MDS Alert

RAI Manual: Pay Attention To These Major RAI Manual Changes

CMS changes maximum resident scores for D0300.

Effective May 20, the **Centers for Medicare & Medicaid Services** (CMS) makes many minor and a few significant changes to the MDS 3.0 RAI Manual. Perhaps the most substantial revisions occur in Section M, but you need to stay up on various changes in other key sections, too. Here's a run-down of manual changes that will alter the way you code.

Heed Important Changes to Sections C & D

First, the updated manual adds some language to Section C0100, page C-1:

"Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.

Additionally, the update adds a bullet point to C0100, page C-2, Coding Tips: "Includes residents who use American Sign Language (ASL)."

In Section D0300, page D-9, the update makes the following change: The maximum resident score is 27 (3 x 9). So, D0300, page D-9, is now 20-27 severe depression, and page D-15 is 20-30 severe depression.

Period Expands from 5 to 7 Days in Section E Items

The update changes the following wording to Section E0600, page E-16:

"3. A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 out of the past 7 days..."

And the update makes similar changes in Section E1100, page E-22:

"1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting into a dangerous place. On the current assessment, the resident was found to wander on 2 of the last 7 days..."

Sections H, K& L: Clarifications, Wording Changes & More

The update changes the wording of H0200, page H-4: "The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility."

Section K0300, page K-4, contains the following changes:

- At a point closest to 30 days preceding the current weight.
- At a point closest to 180 days preceding the current weight.

Section K0300, page K-5, as well as Section K0310, page K-9, contain these changes:

"1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago."
"2. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago."

Section K0310, page K-8, makes the similar change to Steps for Assessment: "This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:"

And in K0700, page K-16, the update changes the coding instruction from K0500b to K0700b.

In Section L0200, page L-3, the manual adds the following language: "Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met."

Get Ready for Many Big Changes to Section M

In Section M0210, page M-5, the update adds the following bullet point to the Coding Tips block:

- "Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made."

Section M0210, page M-5, also adds these bullet points:

- "If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900)."
- "If a pressure ulcer healed during the look-back period, and was not present on prior assessments, code 0."

Section M0300, page M-6, contains the following language changes in Step 1...:

1. "Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved."
2. "Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see step 2 below.) Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item."
   Section M0300, page M-6, also makes several changes to Step 2..., including removing the following sentence:
3. "However, if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured, do not code as unstageable."

   The update then revises the following in this same block:

   2. "Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg."

3. "If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable."

Gain Better Understanding of Pressure Ulcer Staging

Section M0300, page M-9, adds the following bullet point to Planning for Care:

- "If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed."

The update added this bullet point in Section M0300, page M-15, under Coding Tips:

- "Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4."

The following revision occurred in Section M0800, page M-25, under Planning for Care:

- "The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen."

Understand Changes to Worsening Pressure Ulcers

CMS made the following changes and additions to M0800, page M-26, in the Coding Tips block:

"If a numerically staged pressure ulcer increases in numerical staging it is considered worsened."

"Coding worsening of unstageable pressure ulcers:

- "If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage after the assessment, it should be considered worsened."
- "If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and the wound restaged, the determination of worsening can be made."
- "If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened."
- "If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened."
- "If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is not included or coded in this item."

How You Should Now Code Healing Ulcers

The update also makes significant revisions to an item in M0900, page M-29:

- "Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2,

and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care."

Just below this section, in Steps for Assessment, the update adds the following:

- "Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030."

CMS clarifies the instructions under Coding Tips for M1040E Surgical Wounds, page M-34:

- "Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer."

Then in M1040, page M-35, under M1040: Other Ulcers, Wounds and Skin Problems (cont.), CMS makes the following language changes:

- "Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound."

Gain Better Understanding of MASD

And on the same page, under M1040H Moisture Associated Skin Damage (MASD):

- "Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown."

Note: The update also adds five new examples in Section M1040, on pages M-35 and M-36.

In Section M1200, page M-39, CMS revises bullet points beneath M1200F Surgical Wound Care:

- "Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in M1200E, Pressure Ulcer Care. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- "Surgical wound care may include any intervention...."
- "Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound."

Get Clarification on Dashes in Section X

In Section X0300, page X-3, CMS changes the following bullet point:

- "Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record."

Link: To view the revised MDS 3.0 RAI Manual v1.10, visit www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Scroll down to the Downloads section on the web page.

Stay tuned: Keep an eye out for more analysis, advice and tips on these RAI Manual changes in future issues of MDS Alert.