberry. "If you have a patient who has been on isolation and has come off it -- and you then start therapy with a seven-day look back -- it's possible for the MDS to have group or concurrent minutes coded as well as isolation," she says. And it's possible for the resident to go into a Rehab plus Extensive Services RUG category.

"You can cohort people with Clostridium difficile who don't come out of the room even though staff suit up and give therapy in the room," adds Newberry. "But you can't code the person as being on isolation."

That's one thing Newberry monitors: "I watch for Rehab plus Extensive and Extensive Services to make sure the patients in that category are ones with trachs or vents, or if they are coded as being on isolation -- it's truly strict isolation." Of course, if CMS further clarifies coding for isolation, "we will change our process," says Newberry.

Problem #2: Frequent Mood Interviews Putting Some Residents in a Bad Mood

Fitzler has heard complaints about the Section D mood interview (PHQ-9) from patients who say they don't like to answer the same questions so frequently. "A typical short-stay patient will have a 5-day, 14-day, and 30-day MDS with the same questions sometimes being asked within a span of five days," she says.

Strategy: Using the right approach could help ease residents' sense of frustration with repeated interviews, says **David Gifford, MD, MPH,** director of the Rhode Island Department of Health. "If I had someone come in whom I didn't know very well who repeatedly read me questions, I'd view it as a burden too." Instead, you might frame the interview in a way where you explain the purpose behind asking the questions and "incorporate the interview into a visit with the resident," says Gifford.

He advises facilities against viewing the MDS "as a separate data collection tool with a set process for doing it where someone comes in and asks all the questions." In his view, a better approach is to have people caring for the residents all the time collect a lot of the information.

Problem #3: Section Q Quandaries

"Section Q is another problematic section," says Fitzler, in that nursing home staff members don't always understand who is responsible for follow-up.

F-tag trap: "The state may say they will streamline the process and contact and take over for patients who are discharged to the community," Fitzler continues. "But the facility is actually required to have a care plan for discharge." And even if the state surveyors say it's OK for the local contact agency to take over that function, federal surveyors in a lookback survey may not agree, she cautions.

"People are also concerned when they try to reach the local contact agency and continue to get recordings with no-one getting back to them," adds Fitzler. "They worry about how to prove they left a message."

If facilities can't get the local contact agency to respond, they "should contact their state's Point of Contact (POC), who is supposed to help coordinate the nursing home referrals and the LCA," advises **Iara Woody, RN,** health policy associate for the LeadingAge (formerly the American Association of Homes & Services for the Aging). The POC list is available at www.aahsa.org/MDS3.0_SectionQ. "If this doesn't work, nursing homes can contact CMS via e-mail directly."

Resource: See the tool for tracking community referrals on page 34 of this issue.